

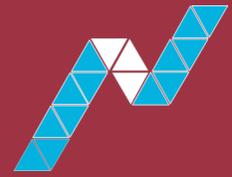
Head and Neck Cancers 2018 Summit Report



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VTSummit



What are summits?

Victorian Tumour Summits (VTS) are clinician-led forums to identify variations in cancer care and outcomes for statewide action.

Understanding the HN2018 Summit

Improving experiences and outcomes for patients with head and neck (H&N) cancers is particularly challenging.

H&N cancers are a non-homogenous group with variations in incidence, treatment modalities and survival according to subsite. The impact of the disease and treatments on quality of life for patients is significant in this tumour stream.

On 12th October 2018, H&N multidisciplinary team members from across Victoria gathered to review data on variations in care and identify opportunities for improvement in patient care experiences and outcomes.

Optimal care pathways snapshot

Optimal care pathways (OCPs) for cancer patients:

- describe the expected standard of care by the major tumour types
- provide a template against which variations in care can be assessed and understood
- are endorsed for implementation nationally.

Statewide tumour summits focus on assessing variation to help better understand the opportunities for improvements in care.

Who spoke at the summit?

Professor Robert Thomas¹ and Ms Kathryn Whitfield² presented on optimal care pathways and Victoria's Cancer Reform Program, respectively.

Mr Stephen Tudge, ENT Surgeon, Alfred Health and Co-chair, H&N Working Party, presented available data on incidence, treatment and survival for H&N cancers in Victoria to participants on the day.

Data were reviewed by the clinical working party prior to the summit. The working party selected seven variations* considered important for further prioritising by summit participants:

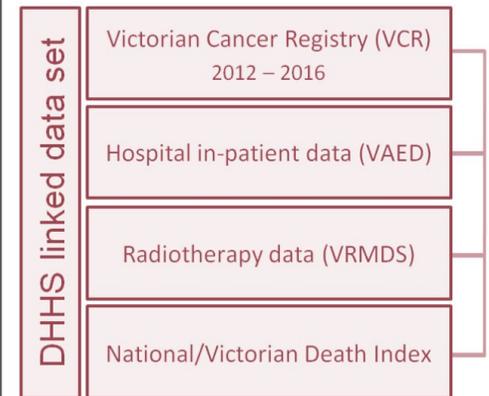
- Many centres provide treatment for less than ten patients per year (39 surgical, 12 radiotherapy).
- Many patients have treatment outside their ICS of residence.
- The proportion of patients with evidence of an MDM discussion of their treatment was lower in Barwon & South Western and Loddon Mallee ICS.
- Fewer regional patients treated locally (66%) start their radiotherapy within eight weeks of diagnosis than regional patients treated in metro (76%) and metro patients treated in metro centres (80%).
- Of all patients having adjuvant radiotherapy, only 37% started within six weeks of surgery, with lower rates in Barwon & South Western and Grampians ICS and in one metro and one regional centre.
- The proportion of patients receiving dietetic care may be lower in regional treatment centres.
- There was poorer survival for oropharyngeal and base of tongue cancer patients who were treated with radiotherapy only, compared to other treatment types.

* variations in data are indicative only.

About the data

Data presented at the HN2018 Summit included:

Linked data sources



and additional unlinked data sources:





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What happened next?

Participants worked in small groups to prioritise one to two variations for action. Prioritising proved a challenge as all seven variations were assessed as high impact on an impact/effort matrix. Two additional variations were also raised by participants:

- use of data from clinical sources
- increasing subspecialty input at remote MDMs.

Priorities for action

Further analysis of participants' feedback grouped variations into three themes:

- appropriateness of care
- timeliness of care
- data.

A number of the variations were concerned with **appropriateness of care**:

- Many centres provide treatment for less than ten patients per year (39 surgical, 12 radiotherapy).
- Many patients have treatment outside of their ICS of residence.
- The proportion of patients receiving dietetic care may be lower in regional treatment centres.
- There is poorer survival for oropharyngeal and base of tongue cancer patients who were treated with radiotherapy only, compared to other treatment types.
- Remote MDMs may not have required subspecialty input.

By definition, appropriate care is based on evidence to ensure that the right thing is done to the right person at the right time³. Appropriate care is provided by multidisciplinary teams that bring together the mix of skills needed to provide best practice care to meet consumers' physical, emotional and supportive care⁴.

Participants indicated the need for H&N cancers patients to have:

- treatment as close to home as is safe
- treatment planned by a multidisciplinary team made up of the core disciplines as outlined in the Optimal Care Pathway
- a dietetic and speech pathology review before treatment for early identification of nutrition, swallowing and communication issues
- information on what their local services can offer, costs of travel/ accommodation and care, and subsidies available to assist with access to best care.

If these needs are met, over time we should see:

- a reduction in the number of health services that provide treatment to ten or less H&N cancers patients per year
- all MDMs providing treatment planning for H&N cancers having core disciplines present and providing prospective treatment planning

- an increase in the proportion of patients receiving dietetic care in regional centres (future malnutrition point prevalence survey)
- ideally, patient experience data providing evidence of improvement in communications to patients as well as overall improvements to care.

It was recognised that not all centres can provide comprehensive high quality care to H&N cancers patients. Volume of service is an important indicator for quality care. Therefore, the need is strong for health care providers to partner with each other to provide integrated care.

What we can do to improve

- ✓ formalise referral links between centres
- ✓ utilise telehealth for allied health consultations
- ✓ use telehealth to achieve core membership at MDMs
- ✓ design and implement a patient information package
- ✓ establish surveillance protocols between metro and regional clinicians for appropriate transfer of care between health services
- ✓ agreement by multidisciplinary teams on criteria for PEG insertion.

3. Department of Health and Human Services, *Clinical excellence in cancer care: A model for safety and quality in Victorian cancer services*, Melbourne, VIC, Metropolitan Health and Aged Care Division, 2007

4. Department of Health and Human Services, *Achieving best practice cancer care: a guide for implementing multidisciplinary care*, Melbourne, VIC, Victoria Government, 2011

Appropriateness of care ✓

Timeliness of care

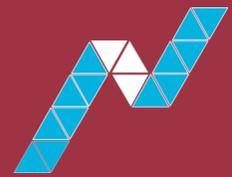
Data



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Priorities for action

Two variations were concerned with **timeliness of care**:

- Fewer regional patients treated locally (66%) start their radiotherapy within eight weeks of diagnosis than regional patients treated in metro centres (76%) and metro patients treated in metro centres (80%).
- Of all patients having adjuvant radiotherapy, only 37% started within six weeks of surgery, with lower rates in Barwon & South Western ICS, Grampians ICS and in one metro and one regional centre.

Participants shared that current referral pathways are convoluted and largely unmapped. There is a need to streamline and coordinate referral pathways to achieve timely care outlined in the optimal care pathway.

Evidence is strong that a six-week timeframe between last surgery and commencement of radiation therapy is a critical therapeutic window to ensure best outcomes (H&N cancers optimal care pathway).

We wish to thank all summit participants. Information you provided is used to inform the Optimal Care Pathways Implementation Program for Victoria.

What we can do to improve

- ✓ map current processes of care and identify gaps
- ✓ improve quality of referral information
- ✓ better communication from MDMs to referring doctor, health service and GP
- ✓ earlier access to dental and allied health services
- ✓ timely access to diagnostic results.

The **quality of the data** presented at the summit was a topical discussion on the day. Participants agreed that there is a need for supplementing existing data with clinical data. Clinicians are encouraged to undertake auditing of data against their own practice to identify opportunities for improvement.

Data flagged by the clinical working party as information clinicians would like to have available were:

- patient experience of care
- HPV status and cancer stage (a current data issue)
- concordance between MDM recommendation and treatment given
- ascertaining if lower volume centres have capability to manage complex patients.

Prevention

Although summits focus on the treatment planning and treatment stages of optimal care pathways, for H&N cancers there is an opportunity to collaborate with the Oral Cancer Screening & Prevention Program (Dental Health Services Victoria) on the optimal care pathway stage of prevention and early detection.



Consumer focus

With the lack of a H&N support group in Victoria for patients and their families, establishment of a peer support group through Cancer Council Victoria will be explored.



Visit <www.beyondfive.org.au> for useful information for clinicians and consumers.

Working with ICS

- ✓ Clinical teams are encouraged to collaborate with their ICS on investigating if priority variations are unwarranted
- ✓ Clinicians can request data related to their institution's performance via their ICS for clinical audits.

Appropriateness of care

Timeliness of care ✓

Data ✓

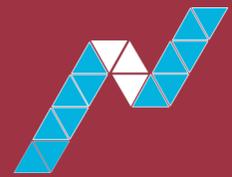
Head and Neck Cancers 2018 Summit Evaluation



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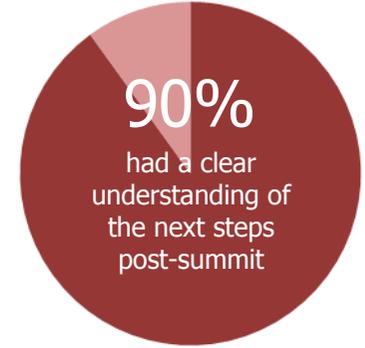
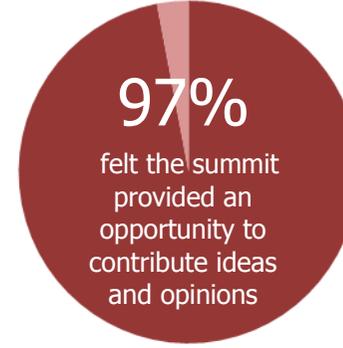
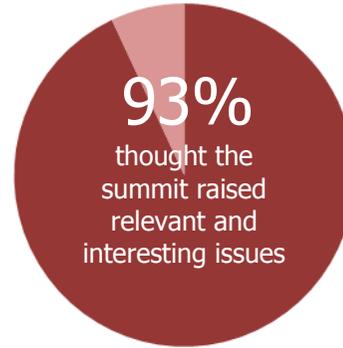
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101 participants attended

72 attendees completed the evaluation (71%)
and **RATED** the summit **9/10**

92% thought the summit provided a good summary
of the EVIDENCE and CONTEXT



Participants' ONE WORD description of the summit:

Important to consider patient's
FUNCTIONAL OUTCOMES

More time needed to brainstorm
'OTHER' VARIATIONS
in individual health organisations



The right people + facilitated discussion = actions & plans
= **CHANGE**



Great team work, collaboration and
insight by all

Have a question or wish to provide
feedback on this report?
contact (03) 9496 3322
<Claire.Porter@austin.org.au>