MULTIDISCIPLINARY TEAMS IN
NSW CANCER CARE SERVICES:
2006 and 2008

Tumour Stream Report

April 2009
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Tumour stream specific characteristics of MDTs in NSW cancer services  

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TUMOUR STREAM SPECIFIC CHARACTERISTICS OF MDTS IN NSW CANCER SERVICES

This section reports on the characteristics of MDTs in NSW cancer services, for each tumour stream. The following information is presented in relation to each tumour stream:

- **Incidence** in NSW (2006 data extracted from the NSW Central Cancer Registry);

- Breakdown of all NSW MDTs by Area Health Service (population level data);

- Breakdown of all NSW MDTs by service type (population level data), with regard to three key variables:
  - metropolitan locations versus regional/rural locations, based on the ARIA+ classification;
  - public versus private sector; and
  - sites with access to radiotherapy facilities versus those without access.

- **Frequency** of meetings (based on the survey data);

- **Case types** or patients groups referred to the MDT (based on the survey data), the range of which may include:
  - all patients diagnosed with the relevant type of cancer;
  - suspected cases;
  - all newly diagnosed early cancer;
  - all newly diagnosed advanced cancer;
  - recurrent cases;
  - difficult cases;
  - screen detected cancers;
  - cases referred for a second opinion; or
  - no protocol (i.e., based on individual clinician's choice of which patients to refer);

- Points along the patient pathway at which patient management is discussed by MDTs (based on the survey data), the range of which may include:
- initial diagnosis and referral;
- determination of treatment;
- after surgery, but before other treatment;
- during treatment;
- at the time treatment is changed (e.g., relapse);
- at each hospital admission;
- follow-up care; or
- end of life care;

Team **composition** (based on the survey data) – that is, those disciplines that attend the MDT meetings on either a regular, occasional or patient-specific basis (excluding any disciplines noted as having referral links only); and

Types of **data or statistics** collected by MDTs (based on the survey data):

- Note that data collection by an MDT is important for the monitoring of team and service performance and to ascertain impact on patient outcomes.

To recap, significant differences over time are identified based on the finite population correction, and differences between each tumour stream and the overall NSW results are calculated using standard statistical significance testing.
5.1 Urological cancers

Urology is the field of medicine that focuses on the urinary tracts of males and females, and the reproductive system of males. The Urology MDT discusses patients with cancer of the kidneys, ureters, bladder, urethra, testes, prostate and penis.

Incidence of urological cancers

The four most common urological cancers are prostate, bladder, kidney and testicular cancer. There were 7,987 new cases diagnosed across these four cancers in 2006, and 1,643 deaths. The distribution of these cases between the four groups is presented below, in Figure 1.

Figure 1: 2006 incidence and mortality of urological cancers

Source: 2006 data extracted from the NSW Central Cancer Registry

Prostate cancer is the most common cancer overall, and is ranked first for cancer in males. From 1997 to 2006, incidence rates rose by 41.2%, while mortality rates fell by 19.7%.

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Urology MDTs in NSW by Area Health Service

As noted in Section 4.1.1, there were 15 Urology MDTs in the NSW population in 2008, which represents an increase of three MDTs since 2006. Figure 2 shows the number of Urology MDTs in each Area Health Service in 2006 versus 2008.

Figure 2: Number of Urology MDTs in NSW by AHS

As the above graph shows, NCAHS and SSWAHS had the largest number of Urology MDTs in 2008 (at three MDTs each). SESIAHS had two Urology MDTs, and HNEAHS, GSAHS, NSCCAHS and SWAHS each had one.

The three new Urology MDTs that were formed between 2006 and 2008 were spread between NCAHS (which had two new Urology MDTs) and HNEAHS (which formed its first Urology MDT).
Urology MDTs in NSW by service type

Figure 3 shows the number of Urology MDTs within each service type, in the NSW population.

In line with the trend for MDTs overall, the majority of Urology MDTs – 11 of the 15 in 2008, or 73% – were located in metropolitan areas. Twelve of the fifteen Urology MDTs were operating within the public system. At 80%, this is a slightly lower proportion than the proportion of MDTs overall that were operating within the public system (90%).

Urology MDTs were slightly more likely than the MDT population as a whole to be based at facilities with access to radiotherapy services, with only 20% being without radiotherapy access in 2008 (compared with 32% for all MDTs).

All three new MDTs in 2008 were public sector MDTs, two of which were in metropolitan areas, and two of which had access to radiotherapy services.
Frequency and duration of Urology MDT meetings

Figure 4 presents survey level data on the frequency with which Urology MDTs were meeting in 2006 versus 2008.

Three quarters of the Urology MDTs surveyed in 2008 were meeting once a fortnight. All remaining Urology MDTs were meeting once a month.

There were no significant changes in the frequency with which Urology MDTs reported meeting from 2006 to 2008. In 2008, there was also no significant difference in the frequency with which Urology MDTs met, compared to MDTs overall (i.e., across all tumour streams).

Based on the 2008 data, the average reported duration of Urology MDT meetings was 75 minutes. Three in four Urology MDTs surveyed indicated that, on average, they spent 5-9 minutes discussing each patient, whereas only 17% reported spending 10-14 minutes discussing each patient, and the remaining 8% reported spending four minutes or less discussing each patient.

Each MDT was also asked to consider all patients discussed at their MDT in the last 12 months, and to specify the proportion that was discussed once, twice, and three or more times. The average results across all Urology MDTs suggest that 83% of patients were discussed once, 11% discussed twice, and 6% discussed three or more times.
Case types referred to Urology MDTs

Figure 5 presents the various patient groups that can be referred to an MDT. It shows the proportion of Urology MDTs surveyed (in 2006 versus 2008) that have each of these patient groups referred to them.

In 2008, patients representing difficult cases were most likely to be referred to a Urology MDT, with 83% of Urology MDTs surveyed reporting this patient group was referred to them. Cases referred for a second opinion were the second most common patient group referred to Urology MDTs (42%).

From 2006 to 2008, there were statistically significant decreases in the proportion of Urology MDTs reporting that they were referred cases for a second opinion (100% to 42%), recurrent cases (83% to 33%), cases based on clinician choice (50% to 17%) and difficult cases (100% to 83%). There was also a significant increase in the proportion of Urology MDTs reporting that suspected cases were referred to their MDT (0% to 17%).

In 2008, the Urology MDTs surveyed were less likely than the population of MDTs surveyed as a whole to have ‘all patients diagnosed with the relevant type of cancer’ referred to them (25% versus 54%).
Points along patient pathway when patient management is discussed at Urology MDTs

The graph below shows the various points along the patient pathway at which patient management might be discussed by an MDT, and presents the proportion of Urology MDTs that were discussing patient management at each of these points (2006 and 2008).

Figure 6: Pathway stages at which patients are discussed at Urology MDTs (%)

Base: 2006 - n=6, 2008 – n=12

Ninety two percent of the Urology MDTs surveyed in 2008 reported discussing patient management at the stage of determination of treatment. The next most common stage at which it was discussed was the time treatment is changed (75% of surveyed MDTs).

From 2006 to 2008, there was a significant decrease in the proportion of Urology MDTs that reported discussing patient management at the time of diagnosis and referral (83% to 50%). No other significant changes were observed over time.

There were no differences in the points at which Urology MDTs, versus MDTs overall, tended to discuss patient management in 2008.
Composition of Urology MDTs

The core disciplines for a Urology MDT were adapted from the Victorian Patient Management Frameworks and include:

- Medical Oncologist
- Nurse
- Pathologist
- Radiation Oncologist
- Radiologist
- Urologist
- Social Worker

The graph overleaf shows all disciplines that were nominated as being involved in MDT meetings by at least one Urology MDT in either the 2006 or 2008 survey. For each discipline, it shows the proportion of Urology MDTs indicating that this discipline was involved with their MDT.
The graph shows that the most common disciplines involved with the Urology MDTs surveyed in 2008 were Medical Oncologists, Radiation Oncologists, Urologists and Nurse Coordinators. Pathologists were represented in three quarters of these MDTs, as were Nurses.

From 2006 to 2008, there was a significant decrease in the proportion of Urology MDTs indicating involvement of Radiologists (83% to 50%) and Nursing Trainees (17% to 0%). There was also an increase in Social Worker involvement (0% to 42%) and General Practitioner involvement (0% to 17%).

Unsurprisingly, compared to MDTs as a whole (i.e., all tumour streams), Urology MDTs were more likely to include a Urologist (92% versus 11%). There were no other differences between the composition of MDTs overall and Urology MDTs in 2008.
Data collection by Urology MDTs

The graph below shows the various types of data and statistics recorded by MDTs, along with the proportion of Urology MDTs that reported they recorded each one.

Figure 8: Data and statistics recorded by Urology MDTs (%)

Base: 2006 - n=6, 2008 – n=12

All Urology MDTs surveyed in 2008 indicated that they recorded at least some data. Team attendance at each meeting was the data most commonly reported as recorded, with all Urology MDTs surveyed indicating that their MDT recorded this. Treatment plans being recorded in patient notes, and data collected regarding the number of patients discussed at each meeting were also common (by 83% and 92% of Urology MDTs surveyed in 2008, respectively).

The proportion of Urology MDTs recording the number of patients discussed at each meeting by week, month or year increased significantly from 17% in 2006 to 67% in 2008. An increase was also seen in the proportion of Urology MDTs recording patient mortality and patient morbidity (both from 0% to 17%). There was also an increase in the proportion of Urology MDTs recording the team present at each meeting (83% to 100%).

There were no differences between Urology MDTs and MDTs overall in terms of the types of data recorded in 2008.
5.2 Breast cancers

Incidence of breast cancer

Breast cancer is the most common cancer in women, and occurs rarely in men. In 2006, there were 4,173 new cases of breast cancer, of which 37 were in males, and 945 total cancer deaths (including four in males). Breast cancer is equal with lung cancer as the most common cause of cancer death in women in NSW.

Overall, the five-year survival rate is 88%, on average, or 97% for those diagnosed with localised disease (e.g., where breast cancer is detected early). From 1997 to 2006, the incidence of breast cancer did not change significantly overall. However, mortality rates fell by 13.8%.

Breast Cancer MDTs in NSW by Area Health Service

In the 2008 study, there were 23 Breast MDTs in the NSW population, as noted in Section 4.1.1. This represents an increase of one MDT since 2006. The following chart provides a snapshot of all Breast MDTs in NSW in 2006 versus 2008, broken down by Area Health Service.

Figure 9: Number of Breast MDTs in NSW by AHS

Base: 2006 - n=22, 2008 – n=23 (including 4 private MDTs, not included in the chart above)

In 2008, SESI AHS and NCAHS each had four Breast MDTs, SSWAHS and SWAHS each had three Breast MDTs, NSCCAHS had two Breast MDTs and HNEAHS, GSAHS and GWAHS each had one.

The one new MDT that emerged between 2006 and 2008 was formed within NCAHS.
Breast MDTs in NSW by service type

The following graph shows the number of Breast MDTs by service type, in the NSW population.

Figure 10: Number of Breast MDTs in NSW by service type

Of the 23 Breast MDTs in NSW in 2008, 70% were located in metropolitan areas and 83% operated within the public sector. The comparable proportions for all MDTs in NSW (regardless of tumour stream) were 74% and 91% respectively.

Breast MDTs were more likely than the MDT population as a whole to have access to radiotherapy facilities in 2008 – 83% had radiotherapy facilities, compared with 69% across all MDTs.

The one new Breast MDT in 2008 was formed within the public sector and within a regional/rural area. This new MDT also had access to radiotherapy facilities.
Frequency and duration of Breast MDT meetings

Figure 11 shows the frequency with which Breast MDTs were meeting in 2006 versus 2008, based on the survey sample data.

Figure 11: Frequency of Breast cancer MDT meetings (%)

Of the 21 Breast MDTs that participated in the 2008 survey, just over half (57%) indicated that their MDT met once a week. A further 38% indicated that they met fortnightly. No MDTs were meeting less often than once a month.

The frequency with which Breast MDTs were meeting did not change significantly between 2006 and 2008. There were also no differences between Breast MDTs and MDTs overall in terms of the frequency of meetings in 2008.

Based on the 2008 data, the average reported duration of Breast MDT meetings was 63 minutes. Fifty seven percent of Breast MDTs surveyed indicated that, on average, they spent 5-9 minutes discussing each patient, whereas 29% reported spending 10-14 minutes discussing each patient, and the remaining 14% reported spending four minutes or less discussing each patient.

Each MDT was also asked to consider all patients discussed at their MDT in the last 12 months, and to specify the proportion that was discussed once, twice, and three or more times. The average results across all Breast MDTs suggest that 76% of patients were discussed once, 17% discussed twice, and 7% discussed three or more times.
Case types referred to Breast MDTs

Figure 12 presents the various patient groups that might be referred to an MDT, and the proportion of surveyed Breast MDTs having each of these patient groups referred to them.

Difficult cases were the patient group most often discussed by Breast MDTs in 2008, with 86% of the Breast MDTs surveyed indicating that such cases were referred to their MDT. Seventy six percent of Breast MDTs indicated that ‘all patients newly diagnosed with early cancer’ was the protocol for patients referred to their MDT.

Significant increases were observed from 2006 to 2008 in the proportions of Breast MDTs indicating they had been referred every type of case, except for recurrent cases. The largest increases were seen in the proportion reporting referral of all newly diagnosed early cancer cases (from 38% to 76%), and difficult cases (from 62% to 86%).

Breast MDTs in 2008 were more likely than MDTs overall (i.e., across all tumour streams) to discuss all newly diagnosed early cancer (76% versus 42%) and screen detected cancers (52% versus 24%), and less likely to discuss some ‘other’ types of cases (5% versus 21%). There were no other significant differences in case types discussed by Breast MDTs versus MDTs overall.
Points along the patient pathway when patient management is discussed at the Breast MDT

Figure 13 shows the various points along the patient pathway at which patient management might be discussed by an MDT, and the proportion of Breast MDTs that reported discussing patient management at each of these points.

Breast MDTs were most likely to discuss patient management after surgery, but before any other treatment, with 95% of MDTs surveyed in 2008 indicating that they did this. (As noted above, this was not provided as a response option in 2006.) In 2008, from half to two-thirds of these MDTs were also discussing patient management at the initial diagnosis and referral stage, at determination of treatment, and at the time when treatment is changed.

A significantly smaller proportion of Breast MDTs reported discussing patient management at the time of determination of treatment in 2008 (67%) compared to 2006 (86%). Significant decreases were also seen in the proportions discussing patient management at follow-up (from 14% to 5%) and at each hospital admission (10% to 5%). However, there was a significant increase in the proportion of Breast MDTs reporting they discussed patient management when treatment changed (43% to 57%).

It should be noted that Breast MDTs were more likely to indicate that they discussed patient management after surgery, but before other treatment (95% versus 60%), but were less likely to do so at the stage of follow-up care (5% versus 26%) and end of life care (0% versus 23%).
Composition of Breast MDTs

The core disciplines for a Breast MDT were adapted from the Victorian Patient Management Frameworks and include:

- Medical Oncologist
- Pathologist
- Radiation Oncologist
- Radiologist
- Breast Surgeon
- Plastic or Reconstructive Surgeon
- Breast Care Nurse
- General Practitioner
- Social Worker
Figure 14 shows the proportion of Breast MDTs that had representatives from each of the disciplines listed involved with their MDT meetings.

All Breast MDTs surveyed in 2008 indicated that Radiation Oncologists and Medical Oncologists were represented within their MDT. Pathologists, Breast Surgeons, Nurse Coordinators and Nurses were represented in more than 80% of the MDTs.

There were a number of significant changes in the composition of Breast MDTs from 2006 to 2008. The biggest decreases were observed in the proportion of Breast MDTs indicating involvement of Pathologists (100% to 86%), Nurse Coordinators (90% to 81%), Medical Trainees (86% to 76%), Pharmacists (14% to 5%), and Palliative Care specialists (33% to 24%). The largest increases were seen in the proportion of Breast MDTs reporting involvement of Nursing Trainees (10% to 29%), Occupational Therapists (5% to 24%) and Dieticians (5% to 19%), Physiotherapists (24% to 33%), Surgeons (62% to 76%), Genetic Counsellors (33% to 43%), Nurses (71% to 81%), as well as Medical Oncologist and Radiation Oncologist (both 95% to 100%).

In 2008, compared with MDTs overall (i.e., all tumour streams), Breast MDTs were more likely to indicate that their MDT involved a number of these health professionals, including Surgeon (76% versus 44%), Breast Surgeon (81% versus 15%), Plastic Surgeon (14% versus 5%), Radiation Oncologist (100% versus 79%),
Medical Oncologist (100% versus 80%), Pathologist (86% versus 56%), Psychologist (48% versus 25%), Genetic Counsellor (43% versus 14%) and Lymphoedema Service (33% versus 10%). They were less likely than MDTs overall to include a Palliative Care representative (24% versus 45%).

**Data collection by Breast MDTs**

Figure 15 shows the various types of data and statistics recorded by MDTs, along with the proportion of Breast MDTs that reported they recorded each one.

The majority of those Breast MDTs surveyed in 2008 reported treatment plans being recorded in patient notes (90%), as well as recording information about the number of patients discussed (86%), team attendance at each meeting (81%), and the number of patients discussed by week, month or year (62%).

From 2006 to 2008, a greater proportion of Breast MDTs reported recording treatment plans in patient notes (67% to 90%), the number of patients discussed by week, month or year (52% to 62%), as well as the percentage of patients treated for that tumour and AHS (10% to 19%). Over this time, there was a decrease in the proportion of Breast MDTs reporting that they recorded patient morbidity (19% to 10%) and patient survival (10% to 5%). There was also a significant decrease in Breast MDTs reporting that they do not record any data (5% to 0%).

There were no significant differences between Breast MDTs and MDTs overall in the types of data and statistics that were recorded in 2008.
5.3 Colorectal cancers

Incidence of colorectal cancer

Colorectal or bowel cancer includes cancers arising from the colon or rectum. Bowel cancer is the second most common cancer in NSW, and the second highest cause of cancer death. It is ranked second in incidence after prostate cancer in males, and second after breast cancer in females. In 2006, there were 4,710 new cases of bowel cancer, of which 2,535 were in males, and 1,690 cancer deaths (of which 928 were in males).

Overall, the five-year survival rate is 65%, on average, or 87% for those diagnosed with localised disease (e.g., where colorectal cancer is detected early). From 1997 to 2006, the incidence of bowel cancer did not change significantly overall, however mortality rates fell by 19.7% in males and 18.9% in females.

Colorectal MDTs in NSW by Area Health Service

There were 16 Colorectal MDTs in the NSW population in 2008 (including nine Colorectal-specific MDTs and seven combined Gastrointestinal MDTs, which discuss both Upper GI and colorectal cancers). This represents an increase of two MDTs since 2006. Figure 16 shows the number of Colorectal MDTs in NSW within each of the Area Health Services, in 2006 and 2008.

Figure 16: Number of Colorectal MDTs in NSW by AHS

In 2008, SSWAHS had the largest number of Colorectal MDTs (four out of 16). SWAHS, NSCCAHS and NCAHS each had two Colorectal MDTs and HNEAHS, GSAHS and SESIAHS each had one. Between 2006 and 2008, NCAHS and SSWAHS each gained one additional Colorectal MDT.

Colorectal MDTs in NSW by service type

Figure 17 shows the number of Colorectal MDTs in the NSW population in 2008 compared to 2006, broken down by service type characteristics (that is, location, sector and radiotherapy access).
Sixty nine percent of Colorectal MDTs in NSW in 2008 were located in metropolitan areas, which is similar to the proportion of MDTs overall (74%). Eighty one percent operated within the public sector, which is slightly lower than the proportion for MDTs overall (91%). Three quarters (75%) had access to radiotherapy services, which is in line with MDTs overall (69%).

The two new Colorectal MDTs that emerged between the 2006 and 2008 surveys were split evenly between metropolitan and regional/rural areas, but were both within the public sector. One of these new MDTs emerged at a site with access to radiotherapy facilities, while the other did not have such access.
Frequency and duration of Colorectal MDT meetings

Figure 18 presents survey level data on the frequency with which Colorectal MDTs were meeting in 2006 versus 2008.

Figure 18: Frequency of Colorectal MDT meetings (%)

In 2008, just under half (46%) of Colorectal MDTs surveyed indicated that their MDT met once a fortnight, with 31% indicating they met once a week. No MDTs met less than once a month.

There were no significant changes in the frequency with which Colorectal MDTs reported meeting between 2006 and 2008. In addition, the frequency with which Colorectal MDTs met did not differ significantly from MDTs overall, in 2008.

Based on the 2008 data, the average reported duration of Colorectal MDT meetings was 61 minutes. Eighty three percent of Colorectal MDTs surveyed indicated that, on average, they spent 5-9 minutes discussing each patient and the remaining 17% reported spending 10-14 minutes discussing each patient.

Each MDT was also asked to consider all patients discussed at their MDT in the last 12 months, and to specify the proportion that was discussed once, twice, and three or more times. The average results across all Colorectal MDTs suggest that 81% of patients were discussed once, 9% discussed twice, and 11% discussed three or more times.
Case types referred to Colorectal MDTs

Figure 19 presents the various patient groups that might be referred to an MDT, as well as the proportion of Colorectal MDTs surveyed indicating that this particular type of patient was referred to their MDT.

Based on the 2008 responses, difficult cases were the group most commonly referred to Colorectal MDTs – with 69% of MDTs indicating that such cases were referred to them. Sixty two percent of Colorectal MDTs surveyed indicated that their MDT discussed all patients diagnosed with the relevant cancer.

There was a significant increase between 2006 and 2008 in the proportion of Colorectal MDTs indicating that screen detected cases had been referred to them (10% to 46%), as well as all those with Colorectal cancer being referred (40% to 62%).

There were no differences in the types of patients referred to Colorectal MDTs compared to MDTs overall, in 2008.
Points along the patient pathway when patient management is discussed at the Colorectal MDT

Figure 20 shows the points along the patient pathway at which Colorectal MDTs reported discussing patient management, for 2006 and 2008.

Figure 20: Pathway stages at which patients discussed at Colorectal MDTs (%)


The 2008 picture suggests that the majority (92%) of Colorectal MDTs discussed patient management after surgery, but before other treatment - a response option that was new to the 2008 survey questionnaire. Over three fifths of Colorectal MDTs reported that they discussed patient management at the time when treatment changed (e.g. relapse) (69%), at diagnosis and referral (62%), and at the determination of treatment (62%).

The only significant change from 2006 to 2008 was a decrease in the proportion of Colorectal MDTs reporting that they discussed patient management at each hospital admission (20% to 0%).

Compared to MDTs overall, in 2008 Colorectal MDTs were more likely to indicate that they discussed patient management after surgery, but before other treatment (92% versus 60%). No other significant differences emerged.

Composition of Colorectal MDTs

The core disciplines for a Colorectal MDT were adapted from the Victorian Patient Management Frameworks and include:
- Medical Oncologist
- Pathologist
- Radiation Oncologist
- Radiologist
- Surgeon
- Nurse
- General Practitioner
- Social Worker
- Dietician

The chart on the following page shows the proportion of Colorectal MDTs that reported involvement of each of the disciplines listed.
All of the Colorectal MDTs in 2008 indicated that Medical Oncologists and Surgeons were involved with their meetings. The majority also indicated involvement of Radiologists (85%), Pathologists (85%), Nurse Coordinators (85%), Radiation Oncologists (77%) and Medical Trainees (77%).

Note that an additional eight disciplines were selected by 10% of MDTs in 2006, but by zero in 2008. To ensure a clear presentation of the changes between 2006 and 2008, these least common disciplines were not included in the chart above. Some may well have been accidentally selected by survey respondents in 2006, as they are unlikely to be genuinely involved with Colorectal MDTs (e.g., various specialised surgeons and clinicians).

Between 2006 and 2008 there was a significant decrease in the proportion of Colorectal MDTs indicating involvement of a Nurse Coordinator (100% to 85%). Conversely, the proportion of MDTs indicating the involvement of a Surgeon increased significantly from 90% to 100%.

In 2008, compared with MDTs overall (i.e., all tumour streams), Colorectal MDTs were more likely to indicate involvement with their meetings by Surgeons (100% versus 44%), Pathologists (85% versus 56%), Radiologists (85% versus 56%), Endoscopists (46% versus 8%) and Stomal Therapy (23% versus 6%), but less likely to indicate involvement by Nurses (38% versus 72%).
Data collection by Colorectal MDTs

Figure 22 shows the types of data and statistics that are recorded by Colorectal MDTs. The proportions of Colorectal MDTs recording each of these, in 2006 versus 2008, are presented.

Figure 22: Data and statistics recorded by Colorectal MDTs (%)

Base: 2006 - n=10, 2008 – n=13

In 2008, the largest proportion (92%) of Colorectal MDTs indicated that they recorded the number of patients discussed. Colorectal MDTs also commonly reported recording team attendance (77%) and the treatment plans being recorded in patient notes (69%).

From 2006 to 2008, there was a significant increase in the proportion of Colorectal MDTs reporting that they recorded treatment plans in patient notes (40% to 69%), and patient morbidity (10% to 31%).

There were no significant differences between Colorectal MDTs and MDTs overall, in terms of the types of data and statistics recorded, based on the 2008 data.

5.4 Melanomas (skin cancers)

Incidence of melanoma

Melanoma arises in melanocytes, which produce pigment or skin colour. It is the fourth most common cancer diagnosed in NSW.
In 2006, there were 3,559 new cases of melanoma, of which 2,171 were in males, and 454 cancer deaths (of which 301 were in males). Overall, the five-year survival rate is 88% for males and 93% for females, on average, or 96% for those diagnosed with localised disease (e.g., where melanoma is detected early).

From 1997 to 2006, the incidence of melanoma increased by 18.5% in males and 16.7% in females. Mortality rates did not change significantly, overall.

**Melanoma (Skin) MDTs in NSW by Area Health Service**

As noted in Section 4.1.1, there were three Melanoma MDTs in the NSW population in 2008, as in 2006. The chart below shows the distribution of these MDTs by Area Health Service.

![Figure 23: Number of Melanoma MDTs in NSW by AHS](chart)

### Figure 23: Number of Melanoma MDTs in NSW by AHS

<table>
<thead>
<tr>
<th>Area</th>
<th>2006</th>
<th>2008</th>
</tr>
</thead>
<tbody>
<tr>
<td>HNE</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>GS</td>
<td>0</td>
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<tr>
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</tr>
<tr>
<td>NC</td>
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<td>0</td>
</tr>
<tr>
<td>NSCC</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>SESI</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>SSW</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>SW</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>CHW</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Base: 2006 - n=3, 2008 – n=3

SESIAHS, SSWAHS and SWAHS each have one Melanoma MDT. As noted, there were no new Melanoma MDTs formed between 2006 and 2008.
Melanoma (Skin) MDTs in NSW by service type

Figure 24 shows the number of Melanoma MDTs in the NSW population in 2008, broken down by service type.

Figure 24: Number of Melanoma MDTs in NSW by service type

As can be seen from the chart, all three Melanoma MDTs were located in metropolitan areas, in the public system, and had access to radiotherapy facilities. As noted above, there were no new Melanoma MDTs formed between 2006 and 2008, so there are no changes to report in this population profile.
Frequency and duration of Melanoma (Skin) MDT meetings

The chart below shows the frequency with which Melanoma MDTs reported meeting in 2006 and 2008. It should be noted that all three Melanoma MDTs participated in the survey in 2008, making it a census.

Figure 25: Frequency of Melanoma MDT meetings (%)

- 67% of Melanoma MDTs in NSW in 2008 reported meeting once per week, while the other Melanoma MDT (33%) reported meeting once a month.

- There was a significant decrease from 2006 to 2008 in the proportion of Melanoma MDTs reporting that they met once a fortnight (from one of two in 2006, to none of three in 2008). There were no significant differences in 2008 in the frequency with which Melanoma MDTs met, compared with MDTs overall.

- Based on the 2008 data, the average reported duration of Melanoma MDT meetings was 60 minutes. All three Melanoma MDTs surveyed indicated that, on average, they spent 5-9 minutes discussing each patient.

- Each MDT was also asked to consider all patients discussed at their MDT in the last 12 months, and to specify the proportion that was discussed once, twice, and three or more times. The average results across all Melanoma MDTs suggest that 77% of patients were discussed once, 17% discussed twice, and 7% discussed three or more times.
Case types referred to Melanoma (Skin) MDTs

The case types of patient groups reported by Melanoma MDTs to have been routinely referred to them are shown in the chart below.

Figure 26: Case types referred to Melanoma MDTs

All three Melanoma MDTs indicated that they were referred difficult cases. Two out of three Melanoma MDTs also reported referral of all people diagnosed with the relevant cancer, as well as suspected cases, early cancer, advanced cancer, recurrent cases and cases requiring a second opinion.

From 2006 to 2008, the proportion of Melanoma MDTs indicating that they were referred patients by clinician choice declined significantly (from one of two to none of three).

There were no significant differences between the types of patient groups referred to Melanoma MDTs and those referred to MDTs overall, based on the 2008 data.

Points along the patient pathway when patient management is discussed at Melanoma (Skin) MDTs

The chart below shows the various points along the patient pathway at which Melanoma MDTs reported discussing patient management, for 2006 and 2008.
Figure 27: Pathway stages at which patients are discussed at Melanoma MDTs (%)

In 2008, all three Melanoma MDTs reported discussing patient management at the determination of treatment. Two out of three also indicated discussion at the points of diagnosis and referral, after surgery but before other treatment (which was a new response option added in 2008), and when treatment changed (e.g. relapse).

There were no significant changes noted from 2006 to 2008 in regard to the points on the patient pathway at which MDTs reported discussing patients.

There were no significant differences in the points at which patient management is discussed between Melanoma MDTs and MDTs overall, in 2008.

**Composition of Melanoma (Skin) MDTs**

The core disciplines for a Melanoma MDT were adapted from the Victorian Patient Management Frameworks and include:

- Dermatologist
- Medical Oncologist
- Radiation Oncologist
- Pathologist
- Surgeon (general, reconstructive or plastic)
- General Practitioner
- Nurse
- Social Worker

Figure 28, on the next page, shows the disciplines that were reported to be involved with MDT meetings by at least one Melanoma MDT in 2006 or 2008.

All three Melanoma MDTs indicated that Radiation Oncologists and Nurses were involved with their MDT. A number of other disciplines were included in two out of three of the Melanoma MDTs’ meetings.

Significant decreases were observed in the proportion of Melanoma MDTs reporting involvement of a Radiologist and a Nurse Coordinator from 2006 to 2008 (which moved from two out of two MDTs in 2006, to one out of three MDTs in 2008). These differences should be interpreted with caution, however, due to the
small sample sizes in question. It is possible that apparent changes over time are simply a result of differences in the characteristics of the third MDT, which did not participate in the survey in 2006.

In 2008, compared with MDTs overall (i.e., all tumour streams), Melanoma MDTs were more likely to report involvement in their meetings by Reconstructive Surgeons (67% versus 11%), Plastic Surgeons (67% versus 5%) and Dermatologists (67% versus 2%).
Data collection by Melanoma (Skin) MDTs

The types of data and statistics recorded by Melanoma MDTs are presented in the chart below.

Based on the 2008 data, two out of three Melanoma MDTs indicated that they routinely recorded team attendance, the number of patients discussed, patient mortality, and that treatment plans were recorded in the patients notes.

From 2006 to 2008, there was a significant decrease in the proportion of Melanoma MDTs reporting that they recorded the number of patients discussed by week, month or year (from two of two MDTs, to zero of three). In addition, a significant increase was seen in the proportion of Melanoma MDTs recording patient mortality data (from zero of two, to two of three).

There were no differences between Melanoma MDTs and MDTs overall in terms of the types of statistics and data recorded in 2008.
5.5 Lung cancers

**Incidence of lung cancer**

Lung cancer arises in the lung, often in cells lining the air passages. It may be small cell lung cancer or non-small cell lung cancer. Lung cancer is the most common cause of cancer death in NSW. It is the leading cause of cancer death in males, and equal with deaths from breast cancer in females.

In 2006, there were 3,137 new cases of lung cancer (of which 1,949 were in males), and 2,468 cancer deaths (of which 1,538 were in males). Overall, five-year survival is 14%, on average, or 29.8% for those diagnosed with localised disease (e.g., where lung cancer is detected early).

From 1997 to 2006, the incidence of lung cancer decreased by 15.7% in males and increased by 21.6% in females. Mortality rates decreased by 18.5% in males and increased by 16.4% in females.

**Lung MDTs in NSW by Area Health Service**

As reported in Section 4.1.1, there were 15 Lung MDTs in the NSW population in 2008, which represents an increase of one MDT since 2006. The breakdown of these MDTs by Area Health Service in 2006 and 2008 is shown in the chart below.

Figure 30: Number of Lung MDTs in NSW by AHS

Base: 2006 - n=14, 2008 – n=15

SESIAHS and SSWAHS have the most Lung MDTs, with four MDTs each. NCAHS, NSCCAHS and SWAHS each have two Lung MDTs, and HNEAHS has one. The one new Lung MDT between 2006 and 2008 was formed within NCAHS.
Lung MDTs in NSW by service type

Figure 31 shows the breakdowns of Lung MDTs within each service type, in 2006 and 2008, based on the NSW population data.

The proportion of Lung MDTs operating in metropolitan areas is slightly higher than that for MDTs overall, at 87% (compared to 74%). All Lung MDTs have been established within the public sector, which is slightly higher than the figure for MDTs overall (91%). A higher proportion of Lung MDTs had access to radiotherapy services (87%), compared to MDTs overall (69%).

The one new Lung MDT that arose between 2006 and 2008 was formed in a regional area, in the public system, and has access to radiotherapy.
**Frequency and duration of Lung MDT meetings**

The frequency with which Lung MDTs reported meeting in 2006 and 2008 is displayed in the chart below, based on survey level data.

Half of those Lung MDTs surveyed reported meeting fortnightly in 2008, with 43% indicating that they meet weekly. The one remaining Lung MDT reported meeting less than once a month.

There was a significant reduction in the average frequency with which Lung MDTs reported meeting between 2006 and 2008. That is, there was a decrease in Lung MDTs reporting that they met weekly (64% to 43%), and an increase in those meeting once a fortnight (27% to 50%).

There were no significant differences in meeting frequency between Lung MDTs and MDTs overall, based on the 2008 data.

Based on the 2008 data, the average reported duration of Lung MDT meetings was 68 minutes. Sixty four percent of Lung MDTs surveyed indicated that, on average, they spent 5-9 minutes discussing each patient, while the remaining 36% reported spending 10-14 minutes discussing each patient.

Each MDT was also asked to consider all patients discussed at their MDT in the last 12 months, and to specify the proportion that was discussed once, twice, and three or more times. The average results across
all Lung MDTs suggest that 69% of patients were discussed once, 22% discussed twice, and 9% discussed three or more times.

**Case types referred to Lung MDTs**

The chart below shows the types of patient groups that Lung MDTs reported were referred to their MDT, in 2006 and 2008.

**Figure 33: Case types referred to Lung MDTs (%)**

Base: 2006 - n=11, 2008 – n=14

The most commonly reported patient type being referred to Lung MDTs in 2008 was difficult cases (86%), followed by those requiring a second opinion (71%). All diagnosed patients with the relevant cancer, and recurrent cases, were each reported to be referred to almost two thirds of those Lung MDTs surveyed (64% each).

There was a significant decrease from 2006 to 2008 in the proportion of Lung MDTs reporting that they were referred suspected cases (64% to 43%). In addition, there was a significant increase in the proportion that reported being referred screen detected cancers (0% to 29%), and patients referred by clinician choice (27% to 43%).

Compared to MDTs overall (44%), Lung MDTs were more likely to indicate that they were referred cases requiring a second opinion (71%), in 2008.
Points along the patient pathway when patient management is discussed at the Lung MDT

Figure 34 shows the points along the patient pathway at which Lung MDTs reported discussing patient management, in 2006 and 2008.

The stages of determination of treatment (79%) and diagnosis and referral (71%) were the most common points along the patient pathway at which Lung MDTs reported discussing patient management. Almost two thirds (64%) of Lung MDTs reported discussing patient management after surgery, but before other treatment (which was a new response option in the 2008 questionnaire).

From 2006 to 2008, there were significant decreases in the proportions of Lung MDTs reporting that they discussed patient management when treatment was changed (82% to 50%), on determination of treatment (100% to 79%), and at diagnosis and referral (91% to 71%).

There were no differences in the points along the pathway at which Lung MDTs discuss patient management compared with MDTs overall, in 2008.
Composition of Lung MDTs

The core disciplines for a Lung MDT were adapted from the Victorian Patient Management Frameworks and include:

- Medical Oncologist
- Pathologist
- Radiation Oncologist
- Radiologist (imaging specialist)
- Thoracic Surgeon
- Respiratory Physician
- Nurse
- General Practitioner
- Social Worker

The chart below shows the disciplines that were reported to be involved with at least one Lung MDT in 2006 or 2008.
Figure 35: Composition of Lung MDTs (%)

Base: 2006 - n=11, 2008 – n=14

All Lung MDTs surveyed in 2008 reported that Medical Oncologists and Radiation Oncologists were involved with their meetings. Respiratory Physicians and Thoracic Surgeons were involved with 93% of Lung MDTs, and Medical Trainees, Radiologists and Nurse Coordinators were involved with 86% of MDTs.

There were a number of significant changes between 2006 and 2008, in terms of the reported composition of Lung MDTs. There were various disciplines that were reported by a greater proportion of Lung MDTs in 2008 than in 2006, with the largest shifts including Nurse Coordinator (55% to 86%), Dietician (0% to 14%), Occupational Therapist (0% to 14%), and Radiation Oncologist (91% to 100%). Conversely, a number of disciplines were reported by a lower proportion of Lung MDTs in 2008, compared to 2006, most notably Palliative Care (82% to 57%), as well as Respiratory Physician (100% to 93%) and General Practitioner (9% to 0%).

In 2008, compared with MDTs overall (i.e., all tumour streams), Lung MDTs were more likely to report involvement of Thoracic Surgeons (93% versus 11%), Radiation Oncologists (100% versus 79%), Medical Oncologists (100% versus 80%), Respiratory Physicians (93% versus 10%), Radiologists (86% versus 56%) and Neuro Oncologists (13% versus 2%), and less likely to report involvement by Surgeons (14% versus 44%).
Data collection by Lung MDTs

The data and statistics reported by Lung MDTs to be recorded in 2006 and 2008 are shown in the chart below.

Figure 36: Data and statistics recorded by Lung MDTs (%)

- The most common type of data recorded by Lung MDTs was the number of patients discussed (79%), followed by treatment plans in patient notes (71%), team present and number of patients discussed by week, month or year (both 64%).

- There were significant increases in the proportion of Lung MDTs reporting that they record the number of patients discussed (percentage of patients treated for that tumour and AHS) and percentage of patients managed according to protocols, both going from 0% in 2006 to 7% in 2008.

- There were no differences in the types of data and statistics recorded by Lung MDTs versus MDTs overall, in 2008.
5.6 Upper gastrointestinal (GI) cancers

Incidence of upper GI cancers

Upper GI cancers include cancers of the stomach, oesophagus, gallbladder and pancreas. In 2006, there were 2,523 new cases of upper GI cancer and 1,974 deaths.

The two main cancers discussed in upper GI MDTs are cancers of the stomach and oesophagus. The following graph demonstrates the significant higher incidence of stomach and oesophageal cancers in males.

Figure 37: 2006 incidence and mortality for upper GI cancers

Source: 2006 data extracted from the NSW Central Cancer Registry

Overall, five-year survival is 88%, on average, or 97% for those diagnosed with localised disease (e.g., where the cancer is detected early).

From 1997 to 2006, the incidence of oesophageal cancer increased by 17% in males, with no significant change for females. Over this period, the incidence of stomach cancer decreased by 20.3% in males and 18.0% in females.
Upper GI MDTs in NSW by Area Health Service

There were 14 Upper GI MDTs in the NSW population in 2008 (including 7 Upper GI-specific MDTs and 7 combined GIT MDTs, which discuss both upper GI and colorectal cancers). This represents an increase of three MDTs since 2006. The figure below presents the number of Upper GI MDTs broken down by AHS.

Figure 38: Number of Upper GI MDTs in NSW by AHS

Base: 2006 - n=11, 2008 – n=14 (including 1 private MDT, not included in the chart above)

As seen in the chart above, in 2008, SSWAHS had the largest number of Upper GI MDTs (4), followed by NSCCAHS (n=3) and SWAHS (n=2). HNEAHS, GSAHS, NCAHS and SESIAHS each had one Upper GI MDT.

The three new Upper GI MDTs formed between 2006 and 2008 arose in different AHSs; one in each of NCAHS (which formed its first Upper GI MDT), NSCCAHS and SSWAHS (both of which had existing Upper GI MDTs).
Upper GI MDTs in NSW by service type

Figure 39 reports the number of Upper GI MDTs in the 2008 NSW population, by service type.

Figure 39: Number of Upper GI MDTs in NSW by service type

- **Metropolitan**: 2006: 9, 2008: 11
- **Regional / Rural**: 2006: 2, 2008: 3
- **Public**: 2006: 10, 2008: 13
- **Private**: 2006: 1, 2008: 1
- **With radiotherapy**: 2006: 9, 2008: 11
- **Without radiotherapy**: 2006: 2, 2008: 3

Base: 2006 - n=11, 2008 – n=14

As with the trend for MDTs overall, the majority of Upper GI MDTs were located in metropolitan regions – 11 of 14 in 2008 (79%), compared to 74% across all MDTs. The proportion of Upper GI MDTs operating in the public system – 13 of 14 (93%) - was also comparable to the proportion for all MDTs. The proportion of Upper GI MDTs that have access to radiotherapy – 11 of 14 (79%) - was slightly higher than that for all MDTs (69%).

Of three new Upper GI MDTs, two were in metropolitan areas, and all were in the public system. Two of the three new Upper GI MDTs have access to radiotherapy services.
Frequency and duration of Upper GI MDT meetings

It should be noted that all 14 Upper GI MDTs completed the survey in 2008, such that a census was achieved. The chart below outlines the frequency with which Upper GI MDTs met in 2006 and 2008.

Figure 40: Frequency of Upper GI MDT meetings

Just over half (57%) of Upper GI MDTs in 2008 reported that they met weekly, with just over a third (36%) indicating they met fortnightly, and the remainder (7%) meeting at least once a month.

There was a significant increase from 2006 to 2008 in the proportion of Upper GI MDTs reporting that they meet once a week (38% to 57%), and a significant decrease in those reporting that they meet once a month (25% to 7%) – indicating an overall shift towards more frequent meetings. In 2008, meeting frequency among Upper GI MDTs did not differ significantly from all MDTs.

Based on the 2008 data, the average reported duration of Upper GI MDT meetings was 59 minutes. Eighty six percent of Upper GI MDTs surveyed indicated that, on average, they spent 5-9 minutes discussing each patient, and 14% reported spending 10-14 minutes discussing each patient.

Each MDT was also asked to consider all patients discussed at their MDT in the last 12 months, and to specify the proportion that was discussed once, twice, and three or more times. The average results across all Upper GI MDTs suggest that 59% of patients were discussed once, 26% discussed twice, and 15% discussed three or more times.
### Case types referred to Upper GI MDTs

The proportion of Upper GI MDTs reporting the referral of different patient types to their MDT is presented in the chart below, for 2006 and 2008.

**Figure 41: Case types referred to Upper GI MDTs (%)**

![Chart showing case types referred to Upper GI MDTs]

<table>
<thead>
<tr>
<th>Case Type</th>
<th>2006</th>
<th>2008</th>
</tr>
</thead>
<tbody>
<tr>
<td>All diagnosed with relevant cancer</td>
<td>64%</td>
<td>63%</td>
</tr>
<tr>
<td>Suspected cases</td>
<td>38%</td>
<td>43%</td>
</tr>
<tr>
<td>Early cancer (new diagnosis)</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Advanced cancer (new diagnosis)</td>
<td>43%</td>
<td>43%</td>
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<tr>
<td>Recurrent cases</td>
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<td>71%</td>
</tr>
<tr>
<td>Screen detected cancers</td>
<td>13%</td>
<td>13%</td>
</tr>
<tr>
<td>Difficult cases</td>
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<td>75%</td>
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<tr>
<td>Second opinion</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Clinician choice</td>
<td>25%</td>
<td>43%</td>
</tr>
<tr>
<td>Other</td>
<td>13%</td>
<td>7%</td>
</tr>
</tbody>
</table>

Base: 2006 - n=8, 2008 – n=14

Patients considered as difficult cases were those most likely to be referred to an Upper GI MDT in 2008 (75%), followed by all patients diagnosed with a relevant cancer (63%). Over half (57%) of Upper GI MDTs indicated that patients requiring a second opinion had been referred to them.

There were significant increases in the proportion of Upper GI MDTs indicating that they were referred screen detected cancers (13% to 36%) and patients referred by clinician choice (25% to 43%), from 2006 to 2008.

The case types referred to Upper GI MDTs in 2008 did not differ significantly from that of all MDTs.
Points along the patient pathway when patient management is discussed at the Upper GI MDT

Figure 42 shows the points on the patient pathway at which Upper GI MDTs reported discussing patient management, for 2006 and 2008.

In 2008, the most common response about when Upper GI MDTs discussed patient management was when treatment changed (e.g., relapse), which was reported by 86%. Also commonly reported by Upper GI MDTs was discussion of patient management at the stage of diagnosis and referral, and determination of treatment (each reported by 79% of these MDTs). In addition, almost two-thirds (64%) of Upper GI MDTs reported that they discuss patient management after surgery, but before other treatment (a new response option in 2008).

Significant increases were seen, from 2006 to 2008, in the proportion of Upper GI MDTs reporting that they discussed patient management when treatment changed (38% to 86%), at diagnosis and referral (63% to 79%), at determination of treatment (63% to 79%), and at each hospital admission (0% to 7%).

In 2008, the points along the patient pathway at which patients tended to be discussed by Upper GI MDTs were comparable to those for all MDTs.
Composition of Upper GI MDTs

The core disciplines for an Upper GI MDT were adapted from the Victorian Patient Management Frameworks and include:

- Endoscopist
- Medical Oncologist
- Pathologist
- Radiation Oncologist
- Radiologist
- Surgeon
- General Practitioner
- Nurse
- Social Worker
- Dietician

The chart below outlines all the disciplines that at least one Upper GI MDT reported was involved with their MDT meetings, in 2006 and 2008. For each discipline, the proportion of Upper GI MDTs indicating that the discipline was represented at their MDT meetings is shown.
All Upper GI MDTs reported involvement of Medical Oncologists and Surgeons, and 93% reported involvement of Radiation Oncologists and Radiologists. The majority of Upper GI MDTs also reported that Medical Trainees (86%), Nurse Coordinators (79%), Pathologists (64%), and Endoscopists (57%) were involved with their MDTs.

A number of significant changes in the composition of Upper GI MDTs were found between 2006 and 2008. There was a reported increase in the representation of Dieticians (13% to 36%), Radiologists (75% to 93%), and Surgeons (88% to 100%). Significant decreases were seen in the proportion of Upper GI MDTs reporting involvement of Psychologists (25% to 7%), as well as Genetic Counsellors and Nursing Trainees (both 13% to 0%).

In 2008, in comparison with MDTs overall (i.e., all tumour streams), Upper GI MDTs were more likely to have a Surgeon (100% versus 44%), Medical Oncologist (100% versus 80%), Radiologist (93% versus 56%) and Endoscopist (57% versus 8%) involved in their MDT meetings.

**Data collection by Upper GI MDTs**

Figure 44 shows the types of data and statistics recorded by MDTs, including the proportion of Upper GI MDTs reporting each of these.
The most common type of data recorded by Upper GI MDTs in 2008 was the number of patients discussed (79%), followed by team attendance and treatment plans being recorded in patient notes (both 71%). No other types of data were reported as recorded by more than half of those Upper GI MDTs surveyed.

There was a significant increase between 2006 and 2008 in the proportion of Upper GI MDTs indicating that they recorded treatment plans in patient notes (50% to 71%). Significant increases were also seen in relation to the recording of patient mortality, patient morbidity and patient survival (all 0% to 14%), as well as the number of patients discussed (proportion of patients treated for that tumour and AHS) and percentage of patients managed according to protocols (both increasing from 0% to 7%).

In 2008, there were no differences in the type of data recorded by Upper GI MDTs compared with MDTs overall.

5.7 Gynaecological cancers

Incidence of gynaecological cancer

Gynaecological cancers include cancers of the cervix, uterus, ovary, fallopian tube, vagina and vulva.

In 2006, there were a total of 1,354 new cases of gynaecological cancers diagnosed, and 492 cancer deaths.
Cervical, ovarian and uterine cancers are the main cancers discussed in the gynaecological MDT. The incidence and mortality data for these specific cancers are illustrated in the following chart.

Figure 45: 2006 incidence and mortality of gynaecological cancer

![Graph showing incidence and mortality for uterine, ovarian, and cervical cancers]

Source: 2006 data extracted from the NSW Central Cancer Registry

As can be seen, uterine cancer is the most common gynaecological cancer, but mortality associated with this cancer is comparatively low. Mortality associated with ovarian cancer is the highest.

**Gynaecology MDTs in NSW by Area Health Service**

As noted in Section 4.1.1, there were seven Gynaecology MDTs in the NSW population in 2008 (as in 2006). The chart below shows the number of Gynaecology MDTs in 2006 and 2008, broken down by Area Health Service.

Figure 46: Number of Gynaecology MDTs in NSW by AHS

![Bar chart showing number of MDTs by AHS]

Base: 2006 - n=7, 2008 – n=7 (including 1 private MDT, not included in the chart above)

SSWAHS has the highest number of Gynaecology MDTs (two), while HNEAHS, NSCCAHS, SESIAHS and SWAHS each have one.

As noted above, there were no new Gynaecology MDTs created between 2006 and 2008.
Number of Gynaecology MDTs in NSW by service type

The chart below outlines the number of Gynaecology MDTs in the NSW population, by service type, across 2006 and 2008.

Figure 47: Number of Gynaecology MDTs in NSW by service type

- Metropolitan: 2006 - 7, 2008 - 7
- Regional / Rural: 2006 - 0, 2008 - 0
- Public: 2006 - 6, 2008 - 6
- Private: 2006 - 1, 2008 - 1
- With radiotherapy: 2006 - 6, 2008 - 6
- Without radiotherapy: 2006 - 1, 2008 - 1

Base: 2006 - n=7, 2008 – n=7

In contrast to the pattern for MDTs overall, all Gynaecology MDTs were located in metropolitan areas. Similar to the pattern for all MDTs, the majority of Gynaecology MDTs – six of seven (86%) - were in the public system. A greater proportion of Gynaecology MDTs has access to radiotherapy services (86%), compared with MDTs overall (69%).

As noted in the previous section, there were no new Gynaecology MDTs formed between 2006 and 2008.
Frequency and duration of Gynaecology MDT meetings

The frequency with which Gynaecology MDTs met, based on survey level data from 2006 and 2008, is shown in the chart below.

Figure 48: Frequency of Gynaecology MDT meetings (%)

<table>
<thead>
<tr>
<th>Frequency</th>
<th>2006</th>
<th>2008</th>
</tr>
</thead>
<tbody>
<tr>
<td>Once a week</td>
<td>83%</td>
<td>67%</td>
</tr>
<tr>
<td>Once a fortnight</td>
<td>17%</td>
<td>33%</td>
</tr>
</tbody>
</table>

Base: 2006 - n=6, 2008 – n=6

The majority of Gynaecology MDTs (67%) reported meeting once a week, with the remainder meeting once a fortnight.

There were no significant changes over time in the frequency with which Gynaecology MDTs reported meeting. There were also no differences between Gynaecology MDTs and MDTs overall in terms of the frequency with which meetings were held, in 2008.

Based on the 2008 data, the average reported duration of Gynaecology MDT meetings was 73 minutes. Four of the Gynaecology MDTs surveyed indicated that, on average, they spent 5-9 minutes discussing each patient, while the remaining two reported spending 10-14 minutes discussing each patient.

Each MDT was also asked to consider all patients discussed at their MDT in the last 12 months, and to specify the proportion that was discussed once, twice, and three or more times. The average results across all Gynaecology MDTs suggest that 61% of patients were discussed once, 16% discussed twice, and 24% discussed three or more times.
Case types referred to Gynaecology MDTs

The chart below illustrates the various patient groups that Gynaecology MDTs reported had been referred to them in 2006 and 2008.

Figure 49: Case types referred to Gynaecology MDTs (%)

Base: 2006 - n=6, 2008 – n=6

In 2008, all Gynaecology MDTs reported that all patients diagnosed with the relevant cancer were referred to them, although many specified other patient groups as well. The next specific patient groups most commonly referred to Gynaecology MDTs were early cancer (new diagnoses), advanced cancer (new diagnoses), recurrent cases and difficult cases, each reported by 83% of Gynaecology MDTs surveyed. Around two-thirds (67%) of Gynaecology MDTs also reported having had suspected cases and screen detected cancers referred to them.

There were significant increases in the proportion of Gynaecology MDTs indicating that they were referred all diagnosed with relevant cancer (from five of six, to all six MDTs surveyed), as well as early cancer (new diagnoses), advanced cancer (new diagnoses), recurrent cases and difficult cases (from three of six, to five of six MDTs surveyed). There was a significant decrease in the proportion of Gynaecology MDTs reporting that they were referred patients according to individual clinician choice (from one of six, to zero of six MDTs surveyed).

In 2008, compared to MDTs overall, Gynaecology MDTs were more likely to report that they had been referred all patients diagnosed with the relevant type of cancer (100% versus 54%), all newly diagnosed early
cancer (83% versus 42%) and screen detected cancers (67% versus 24%). No other significant differences emerged in terms of the case types discussed by Gynaecology MDTs, in 2008.

**Points along the patient pathway when patient management is discussed at the Gynaecology MDT**

Figure 50 shows the points on the patient pathway at which Gynaecology MDTs reported having discussed patient management, in 2006 and 2008.

Figure 50: Pathway stages at which patients are discussed at Gynaecology MDTs (%)


All Gynaecology MDTs reported that patient management was discussed after surgery, but before other treatment (which was a new response option in the 2008 questionnaire). The next most common points at which patient management was discussed by Gynaecology MDTs in 2008 were determination of treatment (83%), and diagnosis or referral and at the treatment stage (both 67%).

From 2006 to 2008, significant decreases were seen in the proportion of Gynaecology MDTs indicating that they discussed patient management at determination of treatment (100% to 83%) and when treatment was changed (e.g. relapse) (83% to 33%).

In 2008, Gynaecology MDTs were more likely than MDTs overall to report that patient management was discussed after surgery, but before other treatment (100% versus 60%). No other significant differences emerged.
Composition of Gynaecology MDTs

The core disciplines for a Gynaecology MDT were adapted from the Victorian Patient Management Frameworks and include:

- Gynaecological Oncologist
- Gynaecologist
- Medical Oncologist
- Pathologist
- Radiation Oncologist
- Nurse
- General Practitioner
- Social Worker

In the chart on the following page, the disciplines that were reported as being involved by at least one Gynaecology MDT in 2006 or 2008 are shown, including the proportion of Gynaecology MDTs that indicated involvement of each of the disciplines.
In 2008, all Gynaecology MDTs reported involvement of Radiation Oncologists, Medical Oncologists, Gynaecological Oncologists, Pathologists, Nurse Coordinators and Medical Trainees. The majority of Gynaecology MDTs also reported involvement of Nurses (83%), Palliative Care services (67%) and Allied Health Trainees (67%).

From 2006 to 2008, significant increases were seen in the proportion of Gynaecology MDTs indicating involvement in their meetings by Medical Trainees (from five of six, to all six MDTs surveyed). A number of significant decreases were also seen, with the biggest changes being observed in representation from Gynaecologists and Psychologists (both shifting from five, to three of all six MDTs surveyed), as well as Surgeons, Reconstructive Surgeons and Stomal Therapy (each falling from two, to none of all six MDTs surveyed), and Nurses (falling from all six, to five of all six MDTs surveyed).

Unsurprisingly, Gynaecologists and Gynaecological Oncologists were more likely to be involved in Gynaecology MDTs than MDTs overall, in 2008 (50% versus 3%, and 100% versus 6%, respectively). So too were Pathologists (100% versus 56%) and Allied Health Trainees (67% versus 20%). Surgeons, however, were less common among Gynaecology MDTs compared with the result across all tumour streams (0% versus 44%).
Data collection by Gynaecology MDTs

The types of data and statistics recorded by Gynaecology MDTs in 2006 and 2008 are shown in the chart below.

Figure 52: Data and statistics recorded by Gynaecology MDTs (%)

Base: 2006 - n=6, 2008 – n=6

All Gynaecology MDTs reported having recorded team attendance, with the number of patients discussed being the next most commonly reported data (83%). Over two thirds (67%) of Gynaecology MDTs reported recording treatment plans in patient notes and patient mortality.

From 2006 to 2008, there was a significant increase in the proportion of Gynaecology MDTs reporting that they record team attendance (from five, to all of the six MDTs surveyed). There were also significant decreases in the proportion indicating that they record the number of patients discussed by week, month or year (from five of the six MDTs surveyed, to three of six) and the number of patients discussed (from all of the six MDTs surveyed, to five of six).

Compared to MDTs overall, a greater proportion of Gynaecology MDTs reported recording patient mortality data in 2008 (67% compared to 24%).
5.8 Bone and soft tissue cancers (sarcoma)

Incidence of bone and soft tissue sarcoma

Soft tissue sarcomas originate in tissues such as fat, muscles, nerves, tendons, and blood and lymph vessels. Sarcomas that originate in the bone are known as osteosarcomas.

In 2006, 236 cases of bone and soft tissue sarcomas were diagnosed in NSW, and there were 88 deaths.

Bone and Soft Tissue Sarcoma MDTs in NSW by Area Health Service

As reported in Section 4.1.1, there were four Bone and Soft Tissue Sarcoma MDTs in the NSW population in 2008, which represents an increase of one MDT since 2006. The chart below shows the breakdown of the 2006 and 2008 Bone and Soft Tissue Sarcoma MDTs by Area Health Service.

Figure 53: Number of Bone and Soft Tissue Sarcoma MDTs in NSW by AHS

<table>
<thead>
<tr>
<th>Area Health Service</th>
<th>2006</th>
<th>2008</th>
</tr>
</thead>
<tbody>
<tr>
<td>HNE</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>GS</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>GW</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>NC</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>NSCC</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>SESI</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>SSW</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>SW</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>CHW</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Base: 2006 - n=3, 2008 – n=4

SESIAHS has the largest number of Bone and Soft Tissue Sarcoma MDTs (two MDTs), while SSWAHS and SWAHS each have one Bone and Soft Tissue Sarcoma MDT.

The single new Bone and Soft Tissue Sarcoma MDT that was formed between 2006 and 2008 was in SESIAHS.
Bone and Soft Tissue Sarcoma MDTs in NSW by service type

Figure 54 shows the breakdown of Bone and Soft Tissue Sarcoma MDTs in 2006 and 2008 by the three service type variables.

Figure 54: Number of Bone and Soft Tissue Sarcoma MDTs in NSW by service type

Base: 2006 - n=3, 2008 – n=4

All four of the Bone and Soft Tissue Sarcoma MDTs in 2008 were located in metropolitan areas, in the public system, and had access to radiotherapy.
Frequency and duration of Bone and Soft Tissue Sarcoma MDT meetings

It should be noted that in 2008, all four Bone and Soft Tissue Sarcoma MDTs participated in survey, making it a census for this tumour stream. Outlined in the chart below, is the frequency with which Bone and Soft Tissue Sarcoma MDTs reported having met in 2006 and 2008.

Figure 55: Frequency of Bone and Soft Tissue Sarcoma MDT meetings (%)

```
<table>
<thead>
<tr>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Once a week</td>
<td>100%</td>
</tr>
<tr>
<td>Once a fortnight</td>
<td>75%</td>
</tr>
<tr>
<td>Once a month</td>
<td>0%</td>
</tr>
<tr>
<td>Less than once</td>
<td>0%</td>
</tr>
<tr>
<td>a month</td>
<td>0%</td>
</tr>
<tr>
<td>Irregularly</td>
<td>0%</td>
</tr>
</tbody>
</table>
```

Base: 2006 - n=2, 2008 – n=4

Three out of the four Bone and Soft Tissue Sarcoma MDTs in 2008 (75%) reported meeting once a week, while the remaining MDT reported meeting once a fortnight.

There were no significant changes from 2006 to 2008 in terms of the frequency with which Bone and Soft Tissue Sarcoma MDTs reported meeting. There was also no difference in the frequency with which Bone and Soft Tissue Sarcoma MDTs, compared with MDTs overall, reported meeting in 2008.

Based on the 2008 data, the average reported duration of Bone and Soft Tissue Sarcoma MDT meetings was 90 minutes. Half (i.e., two of the four) Bone and Soft Tissue Sarcoma MDTs surveyed indicated that, on average, they spent 5-9 minutes discussing each patient and the other half reported spending an average of 15 minutes or more discussing each patient.

Each MDT was also asked to consider all patients discussed at their MDT in the last 12 months, and to specify the proportion that was discussed once, twice, and three or more times. The average results across
all Bone and Soft Tissue Sarcoma MDTs suggest that 58% of patients were discussed once, 26% discussed twice, and 16% discussed three or more times.

**Case types referred to Bone and Soft Tissue Sarcoma MDTs**

The types of cases that Bone and Soft Tissue Sarcoma MDTs reported being referred in 2006 and 2008 are shown in the chart below.

**Figure 56: Case types referred to Bone and Soft Tissue Sarcoma MDTs (%)**

In 2008, there were five case types that were reported as being referred to three of four (i.e., 75%) of the Bone and Soft Tissue Sarcoma MDTs surveyed: namely, all patients diagnosed with the relevant cancer, suspected cases, recurrent cases, difficult cases and patients requiring a second opinion.

There were no significant changes from 2006 to 2008 in terms of the types of cases being referred to Bone and Soft Tissue Sarcoma MDTs. There were also no significant differences in the case types discussed by Bone and Soft Tissue Sarcoma MDTs, compared with MDTs overall, in 2008.
Points along the patient pathway when patient management is discussed at the Bone and Soft Tissue Sarcoma MDT

The chart below shows the points along the patient pathway at which Bone and Soft Tissue Sarcoma MDTs reported discussing patient management, in 2006 and 2008.

Figure 57: Pathway stages at which patients are discussed at Bone and Soft Tissue Sarcoma MDTs (%)

In 2008, all four Bone and Soft Tissue Sarcoma MDTs reported discussing patient management at the stages of diagnosis and referral, determination of treatment, after surgery but before other treatment (a new response option in 2008), and when treatment is changed (e.g., relapse). Three out of four MDTs reported discussing patients at the treatment stage.

From 2006 to 2008, there was a significant decrease in the proportion of Bone and Soft Tissue Sarcoma MDTs that reported discussing patient management at the time of follow-up care (two out of two MDTs, to one out of four).

There were no significant differences between Bone and Soft Tissue Sarcoma MDTs and MDTs overall, in terms of the points at which patient management is discussed.
Composition of Bone and Soft Tissue Sarcoma MDTs

The core disciplines for a Bone and Soft Tissue Sarcoma MDT were adapted from the Victorian Patient Management Frameworks and include:

- Surgeon
- Radiation Oncologist
- Medical Oncologist
- Pathologist
- Radiologist
- General Practitioner
- Nurse
- Social Worker

Figure 58, on the following page, illustrates those disciplines that were reported to have been involved with their MDT meetings by at least one Bone and Soft Tissue Sarcoma MDT in the 2006 and 2008 surveys, along with the proportion of MDTs that indicated each discipline being involved.
In 2008, all four of the Bone and Soft Tissue Sarcoma MDTs reported involvement in their meetings by Surgeons, Radiation Oncologists, Medical Oncologists and Medical Trainees. In addition, three out of four Bone and Soft Tissue Sarcoma MDTs involved Pathologists, Radiologists and Nurses.

Significant increases from 2006 to 2008 were observed in the proportion of Bone and Soft Tissue Sarcoma MDTs indicating involvement by Nurses (from zero to all four MDTs), Medical Trainees (from one of two, to all four MDTs), and Reconstructive Surgeons (from zero, to two of four MDTs). A large number of significant decreases were seen in the proportion of Bone and Soft Tissue Sarcoma MDTs indicating involvement of various disciplines at their meetings. The biggest changes were seen in Clinical Haematologists and Dieticians (from both of the two MDTs surveyed, to zero out of four), and Social Worker (from both of the two MDTs surveyed, to one out of four).

In 2008, compared with MDTs overall (i.e., all tumour streams), Bone and Soft Tissue Sarcoma MDTs were more likely to involve Surgeons (100% versus 44%), Reconstructive Surgeons (50% versus 11%) and Genetic Counsellors (50% versus 14%). No other significant differences in the composition of Bone and Soft Tissue Sarcoma MDTs were found in 2008.
Data collection by Bone and Soft Tissue Sarcoma MDTs

The types of data collected by Bone and Soft Tissue Sarcoma MDTs in 2006 and 2008 are shown in the chart below.

Figure 59: Data/statistics recorded by Bone and Soft Tissue Sarcoma MDTs (%)

Base: 2006 - n=2, 2008 – n=4

All four Bone and Soft Tissue Sarcoma MDTs reported recording treatment plans in patient notes. No other type of data was reported to have been recorded by more than half of the Bone and Soft Tissue Sarcoma MDTs.

From 2006 to 2008, there was a significant decrease in the proportion of Bone and Soft Tissue Sarcoma MDTs reporting that they record data relating to the number of patients discussed (percentage of patients treated for that tumour and AHS), patient mortality, patient morbidity and patient survival (from one of two MDTs, to zero out of four), as well as number of patients discussed (from both of the two MDTs surveyed, to two out of four).

There were no significant differences in the data and statistics recorded by Bone and Soft Tissue Sarcoma MDTs versus MDTs overall, in 2008.
5.9 Paediatric cancers

Incidence of childhood cancers

There were 212 new cases of cancer in children (0-14 years) in NSW in 2006. Around half of these cancers were leukaemia or lymphomas with a good prognosis. Over the past 35 years, the age-standardised incidence rates for childhood cancers have steadily increased in both boys and girls.

Paediatric MDTs in NSW by Area Health Service

As reported in Section 4.1.1, there are eight Paediatric MDTs in the 2008 NSW population, which represents an increase of one MDT since 2006. In the chart below, Paediatric MDTs in 2006 and 2008 are broken down by Area Health Services.

Figure 60: Number of Paediatric MDTs in NSW by AHS

Base: 2006 - n=7, 2008 – n=8

The eight Paediatric MDTs are distributed between Children’s Hospital Westmead (noted as ‘CHW’: three MDTs), SESIAHS (three MDTs) and HNEAHS (two MDTs). The one new Paediatric MDT in 2008 was formed in HNEAHS.
**Paediatric MDTs in NSW by service type**

Figure 61 shows the number of Paediatric MDTs in the NSW population in 2006 and 2008, broken down by service type.

Figure 61: Number of Paediatric MDTs in NSW by service type

Base: 2006 - n=7, 2008 – n=8

All of the Paediatric MDTs were located in metropolitan regions, within the public sector. In line with MDTs overall, 6 out of 8 (i.e., 75%) had access to radiotherapy services. The one new Paediatric MDT does not have access to radiotherapy.
Frequency and duration of Paediatric MDT meetings

The frequency with which Paediatric MDTs reported meeting in 2006 and 2008, based on survey level data, is outlined in the chart below.

Figure 62: Frequency of Paediatric MDT meetings (%)

Base: 2006 - n=5, 2008 – n=6

The majority (67%) of Paediatric MDTs reported meeting once a week, with the remainder (33%) meeting once a month.

There were no significant changes from 2006 to 2008 in terms of the frequency with which Paediatric MDTs reported meeting. There were also no significant differences in the frequency with which Paediatric MDTs reported meeting, compared to MDTs overall, in 2008.

Based on the 2008 data, the average reported duration of Paediatric MDT meetings was 90 minutes. Exactly half of the Paediatric MDTs surveyed indicated that, on average, they spent 5-9 minutes discussing each patient, whereas 17% reported spending up to four minutes discussing each patient and 33% reported spending 10-14 minutes discussing each patient.

Each MDT was also asked to consider all patients discussed at their MDT in the last 12 months, and to specify the proportion that was discussed once, twice, and three or more times. The average results across all Paediatric MDTs suggest that 27% of patients were discussed once, 23% discussed twice, and 51% discussed three or more times.
**Case types referred to Paediatric MDTs**

The types of cases or patient groups referred to Paediatric MDTs in 2006 and 2008 are shown in the chart below.

**Figure 63: Case types referred to Paediatric MDTs (%)**

- All diagnosed with relevant cancer: 2006 - 80%, 2008 - 83%
- Suspected cases: 2006 - 0%, 2008 - 33%
- Early cancer (new diagnosis): 2006 - 0%, 2008 - 17%
- Advanced cancer (new diagnosis): 2006 - 0%, 2008 - 17%
- Recurrent cases: 2006 - 60%, 2008 - 60%
- Difficult cases: 2006 - 17%, 2008 - 17%
- Screen detected cancers: 2006 - 0%, 2008 - 0%
- Second opinion: 2006 - 40%, 2008 - 33%
- Clinician choice: 2006 - 20%, 2008 - 17%
- Other: 2006 - 0%, 2008 - 0%

**Base: 2006 - n=5, 2008 – n=6**

The vast majority (83%) of Paediatric MDTs reported that all patients diagnosed with relevant cancer were referred to them. The next most commonly referred case types were suspected cases, and those requiring a second opinion, which 33% of Paediatric MDTs reported were referred to them.

There was an increase from 2006 to 2008 in the proportion of Paediatric MDTs that reported that all patients diagnosed with the relevant cancer were referred to them (from four of the five MDTs surveyed, to five of six). There were significant decreases over this time in the proportion reporting being referred recurrent cases and difficult cases (both three of five MDTs surveyed, to one of six).

Paediatric MDTs were less likely than MDTs overall to report being referred difficult cases (17% versus less 69%), in 2008.
Points along the patient pathway when patient management is discussed at the Paediatric MDT

Figure 64 shows the points on the patient pathway at which Paediatric MDTs reported discussing patient management in 2006 and 2008.


In 2008, the majority of Paediatric MDTs (83%) reported discussing patient management at the point of diagnosis and referral. Half of the Paediatric MDTs reported discussion of patient management at the determination of treatment, during treatment and when treatment changes (e.g. at relapse).

From 2006 to 2008, there was a significant decrease in the proportion of Paediatric MDTs reporting that they discussed patient management at the time of treatment (from all five MDTs surveyed, to three out of six).

Paediatric MDTs were less likely than MDTs overall to indicate that they discussed patient management after surgery but before other treatment (17% versus 69%). No other significant differences were evident based on the 2008 data.

Composition of Paediatric MDTs

The core disciplines for a Paediatric MDT were adapted from the Victorian Patient Management Frameworks and include:
 Radiation Oncologist
 Medical Oncologist
 Palliative Care Service
 General Practitioner
 Nurse
 Social Worker
 Pharmacist

The chart on the following page shows the disciplines that were reported to have been involved with at least one of the Paediatric MDTs in the 2006 and 2008 surveys, along with the proportion of MDTs that indicated that each discipline was involved.

Figure 65: Composition of Paediatric MDTs (%)
The disciplines most commonly reported to have been involved with Paediatric MDTs were Medical Oncologist, Clinical Haematologist, Radiation Oncologist and Nurse Coordinator, each of which were indicated by 83% of the Paediatric MDTs in 2008.

From 2006 to 2008, there was a significant increase in the proportion of Paediatric MDTs that reported involvement with their meetings by Surgeons (20% to 67%), and Radiation Oncologists (40% to 83%). There were a number of significant decreases in the proportion of Paediatric MDTs indicating involvement of a range of disciplines, with the biggest decreases noted with regard to Nursing Trainees (from three of five, to one of six MDTs), Psychiatrists and Allied Health Trainees (both from two of five MDTs, to zero), Pharmacists and Medical Trainees (from all five MDTs, to four of six), as well as Plastic Surgeons (from one MDT of five to zero).

In 2008, compared with MDTs overall (i.e., all tumour streams), Paediatric MDTs were more likely to report involvement of Neuro Surgeons (50% versus 7%), Neuro Oncologists (33% versus 2%), Clinical Haematologists (83% versus 11%), Psychologists (67% versus 25%), Neuro Radiologists (17% versus 3%), Pharmacists (67% versus 10%), Dieticians (67% versus 30%), Occupational Therapists (50% versus 18%) and Pain Clinic (50% versus 5%).

**Data collection by Paediatric MDTs**

The chart below shows the type of data that Paediatric MDTs reported having recorded in 2006 and 2008.

Figure 66: Data and statistics recorded by Paediatric MDTs (%)
Base: 2006 - n=5, 2008 – n=6

Based on the 2008 data, the most commonly recorded data relates to the number of patients discussed, which 67% of Paediatric MDTs reported having recorded. Half of Paediatric MDTs reported recording team present.

There was a significant increase in the proportion of Paediatric MDTs indicating that they recorded the number of patients discussed by week, month or year (from zero of the five MDTs surveyed, to two of six), and a significant decrease in relation to recording of patient morbidity data (from two of the five MDTs surveyed, to zero out of six).

There were no differences in the types of data recorded by Paediatric MDTs, compared with MDTs overall, in 2008.
5.10 Neurological cancers

There were 484 neurological cancer cases in NSW in 2006. The majority of these, 464, were brain cancers. Brain cancer is a rare malignant type of cancer that arises in the brain and may grow rapidly. Malignant brain cancer has a poor prognosis overall, with 319 deaths in 2006.

From 1997 to 2006, the incidence rates of brain cancer were unchanged but mortality rates fell by 15.3% in males.

Neurology MDTs in NSW by Area Health Service

As noted in Section 4.1.1, there were four Neurology MDTs in the NSW population in 2008, which represents an increase of one MDT since 2006. Figure 67, below, shows the number of Neurology MDTs in each Area Health Service in 2006 and in 2008.

Figure 67: Number of Neurology MDTs in NSW by AHS

A new Neurology MDT was formed in HNEAHS between 2006 and 2008. In 2006 and in 2008 there were two Neurology MDTs in SSWAHS and one new MDT in SWAHS.
Neurology MDTs in NSW by service type

Figure 68, below, shows the number of Neurology MDTs in NSW, broken down by service type: metropolitan or regional/rural; public or private; and those with and without radiotherapy access.

Figure 68: Number of Neurology MDTs in NSW by service type

<table>
<thead>
<tr>
<th>Service Type</th>
<th>2006</th>
<th>2008</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metropolitan</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Regional / Rural</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Public</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Private</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>With radiotherapy</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Without radiotherapy</td>
<td>3</td>
<td>1</td>
</tr>
</tbody>
</table>

Base: 2006 - n=3, 2008 – n=4

All Neurology MDTs in 2008 were in metropolitan areas - higher than the proportion for MDTs overall (74%). All were also in public, rather than private hospitals - again, higher than the proportion for MDTs overall (91%). Three had access to radiotherapy in 2008, while one did not, and this was similar to the proportions for MDTs overall, of which 69% had access to radiotherapy.
**Frequency and duration of Neurology MDT meetings**

Figure 69, below, presents survey level data on the frequency with which Neurology MDTs were meeting in 2006 versus 2008.

![Graph showing frequency of Neurology MDT meetings (%)](image)

Base: 2006 - n=3, 2008 – n=3

As shown in the graph above, two of the three Neurology MDTs surveyed in 2008 were meeting once a month, and the third was meeting once a fortnight.

There were no significant changes in the frequency with which Neurology MDTs reported meeting in 2006 versus 2008. Neurology MDTs also did not differ significantly to MDTs overall on the frequency with which they were meeting in 2008.

Based on the 2008 data, the average reported duration of Neurology MDT meetings was 60 minutes. All three of the Neurology MDTs surveyed reported that, on average, they spent 5-9 minutes discussing each patient.

Each MDT was also asked to consider all patients discussed at their MDT in the last 12 months, and to specify the proportion that was discussed once, twice, and three or more times. The average results across the three Neurology MDTs suggest that the large majority of patients (85%) were discussed only once, while 13% of patients were discussed twice and only 2% discussed three or more times.
Case types referred to Neurology MDTs

Figure 70, below, shows the proportion of all Neurology MDTs surveyed that discussed each case type or patient group.

Figure 70: Case types referred to Neurology MDTs (%)

As shown in the graph above, two of the three Neurology MDTs surveyed in 2008 discussed all patients diagnosed with the relevant cancer type, and the same proportion discussed cases based on individual clinician choice. No Neurology MDTs reported discussing screen detected cancers in 2006 or 2008.

In 2006, all three Neurology MDTs surveyed reported that patient groups referred to them included recurrent cases, difficult cases, and cases in which a second opinion had been sought, but in 2008 the number of MDTs reporting each of these had decreased to one. These changes were statistically significant.

There were no differences in the types of patients referred to Neurology MDTs compared to MDTs overall, in 2008.

Points along the patient pathway when patient management is discussed at the Neurology MDT

Figure 71, below, shows the proportion of Neurology MDTs in NSW that discussed patients at each of the points on the pathway, as described on the horizontal axis.
The majority of Neurology MDTs (two of three) that were surveyed in 2008 discussed patient cases at diagnosis and referral, and after surgery but before other treatment, the latter being a response option that was new to the 2008 survey.

The only significant change from 2006 to 2008 was a decrease in the proportion of Neurology MDTs indicating that patient management was discussed at the time treatment is changed (three of three to one of three).

There were no significant differences in the points at which patient management is discussed between Neurology MDTs and MDTs overall, in 2008.

**Composition of Neurology MDTs**

The core disciplines for a Neurology MDT were adapted from the Victorian Patient Management Frameworks and include:

- Neuro-Surgeon
- Radiation Oncologist
- Medical Oncologist
- Neuro-Oncologist
- Pathologist
- Radiologist or Neuro-Radiologist
- General Practitioner
- Palliative Care Specialist
- Nurse
- Social Worker

Figure 72 below shows all disciplines that were identified by at least one Neurology MDT as having been involved with MDT meetings in 2008. For each discipline the graph shows the proportion of Neurology MDTs that had someone from that discipline interacting with their MDT.

Figure 72: Composition of Neurology MDTs (%)

The graph shows that, in 2008, all surveyed Neurology MDTs reported involvement of a Neuro-Surgeon, a Radiation Oncologist and a Medical Oncologist.
Significant decreases in the proportion of Neurology MDTs reporting involvement of a number of different disciplines were observed from 2006 to 2008, including Neuro-Oncologists (from two of three MDTs, to zero) and Medical Trainees (from all three MDTs to one). Decreases were also observed in representation by Neuro-Radiologists and Nurses (from all three MDTs to two), as well as Surgeons and Radiologists (from one of three MDTs, to zero).

In 2008, compared with MDTs overall (i.e., all tumour streams), Neurology MDTs were significantly more likely to have a Neuro-Surgeon (100% compared to 7% overall), a Neuro-Pathologist (33% compared to 1% overall) and a Neuro-Radiologist (67% compared to 3% overall) involved in their MDT. They were also less likely to involve a Radiologist (0% versus 56%).

Data collected by Neurology MDTs

Figure 73, below, shows the various types of data and statistics recorded by NSW MDTs, and the proportion of Neurology MDTs that collected each type.

Figure 73: Data and statistics recorded by Neurology MDTs (%)

The graph shows that all three Neurology MDTs surveyed in 2008 recorded the team members present, and the number of patients discussed at meetings. Two of the three MDTs recorded the number of patients discussed by week, month or year. None recorded the number of patients discussed as a percentage of patients treated for that tumour in the AHS; patient mortality; or patient morbidity.
From 2006 to 2008, there were significant increases in the proportions of Neurology MDTs reporting that they recorded the team present (from two, to three of three), number of patients discussed (also from two, to three of three), and treatment plans in patient notes (from none, to one of three). During the same period, significant decreases were seen in the proportion of Neurology MDTs recording patient survival (from two, to none of three), patient mortality (from one, to none of three), and patient morbidity (from one, to none of three).

There were no differences between Neurology MDTs and MD Ts overall in terms of the types of statistics and data recorded, in 2008.

5.11 Head and neck cancers

Incidence of head and neck cancer

Head and neck cancers arise in the tongue, mouth, salivary glands, pharynx, larynx, nose and sinuses. Males are three times more likely to be diagnosed with a head or neck cancer than females.

There were 951 new cases of head and neck cancers in 2006, 703 of these in males, and 338 deaths (256 males).

Overall, the five-year survival rate is 60% in males and 61% in females, on average.

From 1997 to 2006, the incidence of head and neck cancer fell by 13.3% in males. There was no change in rates for females. The mortality rates fell 23.7% for males, and 24.3% for females.
Head and Neck MDTs in NSW by Area Health Service

As noted in Section 4.1.1, there were 10 Head and Neck MDTs in the NSW population in 2008, which is an increase of one MDT since 2006. The figure below shows the number of Head and Neck MDTs in each Area Health Service in 2006 and in 2008.

Figure 74: Number of Head and Neck MDTs in NSW by AHS

As shown in the graph above, a new Head and Neck MDT was formed in GSAHS between 2006 and 2008. NSCCAHS, SESIAHS and SSWAHS all maintained two MDTs between 2006 and 2008. HNEAHS and SWAHS each had one.

Base: 2006 - n=9, 2008 – n=10 (including 1 private MDT, not included in the chart above)
Head and Neck MDTs in NSW by service type

Figure 75, below, shows the breakdown of Head and Neck MDTs in NSW by service type.

Figure 75: Number of Head and Neck MDTs in NSW by service type

Consistent with the overall figures for NSW MDTs, 80% of Head and Neck MDTs were in metropolitan areas (compared to 74% for all MDTs). However, the only new MDT for 2008 was formed in a public hospital, in a regional/rural area. Nine of the ten MDTs in 2008 were operating within the public system - the same proportion as for all NSW MDTs. All Head and Neck MDTs had access to radiotherapy, and this was higher than the overall rate for MDTs (69%).
Frequency and duration of Head and Neck MDT meetings

Figure 76, below, presents survey level data on the frequency with which Head and Neck MDTs were meeting in 2006 versus 2008.

[Graph showing frequency of Head and Neck MDT meetings]

As shown in the graph above, four of the eight Head and Neck MDTs surveyed in 2008 (or 50%) were meeting once a week. Two met once a fortnight, one met once a month and one met less than once a month.

There were no significant changes in the frequency with which Head and Neck MDTs reported meeting in 2008 compared with 2006. In addition, the frequency with which Head and Neck MDTs met did not differ significantly from MDTs overall.

Based on the 2008 data, the average reported duration of Head and Neck MDT meetings was 86 minutes. Half of the Head and Neck MDTs surveyed (that is, four of the eight) indicated that, on average, they spent 5-9 minutes discussing each patient, whereas three reported spending up to four minutes discussing each patient and one reported spending 10-14 minutes discussing each patient.

Each MDT was also asked to consider all patients discussed at their MDT in the last 12 months, and to specify the proportion that was discussed once, twice, and three or more times. The average results across
all Head and Neck MDTs suggest that three in four patients (75%) were discussed once, 13% discussed twice, and 12% discussed three or more times.

**Case types referred to Head and Neck MDTs**

Figure 77, below, shows the proportion of Head and Neck MDTs that discussed each case type listed.

Figure 77: Case types referred to Head and Neck MDTs (%)

As shown in the graph above, in 2008 the following criteria were each used by half of all Head and Neck MDTs as the basis for referring cases for discussion: all patients diagnosed with the relevant cancer; difficult cases; or patients chosen by clinicians. No MDTs used screen detected cancers as a basis for referral of patients in 2008.

There were no significant changes between 2006 and 2008 in the types of cases referred to Head and Neck MDTs. There were also no significant differences in 2008 between the types of cases referred to Head and Neck MDTs and those referred to MDTs overall.
Points along the patient pathway when patient management is discussed at the Head and Neck MDT

Figure 78 below shows the proportion of Head and Neck MDTs in NSW that discussed patients at each of the points on the pathway, as described on the horizontal axis.

Figure 78: Pathway stages at which patients discussed at Head and Neck MDTs (%)

Base: 2006 - n=8, 2008 – n=8. Note that “after surgery, but before other treatment” was a new code added in 2008.

Seventy five percent of the Head and Neck MDTs surveyed in 2008 discussed patient cases at the point of diagnosis and referral (a significant increase from the 2006 proportion of 38%). The same proportion discussed cases at determination of treatment (although this represented a significant decrease from the 2006 proportion of 100%). Half discussed patient cases after surgery but before other treatment, a response option that was new to the 2008 survey. None of the surveyed MDTs discussed patient care at each hospital admission, in follow-up care (down from 38% in 2006 – a statistically significant difference), or in end of life care.

In 2008, there were no significant differences in the points at which patient management was discussed between Head and Neck MDTs and MDTs overall.

Composition of Head and Neck MDTs

The core disciplines for a Head and Neck MDT were adapted from the Victorian Patient Management Frameworks and include:
• Diagnostic Radiologist
• Ear Nose and Throat or Head and Neck Surgeon
• Medical Oncologist
• Radiation Oncologist
• Reconstructive Surgeon
• Pathologist
• Nurse
• General Practitioner
• Social Worker
• Dietician
• Speech Pathologist²

² Not specified in questionnaire, so excluded when analysing core discipline representation.
Figure 79, below, shows all disciplines that were identified by at least one Head and Neck MDT as having interacted with the MDT in either 2006 or 2008. For each discipline, the graph shows the proportion of Head and Neck MDTs that indicated that that discipline interacted with their MDT.

The graph above shows that all Head and Neck MDTs surveyed in 2008 involved a Radiation Oncologist. Ear, Nose and Throat Surgeons, Head and Neck Surgeons and Medical Oncologists were each involved in 88% of the MDTs, with Medical Trainees, Dieticians and Radiologists each included in 75% of surveyed MDTs.

Between 2006 and 2008, there were statistically significant increases in the proportion of MDTs reporting involvement of four disciplines, namely Medical Oncologist (50% to 88%), Radiologist and Dietician (both 50% to 75%), and Radiation Oncologist (88% to 100%). The proportions of MDTs reporting involvement of other specialists decreased significantly, including Palliative Care (25% to 0%), Reconstructive Surgeon (75% to 50%) and Surgeon (50% to 25%).

In 2008, compared with MDTs overall (i.e., all tumour streams), Head and Neck MDTs were significantly more likely to include an Ear, Nose and Throat Surgeon (88% compared to 8% overall), a Head and Neck Surgeon (88% compared to 8% overall), a Reconstructive Surgeon (50% compared to 11% overall) and a
Dietician (75% compared to 30% overall). They were significantly less likely to include a Palliative Care Specialist (0% compared to 45% overall).

**Data collection by Head and Neck MDTs**

Figure 80, below, shows the various types of data and statistics recorded by Head and Neck MDTs, and the proportion of Head and Neck MDTs that collected each type.

Figure 80: Data and statistics recorded by Head and Neck MDTs (%)

As shown in the graph above, five of the eight Head and Neck MDTs surveyed in 2008 (63%) recorded treatment plans in patient notes. The team members present, and the number of patients discussed, were each recorded by four surveyed MDTs in 2008 (50%). None recorded the number of patients discussed as a proportion of patients treated for that tumour in the Area Health Service; the proportion of patients managed according to protocols; patient mortality; patient morbidity; or patient survival. One of the MDTs reported that they did not record any data at all in 2008.

Between 2006 and 2008 there was a significant decrease in the proportion of surveyed Head and Neck MDTs reporting recording treatment plans in patient notes. This proportion decreased from 88% in 2006 to the above mentioned 63% (or five of eight MDTs).

The picture for Head and Neck MDTs in 2008 did not differ significantly in any respect from the picture for the MDT sample as a whole.
5.12 Haematological cancers

Incidence and mortality of haematological cancers

Haematological malignancies are a complex group of neoplastic diseases originating in bone marrow derived cells. The four groups of haematological malignancies are leukaemias, lymphomas, myelomas, and myelodysplasia.

The graph below represents the 2006 incidence and death rates for the various haematological cancers.

Figure 81: Incidence and mortality of haematological cancers in NSW in 2006

Source: 2006 data extracted from the NSW Central Cancer Registry

Lymphoma was the most common haematological cancer in NSW, and had a mortality rate of 36%. Leukaemia had a lower incidence, with 858 cases, but a higher mortality rate of 54%. Myeloma had the lowest incidence among haematological cancers, but the highest mortality rate (59%).
Haematology MDTs in NSW by Area Health Service

As noted in Section 4.1.1, there were 13 Haematology MDTs in the NSW population in 2008 – an increase of one MDT since 2006. Figure 82, below, shows the number of Haematology MDTs in each NSW Area Health Service in 2006 and in 2008.

Figure 82: Number of Haematology MDTs in NSW by AHS

Base: 2006 - n=12, 2008 – n=13 (including 1 private MDT, not included in the chart above)

As shown in the graph above, the largest number of MDTs was in SSWAHS (three), with two in each of NSCCAHS, SESIAHS and SWAHS, and one in each of HNEAHS and NCAHS. The only new Haematology MDT formed between 2006 and 2008 was in GSAHS.
Haematology MDTs in NSW by service type

Figure 83, below, shows the breakdown of Haematology MDTs in the NSW population by service type.

Figure 83: Number of Haematology MDTs in NSW by service type

Base: 2006 - n=12, 2008 – n=13

Ten of the 13 Haematology MDTs in NSW in 2008 (77%) were located in metropolitan areas, compared to 74% of all MDTs. However, the newly formed MDT was in a regional/rural area. Twelve of the 13 Haematology MDTs (92%) were operating in public hospitals in 2008, and this was similar to the proportion for all NSW MDTs (91%). Ten of the 13 (76%) had access to radiotherapy, only slightly more than the proportion of all NSW MDTs with access (69%).
**Frequency and duration of Haematology MDT meetings**

Figure 84, below, presents survey level data on the frequency with which Haematology MDTs were meeting in 2006 versus 2008.

**Figure 84: Frequency of Haematology MDT meetings (%)**

- 78% of MDTs met once a week in 2006.
- 36% of MDTs met once a fortnight in 2006.
- 9% of MDTs met less than once a month in 2006.
- 22% of MDTs met once a week in 2008.
- 36% of MDTs met once a fortnight in 2008.
- 9% of MDTs met less than once a month in 2008.

Base: 2006 - n=9, 2008 – n=11

As shown in the graph above, of the 11 Haematology MDTs surveyed in 2008, six (55%) met once a week in 2008 and four (36%) met once a fortnight. One met less than once a month.

Between 2006 and 2008, the proportion reporting meeting once a week decreased significantly from 78% to the above mentioned 55%. The number of MDTs that reported meeting less than once a month increased significantly from no MDTs in 2006 to one in 2008.

The frequency with which Haematology MDTs reported meeting in 2008 did not differ significantly from MDTs overall.

Based on the 2008 data, the average reported duration of Haematology MDT meetings was 59 minutes. Just over half (55%) of the Haematology MDTs surveyed reported spending up to four minutes discussing each patient, whereas 18% reported spending 5-9 minutes discussing each patient, and 27% reported spending 10-14 minutes discussing each patient.
Each MDT was also asked to consider all patients discussed at their MDT in the last 12 months, and to specify the proportion that was discussed once, twice, and three or more times. The average results across all Haematology MDTs suggest that roughly half (49%) of patients were discussed once, 23% discussed twice, and 29% discussed three or more times.

**Case types referred to Haematology MDTs**

Figure 85 shows the proportion of Haematology MDTs that discussed each case type listed.

![Case types referred to Haematology MDTs](image)

As shown above, there was no case type that was referred to a majority of the Haematology MDTs surveyed in NSW in 2008. The most common criteria for referring cases were each used by only 45% of MDTs and included: all patients diagnosed with the relevant cancers; recurrent cases; and difficult cases. No Haematology MDTs discussed screen detected cancers.

The proportion of Haematology MDTs that reported discussing difficult cases decreased significantly between 2006 and 2008 from 78% to 45%. No other statistically significant changes were observed between the survey periods.

Compared with NSW MDTs overall, Haematology MDTs were significantly less likely to discuss patients with screen detected cancers (0% versus 24% overall) in 2008.
Points along the patient pathway when patient management is discussed at the Haematology MDT

Figure 86, below, shows the proportion of Haematology MDTs in NSW that discussed patients at each of the points along the pathway, described on the horizontal axis.

Figure 86: Pathway stages at which patients discussed at Haematology MDTs (%)

As shown in the graph above, seven of the 11 Haematology MDTs surveyed in NSW in 2008 (64%) discussed patients at the time of diagnosis and referral, and the same proportion discussed patients at determination of treatment. Just over half (55%) discussed patients when their treatment changed.

There were two significant changes from 2006 to 2008; a decrease in the proportion of Haematology MDTs reporting that they discussed patient management at the time treatment is changed (89% to 55%), and a decrease in the proportion of Haematology MDTs reporting that they discussed patient management at each hospital admission (44% to 18%).

Compared with NSW MDTs overall, the surveyed Haematology MDTs were significantly less likely to report that they discussed cases after surgery but before other treatment (9% compared to 60% for all MDTs).

Composition of Haematology MDTs

The core disciplines for a Haematology MDT were adapted from the Victorian Patient Management Frameworks and include:
- Clinical Haematologist
- Medical Oncologist
- Radiation Oncologist
- Surgeon
- General Practitioner
- Nurse Specialist
- Pharmacist
- Social Worker
- Symptom Management Specialist (e.g. Palliative Care or Pain Specialists)\(^3\)

Figure 87, on the following page, shows all disciplines that were identified by at least one Haematology MDT as having been involved with MDTs in either 2006 or 2008. For each discipline, the graph shows the proportion of Haematology MDTs that reported the involvement of that discipline.

\(^3\) Symptom management specialist is only noted for Intermediate Grade Non-Hodgkin Lymphoma, so is not treated here as core discipline for Haematology MDTs in general.
As shown in the graph above, 91% of all Haematology MDTs surveyed in 2008 had a Clinical Haematologist interacting with their MDT. Nurses and Radiation Oncologists were each interacting with 73% of the 11 MDTs.

The main statistically significant changes between 2006 and 2008 include decreases in the proportions of MDTs reporting involvement by a Clinical Haematologist (100% to 91%), Medical Trainees (78% to 55%), and a Pharmacist (56% to 27%). There was also an increase in the proportion reporting involvement by a Psychologist (0% to 18%), and a Surgeon (0% to 9%).

In 2008, compared with MDTs overall (i.e., all tumour streams), Haematology MDTs were significantly more likely to include a Clinical Haematologist (91% compared to 11% overall) and a Pharmacist (27% versus 10%); and significantly less likely to include a Surgeon (9% compared to 44% overall) or a Medical Oncologist (45% compared to 80% overall).
Data collection by Haematology MDTs

Figure 88, below, shows the various types of data and statistics recorded by NSW MDTs, and the proportion of surveyed Haematology MDTs that collected each type.

All NSW Haematology MDTs surveyed in 2008 reported that they recorded some data. Most commonly, they recorded treatment plans in patient notes (reported by 91%), number of patients discussed (82%) and team members present (64%). None recorded the number of patients discussed as a proportion of patients treated for that tumour type in the Area Health Service; the proportion of patients managed according to protocols; or patient survival rates.

From 2006 to 2008, there were significant increases in the proportions of Haematology MDTs reporting that they recorded treatment plans in patient notes (44% to 82%), and treatment plans in patient notes (56% to 91%). The proportion reporting that they recorded patient survival decreased significantly from 22% to 0%.

There were no significant differences between Haematology MDTs and MDTs overall in terms of the types of data and statistics recorded.
5.13 Palliative care

The Palliative Care MDT discusses any patient with a life-limiting illness, whether it is cancer or some other relevant illness. These teams have a higher percentage of allied health and supportive care staff than other cancer MDTs and are likely to be linked to, or have members attend a range of, the other cancer MDTs.

Palliative Care MDTs in NSW by Area Health Service

As noted in Section 4.1.1, there were 16 Palliative Care MDTs in NSW in 2008. Figure 89, below, shows the number of Palliative Care MDTs in each Area Health Service in 2006 and in 2008.

As shown in the graph above, NSCCAHS had the largest number of Palliative Care MDTs in 2008, with five. SWAHS had three, and GSAHS and SESIAHS each had two. HNEAHS, GWAHS, NCAHS and SSWAHS each had one. The only Palliative Care MDT in NSW formed between 2006 and 2008 was in GSAHS.
As shown in the graph above, 11 of the 16 Palliative Care MDTs in NSW in 2008 (69%) were located in Metropolitan areas, and five (31%) were located in regional or rural areas. There was a higher proportion of Palliative Care MDTs in regional or rural areas (31%) than for all NSW MDTs (26%). All Palliative Care MDTs operated in public hospitals, a higher proportion than for MDTs overall (91%). A large majority of Palliative Care MDTs (88%) did not have access to radiotherapy, a much larger proportion than for all NSW MDTs (31%).
Frequency and duration of Palliative Care MDT meetings

Figure 91, below, presents survey level data on the frequency with which Palliative Care MDTs were meeting in 2006 versus 2008.

As shown in the graph above, eight of the 13 Palliative Care MDTs surveyed in 2008 (62%) met once a week, while two of the 13 met once a fortnight, two met once a month, and one met less than once a month.

None of the differences observed between 2006 and 2008 meeting frequency data were statistically significant. There were also no significant differences in the frequency with which Palliative Care MDTs versus MDTs overall met.

Based on the 2008 data, the average reported duration of Palliative Care MDT meetings was 98 minutes. Just over half of the Palliative Care MDTs surveyed (54%) indicated that, on average, they spent 5-9 minutes discussing each patient. The remaining MDTs were divided equally between reporting spending up to four minutes discussing each patient (15%), 10-14 minutes discussing each patient (15%), and 15 minutes or more discussing each patient (15%).

Each MDT was also asked to consider all patients discussed at their MDT in the last 12 months, and to specify the proportion that was discussed once, twice, and three or more times. The average results across all Palliative Care MDTs suggest that 22% of patients were discussed once, 12% discussed twice, and 66% discussed three or more times.
Case types referred to Palliative Care MDTs

Figure 92 below shows the proportion of Palliative Care MDTs that discussed each case type listed.

Figure 92: Case types referred to Palliative Care MDTs (%)

As shown in the graph above, the Palliative Care MDTs surveyed in 2008 were most likely to report “other” as the reason for cases being referred to them, with 85% choosing this reason option. Specific case types recorded by research participants under the generic heading of “other” commonly included palliative care appropriate patients, and all in-patients or all registered patients.

Indeed, the proportion nominating “other” increased significantly between the 2006 and 2008 surveys from 64% to 85%. The other statistically significant change observed between the two survey periods was in the proportion of Palliative Care MDTs nominating “all newly diagnosed early cancer” as a reason for cases being referred to them. While one MDT nominated this reason in 2006 (perhaps accidentally), none nominated it in 2008.

The surveyed Palliative Care MDTs were significantly more likely than MDTs overall to report “other” as the reason for referral (85% compared to 21% overall). They were significantly less likely to report the reasons: “all patients diagnosed with the relevant type of cancer” (8% compared to 54% overall); “all newly diagnosed early cancer” (0% compared to 42% overall); “difficult cases” (31% compared to 69% overall); “screen detected cancers” (0% compared to 24% overall); and “cases referred for a second opinion” (8% compared to 44% overall).
Points along the patient pathway when patient management is discussed at the Palliative Care MDT

Figure 93 below shows the proportion of Palliative Care MDTs in NSW that discussed patients at each of the points along the patient pathway, as described on the horizontal axis.

Figure 93: Pathway stages at which patients discussed at Palliative Care MDTs (%)

<table>
<thead>
<tr>
<th>Stages</th>
<th>2006</th>
<th>2008</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnosis &amp; referral</td>
<td>27%</td>
<td>9%</td>
</tr>
<tr>
<td>Determination of treatment</td>
<td>46%</td>
<td>9%</td>
</tr>
<tr>
<td>After surgery, before other treatment</td>
<td>23%</td>
<td>18%</td>
</tr>
<tr>
<td>Treatment</td>
<td>54%</td>
<td>54%</td>
</tr>
<tr>
<td>Treatment changed (e.g. relapse)</td>
<td>18%</td>
<td>18%</td>
</tr>
<tr>
<td>Each hospital admission</td>
<td>45%</td>
<td>77%</td>
</tr>
<tr>
<td>Follow-up care</td>
<td>77%</td>
<td>77%</td>
</tr>
<tr>
<td>End of life care</td>
<td>92%</td>
<td>92%</td>
</tr>
<tr>
<td>Other</td>
<td>31%</td>
<td>64%</td>
</tr>
</tbody>
</table>


Ninety two percent of the Palliative Care MDTs surveyed in 2008 reported that they discussed patients in end of life care. The next most common points at which patients’ care was discussed were at each hospital admission (reported by 77% of Palliative Care MDTs) and in follow-up care (77%).

Between 2006 and 2008 there were statistically significant increases in the proportions of Palliative Care MDTs surveyed that reported discussing patient management at: diagnosis and referral (27% to 54%), determination of treatment (9% to 46%), time of treatment (18% to 54%), time treatment is changed (similarly 18% to 54%), each hospital admission (45% to 77%) and follow-up care (55% to 77%).

In comparison to all NSW MDTs surveyed in 2008, Palliative Care MDTs were significantly less likely to report that they discussed patient care after surgery but before other treatment (23% compared to 60% overall). They were significantly more likely to report that they discussed patient care at each hospital admission (77% compared to 20% overall); during follow-up care (77% compared to 26% overall); and during end of life care (92% compared to 23% overall).
Composition of Palliative Care MDTs

The core disciplines for a Palliative Care MDT were adapted from the Victorian Patient Management Frameworks and include:

- Palliative Care Physician
- General Practitioner
- Nurse
- Social Worker
- Pharmacist

Figure 94 shows all disciplines that were identified by at least one Palliative Care MDT as having been involved with their MDT in 2006 or in 2008. For each discipline the graph shows the proportion of Palliative Care MDTs that reported each discipline being involved in their MDT meetings.
The graph above shows that all Palliative Care MDTs surveyed in 2008 had two of the core Palliative Care disciplines – a Nurse and a Social Worker – involved with their MDT. Of the 13 MDTs, 92% reported the involvement of a Palliative Care Specialist. Occupational Therapists and Physiotherapists were each reported as being involved in 85% of the 13 Palliative Care MDTs.

Between 2006 and 2008, there were a number of significant increases in the proportions of Palliative Care MDTs indicating involvement of a range of disciplines at their meetings, including Allied Health Trainees (18% to 62%), Medical Trainees (36% to 69%), Nursing Trainees (27% to 55%), Physiotherapy (55% to 85%), Lymphoedema Service (0% to 27%), Social Workers (82% to 100%) and Nurses (91% to 100%).

In 2008, compared with MDTs overall (i.e., all tumour streams), Palliative Care MDTs were significantly less likely to have a Surgeon (0% compared to 44%), a Radiation Oncologist (8% compared to 79%), a Medical Oncologist (25% compared to 80%), a Pathologist (0% compared to 56%), and a Radiologist (0% compared to 56%) interact with their MDT.

Palliative Care MDTs were significantly more likely to have interaction from a Palliative Care specialist (92% compared to 45%); a Nurse (100% compared to 72% overall); a Social Worker (100% compared to 45% overall); a Physiotherapist (85% compared to 25% overall); an Occupational Therapist (85% compared to 18% overall); representation from a Lymphoedema service (27% compared to 10% overall); Pastoral Care
representative (54% compared to 10% overall); Nursing Trainees (55% compared to 22%); and Allied Health Trainees (62% compared to 20%).

**Data collection by Palliative Care MDTs**

Figure 95 below shows the various types of data and statistics recorded by NSW MDTs, and the proportion of Palliative Care MDTs that collected each type.

![Figure 95: Data and statistics recorded by Palliative Care MDTs (%)](image)

Base: 2006 - n=11, 2008 – n=13

As shown in the graph above, 11 of the 13 Palliative Care MDTs surveyed in 2008 (85%) reported that they recorded team members present at meetings. Recording of treatment plans in patient notes, and of patient mortality were each reported by 10 of the 13 MDTs (77%). None of the surveyed Palliative Care MDTs recorded the percentage of patients managed according to protocols. One MDT reported that they recorded no data.

Between 2006 and 2008 there were statistically significant increases in the proportion of Palliative Care MDTs reporting that they recorded each of the following data: team present (64% to 85%); number of patients discussed by week, month or year (0% to 23%); patient mortality (45% to 77%); and patient survival (0% to 31%).

In comparison to all MDTs surveyed in 2008, Palliative Care MDTs were significantly more likely to record patient mortality rates; 77% recorded this data, in comparison to 24% of all surveyed.
5.14 Regional or rural MDTs

This section includes data from the following Area Health Services: GSAHS, NCAHS, NSCCAHS, GWAHS, SESIAHS, and HNEAHS. Some of these regions include both metropolitan and regional/rural areas, but only the data from the regional or rural MDTs within each Area Health Service is included in this section.

Regional/Rural MDTs in NSW by Area Health Service

As noted in Section 4.1.1, there were 41 regional or rural MDTs in the NSW population in 2008, which represents an increase of 10 MDTs since 2006. Figure 96, below, shows the numbers of regional or rural MDTs in NSW in each Area Health Service in 2006 and 2008. Data from exclusively metropolitan AHSs - SSWAHS, SWAHS and Children’s Hospital Westmead - are not included in this graph.

In 2008, GSAHS had the largest number of regional or rural MDTs, with 12, followed by NCAHS with nine, NSCCAHS and GWAHS each with six, and SESIAHS and HNEAHS each with two.

Between 2006 and 2008, 10 new regional or rural MDTs were formed in NSW, increasing the total number of NSW regional or rural MDTs to 41. GSAHS had the greatest increase, with five new MDTs formed. Four new MDTs were formed in NCAHS, and one in GWAHS. MDT numbers in the other areas remained steady.
Regional/Rural MDTs in NSW by service type

Figure 97, below, breaks down the number of regional or rural MDTs in the NSW population according to the service type.

Figure 97: Number of Regional/Rural MDTs in NSW by service type

<table>
<thead>
<tr>
<th>Service Type</th>
<th>2006</th>
<th>2008</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public</td>
<td>27</td>
<td>37</td>
</tr>
<tr>
<td>Private</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>With radiotherapy</td>
<td>12</td>
<td>21</td>
</tr>
<tr>
<td>Without radiotherapy</td>
<td>19</td>
<td>20</td>
</tr>
</tbody>
</table>

Base: 2006 - n=31, 2008 – n=41

Ninety percent of regional or rural MDTs were operating within the public hospital system—the same percentage as for NSW MDTs overall. Between 2006 and 2008, the number of regional or rural MDTs in public hospitals increased by 37%, from 27 to 37, while the number in private hospitals remained unchanged at four. The bulk of the increase in MDT numbers was in those with radiotherapy access, which grew by 75% from 12 to 21 MDTs. The number of MDTs without radiotherapy access grew by one to 20.
Number of Regional/Rural MDTs in NSW by tumour type

Figure 98, below, shows the number of regional or rural MDTs in NSW, broken down by tumour type.

<table>
<thead>
<tr>
<th>Tumour Type</th>
<th>2006</th>
<th>2008</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>General - Palliative Care</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Gastrointestinal (GI)</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Haematological</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>GI</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Lung</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>General - Other</td>
<td>13</td>
<td>10</td>
</tr>
</tbody>
</table>

Base: 2006 - n=31, 2008 – n=41

In 2008, Breast Cancer MDTs were the most prevalent regional or rural MDT by tumour type in NSW, with a total of seven. This was followed by Palliative Care MDTs with five, Urology MDTs with four, Haematology MDTs and Gastrointestinal MDTs each with three, and Colorectal MDTs, Head and Neck MDTs, and Lung MDTs all with two. In addition, there were 13 MDTs classified as General (Other). The number of Colorectal MDTs remained steady at two, but numbers of all other tumour-type MDTs increased by one. Three new MDTs in the General (Other) category were also formed.
Frequency and duration of Regional/Rural MDT meetings

Figure 99, below, shows survey level data on the frequency with which regional or rural MDTs were meeting in 2006 versus 2008.

Figure 99: Frequency of Regional/Rural MDT meetings (%)

Base: 2006 - n=27, 2008 – n=37

The majority of regional or rural MDTs surveyed in 2008 (57%) met once a fortnight, while 14% met once a week, 22% met once a month, 8% met less than once a month, and none met irregularly.

Compared to 2006, Regional or Rural MDTs in 2008 were significantly more likely to meet once a fortnight (from 41% of regional or rural MDTs in 2006 to 57% in 2008) and significantly less likely to meet once a week (26% to 14%).

Compared to MDTs in metropolitan areas, Regional and Rural MDTs were significantly more likely to meet fortnightly (57% of regional or rural MDTs compare to 31% in metropolitan areas) or less than monthly (8% compared to 1%); and significantly less likely to meet weekly (14% compared to 59%).

At 56 minutes, the average reported duration of Regional and Rural MDT meetings was significantly lower than the average reported duration of MDTs in metropolitan areas (75 minutes).

Just under two in three (65%) of Regional and Rural MDTs reported spending 5-9 minutes discussing each patient, 8% reported spending up to four minutes discussing each patient, 24% reported spending 10-14
minutes discussing each patient, and 4% reported spending at least 15 minutes discussing each patient. Regional and Rural MDTs did not differ significantly from MDTs in metropolitan areas on this measure.

Each MDT was also asked to consider all patients discussed at their MDT in the last 12 months, and to specify the proportion that was discussed once, twice, and three or more times. The average results across all Regional and Rural MDTs suggest that 70% of patients were discussed once, 15% discussed twice, and 16% discussed three or more times. Once again, no significant differences were revealed between Regional and Rural MDTs versus those in metropolitan areas on this measure.
Case types referred to Regional/Rural MDTs

Figure 100, below, shows the proportion of regional or rural MDTs that discussed each case type.

The majority of regional or rural MDTs surveyed in 2008 (68%) discussed difficult cases. All patients diagnosed with the relevant type of cancer were discussed by 35% of surveyed MDTs in 2008.

Compared to 2006, regional or rural MDTs were significantly more likely to report using the case selection protocols of: individual clinician choice (from 30% of MDTs in 2006 to 41% in 2008) and screen detected cancers (15% to 22%).

Compared to those in metropolitan areas, Regional and Rural MDTs were significantly more likely to report using the case selection protocol of individual clinician choice (41% of regional or rural MDTs compared to 21% of metropolitan MDTs); and less likely to report selecting all cases with the relevant cancer (35% of regional or rural MDTs compared to 62% of metropolitan MDTs).
Points along the patient pathway when patient management is discussed at the Regional/Rural MDT

The figure below shows the proportion of regional or rural MDTs in NSW that discussed patients at each of the points on the patient pathway, as described on the horizontal axis.

Figure 101: Pathway stages at which patients discussed at Regional/Rural MDTs (%)

- Determination of treatment (67% in 2006, 67% in 2008)
- Initial diagnosis and referral (67% in 2006, 67% in 2008)
- After surgery but before other treatment (51% in 2006, 51% in 2008)
- Treatment (44% in 2006, 30% in 2008)
- End of life care (30% in 2006, 22% in 2008)
- Follow-up care (30% in 2006, 22% in 2008)
- At each hospital admission (16% in 2006, 19% in 2008)
- Other (15% in 2006, 16% in 2008)

Base: 2006 - n=86, 2008 – n=118. Note that “after surgery but before other treatment” was a new code added in 2008.

A slight majority of regional or rural MDTs surveyed in 2008 (57%) discussed each patient after surgery but before other treatment (a new option in the 2008 questionnaire). About half of surveyed MDTs discussed each patient at determination of treatment (51%), initial diagnosis and referral (49%) and at the time treatment is changed (51%).

Compared to 2006, Regional or Rural MDTs in 2008 were significantly less likely to report that they assessed patients at: determination of treatment (from 67% of regional or rural MDTs in 2006 to 51% in 2008); initial diagnosis and referral (67% to 49%); during treatment (44% to 30%); and during follow-up care (30% to 22%).

Compared to those in metropolitan areas, Regional or Rural MDTs were significantly more likely to select “other” when asked at what points they assessed patient cases (16% of regional or rural MDTs compared to 4% of metropolitan MDTs). They were significantly less likely to report that they assessed patients at initial diagnosis and referral (49% compared to 68%); at determination of treatment (51% versus 76%); and during treatment (30% versus 53%).
Composition of Regional/Rural MDTs

Figure 102, below, shows all disciplines that were identified by at least one Regional or Rural MDT as having been involved with their MDT in 2006 or in 2008. For each discipline the graph shows the proportion of Regional or Rural MDTs that reported involvement by that discipline in their MDT.

As shown in the graph above, the disciplines most commonly represented in Regional or Rural MDTs in 2008 were Nurse Coordinator (84% of MDTs), Nurse (73%), Medical Oncologist (67%), Radiation Oncologist (65%) and Social Worker (61%).

Compared to 2006, Regional or Rural MDTs in 2008 were significantly more likely to include a number of specific disciplines, with the largest shifts including a Dietician (from 19% of MDTs in 2006 to 42% in 2008); Radiation Oncologist (48% to 65%); Medical Oncologist (56% to 67%); Social Worker (48% to 61%); Physiotherapist (11% to 22%); General Practitioner (30% to 39%); Nursing Trainees (19% to 27%); a Lymphoedema Service (4% to 14%); and Psychologist (4% to 14%).

Compared to 2006, Regional or Rural MDTs in 2008 were significantly less likely to include a Pharmacist (15% to 8%), Pastoral Care representative (11% to 5%), or Endoscopist (7% to 3%).

Compared to those in metropolitan areas, Regional or Rural MDTs in 2008 were significantly more likely to involve: a GP (39% of regional or rural MDTs compared to 5% of metropolitan MDTs); a Social Worker (61% compared to 39%); and Stomal Therapist (14% compared to 3%).

Compared to those in metropolitan areas, Regional or Rural MDTs in 2008 were significantly less likely to include a Reconstructive Surgeon (0% of Regional or Rural MDTs compared to 15% of metropolitan MDTs); Radiation Oncologist (65% compared to 85%); Medical Oncologist (67% compared to 85%); or Palliative Care representative (31% compared to 51%).

Data and statistics recorded by Regional/Rural MDTs (%)

Figure 103, below, shows the types of data and statistics collected by NSW MDTs, and the number of regional or rural MDTs in NSW that collected that type of data.

Large majorities of NSW regional or rural MDTs surveyed in 2008 recorded the number of patients discussed at each meeting (81%), the team members present at each meeting (76%), and the treatment plans recorded in the patients notes (70%). In 2008, none collected data on the number of patients discussed as a proportion of total patients treated for the tumour type, or for the proportion of patients managed according to agreed protocols.

Compared to 2006, Regional or Rural MDTs in 2008 were significantly more likely to report that they recorded: the number of patients discussed at each meeting (from 70% in 2006 to 81% in 2008); team present at each meeting (59% to 76%); treatment plans recorded in the patient notes (41% to 70%); and number of patients discussed at each meeting by week, month or year (33% to 46%).
Compared to those in metropolitan areas, Regional or Rural MDTs in 2008 were significantly less likely to report that they recorded patient survival data (3% of regional or rural MDTs compared to 16% of metropolitan MDTs).