

Annual Report 2023-2024



Acknowledgements

SMICS and the Victorian Government acknowledge Aboriginal and Torres Strait Islander people as the Traditional Custodians of the land and acknowledges and pays respect to their Elders, past, present and emerging.

We are committed to safe and inclusive workplaces, policies and services for people of LGBTIQ communities and their families.

The Victorian Integrated Cancer Services are supported by the Victorian Government.



Table of Contents

Introduction.....	3
VICS Implementation Plan statewide projects 2020-24.....	4
About SMICS	7
Message from the SMICS leadership team.....	8
Understanding Our Community.....	10
Data unit requests	14
SMICS year highlights	15
Strengthening Workforce Capability	22
SMICS Funding Program.....	23
Financial report.....	32
Our Team	33



Introduction

The Victorian Integrated Cancer Services (VICS) is Victoria's cancer service improvement network. We connect **123 member services** that support Victorians affected by cancer - to drive best practice and improve patient experiences and outcomes.

Improving cancer outcomes for all Victorians

The VICS have been a key mechanism driving local and statewide implementation of the Victorian Cancer Plan 2020-24. Our role, as defined in that plan, is to promote and enable:

- system integration across structural boundaries
- collaborative approaches to evidence-based service development
- quality improvement at the local level.

In 2020-24, the VICS undertook more **than 400 projects** in support of the Victorian Cancer Plan. With our support, all 5 short-term goals of the Victorian Cancer Plan have been met or are making progress towards achievement in 2024.

Cancer policy and system reform

The VICS build relationships between healthcare providers and other stakeholders to develop, implement and evaluate initiatives that improve how Victoria's health services provide care and support to people affected by cancer.

Our **statewide collaboration with the Australian Cancer Survivorship Centre:**

- supported VICS member services to ensure appropriate policies are in place
- helped health services implement survivorship models of care
- improved health services' confidence, capacity and capability in survivorship care.

Our **Care of the Older Person with Cancer Toolkit** (updated in August 2023 and April 2024) helps health providers to identify and address barriers to quality care and to find key resources such as how-to guides and patient information.

Other work undertaken by the VICS includes:

- implementation of a new model of care for improved cancer care closer to home
- development and application of resources that inform improved delivery of cancer care for the older person
- increased awareness and understanding by clinicians of the need to improve cultural safety for Aboriginal and Torres Strait Islander cancer patients and carers
- policy implementation by health services to support best-practice survivorship care practices.

For more information visit www.vics.org.au

VICS Implementation Plan statewide projects 2020-24

Victoria's nine Integrated Cancer Service (ICS) partnerships work together to deliver statewide improvement projects guided by the VICS Implementation Plan.

Improving adoption of quality cancer care closer to home

SMICS/LMICS/PICS/BSWRICS/GRICS/GICS

Telehealth and telemedicine guidelines were developed and 53 health services participated in a telehealth audit. Additionally, 25 local ICS telehealth projects were delivered.

Four pilot sites tested the Chemo@home or closer-to-home projects, involving 10 health professionals and leading to professional workshops to upskill staff. This work was also supported by thirty-one local projects.

A project on improving processes around the My Health record was delivered with two health services involved in a pilot and supported by nine local activities.

Outcomes included improved access to clinical services close to home, increased clinician accessibility, better patient experiences, reduced travel, and enhanced care for patients and families. Health service staff experienced improved retention, increased capacity, and professional development.

Increasing alignment with the Multidisciplinary Meeting (MDM) Quality Framework

LMICS

VICS worked collaboratively in developing governance structures aligned with the MDM quality framework. This was supported by 38 local activities including 22 health services audited, 55 ICS and Health Service staff attending the Multi-Disciplinary Meeting (MDM) webinar.

Outcomes included improved processes and compliance with the MDM Quality Framework recommendations, and enhanced mechanisms for treatment decisions, multidisciplinary communication, and patient care.

Addressing the needs of the older person in routine cancer care

HRICS & SMICS

Activities included 33 health services participating in an environmental scan of their service improvement projects for older cancer patients, with 16 delivering projects and 25 planning. A GeriOncology Toolkit was created, a workshop by subject matter experts was held, and 12 local ICS projects supported the needs of older patients.

Outcomes included support for clinicians in person-centred care, improved quality of care for older cancer patients, geri-oncology screening to inform appropriate care, increased confidence in adapting service models through the Toolkit, and increased consistency in referral pathways, screening, service coordination, and delivery of geri-oncology care.

Implementing the Aboriginal and Torres Strait Islander Optimal Care Pathway (OCP)

HRICS & WCMICS

Activities included 56 ICS staff participating in a cultural awareness audit and 114 clinicians assessing their OCP knowledge. 33 local ICS projects supported the Aboriginal & Torres Strait Islander OCP implementation, such as exploring patient navigation models, collaborating with local communities, creating over 40 culturally welcoming treatment spaces, and reviewing processes like the SCNAT-IP tool.

Outcomes included increased understanding of Aboriginal culture by ICS staff, improved OCP awareness among clinical staff, enhanced delivery of culturally sensitive healthcare, and increased distribution of Aboriginal artwork to improve cultural safety in healthcare settings.

Addressing variation in quality and timeliness of cancer care

NEMICS & GICS

The VICS delivered six VICS Optimal Care Summits (formerly Victorian Tumour Summits) consultations. Each identified unwarranted variations across Victoria in care and patient outcomes, for specific tumour types, and codesigned actions to address those variations.

Participants including consumers, multidisciplinary clinicians, and cancer organisations. The VICS led and collaborated on service improvement projects based on summit recommendations, resulting in 18 local ICS projects to address identified variations.

The summit data and recommendations led to improved clinical practices across six tumour streams, increased clinician engagement, and the identification of unwarranted variations in cancer care. This work improved cancer care practices and models, reduced variations, and ensured more consistent and improved care for cancer patients.

Monitoring and communicating alignment with OCPs

PICS & WCMICS

Activities included conducting a gap and opportunity analysis of VICS data processes, reviewing OCPs to determine appropriate indicators, developing standardized monitoring and reporting processes, piloting and implementing 21 clinical indicators, and modifying three SCIP-based indicators. Additionally, 34 local ICS projects and 10 PICS projects were delivered.

Outcomes included the formation and improvement of standardised monitoring and reporting processes, consistent statewide monitoring and reporting of health service performance, identification of service improvement opportunities, improved care, and enhanced engagement with clinical stakeholders.

Facilitating high quality supportive care

GICS & GRICS

Activities included 54 health services participating in the Supportive Care policy audit tool, auditing patients at two health services (WCMICS and GICS), making several recommendations, and hosting two supportive care showcases. There was a 300% increase in supportive care uptake through the 131120 ACCESS project, and 52 local projects were delivered.

Outcomes included increased patient access to supportive care services, implementation of clear policies and protocols for supportive care screening, increased service improvement opportunities, improved quality of life for patients, and a strong partnership with Cancer Council Victoria enhancing supportive care provision statewide.

Facilitating high quality survivorship care

LMICS & WCMICS & PICS

Activities included developing a survivorship care policy template, informing 43 Victorian health services about its importance, and creating a Survivorship Needs Assessment tool and Survivorship Care Plan through co-design workshops. Twelve pilot sites tested the tools, survivorship education was provided to various health services, and 30 local projects were delivered.

Outcomes included increased consistency and sustainability of survivorship care statewide, enhanced workforce knowledge and confidence in survivorship care, improved quality of life for cancer patients, and better survivorship support for paediatric patients through resources developed by PICS.

Addressing variation in palliative care referrals and advance care planning

BSWRICS & SMICS

The Palliative Care Scoping project delivered a qualitative review and data analysis of end-of-life care currently provided in the Victorian health sector. 18 recommendations were released in the report. These informed the implementation of 15 service improvement projects by the ICS. Outcomes included increased patient access to palliative care and advance care services, improved equity and quality of life for cancer patients, and enhanced monitoring and reporting of health service performance in these areas.

Improving the capture of cancer staging at diagnosis

Cancer stage at diagnosis is to be reported by health services to the Victorian Cancer Registry (VCR) as part of cancer registrations. Stage is generally captured by Health Information Managers / medical coders (HIMs) from clinical notes and multidisciplinary team meeting (MDM) notes. However, less than 10% of cancer registrations contain complete and correctly formatted data.

A statewide collaboration between the VICS and the VCR is working with HIMs and key MDM participants to improve documentation of stage information available to the VCR. This population-based initiative will enable improved capture of cancer registration information and better understanding of the type and stage of disease in Victoria, with a strong focus on improving the capture of breast cancer stage.

Consumer engagement

The VICS take a consistent approach to consumer engagement. In 2020-24, more than 120 consumers were involved in both local and statewide work through ICS Consumer Advisory Groups (CAGs), ICS governance committees, grant committees, and project working groups. Their input informed the development and review of a range of statewide cancer service improvement initiatives.

Supporting service improvement

ICS grants programs help our member services to undertake cancer service improvement initiatives that are important to them, for which alternative resourcing is not available. Grants provide health services with funding to support innovative project applications designed to positively impact patient care and experience. This approach enables new initiatives to be scoped, trialled, evaluated and identified as being able to be scaled statewide. Many of these initiatives focus on upskilling staff in contemporary practice or expanding service provision to underserved populations.



About SMICS

Southern Melbourne Integrated Cancer Service (SMICS) provides a network to improve the quality and continuity of patient care and ensures that appropriate links exist between health services to optimise patient pathways for persons affected by cancer. SMICS is pivotal in ensuring strong coordination and planning across the southern Melbourne region.



Our vision

Improving patient experiences and outcomes by connecting cancer care and driving best practice.



Our Member Health Services

Our member health services deliver over **71,200 episodes of acute cancer care per annum**, including medical, surgical, radiation oncology, day chemotherapy, imaging, pathology, palliative care, psycho-oncology, supportive care and allied health services.



Message from the SMICS leadership team

Our commitment to improving cancer care and the experience and outcomes for people affected by cancer who live and/or receive care in the SMICS catchment continues, and it is with pleasure that we celebrate the collaborative accomplishments of SMICS and our partners from the 2023-24 year.



Seleena Sherwell
Program Director



A/Prof Zee Wan Wong
Joint Clinical Director



A/Prof Andrew Haydon
Joint Clinical Director

completed
20
local projects

led
3
statewide projects

supported over
20
projects improving alignment
with the optimal care
pathways

supported
4
projects directly related to
improving equity for priority
groups in our community

funded
6
local initiatives in member
health services

presented our work at
8
different conferences /
workshops

SMICS has also continued to build on previous successful initiatives.



The care of the older person with cancer toolkit developed by SMICS and Hume Regional Integrated Cancer Service (HRICS) provides a guide and tools to identify and meet the needs of the older vulnerable cancer patient. Over the past year SMICS has supported 2 separate projects at partner health services that will improve the care for older people with cancer.



In 2024 SMICS partnered with VCCC to refine and convert the Optimal Cancer Care for Aboriginal and Torres Strait Islander education package to an online format, to make it more accessible to Aboriginal and Torres Strait Islander people and cancer health professionals across Victoria. The OCCAP package will support adoption of the Aboriginal and Torres Strait Islander People Optimal Care Pathway and will be available in early 2025.



An Alfred Health grant funded project that used Computed Tomography (CT) body composition assessment to measure skeletal muscle mass as part of malnutrition diagnosis for patients undergoing surgical resection of oesophageal and gastric cancer was recognised by the Clinical Oncology Society of Australia (COSA) as an exemplar of evidenced based care in practice.

After 4 years providing strategic oversight and guidance to the SMICS program Felicity Topp stepped down from her role as Monash Comprehensive Cancer Consortium (MPCCC)/SMICS Governance Chair in June 2024. Felicity's leadership was central to the separation of SMICS and MPCCC shared Governance. SMICS refreshed governance structure and new reporting lines support a strengthened network and opportunities for system level improvements for people with cancer.

We are delighted to welcome Professor Eugene Yafele, Chief Executive, Monash Health as the new SMICS Governance Committee Chair along with new members Adjuvant Associate Professor Helen Cooper, Chief Executive Peninsula Health and Mr Adam Horsburgh Chief Executive Alfred Health.

On behalf of the SMICS team, we wish to acknowledge the tireless efforts of the health professionals who serve the southern Melbourne region, the consumers and SMICS Governance members who generously give of their time and expertise to further the work of SMICS and help improve the experience and outcomes of people affected by cancer.

Understanding Our Community

SMICS services southeast Melbourne, the fastest growing population area in Victoria. The SMICS catchment covers a total area of 2,967 square kilometres. It aligns most closely with eleven local government areas (LGAs):





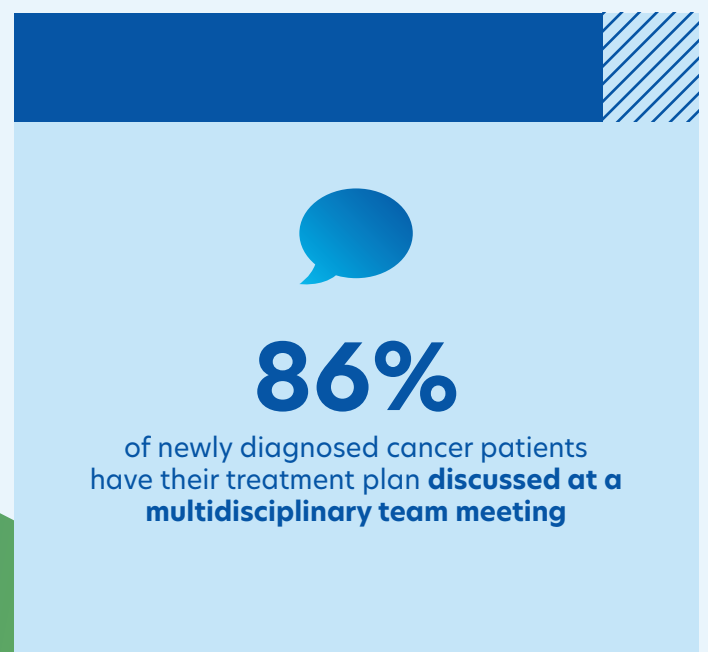
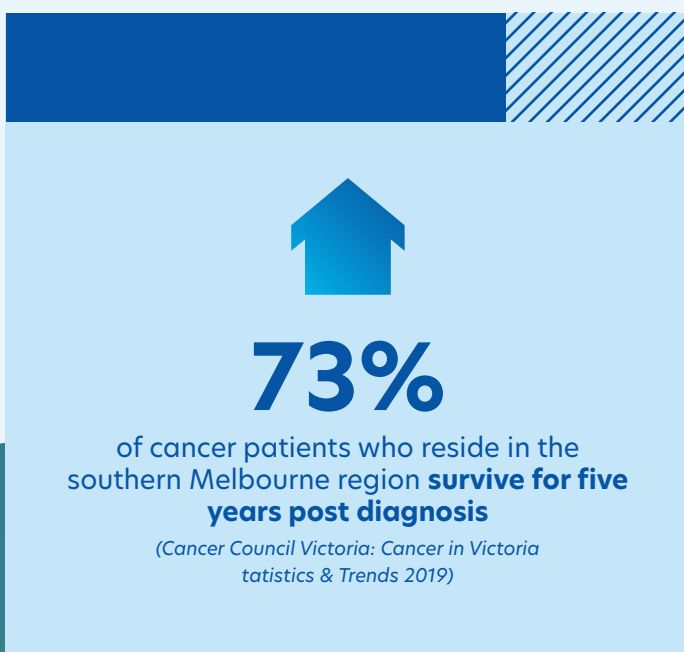
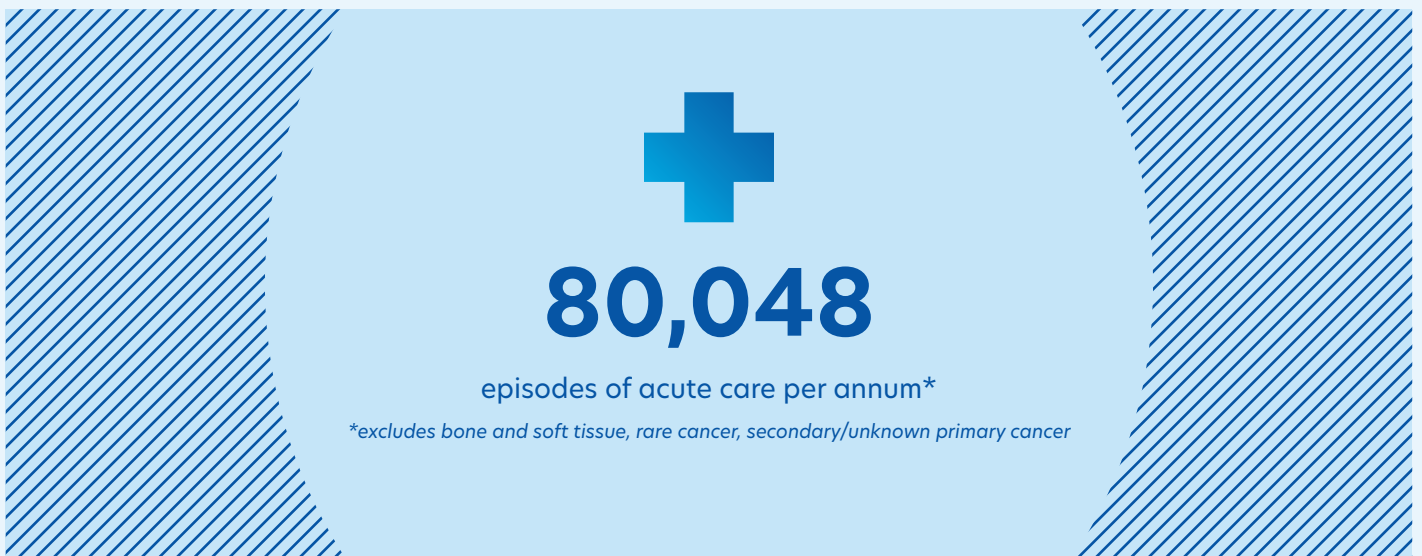
The SMICS region is also home to a significant refugee population with the Greater Dandenong Local Government Area a signatory of the Refugee Welcome Zone declaration, to welcome refugees into the community, and enhance cultural and religious diversity.

Cancer incidence in Southern Melbourne

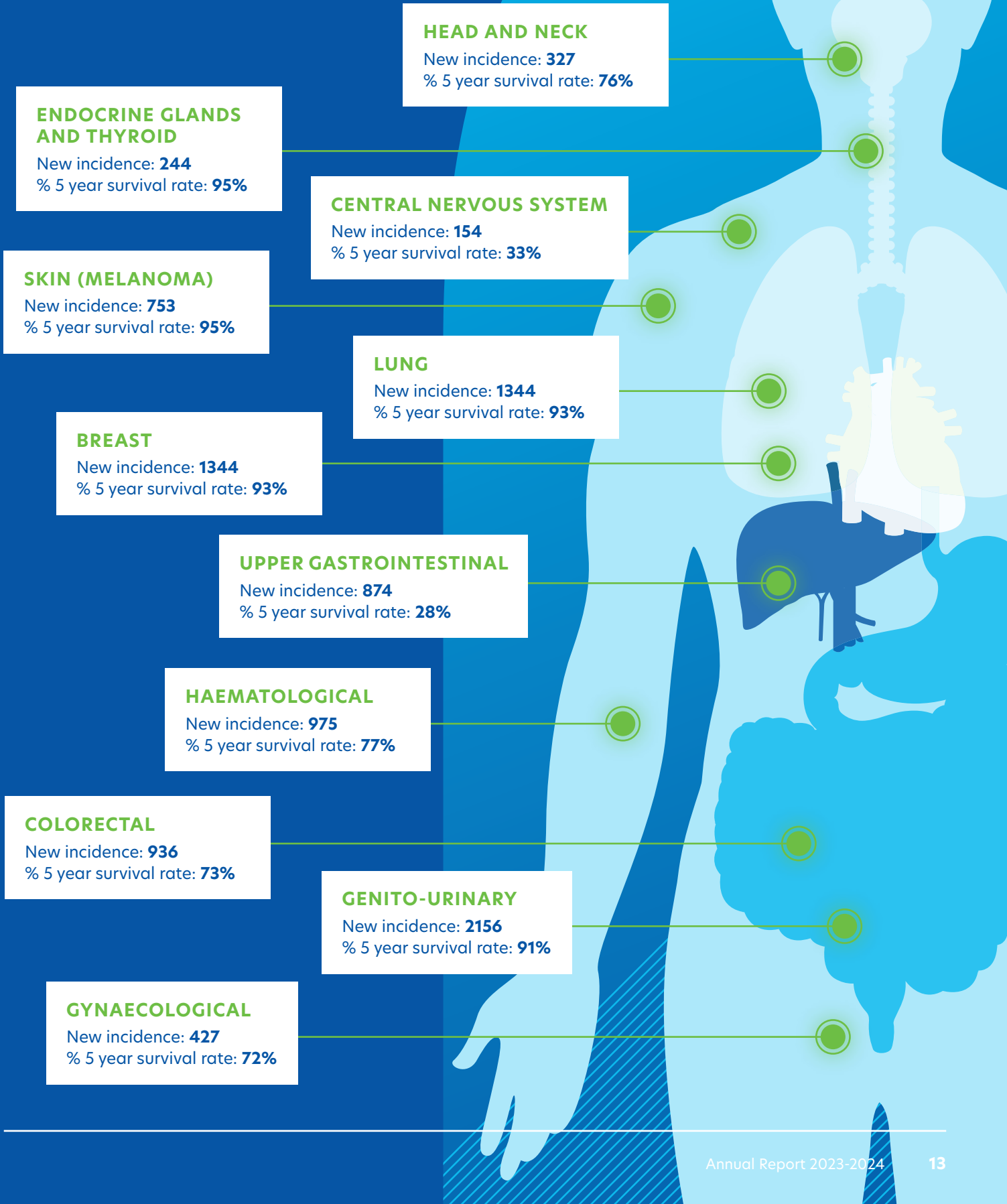
SMICS provides a network to improve the quality and continuity of patient care and ensures that appropriate links exist between health services to optimise patient pathways for persons affected by cancer. SMICS is pivotal in ensuring strong coordination and planning across the southern Melbourne region.

The annual incidence for new cancer diagnoses in our region currently exceeds 9,983 with more than 2,981 persons dying from cancer each year. It is predicted that the annual incidence of new cancers in Victoria will exceed 52,000 per annum by 2036.

Source: Victorian Cancer Registry



New incidence of cancer in the SMICS region

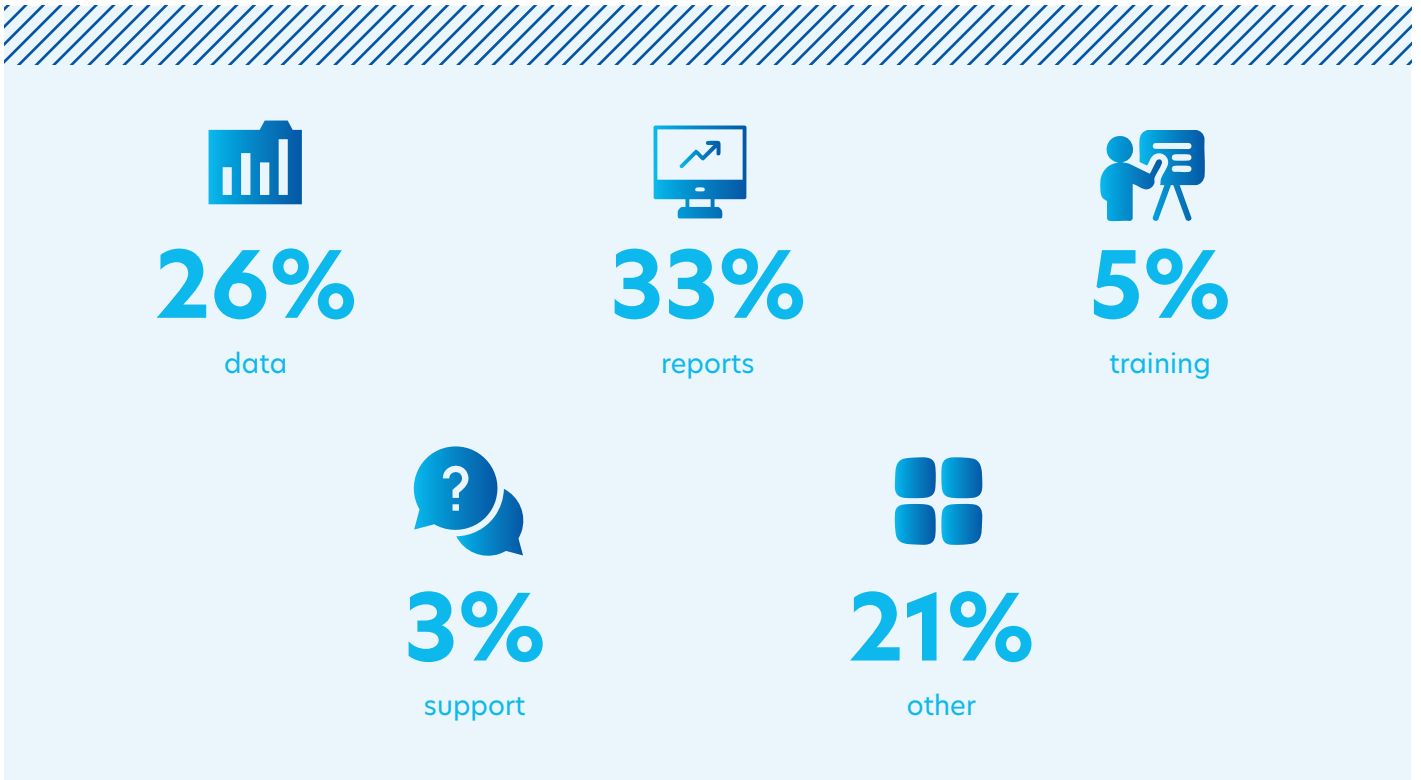


Data unit requests

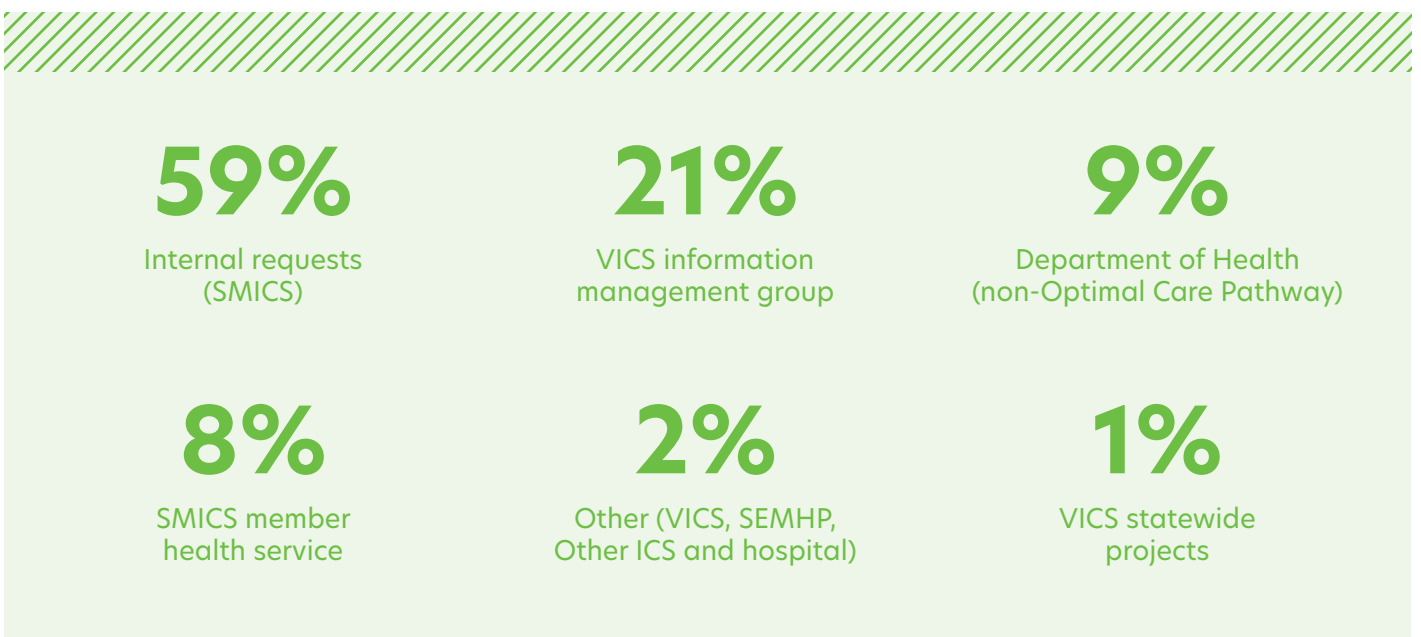
SMICS has access to a range of administrative datasets to assist health services measure and/or monitor quality, or inform and evaluate improvement initiatives.

During 2023 - 2024, the SMICS Data Unit responded to 109 requests.

DATA REQUEST BREAKDOWN



DATA SOURCE OF REQUEST BREAKDOWN



SMICS year highlights



A revised medical alert card for neutropenia

Early recognition of infection in a patient with cancer can help prevent sepsis from developing. SMICS has assisted the Monash Health Chemotherapy Day Unit to update its current medical alert card for neutropenia, which will equip patients and clinicians with the information they need to identify the risk.

White blood cells are essential for a full immune response to infection. Patients undergoing chemotherapy have lowered levels of white blood cells, which means they are at increased risk of infection and neutropenic sepsis can result.

Whilst chemotherapy temporarily reduces the number of white blood cells in the blood, this is less common with immunotherapy, another type of cancer treatment, which can be used alone or in combination with chemotherapy and/or other cancer treatments. Having a lower number of white blood cells still means that a minor infection can become very serious and life-threatening.

The new card ensures clear messages are communicated to the patient, and processes are clearly articulated to Emergency Department teams across three Monash Health sites.

It is designed to encourage patients to attend emergency and show their medical alert card upon arrival, and ensures the escalation of symptomatic cancer patients when they arrive in emergency departments.

The project involved broad consultation with the oncology, haematology and emergency teams, as well as Quality, consumers, nurse education, and communications.

All patients commencing chemotherapy will be given the card along with information on its use. The card is also available in a PDF format, and is downloadable from the Monash Health website, allowing patients to conveniently store the card on their phones.



Consumer engagement at SMICS

Throughout the last 12 months, SMICS continued to work closely with its consumer group, which also actively participated in the SMICS Governance Group, with two consumers taking part in the grant review and assessment process as part of the SMICS funding program.

Four of the SMICS consumers have participated in the craft focus group earlier in the year, providing important input into our local business planning for 2024.

SMICS has also engaged consumers from Peninsula Health and Alfred Health to review patient information tools, which were developed during the course of the year.

SMICS led the development of a new state-wide tool named, 'Partnering with Consumers Toolkit', 2023 edition. The revised toolkit is designed to support all VICS staff to plan, engage, manage, and evaluate consumer engagement across the relevant activities in their program of work. This initiative was delivered in partnership with the state-wide Consumer Engagement Peer Group. SMICS has also become the Chair of the group in 2024, and led the development and delivery of a 'Consumer Catch Up' event featuring guest speakers from Cancer Australia, Cancer Council Victoria, and South West Healthcare. The online forum attracted 32 consumer and staff participants from across the state.

Care Plus project

The Care Plus initiative is a new care model, supported by SMICS, that provides early palliative care to patients with advanced pancreatic cancer.

The initiative aims to optimise the health and wellbeing of advanced pancreatic cancer patients, and their caregivers, by creating structures and processes that standardise access to early palliative care in a hospital outpatient setting.

Care Plus provides three additional consultations with a palliative care specialist, alongside the patient's usual cancer care, integrating palliative and oncological care.

The focus is on supporting patients' wellbeing ensuring they, their families, and caregivers, have the support they need.

Care Plus fosters confidence in patients and their families, consolidates relationships between care providers, and seeks to:

- provide a standardised pathway to early palliative care
- enable more timely and equitable access to early palliative care
- provide better support for advanced cancer patients, their families and caregivers
- assess the acceptability of Care Plus according to patients, families and healthcare providers.

A pilot project for Care Plus is underway at Alfred Health and Peninsula Health.



Colorectal Cancer Partnered Survivorship Care Plan project

The Colorectal Cancer Partnered Survivorship Care Plan (CRC PSCP), supported by SMICS, is designed to support early-stage CRC survivors as they transition from active treatment to surveillance care.

The CRC PSCP supports the provision of tailored care, by understanding individual needs and concerns, to inform healthcare plans and improve access to follow-up care closer to home.

Survivors are provided not only with information on their diagnoses, treatment, and follow-up care, but also lifestyle advice to help improve their well-being, empowering them to make decisions that are right for them.

A consistent management plan and flow of information between providers enhances the coordination and integration of care across different treatments, providers, and health settings.

Before completing the PSCP, the survivor's unmet needs and level of distress were assessed using the validated Distress Thermometer and Problem List (DTPL).

Interim nine-month results reveal

Of the 30 survivors who completed the validated DTPL assessment, 16 reported unmet needs resulting in six referrals to Cancer Council Victoria and one to Allied Health Services. Feedback from 11 participants indicated that 100% of respondents strongly agreed/agreed that the PSCP:

- addressed their wellbeing goals
- prepared them for what to expect after treatment
- provided a valuable overview of their cancer diagnosis and treatment
- effectively summarised their cancer management information in one document
- helped them better manage their health condition and the follow-up care they needed
- increased their awareness of promptly reporting any new or persistent symptoms
- introduced them to reliable self-support resources.

A CRC PSCP pilot project at Monash Health was completed in September 2024.



Multidisciplinary team meetings

The multidisciplinary team meeting (MDM) continues to be considered the gold standard for bringing the multidisciplinary team together to discuss treatment plans for patients living with cancer.

Within the SMICS region there are approximately 39 different MDM teams operating across the four health services. These MDMs discuss and plan treatment for approximately 21 different tumour streams.

Over the past year, SMICS has supported health services in the region to review and identify strategies to evaluate the quality, resources, performance and governance - including review of funding models - of these important meetings.



Geriatric oncology model of care at Monash Health

SMICS and Monash Health have developed a new model of care for older people with cancer which is being piloted in the gastrointestinal outpatient clinic at Moorabbin.

It is known that older people can present with age-related impairments and pre-existing health conditions which makes them more vulnerable to cancer treatments and may lead to higher rates of toxicities, complications, and unplanned hospitalisation as well as poor quality of life.

The Frailty Informed Treatment (FIT) project, for cancer patients aged 65 years and older, aims to introduce a systematic and validated assessment tool to identify vulnerable older patients with cancer prior to receiving treatment. Each patient's condition will be discussed at a newly created geriatric oncology multidisciplinary meeting to develop tailored suggestions to benefit the individual.

The results of the Practical Geriatric Assessment (PGA) will inform decisions around cancer treatment planning, promote patient centred care, enhance communication around the risks and benefits of treatments and address any individual issues and concerns via optimisation of timely referrals and interventions.

This model aims to provide clinicians with important information required to inform their clinical decision making and to also support patients, families and carers to manage their cancer treatments better. If feasible, this pilot may serve as a useful template for treating other cancers.



Facilitating high-quality supportive care

In April 2024, VICS undertook a statewide self-assessment survey of vital stakeholders involved in clinical cancer care and management at each health member organisation facilitated by each ICS. This work is part of the VICS Implementation Plan 2021-2022, focusing on enhancing the quality of supportive care in line with the Victorian Cancer Plan 2020-2024.

An in-depth analysis of these survey results has provided insight into the current practices, challenges, and opportunities related to supportive care screening within Victorian health services. Several areas where improvements to increase supportive care screening rates can be made have been identified, including:

- standardising supportive care screening practices
- enhancing referral documentation and processes
- improving the use of screening data
- leveraging technology for data sharing
- strengthening communication and training particularly in cultural competency.

To address some of these challenges, a Supportive Care Resource Toolkit is in development and local ICS supportive care service improvement opportunities are being prioritised.

SMICS has begun this process already by supporting Monash Health to implement a digital supportive care screening tool into the inpatient oncology wards to increase screening rates and optimise supportive care for their patients.



Melanoma optimal care pathway

With support from co-clinical director, A/Prof Andrew Haydon, the SMICS team is working in partnership with public health services in the catchment to implement local responses to the recommendations from the Melanoma Optimal Care Summit:

- an agreed common approach across the catchment on follow-up care for melanoma patients based on their stage at diagnosis to improve care coordination
- providing information to patients regarding follow-up care and surveillance after treatment, including feeding back this information to GPs
- providing a consistent resource on sentinel lymph node biopsy to inform patients about the procedure, risks, and benefits.



Care of the older person with cancer

As leads for the VICS Focus Area 3: Address the needs of the older person in routine cancer care, SMICS and Hume Regional Integrated Cancer Service (HRICS) led these key activities:

- updates to the *Care of the Older Person with Cancer Toolkit*. The toolkit provides information to help identify and address existing barriers, examples of existing geriatric oncology services and key resources including how-to guides, education opportunities, and patient resources. The updates enhance the currency of the toolkit with the aim that it is used by health service staff and ICS to improve the care of older people with cancer.
- Additional content includes:
 - discussing goals of care
 - ageism
 - the Australian Cancer Plan
 - NACCHO Aboriginal and Torres Strait Islander Cancer Plan
 - updated guidelines, education modules, carers' resources and examples of delivery including a telehealth implementation guide
 - additional assessment tools/pathways, suggested metrics, role of the GP and quick links table.

A statewide evaluation of the *Care of the Older Person with Cancer Toolkit* was conducted in May 2024 to understand the toolkit's value. The evaluation, including interviews and surveys highlighted the toolkit's relevance, effectiveness and benefit as an engagement tool with health services.



Accessing cancer care equitably using support services (ACCESS) project

Led by the Cancer Council Victoria (CCV), the Accessing Cancer Care Equitably using Support Services (ACCESS) project continues to bridge the supportive care gap for patients unable to access local services.

Now complete, the cumulative impact of the ACCESS project promotion and education activities over the past three years has been significant. The project continues to increase connections with the Cancer Council support line, into specialised supportive care programs, including emotional support, financial counselling and legal support, and referrals by health professionals.

From January 2022 to December 2023, there was a 132% growth in referrals in the SMICS region from health professionals at participating health services via the CCV online form. A total of 670 cancer support referrals were made in 2023, the highest number of cancer support referrals of all ICS regions. Monash Health campuses comprised 78% of referrals, Alfred Health had a 40% increase, and Peninsula Health saw a 25% increase in referrals to ACCESS services. There was also a significant increase of 77% in calls to the 13 11 20 support line.

Phase two of the project provided additional targeted education sessions and a dedicated CCV nurse as a contact for participating SMICS health services. A promotional campaign to help increase awareness and uptake of support services within the Arabic and Vietnamese speaking communities was also developed by CCV. Strategies and activities are now being devised to sustain the positive impact ACCESS has had on cancer patients and health professionals in Victoria.



Victorian statewide collaboration to improve cancer survivorship care project

VICS partnered with the Australian Cancer Survivorship Centre (ACSC) to improve survivorship care across Victoria. This two-year project aimed to improve survivorship care by supporting health services to implement survivorship care policies, models of care, and by building capability and capacity in survivorship care.

SMICS worked with member health services to develop survivorship care policies and supported the team at the Peter MacCallum Cancer Centre in Moorabbin to pilot a co-designed survivorship care improvement strategy. The team implemented a new process to provide information on survivorship care planning resources and services to breast, and head and neck cancer patients receiving radiation therapy. 20 patients received this information as part of a pilot with steps to continue and build on survivorship care.

In March 2024, SMICS, along with the VICS and the Australian Cancer Survivorship Centre, participated in a statewide workshop Sustaining Improvements in Cancer Survivorship Care held at Peter MacCallum Cancer Centre. This was a fantastic opportunity to learn about the inspiring survivorship work and pilots undertaken as part of the Victorian Statewide Collaboration to Improve Cancer Survivorship Care project. It was also an opportunity to engage with everyone involved across the state and plan for future survivorship success.



Referral and repatriation pathways

SMICS and Gippsland Regional Integrated Cancer Service (GRICS) undertook a local project to examine the opportunities and barriers of using My Health Record (MHR) to support continuity of patient care.

SMICS and GRICS engaged clinicians at Wonthaggi and Latrobe Regional Hospital to review information sharing for referral between metropolitan hospitals and regional centres. Results indicated that currently, the use of the MHR platform is not being optimised for information sharing between health services and it does not provide enough information for the purposes of repatriating oncology patients. There are inconsistencies in terms of the information that is uploaded to MHR, access to MHR, and the regularity of uploads across health services. Buy in for the adoption of MHR for information sharing generally exists at health services, and current new initiatives undertaken at both a federal and state level should add further to an improved uptake and use of MHR in oncology.

The project included delivery of an all-day cancer education program to 26 allied health professionals located in the Gippsland region, to help further facilitate the repatriation of patients from metropolitan sites. Mapping of local allied health services available in Gippsland for returning cancer patients was also completed.

Strengthening Workforce Capability

SMICS 2023 ANNUAL FORUM

Providing Optimal Cancer Care in southern Melbourne

Online forum Thursday 26 October 2023

Participants had the opportunity to raise questions and offer perspectives in a one-hour forum, hosted by SMICS Clinical Directors, Associate Professor Andrew Haydon, and Associate Professor Zee Wan Wong. The online forum aimed to inform clinicians, primary care professionals, cancer-related non-government organisations, and consumers on three exciting initiatives undertaken at SMICS.



The projects presented were:

The Metastatic Breast Cancer Nurse Training Program, an Australian first pilot project, designed to upskill and empower McGrath Breast Care Nurses who care for people with metastatic breast cancer. 'Rosie', the telepresence robot allows nurses to take part in the training program at Moorabbin Hospital from anywhere in Australia. The program is delivered by the McGrath Foundation, Monash Health, Monash University and SMICS.

Presented by Dr Olivia Cook, Head of Nurse Education and Research, McGrath Foundation and Gil Kruss, Metastatic Breast Cancer Nurse Practitioner, Monash Health.

An Alfred Health program that aims to identify nutritional biomarkers in oesophago-gastric cancer patients to identify malnutrition early, and more accurately, to assist dietitian assessment and nutrition intervention. The project also aims to develop mechanisms for communication with all relevant treating clinicians of patients at high nutritional risk, regardless of their location, and to develop feasible, standardised nutrition care pathways for nutritionally high-risk patients across health care services.

Presented by Lisa Murnane, Senior Dietician, Oesophago-Gastric Cancer Surgery, Alfred Health

A Monash Health-led pilot project that focuses on a specialist speech pathology service for head and neck oncology patients with an altered airway, through implementation of proactive and preventative community-based care via telepractice. Supported by the SMICS Funding Program, the project uses video and phone calls to extend standard onsite care, supporting patients through post-surgical grief and adjustment, improving equity of access to speech pathology for those living regionally, and interventions to improve client outcomes and prevent adverse events.

Presented by Madlyn Connolly, Speech Pathologist, Monash Health

SMICS Funding Program

Six new projects commenced between 1 July and 20 October 2023, supported by the SMICS Funding Program to a total of \$623,918.

Optimising post-transplant outcomes via the delivery of a contemporary home-based rehabilitation program for Alfred Health patients undergoing stem cell transplantation

ALFRED HEALTH

It is known that high-dose chemotherapy and stem cell transplantation (SCT) is associated with treatment related physical and psychosocial complications and side effects, including decreased nutritional status and quality of life, increased fatigue, and reduced lean body mass.

The Optimal Care Pathways (OCPs) framework recommends that cancer patients should receive standardised care across the key phases of their cancer journey: Prehabilitation, Inpatient Treatment, Outpatient Treatment, Follow-up Care and Survivorship.

Evidence suggests that patients who are better nourished at the time of SCT may experience improved outcomes post SCT. Additionally, participants of early multimodal prehabilitation programs have been shown to have improved treatment tolerance and reduced toxicities, improved physical and psychological functioning, improved quality of life, and reduced inpatient length of stay.

Rehabilitation is equally as important, with evidence demonstrating improvement in functional and physical status, and quality of life levels. For successful rehabilitation, it should be delivered by allied health clinicians with the appropriate knowledge and specialised cancer recovery skills regardless of their treatment location. Therefore, shared care models with standardised, evidenced based information can help bridge this gap.

This project aims to align nutrition and exercise management of SCT patients with best practice guidelines and the OCPs, by providing a prehabilitation and rehabilitation service at Alfred Health.

It aims to standardise the care provided to patients receiving treatment across multiple sites or who require allied health supportive care closer to home, and improve referral and communication pathways between health services under a shared-care model. Whilst nutrition and exercise programs for patients undergoing SCT exists at other cancer service hospitals, this fundamental care remains a significant service gap at Alfred Health.

This project will provide the opportunity to create and embed evidenced based practice that is well researched and documented, while doing it in a thorough way to develop, evaluate and build a sustainable, scalable model of care.

1.7 → 3.9

Average attendance face-to-face at group sessions increased. In the period February to April there were 1.7 participants, and in the period May to July there were 3.9 participants.

18% → 13%

Did Not Attend (DNA) rate at face-to-face group sessions decreased: In the period February to April = 18%, and in the period May to July = 13%.

39 → 45

Average days between referral and planned treatment admission has now increased from 39 to 45 days.

31% → 12.5%

The percentage of patients unable to attend prehabilitation due to insufficient time between referral and planned admission has reduced from 31% to 12.5%.

31% → 12.5%

There was an increase in the number of referrals to the service from April (9) and May (18) from previous months (January to March, monthly average: 5.7 referrals).

Educating patients/carers to perform routine Central Venous Access Device (CVAD) care: a feasibility project

ALFRED HEALTH

This project aims to improve patient's wellbeing and experience of care with a focus on those patients living in the regions. This will be achieved by facilitating/ expediting a patient's return home, reducing travel and associated costs, and allowing for patient self-management of care.

Currently there are approximately 40 patient encounters per month in the chemotherapy day unit specifically and solely for CVAD care. If even a fraction of these could be diverted by this model, the chair time saved would be significant, assisting the creating capacity for the constant growth in ambulatory cancer care.

Additionally, arranging local CVAD care can be a barrier to ward discharges, lengthening admissions. In implementing the project, this barrier could potentially be eliminated for a number of patients and reduce length of stay for the organisation.

Integrating PROMs into supportive and palliative care to facilitate high quality, pro-active patient-centred supportive care

MONASH HEALTH

Palliative care is a holistic discipline for people with incurable illnesses, encompassing physical, psychological, social, and spiritual care for patients and their carers. The Supportive and Palliative Care Unit (SPCU) at Monash Health offers complex symptom management for patients with advanced cancer.

Implementing Patient Reported Outcome Measures (PROMs) in the routine care of SPCU will facilitate proactive patient-initiated and driven care by detecting potential clinical problems early. No palliative care unit in Australia has implemented real-time outpatient PROMs to drive care that is proactive, patient-initiated, and patient centred.

The overall aim of this quality improvement initiative is to integrate the collection of patient-reported outcomes into routine care provided by the SPCU to ensure care is truly patient driven. The specific objectives are to:

- assess the feasibility of integrating PROMs into the care of advanced cancer patients under the care of the SPCU
- investigate if the integration of PROMs into routine care reduces unplanned emergency presentations
- improve the understanding of the supportive and palliative care needs of those who are culturally and linguistically diverse within the community
- explore if the integration of PROMs in the SPCU is acceptable and useful to patients, carers and SPCU health professionals.

What our clinicians said



I just had a quick look at the paper copy (system overview) and I saw the two videos (demonstration videos for the Palcare desktop and Palcare Home), I think it's a great system if you have patients who are able to then fill this in (phone app) and obviously if it's virtual then they could do it in the comfort of their home. So I think it's great.



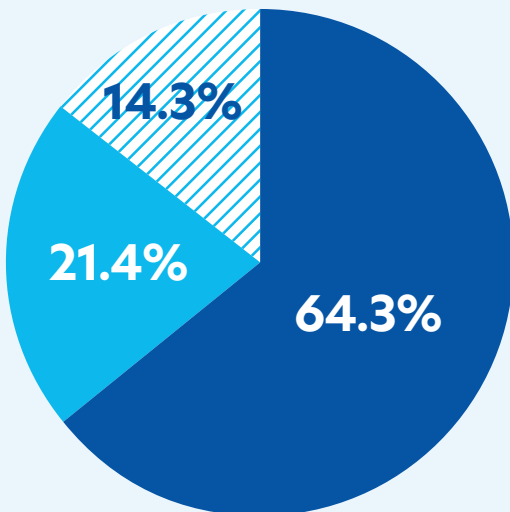
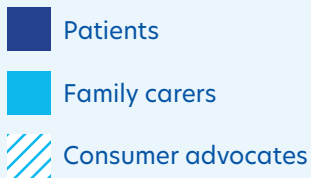
I can see it (e-PROM software) fitting in quite easily. Would work very well. So what I currently do is I log in and I look at SMR(scanned medical records) which is where all the clinic notes are documented. And I look at all of the clinic notes that have occurred since my last review in the hopes of getting clues as to what are the issues that will be raised by the patient today.

When considering different measures for the ePROM, 88.9% of clinicians say they are happy to use the "Integrated Palliative care Outcome Scale" [IPOS]. This is available in multiple languages. They felt it was comprehensive with the ability for patients to voice their main concerns and given its availability in multiple languages appropriate for their patients.

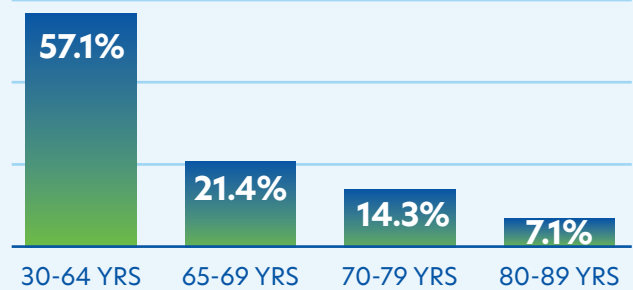
Consumer feedback on the e-PROM mobile app

A total of 14 consumers participated in the verbal survey which consisted of 9 patients, 3 family carers and 2 consumer advocates.

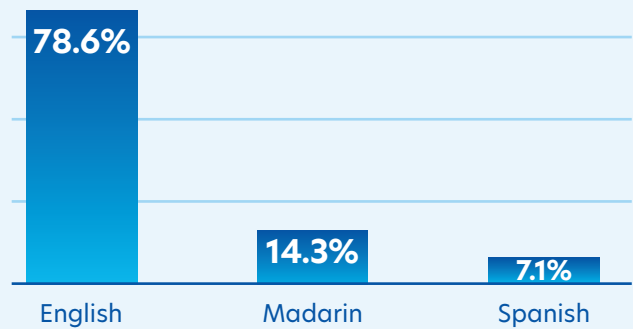
DEMOGRAPHIC OF CONSUMERS



AGE



LANGUAGE SPOKEN AT HOME



Only 16.7% of patients and family carers had prior experience using this kind of mobile app, however, all of them had confidence in reporting their symptoms via the PalCare mobile app. Approximately 88.9% of patients also expressed that their family could help with the reporting.

What our patients said

“

I think this mobile app will help to tell my health condition to clinicians as I am living far from the hospital. It seems easy for me to access, so I like that.

“

No concerns. I am happy to try it.

“

I can give it a go, willing to negotiate and with daughter's help.

What our patients' families said

“

I like the idea of this mobile app. I am happy to report my husband's condition whenever clinicians need me. Happy to discuss with our clinicians.

“

I don't think it will take a long time to report the conditions. Maybe 10 minutes? So, I can report whenever clinicians need.



Optimising Adolescent and Young Adult Cancer Care through alignments with OCP and development of a coordinated multidisciplinary approach

MONASH HEALTH

Adolescent and Young Adult (AYA) patients with a diagnosis of cancer have complex and unique medical and psychosocial needs. It is recognised that a multidisciplinary, age, and developmentally targeted approach to care is needed for this population, with access to psychosocial support, allied health, clinical trials, educational/vocational support and fertility preservation.

This has been recognised with the development of the Australian Youth Cancer Framework, the AYA cancer Optimal Care Pathways (OCPs), and the establishment of the nationwide Youth Cancer Service, designed to support cancer care for 15-25-year-olds in Australia.

Currently the only specific Youth Cancer Service in Victoria is the ONTrac program, run through the Peter MacCallum Cancer Centre. While ONTrac provides an important service for the state, it is unable to adequately or locally meet the care needs of patients in the Monash Health catchment, or Gippsland region.

The initiative aims to identify current gaps in service, and develop strategies for improvement, with a priority for innovative solutions that optimise the use of existing health resources.

It will develop the key tools, policies and referral pathways needed to assess and meet the care needs of AYA patients and further use technology to foster a collaborative, multidisciplinary model of care and facilitate quality care close to home for all patients.

Mentorship will be provided to the Gippsland cancer team to develop a Monash and SMICS/PICS supported project plan. This will establish a framework for Gippsland regional health services to build sustainable, safe and patient centred paediatric and AYA cancer services appropriate for local infrastructures and formally linked to a metro mentorship service.

AYA patients that received an informal care needs assessment:

90%

of those treated in a paediatric setting

45%

of those treated in an adult setting.

AYA patients that received a referral to a speciality allied health team:

100%

of those treated in a paediatric setting - 4.7 referrals per person

88%

of those treated in an adult setting - 1.5 referrals per person

AYA patients who had engagement with a Clinical Nurse Consultant

85%

for those in paediatric setting

66%

for those in an adult setting

Rates of referral to specialty allied health teams were high across both groups, however increased in paediatric-treated patients, with 100% receiving at least one referral, versus 85% of adult-treated AYAs.

Significant differences were demonstrated in the number of referrals made per patient, with paediatric-treated AYAs receiving an average of 4.4 referrals (range 1 to 9) throughout treatment, vs 1.4 referrals for adult-treated AYAs (range 0-4). These patterns were consistent across specific allied health professionals, with 70% of paediatric-treated vs 45% of adult-treated referred for Social Work review, 80% vs 30% for Dietitian review and 30% vs 5% for Psychology review respectively.

When examining the gaps in direct supported care by either Clinical Nurse Consultant (CNC) or Nurse

Practitioner (NP), in the paediatric setting 100% of patients were supported directly by the CNC, NP or both, while in the adult care space 27% of patients received no direct support.

Results also highlight that AYA patients across MH are not utilising external AYA specific services, with only 26% of AYA patients received a referral to specialised AYA support.

Preliminary findings suggest that in the absence of a dedicated AYA service, within the same institution, AYAs managed under adult haematology/oncology departments have significantly reduced access and referral to allied health professionals, which will likely have a negative impact on holistic patient care and healthcare experience.

ALLIED HEALTH REFERRAL PATTERNS

AYAs treated under Paediatric or Adult Haematology/Oncology units

	Paediatric Unit	Adult Unit	Total
Number	10	20	30
Age, median (range)	17.5 (15-19)	23.5 (15-30)	18 (15-30)
Number referred to allied health (%)	10 (100%)	17 (85%)	27 (90%)
Number with documented formal AYA psychosocial screening assessment (%)	0%	0%	0%
Number with documented informal AYA psychosocial screening assessment (%)	90%	45%	60%
Average number of referrals per patient (range)	4.4 (1 -9)	1.4 (0 - 4)	2.34 (0 -9)
Number of referrals to specific Allied Health specialty (%)			
• Social Work	7 (70%)	9 (45%)	16 (53.3%)
• Dietitian	8 (80%)	6 (30%)	14 (46.7%)
• Psychology	3 (30%)	1 (5%)	4 (13.3%)
• Physiotherapy	6 (60%)	5 (25%)	11 (36.6%)
• Occupational Therapy	4 (40%)	0 (0%)	4 (13.3%)
• Music/Art Therapy/Child Life Therapy	10 (70%)	0 (0%)	10 (33.3%)
• Other (Podiatry, Teachers, Neuropsychology)	8 (80%)	4 (20%)	12 (40%)

Establishment of a best practice Breast Cancer Nurse Led Clinic - Close to Home

MONASH HEALTH

Providing a breast care clinic in Melbourne's outer east will address a gap in breast care nursing in the region. A Monash Health Breast Oncology Clinic, run at Berwick Healthcare, will improve efficiencies for McGrath breast care nurses by improving access to medical oncologists for ordering and diagnostic management.

Establishing a nurse-led supportive care clinic, working together with the medical model, will provide comprehensive specialist nursing and supportive multi-disciplinary approach to care for patients in this catchment area.

Nurse-led clinics provide comprehensive holistic care for patients, resulting in improved patient experience whilst easing the pressure on the medical team. In addition, these clinics provide career progression opportunities for nurses, allowing them to use their advanced practice skills for optimal patient outcomes.

Monash Health treats the largest amount of breast cancer patients in public health care in Victoria and has approximately 345 new diagnoses per year across all sites. A new approach will optimise timely comprehensive care for breast cancer patients in the region.

Staff evaluation of the clinic highlighted strong staff satisfaction, and the results supported the projects' key objective to provide top of scope breast cancer supportive care for patients closer to their homes

Medical and nursing staff recognised increased appointment efficiency across the service, with earlier intervention by the breast care nurses leading to both care coordination improvements and improved communication and collaboration between the medical oncology team and nurses.

Overall, the majority patients were satisfied that they were active participants in their care, they felt listened to, and found the supportive care assessment tools relevant to their breast cancer treatment and follow up.

There is strong recommendation from both the clinical and project team to implement the clinic in an ongoing capacity due to the positive impact on the clinic for staff and patients alike.

The Breast Cancer Nurse Led Clinic ran for eight weeks:

38

patients booked

87.5%

attendance

42%

response rate to patient evaluation questionnaire

100%

of respondents found it useful to attend a clinic close to home.

Key results from the evaluation survey:

- All patients felt they could participate in discussions and decision making of their care,
- All patients felt they were listened to carefully,
- They all felt there was time to ask questions,
- All patients felt it was helpful to see a breast cancer nurse close to where they live



I feel that this clinic was very helpful and needed.



Very appreciated thank you.



I'm extremely happy there is a clinic close to home.

Geriatric Oncology Model of Care

PENINSULA HEALTH

International and national guidelines support an integrated approach to geriatric oncology for care of older patients with cancer to achieve optimal outcomes. The Peninsula Health Oncology and Supportive Intervention Service (OASIS) will comprise of a multidisciplinary clinic with an oncologist, geriatrician, rehabilitation physician and nurse coordinator in attendance.

Newly diagnosed patients over 65, will be referred to a one-stop clinic at the Rosebud Cancer and Clinical Trial's Hub from February 2024, with patients residing outside of the Rosebud catchment area also offered the opportunity to attend. It is planned that the service will extend to Frankston Hospital in the future.

This model of care aims to help patients make decisions about the cancer care and treatment that is appropriate and in accordance with what matters most to them. The clinic supports them through their cancer journey with individualised care plans to meet their needs. Active engagement and inclusive communication with primary health providers in the community will be key to the success of this model of care.

Services offered will include geriatric or rehabilitation assessments with referrals to appropriate allied health or community programs dependant on the assessment outcomes. Patients will be monitored throughout and re-assessed at key milestones in their treatment to achieve safe, personal, and effective care to cancer patients and families in the community.

From February to end of June 2024:

57

patients were screened for the OASIS clinic

10

geriatrician assessments undertaken

13

rehab physician assessments

58%

of patients referred to a cancer rehab program.

Other services accessed by patients include:

- My Aged Care packages
- Palliative care services
- Dietetic interventions

Financial report

2023-24

INCOME		\$
grants - state	2,056,061	
EXPENDITURE		
SALARIES & WAGES		
SMICS program office	1,001,651	
clinical directors	213,166	
salary on-costs	167,277	
salaries & wages sub-total	1,382,094	
PROJECT EXPENSES		
projects-local	62,750	
salary on-costs	160,677	
project expenses sub-total	223,427	
OPERATING EXPENSES		
general administration	51,037	
host agency corporate management fee	99,043	
other expenses	52,742	
operating expenses sub-total	202,822	
BALANCE		
total income	2,056,061	
total expenditure	1,808,343	
planned deficit as at June 2022	247,718	

Our Team

Tracey Bucki

Jodi Dumbrell

Andrew Haydon

Chamaree Jasintha

Geraldine Largey

Anna Maciejewska

Saeid Reza Kalbasi

Seleena Sherwell

Nell Sproule

Charmaine Thoy

Jennifer Thresher

Zee Wan Wong





p 03 9928 28541
e smics@monashhealth.org
w vics.org.au/smics
a **Moorabbin Hospital, Monash Cancer Centre**
823-865 Centre Road
East Bentleigh VIC
Australia 3165