Brain Cancer 2020 Summit Summary Report

@vtsummit VTSummit Victorian Tumour Summits

Improving brain cancer care in Victoria

THE BRAIN CANCER 2020 Summit (BRAIN2020 Summit) was the first summit VTS has held for this tumour stream and the first online summit, due to COVID-19. The Summit presented statewide data and facilitated two sessions of small group work to plan local investigation and action from the Summit.

Survival and Incidence

Survival rates for glioblastoma vary numerically by Integrated Cancer Service, but not at a statistical level. However, this is low volume data and as such, not suitable for extrapolation. Survival rates for brain cancer have not improved in 30 years, and therefore the implementation of and adherence to evidence-based care is important for best outcomes.

Data linkage performed by the Centre for Victorian Data Linkage

DHHS linked data set

- Victorian Cancer Registry (VCR) 2008 – 2017
- Hospital admissions data (VAED) 2007 - 2018
- Radiotherapy course data (VRMDS) 2011 - 2018
- Emergency presentations (VEMD) 2007 - 2018
- Death Index (Victorian and National) 2008 - 2018

Unlinked data source

Cancer Services Performance Indicator (CSPI) medical record audit 2017

(2013-2017)

Median age of diagnoses is 62 years and 59% of diagnoses are male, with less chromosomal material possibly a factor. Incidence was evenly dispersed in the population, regardless of socioeconomic position. Charlson comorbidity index score was 61% with 0, 25% with 1, and 13% with 2 or more conditions.

Tumours were categorised by ICD-10-AM primary diagnosis into three main types: Glioblastoma, oligodendroglioma and astrocytoma, with the latter including anaplastic astrocytoma. Most patients were diagnosed based on histology following surgery and pathology review. A small number of cases did not go to biopsy.

The data

What's good about it?

- Reliable and can tell us about patterns of illness experience
- Includes IV chemotherapy, although this tends to be at relapse and in a minority of cases
- Data set straddles improved oligodendroglioma diagnosis, becoming less based on morphology
- Albury radiotherapy included in HRICS data.

What's not so good about it?

- Can be errors in hospital coding
- Does not identify consultations, particularly in the private setting. Does not include temozolomide treatment as cannot be linked with federal data on prescriptions
- Less robust oligodendroglioma diagnoses included in data might impact on analysing outcomes within tumour types, but with low volume data this would not be possible anyway
- Albury admissions not included in HRICS data.

Summit highlights

Victorian Tumour Summits are clinician-led forums to identify variations in cancer care and outcomes for statewide action. Steering committee chair Paul Mitchell spoke on the importance of consumer input into improving care and putting ideas from the Summit into practice by collaboration between clinicians, the ICS and the Department.

Ms Kathryn Whitfield, Director of Cancer and Aged Care - Commissioning, DHHS, drew attention to the new *Victorian cancer plan 2020–2024*. Summits contribute to the *plan*'s reform agenda by benchmarking statewide cancer care against the OCPs. Summit ideas for ongoing work should be ones that make a meaningful difference, and which can be monitored and measured: Video link

The areas determined by the BRAIN2020 Summit consumer panel to be of most importance for improvement were: Communication of brain cancer diagnoses, as well as communication and coordination of patients' treatment plans. Likewise, coordination of care between public/private and metro/regional health services was considered varied: Video link

Your Brain Tumor Pathway is a downloadable resource designed to be completed by the treating team or for clinicians to give to patients at diagnosis. *It's Okay to Ask* is a question prompt list available as a downloadable booklet. *Building the Bridge to Life with Brain Cancer* is a Victoria-specific survivorship resource.

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PROFESSOR ANDREW DANKS, working party co-chair, presented in the first online summit session. Important variations identified for discussion were:

1. There are a number of low-volume surgery campuses despite brain surgery being complex.
2. There is significant variation between campuses in length of stay for major surgery (ER and non-ER admissions).
3. There are variations in timeliness to radiotherapy. Is further investigation required and is there impact on experience of care?

PROFESSOR HUI GAN, working party co-chair, presented in the second online summit session. Important variations identified for discussion were:

6. More data on Grade 2 astrocytomas is needed to better understand the use of radical radiotherapy.
7. Access to early palliative care planning and utilisation of services 30 days prior to death may be areas for improvement.
8. There is variation in supportive care screening practice in public brain cancer services, although some screening may not be captured.

Consumers felt there was significant variation in:

4. communication of diagnosis and treatment planning.
5. coordination of care for patients with public/private and metro/regional service delivery.

WORKING PARTY

Vishal Boolell	Becky Chapman	Lawrence Cher	Jonathon Clark
Mike Dally	Andrew Danks	Rana Dhillon	Tony Dowling
Kate Drummond	Ronnie Frielich	Hui Gan	Martin Hunn
Craig Macleod	Paul Mitchell	Jenny Philip	Claire Phillips
Simone Reeves	Emma Reiterer	Ayesha Saqib	Mori Wada

VICTORIA State Government VICS VICTORIAN INTEGRATED CANCER SERVICES Cancer Council

Eight groups, based on the ICS regions, discussed variations identified from Summit data, and from consumer feedback and a stakeholder survey.

Key areas of focus across the groups were:

- timeliness to radiation for regional and rural patients
- communication at diagnosis and around treatment planning
- length of stay for regional and rural patients with a focus on coordination of care and referral pathways
- coordination of care and referral pathways
- access to immunohistochemistry (molecular diagnosis)
- access to palliative care
- access to neuropsychology and allied health services.

The common threads through the above areas were: Communication, referral pathways and care coordination. These were seen as areas of focus that impact outcomes and where improvements can be made. Suggested improvements include:

- streamlined referral processes by using electronic platforms ('axe the fax'), improved systems for transfer of patients from metro to regional services and identifying of trigger points, earlier referral to palliative care and referral to other allied health and support services
- better communication through consistent messaging and quality information, an appropriate level of expertise in staff delivering diagnoses, and through regional clinician participation in MDMs
- care coordination between services and sites (possibly with a regional care coordinator), grouping appointments (a 'one-stop shop' approach), better utilisation of resources (e.g. care coordinators).

Have a question?
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