



Recommendations to improve uptake of multidisciplinary cancer care in Australia

NATIONAL BREAST AND OVARIAN CANCER CENTRE

Recommendations cont.

Multidisciplinary team level

11 Patient consent: Multidisciplinary teams (in conjunction with health services) should implement processes to ensure that all cancer patients are informed when their case is to be discussed by an MDT. All teams should aim to obtain informed patient consent to discuss cases at team meetings. All teams should aim to provide patients with written information about the members of their team, what and how information is shared between team members, and the treatment planning process.

12 Communication with GPs and continuity of care: Teams need to implement systems to ensure that communication with GPs on treatment plans is timely and adequate, given that coordination of care between hospital and community sectors is essential for good patient care. GPs are ideally placed to assist in providing continuity of care.

13 Recording of treatment plans: Multidisciplinary teams should develop processes for ensuring that the outcomes of MDT planning meetings are routinely recorded in patients' notes.

14 Involvement of the patient in treatment planning: The treating clinician should discuss the recommendations of the MDT planning meeting with the patient and use effective communication techniques to ensure that patients understand their options and have as much input into their treatment plan as they wish. MDC teams should implement processes to ensure that there is an agreed approach to dealing with and recording changes to the treatment plan following discussion with the patient.

References

1. Cancer Institute NSW. NSW cancer plan 2007–2010. 2006 Cancer Institute NSW, Sydney.
2. WA Health Services Taskforce. WA health cancer services framework. 2006 Department of Health, Perth.
3. Collaboration of Cancer Outcome Research and Evaluation. Cancer services framework highlights report. 2003 Department of Human Services, Melbourne.
4. The Cancer Council South Australia and South Australian Department of Health. Statewide cancer control plan 2006–2009. 2006 Government of South Australia, Adelaide.
5. Zorbas H, Barraclough B, Rainbird K, Luxford K, Redman S. Multidisciplinary care for women with breast cancer in the Australian context: What does it mean? Medical Journal of Australia 2003; 179(10): 528–531.
6. National Breast Cancer Centre. Multidisciplinary meetings for cancer care: a guide for health service providers. 2005 National Breast Cancer Centre, Camperdown NSW.

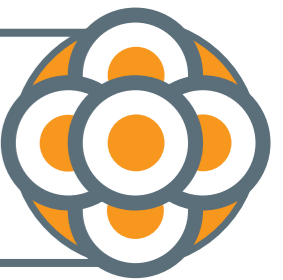
© National Breast and Ovarian Cancer Centre 2008
Locked Bag 3 Strawberry Hills NSW 2012 Australia
Suite 103, 355 Crown Street, Surry Hills, NSW, 2010
Telephone: +61 2 9357 9400 Fax: +61 2 9357 9477
Website: www.nboocc.org.au
Email: directorate@nboocc.org.au

This work is copyright. Apart from any use as permitted under the Copyright Act 1968, no part may be reproduced by any process without prior written permission from National Breast and Ovarian Cancer Centre. Requests and enquiries concerning reproduction and rights should be addressed to the Public Affairs Manager, National Breast and Ovarian Cancer Centre, Locked Bag 3 Strawberry Hills NSW 2012 Australia.

National Breast and Ovarian Cancer Centre is funded by the Australian Government Department of Health and Ageing.



Multidisciplinary Cancer Care in Australia



NATIONAL BREAST AND OVARIAN CANCER CENTRE

National audit investigating the implementation of multidisciplinary cancer care in Australia

Multidisciplinary care (MDC) is recognised as best practice in treatment planning and care for patients with cancer.^{1–4} National Breast Cancer Centre (now National Breast and Ovarian Cancer Centre, NBOCC) developed the Principles of Multidisciplinary Care⁵ to provide a flexible framework for implementation of MDC in Australia (see box 1).

New Medicare Benefits Schedule (MBS) item numbers to support attendance by specialists at multidisciplinary treatment planning meetings were introduced on 1 November 2006. Prior to the introduction of the MBS items, NBOCC conducted a national audit to investigate the implementation of MDC across five cancer types: breast, colorectal, gynaecological, lung and prostate.

The aims of the national audit were to:

- investigate the implementation of MDC across a range of cancer types and service delivery settings
- provide information about the level of MDC before the introduction of the new MBS items against which any impact of the introduction can be measured
- identify areas where MDC needs to be further developed and supported.

The summary report and full report are available at www.nboocc.org.au

BOX 1:

The Principles of Multidisciplinary Care:⁵

- a **team approach**, involving core disciplines integral to the provision of good care, 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 accord with **nationally agreed standards**
- **involvement of patients** in decisions about their care.

Methodology

A multidisciplinary steering committee was established at the outset of the audit to oversee and provide expert advice on the methodology and final report.

A sampling plan was developed to select a representative sample of hospitals that would give a national picture of MDC activity across Australia. Hospitals were stratified by state, location (metropolitan or regional) and type (public or private).

Collaboration with state-based cancer organisations in NSW and Victoria led to different methodological approaches in these two states. This resulted in three samples (a NSW sample, a Victorian sample and a sample of the remaining states and territories coordinated by NBOCC), which were analysed separately.

A survey tool was developed, and representatives from hospitals treating one or more of the five cancer types completed the survey via telephone, online or by fax. All data were entered and analysed with cancer type as the main variable. Further bivariate analyses were undertaken using hospital, location and type. Following analysis of the results, recommendations to improve the uptake and implementation of MDC in Australia were developed.

Key results

Despite methodological differences between the three samples (NSW sample, Victorian sample and NBOCC sample), the responses showed similarities, suggesting that regardless of methodological approach, jurisdiction or health service, there are areas of congruence across Australia in the implementation of MDC for cancer treatment planning.

Randomly sampled hospitals were invited to participate in the audit. Surveys providing information on MDC meetings across 5 cancer types, were received from 123 hospitals in the NBOCC sample (520 surveys), 17 hospitals in NSW (49 surveys) and 15 hospitals in Victoria (42 surveys). Each survey provided information on one MDC meeting in one of the five cancer types: breast, colorectal, gynaecological, lung and prostate.

- 30% to 34% of respondents reported an MDC team for at least one of the five cancer types in the audit. Irrespective of cancer type or hospital setting, between 60% and 70% of respondents indicated they did not have multidisciplinary cancer teams in any of the five cancer types. More respondents from metropolitan hospitals reported an identified team than those from regional hospitals.
- Almost all MDC meetings held did not have the minimum core team members (core members are cancer specific) regularly attending MDT planning meetings.
- Fewer than half of all meetings were held weekly or fortnightly. Most meetings were held face-to-face, but between 10% and 30% used teleconferencing (mostly in regional areas).
- 77% to 85% of respondents reported that patients were informed that their case would be discussed by a MDT – however, formal consent was not always obtained in these cases and where it was obtained, in most cases verbal consent was sought.
- A treatment plan was not recorded in the patient notes for up to a quarter of cancer patients whose cases were discussed by MDC teams.
- Specialists were most frequently identified as the health professionals responsible for communicating the outcome of the MDT meeting to the patient.
- 33% to 78% of hospitals had links to palliative care, but most had no links to some key services. For example, links to psychology and psychiatry were not established in more than two-thirds of the NBOCC and Victorian samples (limited results were available in NSW). In addition, links to specific services (where relevant), such as stomal therapy, erectile dysfunction services, genetic counselling, lymphoedema services and plastic surgery, were not established in most meetings.
- Up to one third of meetings did not communicate treatment plans to GPs.
- There appears to be very wide variability in the approach to encouraging patient input into treatment plans.
- Many teams did not collect data systematically. Of those that did collect data, few had an organised system for review.
- The most commonly reported barriers to implementing MDC were time (lack of time, coordination of time), staffing resources, a small case load and funding.



NATIONAL BREAST
AND OVARIAN
CANCER CENTRE

Recommendations to improve uptake of multidisciplinary cancer care in Australia

Recommendations

Based on the results of the audit, recommendations to improve the uptake and implementation of MDC have been made.

Strategic and national levels

- Resourcing:** The adequate allocation of staff and time in order to implement MDC should be promoted in national and state cancer plans and frameworks as important factors to consider in workforce planning.
- Networks:** National, state and regional networks should be established and promoted for the exchange of knowledge and expertise between centres with larger and smaller case loads to support the implementation of MDC. A comprehensive strategy to support multidisciplinary care for cancer treatment planning in regional and country areas, including resources to support increased use of telemedicine, is required.
- Incentives:** Services and governments should determine appropriate incentives, such as funding, to specifically implement multidisciplinary cancer care.
- Education and promotion:** Further national education and promotion strategies regarding MDC should be developed. To target health services, education and promotion strategies at national and state levels should emphasise NBOCC's Principles of Multidisciplinary Care⁵, and specifically highlight the importance of:
 - core membership of the multidisciplinary team (cancer specific)
 - resource and workforce planning
 - links to the full therapeutic range of services
 - processes for MDT data collection and review
 - communication with GPs and continuity of care
 - patient consent
 - patient involvement in treatment planning.

5 Follow-up study: A further investigation of MDC after the introduction of the MBS items should be undertaken to compare uptake with the current audit findings.

Health services level

- Core team:** Core membership of the cancer-specific teams should be established and known. Although it may be difficult to ensure attendance by certain disciplines owing to workforce or resource impediments, time to attend MDC meetings should be factored into workforce planning. To increase full core team attendance, scheduling of meetings should take into account the timing of visiting specialists. Teleconferencing and videoconferencing facilities should be used to ensure that all core disciplines are represented at meetings, for example linking larger treating centres and clinicians located off-site.
- Regular meetings:** The importance of having regular, scheduled meetings should be promoted. NBOCC's Multidisciplinary Meetings for Cancer Care: A Guide for Health Service Providers⁶ provides practical tools and guidance on setting up regular MDC meetings.
- Links to the full range of services:** Health services need to review workforce availability and implement specific strategies to improve linkages with non-core specialities. All cancer services should ensure adequate links to the full range of general and cancer-specific services for all cancer patients.
- Data collection:** Health services should allocate resources to implementing data collection and reviewing systems to facilitate quality improvement and benchmarking.
- Professional development:** Health services should support and acknowledge the importance of training for cancer health professionals such as communication skills training to improve interactions with patients and within teams.