

# HUNTER NEW ENGLAND

## CANCER SERVICES PLAN 2006 - 2010

### Appendices

This Plan has two parts presented in separate documents

**1. THE PLAN**

Executive Summary, Introduction and Background,  
The Strategic Directions and Strategic Action Plan

**2. APPENDICES**

**Please forward any comments to:**

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## APPENDICES

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## **APPENDIX ONE: PLANNING GROUP, STAKEHOLDERS AND PLAN FEEDBACK**

### **Appendix 1.1 Planning Committee**

#### **Cancer Planning Committee**

Membership of the Planning Group comprised the following:

- Allan Spigelman, Director of Area Cancer Services (Chair)
- Chris Wratten, Director of Radiation Oncology
- Stephen Ackland, Director of Medical Oncology
- Peter Ravenscroft, Director of Palliative Care
- Stephen Deane, Professor of Surgery JHH
- David Rhodes, Director of Allied Health
- Jill Lack, Cancer Development Manager and Plan Leader
- John Wiggers, Director of Population Health
- Ailsa Hawkins, Director Clinical Services (Nursing) - Operations Manager  
Oncology & Haematology
- Tim Mooney, General Manager, Manning Base Hospital
- Scott McLachlan, Director of Primary and Community Networks
- Fergus Fitzsimons, General Manager, Tamworth and Armidale Rural Referral  
Hospitals
- Delys Brady, Director of Integration and Partnerships (Liaising with Divisions  
of General Practice)
- Trish Beatty, Consumer representative
- Fiona Abell, Lead Clinician (Lung Cancer); A/DACs February
- Tony Proietto, Lead Clinician (GynaeOncology)
- Michael Seldon, Lead Clinician (Haematology)
- Anne MacKenzie, Planner
- Denise Kaminski Cancer Data Project Officer

**Appendix 1.2 Stakeholders**  
**Cancer Services Stakeholders**

Key Stakeholder Groups consulted

<b>Tumour Groups</b>	<b>Name</b>
Haematology	Michael Seldon
Surgical Oncology/Breastscreen	John Forbes Frank Sardelic (NE) Paul Hopkins (Director NE) Dorothy McEachern
Melanoma/Skin	Bob Sillar
Gynaecology	Tony Proietto
Paediatrics	Frank Alvaro
Urology	Phil Sprott
Lung	Fiona Abel
Colorectal	Stan Chen
Head and Neck	Linda Fenton
Bone and soft tissue	Joe Gabriel
Palliative care	Peter Ravenscroft
Molecular Genetics	Rodney Scott
Neurology/Neurosurgery	John Christie
Gastroenterology	Anne Duggan
Nuclear Medicine	Paul Thomas
Radiology	Barry Soans /Michael Symonds
Pathology	Tony Leong/Stephen Braye

Visiting Medical Officers

<b>Base Hospital</b>	<b>Service to (Hospital)</b>	<b>Specialty</b>	<b>Sessions</b>	<b>Name</b>
POW	TBH			Brian Brigham
		Haematology		Stephen O'Mara
JHH	TBH	Cardiothoracic Surgery		Al James
RNS	Armidale	Lung/Breast/GI	2/month	D. Bell
RNS	Armidale	Lung/GI (colon)/Prostate	2/month	N. Pavlakis
Mater (Crow's Nest)	Armidale	Radiotherapy consultations	monthly	M. Izard
Randwick Children's Hospital	Armidale	Paediatric Haematology	3 <sup>rd</sup> monthly	R. Cohn
NMMH	MBH	Medical Oncology	3 clinics per month	John Stewart Fiona Abell Tony Bonaventura
TBH	TBH	Breast/Endocrine		Frank Sardelic

<b>Divisions of General Practice</b>	<b>Delys Brady to coordinate</b>
Hunter Urban Division	
Hunter Rural Division	
Barwon Division	
New England Division	
North West Slopes	

<b>Associated stakeholders</b>	
Director of Nursing	Jenny West
Director of Operations – Acute Networks	Michael Dirienzo
Director of Operations – Primary & Community Networks	Scott McLachlan
Newcastle Mater Hospital	Colin Osborne
Director of Medical Services NMMH	Marie Jump
Director of Strategic and Clinical Services	Sue Carter
Chronic Disease	Carolyn Bailey
Ongoing Care	Viki Brummel
Manager Workforce Development & Planning	David Kemp
DON, Manning	Peter Avery
DON Tamworth	Chris Coombes
DON Armidale	Dona Withnell
DON JHH	Chris Kewley
Director of Nursing/Operation Manager	Ailsa Hawkins
Director Medical Oncology	Steve Ackland
Director Radiation Oncology	Chris Wrattten
Director Palliative Care	Peter Ravenscroft
Professor of Surgery	Stephen Deane
Respiratory Medicine	Michael Hensley
Director of Aboriginal Health	Tony Martin/Leona Quinnell
Manager of Multicultural Health	Catherine Norman
NMMH Palliative Care	Lynn O'Brien
Community based Palliative Care Southern	Denise McLoughney, Margaret Maddison, Pearl O'Hara, David Cornwell, Mary Downey
Community based Palliative Care Armidale	Marilyn McCarthy and Matthew Bullen
Palliative Care Tamworth (NUM)	Naida Hunt
Community based palliative care Taree	Judy Aird
Oncology NUM Outpatients NMMH	Douglas Bellamy
Chemotherapy NUM (NMMH)	Robyn Keath
Chemotherapy NUM (Muswellbrook)	Chris Threadgate
NUM Palliative Care Ward MBH	Stephen Reilly
Oncology CNC Taree	Tricia Fletcher
Oncology NUM Taree	Maria Biancotti
Oncology NUM Tamworth	Peter Freeman
Oncology CNC Armidale (Day Unit)	Pam Pateman
Director Allied Health	David Rhodes
Psycho-Oncology Service	Greg Carter
Psychology Newcastle (JHH)	Wayne Levick
Psycho-Social Research	Afaf Girgis
Social Work Newcastle (NMMH)	Lyn Herd
Social Work GynaeOncology	
Psychology Paediatric Oncology	Janice McKay
Social Work Tamworth	Susan Heyman/James Curtain
Social Work Armidale	Fiona Ord
Social Work Taree	Chris Moore
Chief Radiotherapist	Karen Javanovich
Principal Scientific Officers (JHH & NMMH)	Paul Cardew; Steve Howlett
Pharmacy	Helen Dowling/ Rosemary James
<b>Consumers &amp; NGOs</b>	
The Cancer Council NSW	Chris Page
Cancer Voices (Peak Consumer body)	Annette Clement

### Appendix 1.3 Plan Feedback

The following feedback was received from the key stakeholders following circulation of the Draft Cancer Services Plan. All comments were acknowledged by the Director of Area Cancer Services and presented to the planning committee for consideration at the planning meeting on 28<sup>th</sup> March 2006. The Plan was amended in accordance with committee recommendations.

<b>HNE CANCER PLAN FEEDBACK</b>		
<b>Name</b>	<b>Comment</b>	<b>Action</b>
Allied Health - Northern	<ul style="list-style-type: none"> <li>• Add mention of referral patterns Tamworth, Armidale, Taree, Newcastle</li> <li>• Review of social work funding in relation to patient numbers</li> <li>• Sharing needs analysis info to avoid duplication</li> <li>• Access to specialist counselling services in rural areas</li> </ul>	<ul style="list-style-type: none"> <li>• Accepted - see Section 4.1.1</li> <li>• No action - refer to Strategic Action Plan (SAP) "Recruiting and retaining high quality staff" initiative 2 and 7</li> </ul>
Clinician - Southern	<ul style="list-style-type: none"> <li>• Estimates suggest HNE can cope with increased colonoscopy (137-229 cases) but difficulties with ongoing surveillance will be problematic. Guidelines need to be implemented re surveillance of polyps.</li> <li>• Add recommendation for a surveillance nurse to F/U polyps detected according to guidelines</li> </ul>	<ul style="list-style-type: none"> <li>• No action – see Section 4.3 and SAP "Improved screening and prevention programs for all" initiative 4</li> </ul>
Senior Manager	<ul style="list-style-type: none"> <li>• Include COB in data analysis</li> <li>• Include CALD communities section under section 4.8 on page 22</li> <li>• Analysis of risk factors in migrant communities; where high risk groups identified implement specific initiatives for these communities</li> <li>• Need education re benefits of screening</li> <li>• Need CALD committee member on Cancer Mgmt Committee</li> <li>• Promote consumer reps on cancer committees from</li> </ul>	<ul style="list-style-type: none"> <li>• No action</li> <li>• see Section 5.5</li> <li>• see SAP "Reduction in health disadvantage"</li> </ul>

	CALD minority backgrounds	
Clinician - Southern	<ul style="list-style-type: none"> <li>• Need to add outflow information to appendix</li> <li>• Mention potential for Rural cancer nurse practitioner roles</li> </ul>	<ul style="list-style-type: none"> <li>• New self sufficiency table included in appendix by cluster</li> <li>• To be followed up by Oncology Nursing (MCN)</li> </ul>
Clinician - Northern	<ul style="list-style-type: none"> <li>• Current referral patterns work well for patients in Tamworth/Armidale</li> <li>• Referral patterns to Coffs Harbour from Armidale need to be considered for RT</li> </ul>	<ul style="list-style-type: none"> <li>• No action - no intention to change these</li> <li>• section 5.2.2 and SAP "Integration of cancer service delivery to improve patient centred care" initiative "Monitor flows....."</li> <li>• Flows to and from North Coast to be followed up</li> </ul>
Community	<ul style="list-style-type: none"> <li>• Cancer education must be for both patients and workforce</li> <li>• Appendix 3.10 Few of the listed Allied Health services are available in LMNC</li> <li>• Appendix 3.10 Physio – Breast, should include presurgical education especially re lymphoedema</li> <li>• Under 5.2.2 (pg 27) include education of GPs in the management</li> <li>• Under 4.10 ( pg22) mention waiting list for Palliative Care in Taree/Forster</li> <li>• Implement Innovative screening techniques eg particular protein in their tears to screen for breast cancer</li> <li>• Add information on complimentary medicine and complimentary medical practitioners</li> <li>• As up to 84% of cancer patients use complimentary therapies I believe that advice and education on these should be include in the cancer services plan, but not funded by Area Health.</li> </ul>	<p>Nil due to</p> <ul style="list-style-type: none"> <li>• Recommendations regarding treatment are not appropriate for a Strategic Plan</li> <li>• Lack of evidence regarding suggested alternative therapies</li> </ul>

Clinician - Southern	<p>Re bowel cancer screening:</p> <ul style="list-style-type: none"> <li>• Lack of capital infrastructure &amp; radiologists</li> <li>• waiting list for routine radiology</li> <li>• Radiation risk analysis needs to be undertaken if increased use of radiological screening</li> </ul>	<ul style="list-style-type: none"> <li>• No action – see Section 4.3</li> </ul>
Clinician - Southern	<ul style="list-style-type: none"> <li>• Delete last sentence in future/prevention services p13 funding for prevention of childhood obesity</li> <li>• Table 4.4 (pg19) Haematology – add under therapeutic general &amp; specialty surgery</li> </ul>	<ul style="list-style-type: none"> <li>• Not deleted - Evidence for inclusion added</li> <li>• Accepted</li> </ul>
Allied Health - Northern	<ul style="list-style-type: none"> <li>• Recruitment &amp; retention of Medical Radiation Scientists &amp; Radiologists</li> <li>• Add MRS &amp; radiologists to appendix 3.10</li> </ul>	<ul style="list-style-type: none"> <li>• SAP “Recruiting and retaining high quality staff” initiative “Review the workforce.....”</li> <li>• Accepted</li> </ul>
Senior Manager	<ul style="list-style-type: none"> <li>• Investigate need for Radiation Oncology outreach clinic at Taree</li> </ul>	<ul style="list-style-type: none"> <li>• SAP “Integration of cancer service delivery to improve patient centred care” initiative “Monitor flows.....”</li> <li>• Flows to and from North Coast to be followed up</li> </ul>
Allied Health - Southern	<ul style="list-style-type: none"> <li>• Appendix 3.10 include psychosocial assessment, education, meditation and expand groupwork to include general and tumour specific, participate in policy development</li> </ul>	<ul style="list-style-type: none"> <li>• Accepted</li> </ul>
Clinician - Northern	<ul style="list-style-type: none"> <li>• Role of women’s health nurses in cervical screening</li> <li>• Telecolposcopy initiative</li> </ul>	<ul style="list-style-type: none"> <li>• No action due to Strategic nature of Plan</li> </ul>
Clinician - Northern	<ul style="list-style-type: none"> <li>• Information content good</li> <li>• Use capital “A” for Aboriginal</li> </ul>	<ul style="list-style-type: none"> <li>• Accepted</li> </ul>
Clinician - Southern	<ul style="list-style-type: none"> <li>• Include cancer genetics/family cancer</li> <li>• Table 4.4 (pg 16) Family Cancer Services = counselling, genetic testing, surveillance according to evidence and overall – prevention or early diagnosis</li> </ul>	<ul style="list-style-type: none"> <li>• Accepted</li> <li>• Accepted</li> </ul>
Allied Health - Southern	<ul style="list-style-type: none"> <li>• Review need for additional dietitians at community</li> </ul>	<ul style="list-style-type: none"> <li>• SAP “Recruiting and retaining high quality</li> </ul>

	<p>health clinics</p> <ul style="list-style-type: none"> <li>Appendix 3.10 Allied Health, that the 1.2 FTE community health centre services provides nutrition support to all tumour groups in the community, access to dietetic support by home visits</li> </ul>	<p>staff” initiative “Review the workforce.....”</p> <ul style="list-style-type: none"> <li>FTEs not included in table</li> </ul>
Clinician - Southern	<ul style="list-style-type: none"> <li>need for urological oncology expertise/succession should be highlighted in workforce discussion</li> <li>Table 4.4 (pg 19) relabel – Summary of Specialties performing interventional procedures involved with the Diagnosis and Treatment of Cancer</li> <li>Table 4.4 order of cancers in table by frequency?</li> <li>Key C’s p21 include “Diagnostic Surgery generated by screening programmes” and “Breadth of Proceduralists involved in cancer interventions”</li> <li>Strat Dir p21 “Safe, quality evidence based health care experience” and “Improved screening programmes for all”</li> <li>p25 include – “diagnostic” between “include” and “curative”</li> </ul>	<ul style="list-style-type: none"> <li>SAP “Recruiting and retaining high quality staff” initiative “Review the workforce...” Urology oncologist fellowship advertised in July’ 06</li> <li>Table 4.4 adjusted and ordered alphabetically</li> <li>Accepted</li>   <li>Accepted</li>   <li>Accepted</li> </ul>
Clinician - Southern	<ul style="list-style-type: none"> <li>Not enough consideration is given to increased prevalence of cancer and its affect on requirements</li> <li>Too little devoted to research</li> <li>“Undertake assessment and feasibility of supporting medical oncologists in Tamworth and Taree” and why it doesn’t include Armidale</li> <li>A major thing lacking in the plan is reference to pathology</li> </ul>	<ul style="list-style-type: none"> <li>SAP “Prioritisation and allocation of resources to best meet cancer service needs” initiative “Develop a robust methodology.....”</li> <li>Additional on research included</li> <li>SAP “Integration of cancer service delivery to improve patient centred care” initiative “Review long term plans for servicing rural areas....”</li> <li>Section 4.3 and 4.6 include reference to increased pathology services</li> </ul>

Clinician – Southern	<ul style="list-style-type: none"> <li>• Need for uro oncologist position as part of succession planning for urology services</li> <li>• Table 4.4 (pg 19) Inclusion of Gynaecology in both the Diagnostic and Therapeutic categories for Specialities involved – delete</li> </ul>	<ul style="list-style-type: none"> <li>• SAP “Recruiting and retaining high quality staff” initiative “Review the workforce...” Urology oncologist fellowship advertised in July’ 06</li> <li>• Deletion accepted</li> </ul>
Senior Manager	<ul style="list-style-type: none"> <li>• Business case for palliative care services Cessnock, Kurri Kurri and Singleton presented</li> </ul>	<ul style="list-style-type: none"> <li>• SAP “Improved equity of access to services” initiative “Review palliative care staffing.....”</li> </ul>
Clinician – Northern	<ul style="list-style-type: none"> <li>• addition to 5.2.5 (pg 28) - Research</li> </ul>	<ul style="list-style-type: none"> <li>• Accepted</li> </ul>
Senior Manager	<ul style="list-style-type: none"> <li>• Include measure in BSC</li> </ul> <p>Internal Networking and Processes Effective Integrated services Measure: % initiatives/actions implemented from Clinical Service Plan within a set timeframe (6mthly/yrly) Responsibility: MCN</p>	<ul style="list-style-type: none"> <li>• Accepted</li> </ul>
Allied Health - Southern	<ul style="list-style-type: none"> <li>• Add psycho oncology section under 4.10 (pg 22)</li> <li>• Include psychology services in Appendix 3.10</li> </ul>	<ul style="list-style-type: none"> <li>• Accepted</li> <li>• Accepted</li> </ul>
Allied Health - Southern	<ul style="list-style-type: none"> <li>• Addition to Appendix 3.10</li> </ul>	<ul style="list-style-type: none"> <li>• Accepted</li> </ul>
Allied Health - Southern	<ul style="list-style-type: none"> <li>• Addition to Appendix 3.10</li> </ul>	<ul style="list-style-type: none"> <li>• Accepted</li> </ul>
Senior Manager	<p>Name/word changes</p> <ul style="list-style-type: none"> <li>• Part A The Plan → Introduction and Background</li> <li>• Part B Balanced Scorecard → Strategic Directions (frontpage) and Strategic Action Plan (rest of BSC)</li> <li>• What encompasses cancer control p5</li> <li>• MCN → Cancer Services MCN</li> <li>• CI, AHS, NMMH, CSF, &amp; → in full</li> <li>• Evidence to Support Plan Development → “Burden of Illness” ? P9</li> </ul> <p>Other</p> <ul style="list-style-type: none"> <li>• Difference between prevalence and incidence p9</li> <li>• Inpatient projections ? p 10</li> <li>• Qualified in terms of reliability – this needs expanding</li> </ul>	<ul style="list-style-type: none"> <li>• Accepted</li> <li>• Reworded</li> <li>• Reworded</li> <li>• Reworded</li> </ul>

	<p>p11</p> <ul style="list-style-type: none"> <li>• Prevention statements – negative vs positive p13</li> <li>• Additional information on obesity funding p13</li> <li>• Remove “Timely access to services” p15</li> <li>• p16 Is a survey the only answer?</li> <li>• “Cluster” p22 first mention</li> <li>• Expand 5.1, to include more of MCN addressing the issues</li> <li>• Expand 5.2, to include how and who determined strengths, gaps and priorities</li> <li>• Expand 5.2 last paragraph to introduce priority issues</li> <li>• Workforce p 25 –include in workforce appendix</li> </ul> <p>Still to do</p> <ul style="list-style-type: none"> <li>• More detail on consultation process – feedback</li> <li>• Aboriginal Impact Statement</li> <li>• Ethnic Affairs Priority Statement (EAPS)</li> <li>• Resources/budget Required</li> <li>• Service Triangles</li> </ul>	<p>Accepted</p> <p>To be followed up</p>
Senior Manager	<ul style="list-style-type: none"> <li>• Why single out the Mater – last paragraph p6</li> <li>• Screening targets p15</li> <li>• Ambiguity – colonoscopy last para p15</li> <li>• Key Consid p15 – low rates of screening in some areas – geographic or specialties?</li> <li>• 52% RT benchmark p18 – reference</li> <li>• Rt services p 27 – what will be available in 2008</li> <li>• 5.3 biomedical engineering – 3 now?</li> <li>• BSC p 6 first strategy – this is happening now and should come out</li> <li>• BSC p 13 Why monitor haematology</li> </ul>	<ul style="list-style-type: none"> <li>• No action</li> <li>• SAP strategy set by Cancer Institute</li> <li>• Reworded</li> <li>• Reworded</li> <li>• Accepted NSW Health</li> <li>• Accepted</li> <li>• No action</li> <li>• No action</li> <li>• Accepted - widened to all units</li> </ul>

## APPENDIX TWO: EVIDENCE TO SUPPORT PLAN DEVELOPMENT

### Incidence 1999-2003

The top five reported cancers during the five year period 1999-2003 for overall HNE, females and males.

Top five HNE	Females	Males
Breast (12.8%)	Breast (27.9%)	Prostate (21.7%)
Prostate (11.8%)	Colon (10.6%)	Lung (11.5%)
Melanoma (10.8%)	Melanoma (10.2%)	Melanoma (11.3%)
Colon (9.5%)	Indef&Unspec (6.8%)	Colon (8.6%)
Lung (9.2%)	Lung (6.4%)	Indef&Unspec (6.4%)
Total top five: 54.1% (11,279)	Total top five: 61.9% (5,869)	Total top five: 59.5% (6,759)

Notes: 1. Indefinite and Unspecified Site – includes cancers of other and ill defined sites of the digestive tract (C26), respiratory system and intrathoracic organs (C39), retroperitoneum and peritoneum (C48) and ill defined sites (C76) and unknown primary sites (C80),

### Projected Incidence 2011

HNE Actual and projected new cases for selected and total cancers 2003 to 2011				
	*actual	**proj	**proj	
	2003	2006	2011	% change 2003-2011
Large bowel	605	696	792	31%
Prostate	541	600	724	34%
Breast	562	610	690	23%
Melanoma	503	530	617	23%
Lung	375	413	433	15%
Total	2586	2849	3256	26%
All others	1853	1997	2277	23%
Total All cancers	4439	4846	5533	25%
Source: * NSW Cancer Registry ** Incidence & Mortality Report				

### Mortality 1999-2003

The top five causes of cancer deaths during the five year period 1999-2003 for overall HNE, females and males.

Top Five HNE	Female	Male
Lung (18%)	Breast (14.9%)	Lung (21.6%)
Indef & Unspec (9.2%)	Lung (12.9%)	Prostate (15.1%)
Colon (8.9%)	Colon (11.2%)	Indef & Unspec (8.2%)
Prostate (8.8%)	Indef & Unspec (10.7%)	Colon (7.3%)
Breast (6.2%)	Other (6.3%)	Rectal (5.3%)
Total top five 51% (4,493)	Total top five 56% (2,033)	Total top five 57.5% (2,956)

### **Incidence 1999-2003 by Cluster and LGA**

Cluster	1999-2003	Avg per year	LGA	1999-2003	Avg/yr
Greater Newcastle	10170	2034	Lake Macquarie	4803	961
			Newcastle	3797	759
			Port Stephens	1570	314
Lower Hunter	3004	601	Cessnock	1179	236
			Dungog	210	42
			Maitland	1212	242
			Singleton	403	81
Lower Mid North Coast	2659	532	Gloucester	129	26
			Great Lakes	1281	256
			Greater Taree	1249	250
McIntyre	471	94	Bingara	54	11
			Inverell	417	83
Mehi	685	137	Moree Plains	285	57
			Narrabri	329	66
			Yallaroi	71	14
Peel	1803	361	Barraba	82	16
			Gunnedah	356	71
			Nundle	30	6
			Tamworth - Parry	1218	244
			Walcha	117	23
Tablelands	1198	240	Armidale - Dumaresq	526	105
			Glen Innes	214	43
			Guyra	112	22
			Severn	65	13
			Tenterfield	161	32
			Uralla	120	24
Upper Hunter	864	173	Manilla	88	18
			Merriwa	72	14
			Murrurundi	62	12
			Muswellbrook	284	57
			Quirindi	138	28
			Scone	220	44
Total	20854	4171	Total	20854	4171

## APPENDIX THREE: CURRENT AND PROJECTED SERVICE PROVISION

### Appendix 3.1 Inpatient activity by residential and hospital cluster Separations and Beddays

**HNE Residents/HNE Hospitals 2003/04 (Source: HIE 20/7/05)**

<b>Separations</b>	<b>Resi Cluster</b>								
Hosp cluster	Greater Ncle	Lower Hunter	Lower MNC	McIntyre	Mehi	Peel	Tablelands	Upper Hunter	Total Hospital
Greater Ncle	3960	736	246	22	13	45	22	120	5164
Lower Hunter	166	834	18	1		1		22	1042
Lower MNC	2		802	2			1	1	808
McIntyre				162			46		208
Mehi			1	18	126				145
Peel	1			107	84	672	45	45	954
Tablelands				29	1	14	446		490
Upper Hunter	1	1				3		226	231
Total Resident	4130	1571	1067	341	224	735	560	414	9042

**HNE Residents/HNE Hospitals 2003/04 (Source: HIE 20/7/05)**

<b>Beddays</b>	<b>Resi Cluster</b>								
Hosp cluster	Greater Ncle	Lower Hunter	Lower MNC	McIntyre	Mehi	Peel	Tablelands	Upper Hunter	Total Hospital
Greater Ncle	22966	3726	1901	187	38	350	236	792	30196
Lower Hunter	490	4632	52	1		1		75	5251
Lower MNC	2		3557	9			3	2	3573
McIntyre				543			137		680
Mehi			7	19	777				803
Peel	6			715	377	3831	296	244	5469
Tablelands				91	1	77	1826		1995
Upper Hunter	8	1				47		1870	1926
Total Resident	23472	8359	5517	1565	1193	4306	2498	2983	49893

**Non HNE Residents/HNE Hospitals 2003/04 (Source: HIE 20/7/05)**

Hosp cluster	Seps	Beddays
Greater Ncle	221	1391
Lower Hunter	13	27
Lower MNC	11	35
Mehi	11	126
Peel	117	679
Tablelands	4	26
Upper Hunter	11	81
Total	388	2365

## Flows and Self sufficiency %

Separations 2003/04 (Source: HIE 20/7/05)

Hosp cluster	Residential Cluster								Total
	Greater Ncle	Lower Hunter	Lower MNC	McIntyre	Mehi	Peel	Tablelands	Upper Hunter	
Greater Ncle	3960	736	246	22	13	45	22	120	5164
Lower Hunter	166	834	18	1		1		22	1042
Lower MNC	2		802	2			1	1	808
McIntyre				162			46		208
Mehi			1	18	126				145
Peel	1			107	84	672	45	45	954
Tablelands				29	1	14	446		490
Upper Hunter	1	1				3		226	231
Total	4130	1571	1067	341	224	735	560	414	9042
Cluster self sufficiency for HNE residents utilising HNE public hospitals	96%	53%	75%	48%	56%	91%	80%	55%	

Outflows - Private hospitals	3145	692	458	26	41	120	85	47	4614
Outflows - Non HNE public	164	39	88	44	28	80	68	23	534
Outflows - Interstate	0	0	7	44	43	2	85	2	183
Total outflows	3309	731	553	114	112	202	238	72	5331
Total demand by HNE residents	7439	2302	1620	455	336	937	798	486	14373
Outflows from HNE public as a % of demand	44%	32%	34%	25%	33%	22%	30%	15%	37%
HNE public self sufficiency ie % of demand by residents for public sector services and supplied by HNE public	96%	98%	92%	89%	89%	90%	89%	95%	63%
Overall HNE self sufficiency inc private ie % of demand by HNE residents for either private or public sector services and supplied by HNE public	56%	68%	66%	75%	67%	78%	70%	85%	63%

### **Appendix 3.2 Cancer Dataset**

The “cancer” dataset for this Plan comprises the following:

All hospital activity from the HNE HIE where the inpatient episode had either a primary cancer diagnosis (ICD 10: C00-C96) or was assigned one of 46 “cancer” DRGs. The either/or was necessary as preliminary checking indicated that using either one alone would significantly understate activity. Outflows and private data were sourced from FlowInfo. However as FlowInfo data does not have an attached primary diagnosis the search was restricted to the 46 “cancer” DRGs. Limitations in this dataset are acknowledged. Development of a statewide comprehensive cancer dataset commenced late in 2005 and is a joint effort by NSW Health (Statewide Services) and the Cancer Institute.

## Forty Six (46) Diagnostic Related Groups (DRGs) for Cancer Care

B66A	Nervous system neoplasms age > 64 years
B66B	Nervous system neoplasms age < 65 years
D60A	Ear, nose, mouth and throat malignancy with catastrophic or severe cc
D60B	Ear, nose, mouth and throat malignancy without catastrophic or severe cc
E71A	Respiratory neoplasms with cc
E71B	Respiratory neoplasms without cc
G60A	Digestive malignancy with catastrophic or severe cc
G60B	Digestive malignancy without catastrophic or severe cc
H02A	Major biliary tract procedures with malignancy
H61A	Malignancy of hepatobiliary system, pancreas age > 69 years with catastrophic
H61B	Malignant hepatobiliary system, pancreas
H61C	Malignancy of hepatobiliary system, pancreas age < 70 years
I65A	Connective tissue malignancy, including pathological fracture age > 64 years
I65B	Connective tissue malignancy, including pathological fracture age < 65 years
J06A	Major procedures for malignant breast conditions
J07A	Minor procedures for malignant breast conditions
J62A	Malignant breast disorders age > 69 years
J62B	Malignant breast disorders
J62C	Malignant breast disorders age < 70 years without cc
L62A	Kidney and urinary tract neoplasms with catastrophic or severe cc
L62B	Kidney and urinary tract neoplasms without catastrophic or severe cc
M60A	Malignancy, male reproductive system with catastrophic or severe cc
M60B	Malignancy, male reproductive system without catastrophic or severe cc
N02A	Uterine, Adnexa Proc for Ovarian or Adnexal Malignancy W CC
N02B	Uterine, Adnexa Proc for Ovarian or Adnexal Malignancy W/O CC
N60A	Malignancy, female reproductive system with catastrophic or severe cc
N60B	Malignancy, female reproductive system without catastrophic or severe cc
R01A	Lymphoma and leukaemia with major O.R. procedures with catastrophic
R01B	Lymphoma and leukaemia with major O.R. procedures without catastrophic
R02A	Other neoplastic disorders with major O.R. procedures with catastrophic
R02B	Other neoplastic disorders with major O.R. procedures without catastrophic
R03A	Lymphoma and leukaemia with other procedures with catastrophic or severe cc
R03B	Lymphoma and leukaemia with other or procedures without catastrophic or severe cc
R04A	Other neoplastic disorders with other O.R. procedures with catastrophic
R04B	Other neoplastic disorders with other O.R. procedures without catastrophic
R60A	Acute leukaemia with catastrophic cc
R60B	Acute leukaemia with severe cc
R60C	Acute leukaemia without catastrophic or severe cc
R61A	Lymphoma and non-acute leukaemia with catastrophic cc
R61B	Lymphoma and non-acute leukaemia without catastrophic cc
R61C	Lymphoma and Non-acute leukaemia, sameday
R62A	Other neoplastic disorders with cc
R62B	Other neoplastic disorders without cc
R63Z	Chemotherapy
R64Z	Radiotherapy
S62Z	HIV-Related Malignancy

### Appendix 3.3 Cervical and Breast Screening Rates

Biennial Breast and Cervical Screening Rates		
	*Cervical	**Breast
Clusters	rate range****	rate range****
Greater Newcastle	60.7 - 63.3	49.6 - 55.0
Lower Hunter	53.8 - 65.1	32.7 - 48.3
Lower Mid North Coast	61.3 - 71.7	34.1 - 47.3
McIntyre	55.4 - 64.8	63.5 - 64.1
Mehi	56.5 - 62.7	44.7 - 70.4
Peel	46.4 - 75.0	53.6 - 83.5
Tablelands	43.9 - 79.8	42.0 - 75.8
Upper Hunter	52.8 - 68.9	30.9 - 61.3
HNE	61.3 - 65.6***	50.4
NSW	61	51.8
* Cervical Screening in NSW, Annual Report 2003		
** NSW Breast Screening - June 05 quarter, unpublished		
*** Based on old Hunter, NEAHS and MNC		
**** Range is due to the rate for each LGA within a cluster		

## Appendix 3.4 Chemotherapy

### Benchmark:

- 50% of all new cases (2220 in 2003) plus 25% retreatment of new cases (555 in 2003) ie total cases in 2003 to meet benchmark = 2775

### Required number of chairs

- number of chairs based on Incidence x 0.005 (NSW Health)
- in 2003 = 22 chairs (4,439 x 0.005)
- in 2011 = 28 chairs (5,539 x 0.005)
- 2005 supply of chairs = 34 (Taree 6, Mater 12, M,Brk 2, Armidale 6+1bed, Tamworth 7)

### Patients by Tumour group

Non Inpatient Chemotherapy 2004/5							
Number of Patients by Tumour group – Total estimate 2621							
	RNH	Mater	Mbrk	Manning	Armidale	Tamworth	**Inpatients
Breast		245	13		27		
Colon		114	17		18		
Lung		75	3		17		
Unknown		31	1		0		
Rectum		57	2		5		
Oesophagus		21	0		6		
Pancreas		12	2		3		
Ovary		45	1		7		
Prostate		20	0		7		
Lymphoma		46	3		12		
Urology	*80	11	0		2		
Gynae		19	0		0		
Head & Neck		38	0				
All other		50	1		21		
<b>Total</b>	<b>*80</b>	<b>784(*875)</b>	<b>43(*46)</b>	<b>*185</b>	<b>104(*554)</b>	<b>*491</b>	<b>**390</b>
*Estimate in brackets is based on Chemotherapy OOS/8.2 treatment sessions per patient compared to actual figures provided where possible							
**Estimate based on Inpatient separations (3205 in 2003/04)							

Linking activity and incidence

Estimated Number of Patients receiving Chemotherapy and % of incidence								
	Greater Newcastle, Lower and Upper Hunter				New England		LMNC	
	RNH	Mater	Mbrk	Inpatient	Armidale	Tamworth	Manning	Total
*Patients	80	875	46	390	554	491	185	2621
**Incidence 2003	2984				886		563	4433
% of incidence receiving chemotherapy ***	47%				>100%		33%	59%
Benchmark	50%				50%		50%	50%
*From previous table based on estimates using OOS and inpatient seps								
** Estimated from 1999-2003 average and 2003 incidence								
*** Benchmark is 50%								
Note: all inpatients were allocated to GNS, LH and UH sectors								

## Appendix 3.5 Radiotherapy

### Benchmark

- 52% of all new cases plus additional 25% of the 52% for retreatment
- In 2003 the benchmark number for new cases for HNE would be 2,308.

### Referrals

	2001	2002	2003	2004
Hunter	887	906	892	981
New England	428	363	390	329
*Mid North Coast	300	330	360	389
Total	1615	1599	1642	1699
Source: 2004 RMIS Report * Old AHS				

	Hunter	New England	MNC
Illawarra CC	0	2	1
Liverpool CTC	1	1	1
Macarthur CTC	1	0	0
Nepean CCC	0	1	2
Mater Ncle	893	160	65
POWH	29	87	28
RNSH	5	15	132
RPAH	8	2	35
St George CCC	3	2	12
St V public	1	11	7
Westmead	6	11	15
Total NSW Public	947	292	298
Central Coast OC	11	1	2
SAH	2	0	4
Mater Crows Nest	11	13	39
St V private	8	10	12
Riverina CCC	0	1	2
Total NSW	979	317	357
ACT Public	0	0	1
Qld Public	1	11	21
SA Public	0	1	1
Vic Public	1	0	5
Vic Private	0	0	4
Total All	981	329	389

## Utilisation

Proportion of new cancer cases receiving radiotherapy				
	2000	2001	2002	*2003
Hunter	34%	37%	35%	30%
New England	42%	61%	44%	42%
Mid North Coast	26%	26%	26%	N/A
Source: CCORE p 48 *Estimate from the number of new cases seen in radiation oncology departments 2003 and the 2003 incidence				

## Attendances

New Treatment v Re Treatment: NMMH Centre						
	2000	2001	2002	2003	2004	2000/04 % change
New Courses	935	841	1064	1055	1233	32%
Retreatment	246	206	221	292	254	3%
Retreatment as a % of New courses	26	25	21	28	21	
Retreatment Benchmark	25%					
Source: 2004 RMIS report						

## Treatment by Tumour groups at Newcastle Mater

*New Course Treatment activity by Cancer Site (Primary Diagnosis) 2004					
Cancer site	Rectum (C19- C20)	Lung (C34)	Breast (C50)	Prostate (C61)	Head & Neck (C00-C14; C30- C32; C49.0; C69;C76.0)
**New Treatment	52	140	277	176	65
% of all new treatments	4%	11%	22%	14%	5%
***Incidence 2003	202	375	553	541	137
% New Course to incidence	26%	37%	50%	33%	47%
****Benchmark	61%	76%	83%	60%	78%
*Source: 2004 RMIS report **12 month estimate ***NSW Cancer Registry ****CCORE 2003					

### Radiotherapy Waiting times

Benchmark (CSF p16)

- 3 weeks between decision to treat and commencing treatment

<b>Waiting times for Radiotherapy Treatment at NMMH 2004/5</b>		
Category*	June 05	Monthly waiting time range Jul 04 to June 05
A1– within 24 hrs	83.3%	75-100%
A2– within 7 days	50%	50-100%
B1– within 21 days	70%	42.4-83.3%
B2- within 21 days	48%	21.7-78.9%
C – within 21 days	47.5%	29-70.8%
D – within 21 days	80%	41.7-82.4%
E – within 21 days	90%	72.2-100%
Median wait time non urgent	18 days	14-28 days

#### \* Definitions

Patients are routinely categorised according to clinical urgency using the following criteria.

Category A1 - Urgent, should receive treatment within 24 hours

Category A2 - Urgent, should receive treatment within 7 days

Category B - Radical Patients who should not wait as no other treatment is available

B1 & B2 refers to predicted survival rates following treatment.

B1 have higher survival rate than B2

Category C - Radical Patients that can wait, may require other treatments as well eg chemotherapy

Category D - Palliative requiring more than 10 treatments

Category E - Palliative requiring 1-5 treatments.

## Appendix 3.6 Surgery

### Identified Top five cancers and their top five procedures 2003/04

Cancer group/procedure	2001/02	2002/03	2003/04	2004/05*	Total all 2003/04**	% of 03/04 to all in 03/04***
<b>Breast</b>						
30336-00 Radical excision of lymph nodes, axilla	26	31	29	25	29	100%
31500-00 Excision of lesion of breast	269	165	199	155	438	45%
31515-00 Re-excision of lesion of breast		39	32	27	41	78%
31518-00 Simple mastectomy, unilateral	148	160	143	120	171	84%
34527-00 Ins impl vascular infusion dev oth vesl	30	30	29	20	54	54%
<b>Total</b>	<b>473</b>	<b>425</b>	<b>432</b>	<b>347</b>	<b>733</b>	<b>59%</b>
<b>Colon</b>						
32003-00 Limited excision lrg intestine w anstms	22	25	38	37	66	58%
32003-01 Right hemicolectomy with anastomosis	83	91	93	104	134	69%
32005-01 Extended right hemicolectomy w anstms		13	19	28	20	95%
32090-01 Fiberoptic colonoscopy to caecum w Bx	87	82	96	60	727	13%
32093-00 Fiberoptic colonoscopy to caecum w PP	37	30	36	54	1402	3%
<b>Total</b>	<b>229</b>	<b>241</b>	<b>282</b>	<b>283</b>	<b>2349</b>	<b>12%</b>
<b>Lung</b>						
38403-00 Therapeutic thoracentesis	33	38	52	47	152	34%
38412-00 Percutaneous needle biopsy of lung	48	53	53	44	75	71%
38438-01 Lobectomy of lung	11	10	13	9	14	93%
38440-00 Wedge resection of lung	7	5	11	16	14	79%
41898-01 Fiberoptic bronchoscopy with biopsy	12	89	102	96	298	34%
<b>Total</b>	<b>111</b>	<b>195</b>	<b>231</b>	<b>212</b>	<b>553</b>	<b>42%</b>
<b>Melanoma</b>						
31205-00 Exc lesion of SSCT, other site	245	277	348	292	691	50%
31230-02 Excision of lesion SSCT, ear	60	80	89	89	139	64%
31235-00 Exc lesion SSCT, oth site of head	198	207	226	251	412	55%
31235-01 Excision lesion of SSCT, neck	37	36	46	33	137	34%
31235-03 Excision of lesion SSCT, leg	163	203	209	219	326	64%
<b>Total</b>	<b>703</b>	<b>803</b>	<b>918</b>	<b>884</b>	<b>1705</b>	<b>54%</b>
<b>Prostate</b>						
36800-00 Bladder catheterisation	10	12	8	9	121	7%
37201-00 Transurethral needle ablation prostate	4	1	8	7	35	23%
37203-00 Transurethral resection of prostate	92	88	60	91	361	17%
37209-00 Radical prostatectomy	9	3	11	21	11	100%
37210-00 Rad prostatectomy w bladder neck recon	3	2	6	9	6	100%
<b>Total</b>	<b>118</b>	<b>106</b>	<b>93</b>	<b>137</b>	<b>534</b>	<b>17%</b>

\* Incomplete

\*\* All diagnosis where primary procedure equalled top 25 identified procedures

\*\*\*Where top 25 primary procedures had a primary cancer diagnosis.

TABLE 1: Cost by Hospital Peer Group for Top Five Procedures on 2003/04 for Top Five Cancers - Primary Cancer Diagnosis only.

Hospital Peer Grp		Breast	Colon	Lung	Melanoma	Prostate	Total
A1a	No	20	58	91	77	0	246
	hrs	23	131	152	68	0	374
	\$	\$ 86,464	\$ 806,339	\$ 656,647	\$ 277,731	\$ -	\$ 1,827,181
A3	No	200	20	48	195	31	494
	hrs	239	36	64	172	51	562
	\$	\$ 726,748	\$ 176,801	\$ 168,861	\$ 481,080	\$ 177,099	\$ 1,730,589
B2	No	141	108	71	280	38	638
	hrs	169	184	89	255	61	758
	\$	\$ 571,604	\$ 899,467	\$ 312,474	\$ 790,955	\$ 211,555	\$ 2,786,055
C1	No	59	51	13	30	8	161
	hrs	67	82	16	26	9	200
	\$	\$ 203,298	\$ 349,438	\$ 66,029	\$ 105,320	\$ 30,956	\$ 755,041
C2	No	12	45	8	336	16	417
	hrs	15	41	10	300	13	379
	\$	\$ 45,051	\$ 99,660	\$ 32,330	\$ 754,535	\$ 75,348	\$ 1,006,924
Total \$ using 05/06 PRCs*	No	432	282	231	918	93	1956
	hrs	512	474	331	822	134	2273
	\$	\$ 1,633,165	\$ 2,331,705	\$ 1,236,341	\$ 2,409,621	\$ 494,958	\$ 8,105,790
% of all top five procedures (Table 2)	No	59%	12%	42%	54%	17%	33%
	hrs	60%	22%	45%	55%	24%	39%
	\$	71%	36%	45%	59%	22%	46%
%Increase in incidence		23%	31%	15%	23%	34%	
% inc CPI x 4yrs		12%	12%	12%	12%	12%	
Projected 2011	No	531	369	266	1129	125	2420
	hrs	630	817	380	1011	180	3018
	\$	\$ 2,249,848	\$ 3,421,078	\$ 1,592,407	\$ 3,319,494	\$ 742,833	\$ 11,325,660

TABLE 2: Cost by Hospital Peer Group for Top Five Procedures on 2003/04 for Top Five Cancers - All diagnoses.

Hospital Peer Grp		Breast	Colon	Lung	Melanoma	Prostate	Total
A1a	No	28	178	220	145	5	576
	hrs	32	284	321	129	2	768
	\$	\$ 112,222	\$ 1,561,578	\$ 1,384,777	\$ 459,833	\$ 9,821	\$ 3,528,231
A3	No	304	227	88	271	150	1040
	hrs	356	200	114	232	168	1070
	\$	\$ 1,005,130	\$ 523,461	\$ 300,207	\$ 623,440	\$ 661,150	\$ 3,113,388
B2	No	231	616	161	510	210	1728
	hrs	270	597	201	459	232	1759
	\$	\$ 752,618	\$ 1,973,058	\$ 642,431	\$ 1,345,012	\$ 952,554	\$ 5,665,673
C1	No	118	569	63	76	52	878
	hrs	131	490	79	64	59	823
	\$	\$ 304,403	\$ 1,248,369	\$ 317,889	\$ 191,963	\$ 200,197	\$ 2,262,821
C2	No	52	759	21	703	117	1652
	hrs	59	576	26	622	91	1374
	\$	\$ 117,470	\$ 1,159,435	\$ 84,482	\$ 1,470,724	\$ 377,696	\$ 3,209,807
Total \$ using 05/06 PRCs*	No	733	2349	553	1705	534	5874
	hrs	848	2147	740	1506	551	5792
	\$	\$ 2,291,843.00	\$ 6,465,901.00	\$ 2,729,786.00	\$ 4,090,972.00	\$ 2,201,418.00	\$ 17,779,920

\*Peer reference Costs

**Table 3: Operating Theatre Time and Projections 2003/04 to 2011 for Top Five Procedures with Primary Cancer Diagnosis**

Cancer group	Primary procedure	No proc 03/04	avge OT time**	Total mins 03/04	hrs	No proc 2011***	Total mins 2011	hrs	increase (hrs)
<b>breast</b>	30336-00 Radical excision of lymph nodes, axilla	29	84	2436	41	36	2996	50	9
	31500-00 Excision of lesion of breast	199	66	13134	219	245	16155	269	50
	31515-00 Re-excision of lesion of breast	32	28	896	15	39	1102	18	3
	31518-00 Simple mastectomy, unilateral	143	84	12012	200	176	14775	246	46
	34527-00 Ins impl vascular infusion dev oth vesl	29	77	2233	37	36	2747	46	9
<b>Total</b>		<b>432</b>		<b>30711</b>	<b>512</b>	<b>531</b>	<b>37775</b>	<b>630</b>	<b>118</b>
<b>colon</b>	32003-00 Limited excision lrg intestine w anstms*	38	150	5700	95	50	10454	174	79
	32003-01 Right hemicolectomy with anastomosis*	93	150	13950	233	122	25584	426	194
	32005-01 Extended right hemicolectomy w anstms*	19	150	2850	48	25	5227	87	40
	32090-01 Fibreoptic colonoscopy to caecum w Bx	96	45	4320	72	126	5659	94	22
	32093-00 Fibreoptic colonoscopy to caecum w PP	36	45	1620	27	47	2122	35	8
<b>Total</b>		<b>282</b>		<b>28440</b>	<b>474</b>	<b>369</b>	<b>49046</b>	<b>817</b>	<b>343</b>
<b>lung</b>	38403-00 Therapeutic thoracentesis	52	75	3900	65	60	4485	75	10
	38412-00 Percutaneous needle biopsy of lung	53	75	3975	66	61	4571	76	10
	38438-01 Lobectomy of lung	13	180	2340	39	15	2691	45	6
	38440-00 Wedge resection of lung	11	180	1980	33	13	2277	38	5
	41898-01 Fibreoptic bronchoscopy with biopsy	102	75	7650	128	117	8798	147	19
<b>Total</b>		<b>231</b>		<b>19845</b>	<b>331</b>	<b>266</b>	<b>22822</b>	<b>380</b>	<b>50</b>
<b>melanoma</b>	31205-00 Exc lesion of SSCT, other site	348	44	15312	255	428	18834	314	59
	31230-02 Excision of lesion SSCT, ear	89	44	3916	65	109	4817	80	15
	31235-00 Exc lesion SSCT, oth site of head	226	70	15820	264	278	19459	324	61
	31235-01 Excision lesion of SSCT, neck	46	42	1932	32	57	2376	40	7
	31235-03 Excision of lesion SSCT, leg	209	59	12331	206	257	15167	253	47
<b>Total</b>		<b>918</b>		<b>49311</b>	<b>822</b>	<b>1129</b>	<b>60653</b>	<b>1011</b>	<b>189</b>
<b>prostate</b>	36800-00 Bladder catheterisation	8	20	160	3	11	214	4	1
	37201-00 Transurethral needle ablation prostate	8	60	480	8	11	643	11	3
	37203-00 Transurethral resection of prostate	60	70	4200	70	80	5628	94	24
	37209-00 Radical prostatectomy	11	180	1980	33	15	2653	44	11
	37210-00 Rad prostatectomy w bladder neck recon	6	210	1260	21	8	1688	28	7
<b>Total</b>		<b>93</b>		<b>8080</b>	<b>135</b>	<b>125</b>	<b>10827</b>	<b>180</b>	<b>46</b>
<b>Total all top five procedures</b>		<b>1956</b>		<b>136387</b>	<b>2273</b>	<b>2420</b>	<b>181122</b>	<b>3019</b>	<b>746</b>

\* Operating theatre time for these procedures is expected to increase by 60 mins (due to laproscopic technique) and has been used in the 2011 projections

\*\* Sourced from Royal Newcastle (prostate), John Hunter (colon, lung), NMMH (breast, melanoma) Note: If a time range was indicated, then midway was used

\*\*\* Projections were estimated using 03/04 procedure numbers multiplied by the overall increase in incidence for that particular cancer group

**Table 4: Operating Theatre Time and Projections 2003/04 to 2011 for Top Five Procedures, All diagnoses**

Cancer group	Primary procedure	No proc 03/04	avge OT time**	Total mins 03/04	hrs	No proc 2011***	Total mins 2011	hrs	increase (hrs)
<b>breast</b>	30336-00 Radical excision of lymph nodes, axilla	29	84	2436	41	36	2996	50	9
	31500-00 Excision of lesion of breast	438	66	28908	482	539	35557	593	111
	31515-00 Re-excision of lesion of breast	41	28	1148	19	50	1412	24	4
	31518-00 Simple mastectomy, unilateral	171	84	14364	239	210	17668	294	55
	34527-00 Ins impl vascular infusion dev oth vesl	54	77	4158	69	66	5114	85	16
<b>Total</b>		<b>733</b>		<b>51014</b>	<b>850</b>	<b>902</b>	<b>62747</b>	<b>1046</b>	<b>196</b>
<b>colon</b>	32003-00 Limited excision lrg intestine w anstms*	66	150	9900	165	86	18157	303	138
	32003-01 Right hemicolectomy with anastomosis*	134	150	20100	335	176	36863	614	279
	32005-01 Extended right hemicolectomy w anstms*	20	150	3000	50	26	5502	92	42
	32090-01 Fibreoptic colonoscopy to caecum w Bx	727	45	32715	545	952	42857	714	169
	32093-00 Fibreoptic colonoscopy to caecum w PP	1402	45	63090	1052	1837	82648	1377	326
<b>Total</b>		<b>2349</b>		<b>128805</b>	<b>2147</b>	<b>3077</b>	<b>186027</b>	<b>3100</b>	<b>954</b>
<b>lung</b>	38403-00 Therapeutic thoracentesis	152	75	11400	190	175	13110	219	29
	38412-00 Percutaneous needle biopsy of lung	75	75	5625	94	86	6469	108	14
	38438-01 Lobectomy of lung	14	180	2520	42	16	2898	48	6
	38440-00 Wedge resection of lung	14	180	2520	42	16	2898	48	6
	41898-01 Fibreoptic bronchoscopy with biopsy	298	75	22350	373	343	25703	428	56
<b>Total</b>		<b>553</b>		<b>44415</b>	<b>740</b>	<b>636</b>	<b>51077</b>	<b>851</b>	<b>111</b>
<b>melanoma</b>	31205-00 Exc lesion of SSCT, other site	691	44	30404	507	850	37397	623	117
	31230-02 Excision of lesion SSCT, ear	139	44	6116	102	171	7523	125	23
	31235-00 Exc lesion SSCT, oth site of head	412	70	28840	481	507	35473	591	111
	31235-01 Excision lesion of SSCT, neck	137	42	5754	96	169	7077	118	22
	31235-03 Excision of lesion SSCT, leg	326	59	19234	321	401	23658	394	74
<b>Total</b>		<b>1705</b>		<b>90348</b>	<b>1506</b>	<b>2097</b>	<b>111128</b>	<b>1852</b>	<b>346</b>
<b>prostate</b>	36800-00 Bladder catheterisation	121	20	2420	40	162	3243	54	14
	37201-00 Transurethral needle ablation prostate	35	60	2100	35	47	2814	47	12
	37203-00 Transurethral resection of prostate	361	70	25270	421	484	33862	564	143
	37209-00 Radical prostatectomy	11	180	1980	33	15	2653	44	11
	37210-00 Rad prostatectomy w bladder neck recon	6	210	1260	21	8	1688	28	7
<b>Total</b>		<b>534</b>		<b>33030</b>	<b>551</b>	<b>716</b>	<b>44260</b>	<b>738</b>	<b>187</b>
<b>Total all top five procedures</b>		<b>5874</b>		<b>347612</b>	<b>5794</b>	<b>7427</b>	<b>455239</b>	<b>7587</b>	<b>1794</b>

\* Operating theatre time for these procedures is expected to increase by 60 mins (due to laproscopic technique) and has been used in the 2011 projections

\*\* Sourced from Royal Newcastle (prostate), John Hunter (colon, lung), NMMH (breast, melanoma) Note: If a time range was indicated, then midway was used

\*\*\* Projections were estimated using 03/04 procedure numbers multiplied by the overall increase in incidence for that particular cancer group

## **Cancer Surgery Model**

There were four components to the selected surgery exercise.

- To gain an indication of how much of the surgery is due to a cancer diagnosis and how much is “cancer related”
- To gain an indication of the likely funding required for 2011
- To gain an indication of the likely operating theatre time required for 2011
- Given the complexities involved in identifying these data this exercise is a starting point only in associating activity with funding and operating theatre requirements.

## **Methodology**

- The top five primary procedures (by separations) for 2003/04 were identified for the top five cancers from incidence data.
- The HIE was then searched for all episodes where the primary procedure matched the identified 25 procedures irrespective of primary diagnosis
- The resultant dataset was then analysed to identify the number of procedures where the primary diagnosis was “cancer” compared with the total number for each procedure.
- Each cancer grouping was then grouped by Hospital Peer Group and an estimated cost obtained for each using cost weights and the 05/06 Peer Reference Costs.
- The numbers of each procedure in the “cancer” dataset were then projected using the incidence for each cancer grouping resulting in a projected number of procedures for 2011. Note: The next step in development would be the identification and then incorporation of an adjustment for the differences in surgery rates for each type of cancer.
- The projected numbers of each procedure were then multiplied by the 05/06 Peer Reference Cost and CPI of 3% per year was added.
- The average theatre time for each procedure was sourced from John Hunter (colon, lung), NMMH (breast, melanoma) and Royal Newcastle (prostate)
- The number of procedures 03/04, the projected number for 2011 (using the increase in incidence) were multiplied by the average times to gain an indication of the operating theatre time needed in 2011 for the 25 procedures.

### **HOSPITALS BY HOSPITAL PEER GROUP including Peer**

#### **Reference Cost (PRC \$)**

**Peer Grp & PRC**

**Facility/hospital**

A1a - \$3,157	John Hunter Hospital
A3 - \$2,977	Newcastle Mater Misericordiae Hospital Royal Newcastle Hospital
B2 - \$3,017	Maitland Hospital Manning Base Hospital Tamworth Base Hospital
C1 - \$2,964	Armidale and New England Hospital Belmont Hospital
C2 - \$2,827	Cessnock District Hospital Gunnedah District Hospital Inverell District Hospital Kurri Kurri District Hospital Moree District Hospital Muswellbrook District Hospital Narrabri District Hospital Singleton District Hospital
The following hospitals have also been included in C2 group	
	Bulahdelah District Hospital Glen Innes District Hospital Gloucester Soldier's Memorial Hospital Merriwa District Hospital Quirindi District Hospital Scott Memorial Hospital, Scone Wee Waa District Hospital Werris Creek District Hospital

### Appendix 3.7 Palliative Care Separations 2003/04

#### Palliative Care: HNE residents / HNE hospitals

Seps	Resi Cluster								
Hospital Name	Greater Ncle	Lower Hunter	Lower MNC	McIntyre	Mehi	Peel	Tablelands	Upper Hunter	Total
Armidale and New England Hospital						1	14		15
Cessnock District Hospital		20							20
Dungog District Hospital		1							1
Glen Innes District Hospital							2		2
Gunnedah District Hospital						1	10		11
Guyra and District War Memorial Hospital							2		2
Inverell District Hospital				23			5		28
John Hunter Hospital	1								1
Kurri Kurri District Hospital		3							3
Maitland Hospital		10							10
Manning Base Hospital			109	1					110
Moree District Hospital						11			11
Muswellbrook District Hospital								5	5
Narrabri District Hospital						13			13
Nelson Bay and District Polyclinic	5								5
Newcastle Mater Misericordiae Hospital	410	16	7					1	434
Prince Albert Memorial, Tenterfield							1		1
Quirindi District Hospital								6	6
Singleton District Hospital		2							2
Tamworth Base Hospital				2		59		1	62
Walcha District Hospital						4			4
Wee Waa District Hospital					2				2
Werris Creek District Hospital						2			2
Grand Total	416	52	116	26	27	76	24	13	750

#### Maintenance Care: HNE residents / HNE hospitals

Seps	Resi Cluster					
Hospital Name	Greater Ncle	Lower Hunter	McIntyre	Tablelands	Upper Hunter	Total
Cessnock District Hospital		5				5
Guyra and District War Memorial Hospital				1		1
Inverell District Hospital			1			1
John Hunter Hospital	2					2
Kurri Kurri District Hospital		3				3
Merriwa District Hospital					1	1
Newcastle Mater Misericordiae Hospital	13					13
Royal Newcastle Hospital	1					1
Vegetable Creek Multi-Purpose Service				1		1
Grand Total	16	8	1	2	1	28

## Beddays 2003/04

### Palliative Care: HNE residents / HNE hospitals

Beddays	Resi Cluster								
Hospital Name	Greater Ncle	Lower Hunter	Lower MNC	McIntyre	Mehi	Peel	Tablelands	Upper Hunter	Total
Armidale and New England Hospital						10	91		101
Cessnock District Hospital		172							172
Dungog District Hospital		9							9
Glen Innes District Hospital							30		30
Gunnedah District Hospital						1	47		48
Guyra and District War Memorial Hospital							33		33
Inverell District Hospital				206			39		245
John Hunter Hospital	17								17
Kurri Kurri District Hospital		13							13
Maitland Hospital		91							91
Manning Base Hospital			976	8					984
Moree District Hospital					106				106
Muswellbrook District Hospital								39	39
Narrabri District Hospital					221				221
Nelson Bay and District Polyclinic	21								21
Newcastle Mater Misericordiae Hospital	5416	221	125					4	5766
Prince Albert Memorial, Tenterfield							1		1
Quirindi District Hospital								56	56
Singleton District Hospital		9							9
Tamworth Base Hospital				29		1160		8	1197
Walcha District Hospital							99		99
Wee Waa District Hospital					116				116
Werris Creek District Hospital						46			46
Grand Total	5454	515	1101	243	444	1362	194	107	9420

### Maintenance care - beddays

Beddays	Resi Cluster					
Hospital Name	Greater Newc	Lower Hunter	McIntyre	Tablelands	Upper Hunter	Total
Cessnock District Hospital		429				429
Guyra and District War Memorial Hospital				39		39
Inverell District Hospital			12			12
John Hunter Hospital	16					16
Kurri Kurri District Hospital		281				281
Merrriwa District Hospital					248	248
Newcastle Mater Misericordiae Hospital	152					152
Royal Newcastle Hospital	5					5
Vegetable Creek Multi-Purpose Service				81		81
Grand Total	173	710	12	120	248	1263

## Palliative Care Inpatient Summary

Residential Cluster	Palliative Care		Maintenance Care	
	seps	beddays	seps	beddays
Greater Newcastle	416	5454	16	173
Lower Hunter	52	515	8	710
Lower MNC	116	1101		
McIntyre	26	243	1	12
Mehi	27	444		
Peel	76	1362		
Tablelands	24	194	2	120
Upper Hunter	13	107	1	248
Total	750	9420	28	1263

## **APPENDIX 3.8: CANCER SERVICES TO ABORIGINAL PEOPLE**

### Utilisation – Inpatient Summary:

Resi Cluster	Seps	Beddays
Greater Newcastle	43	164
Lower Hunter	27	132
Lower Mid North Coast	6	10
McIntyre	7	37
Mehi	8	17
Peel	18	206
Tablelands	10	96
Upper Hunter	1	1
Total HNE resi/HNE hosp	120	663
Outflows HNE residents	22	66
Total HNE residents	142	729
Non-Hunter (inflows)	12	44
Total HNE hospitals	132	707

## **Appendix 3.9 Paediatrics**

### Population:

Expected decrease in 0-14 age group from 2001 to 2011 of nearly 9% (15,190)

### Inpatient utilisation:

2003/04	Seps	Beddays	alos
*HNE resi/HNE hosp	404	1166	2.9
**Outflows - pub	148	459	3.1
- priv	17	31	1.8
Total HNE residents	569	1656	2.9
*Inflows	9	23	2.6
Total HNE hospitals	413	1189	2.9
Source: * HIE 20/7/05 , ** Flowinfo			

Further analysis will be provided in the “Children and Young Peoples Plan“

### Appendix 3.10 Allied Health

<b>Profession</b>	<b>Major Tumour Groups</b>	<b>Examples of Cancer related Interventions/Activities</b>	<b>Outcomes Targeted</b>
Dietetics	General for all tumour groups	Liaison with relevant clinics / Clinical Care Co-ordinator on nutrition management Oral supplementation Enteral nutrition TPN	Decreased no. of hospital admissions Decreased LOS during the above hospital admissions Quality of life
	Head & Neck Oesophageal	Nutrition Support Inpatient / Outpatient Automatic Radiotherapy (RTx) referral network established Prophylactic PEG placement and Nutrition Support Home Enteral Nutrition (HEN) Supervision of 'weaning process' from PEG feeds once side effects settle Research	Decreased no. of hospital admissions related to dehydration + mucositis Decreased LOS during the above hospital admissions Oral diet re-established, PEG removed
	Prostate	Nutrition Support Inpatient / Outpatient RTx Referral Network established Community - Support Group Talks Potential for Research	Better management of treatment related side-effects through appropriate dietary intervention
	Lung	Nutrition Support through all stages of treatment (Chemotherapy, Radiation Therapy, Palliation) Automatic TRx referral network for those having mediastinal RTx	Better management of treatment related side-effects through appropriate intervention
Dietetics cont'd	GIT	Nutrition Support through all stages of treatment (ChemoTx, RTx, STx) Automatic RTx referral network established	Better management of treatment related side-effects through appropriate intervention
	Breast	Nutrition Support through all stages of treatment (ChemoTx, RTx) – limited service Community – Support Group Talks	
	Gynaecological	Nutrition Support through all stages of treatment (ChemoTx, RTx, Palliative) Automatic RTx referral network established	Better management of treatment related side-effects through appropriate intervention

	Haematology	Inpatient Nutrition Support Limited Outpatient Service Community – Leukaemia Foundation Support Group Talks Community – Patient / Care Focused Talks	Decreased LOS during hospital admissions
	Palliative Care	Nutrition Support for Palliative Care Inpatients Service to the Hospice limited to Enteral Nutrition, education re HEN Nutrition Support through for patients receiving palliative RTx treatment to the GIT Referral from Palliative Outreach Nursing: phone service Education of carers re appropriate nutrition	Quality of life
	Other	Links with NSW Cancer Council NSW Oncology SIG Group	Continuing education Research opportunities

<b>Profession</b>	<b>Major Tumour Groups</b>	<b>Examples of Cancer related Interventions/Activities</b>	<b>Outcomes Targeted</b>
Imaging	All Cancer services	Cancer related screening services and imaging examinations to facilitate diagnostics and treatment interventions	Improved diagnostic outcomes and better management of treatment interventions in conjunction with other clinicians
		Provision of specialised imaging services to perform complex examinations in a safe and appropriate imaging facilities. Provision of interventional imaging eg biopsies examinations	An example is the increased access to services such as Modified Barium Swallows in centres equipped to provide appropriate tests
		Provision of multi disciplinary education on imaging servicestaff	All imaging staff to have appropriate training in the multidisciplinary treatment of cancers and associated outcomes
		Maintaining partnership with referrers and cancers service providers	Direct and documented communication paths for key stakeholders
Occupational Therapy	Most tumour groups	Provision of assistive aids for helping cancer sufferers to remain at home during their treatment. E.g. wheelchairs Assessing home environments for aids and modifications. Pressure care; prescribing equipment and mattresses Educating carers on correct positioning techniques. Palliative care Day activity program Oncology equipment loan pool program where patients are prescribed assistive aids Facilitating Cancer Support Group and meditation group for cancer sufferers.	Improved functional capacity and independence of the client in relevant settings, particularly at home Supported, more confident carers Enhanced access to equipment and knowledge of their application

<b>Profession</b>	<b>Major Tumour Groups</b>	<b>Examples of Cancer related Interventions/Activities</b>	<b>Outcomes Targeted</b>
Pharmacy	General for all tumour groups	Liaison with relevant clinicians and community providers Chemotherapy support – advice and provision TPN Monitor adherence to relevant guidelines / protocols Medication history and reconciliation at discharge Medication regimen review Medication risk management advice Medication education	Enhanced management of cytotoxic chemotherapy treatment as well as treatment related side-effects thro' appropriate medication use Minimise continuum of care issues at discharge with respect to medicines
	Palliative Care		
	Haematology		
	Paediatrics	As above for "general" Medication education for carers Clinical trial support	
	Chemotherapy for Adults and Paediatrics	Imprest and dispensing services Preparation of patient specific cytotoxic chemotherapy	

<b>Profession</b>	<b>Major Tumour Groups</b>	<b>Examples of Cancer related Interventions/Activities</b>	<b>Outcomes Targeted</b>
Physiotherapy	Breast	Post surgical education re scar management, lymphoedema, shoulder dysfunction prevention (inpatient and outpatient). Support groups education re return to activity post chemotherapy and radiotherapy, lymphoedema (community)	100% mastectomies axillary dissections reviewed prior to discharge Full shoulder ROM 6/52 post op, No functional loss due to lymphoedema Some form of functional questionnaire
	Lung	Post surgical chest and shoulder management, management of thoracic and cervical spine pain (inpatient and outpatient). General fitness program and education on management of Shortness of breath (community program).	100% thoracotomies reviewed post op
	Brain both primary and secondary	Mobility aids, exercise programs to increase strength and balance. Assistive devices for support of poorly functioning muscle groups (inpatient and outpatient)	
	Melanoma	Post –op scar management especially if across a joint. Lymphoedema management (mainly outpatient).	
	General	Cancer support education talks on lymphoedema, return to activity and the benefits of activity in the community	
	Chemotherapy and Radiotherapy	Those under going chemo receive assistance with mobility issues, assistive devices for peripheral muscle weakness both upper and lower limb, general strengthening exercises, lymphoedema, joint ROM especially for those with surgery across joints. Scar management (all as required)	

<b>Profession</b>	<b>Major Tumour Groups</b>	<b>Examples of Cancer related Interventions/Activities</b>	<b>Outcomes Targeted</b>
Psychology	General for all tumour groups	<p>Service provided as part of specialised multidisciplinary psycho-oncology service</p> <p>Liaise with Cancer Care Co-ordinator (General and specific tumour types) re psychosocial need and psycho-oncology intervention</p> <p>All cancer types seen at Mater Hospital</p> <p>Gynae-Oncology and Paediatric Oncology services at John Hunter Hospital</p> <p>Introduction of touch screen computers to screen all outpatient attendances for psychosocial distress and refer appropriately to psych-oncology, social work, nursing and other allied health services.</p> <p>Collaborative research with neuropsychology into cognitive effects of treatments for cancer, eg "chemobrain"</p>	<p>Decrease in symptoms of Anxiety and Depression as measured by the HADS</p> <p>Increase in Quality of Life as measured by the WHOQoL-BREF</p>
	Head & Neck Oesophageal	<p>Individual- severe depression/anxiety/inability to cope</p> <p>Group- mild depression/anxiety/inability to cope</p> <p>Collaborative Research with Radiation Therapy and Social Work Departments - into levels of psychological distress in Head and Neck patients and their reactions to Radiotherapy. Aim to develop early intervention for those patients with high levels of anxiety to increase compliance and reduce time taken to treat</p> <p>Collaborative research with dietetics into depression and its impact on compliance with PEG Feeding directions.</p>	As above
	Prostate	<p>Individual- severe depression/anxiety/inability to cope</p> <p>Group- mild depression/anxiety/inability to cope</p> <p>Plan to develop specialist individual and group interventions once urology established at JHH</p>	As above

<b>Profession</b>	<b>Major Tumour Groups</b>	<b>Examples of Cancer related Interventions/Activities</b>	<b>Outcomes Targeted</b>
Psychology cont'd	Lung	Individual- severe depression/anxiety/inability to cope Group- mild depression/anxiety/inability to cope All patients screened for anxiety, depression and quality of life and seen by psycho-oncology service as required – co-ordinated by CCC(Lung)	As above
	GIT	Individual- severe depression/anxiety/inability to cope Group- mild depression/anxiety/inability to cope Plan to introduce system where all patients are screened for anxiety, depression and quality of life and seen by psycho-oncology service as required – co-ordinated by CCC(GI)	As above
	Breast	Individual- severe depression/anxiety/inability to cope Group- mild depression/anxiety/inability to cope Proposed research (clinical fellow in psycho-oncology CINSW) into screening for ASD at time of diagnosis and developing timely group intervention to increase compliance with treatment Co-Facilitation of community based group for young women with Breast cancer, and involvement in advanced breast cancer group held at Lingard Hosp	As above
	Gynaecological	Individual- severe depression, anxiety, loss of self esteem, grief and loss issues, impaired expression of sexuality, relationship concerns and end of life issues Plan to introduce system where all patients screened for anxiety and depression and quality of life and seen by psycho-oncology service as required – co-ordinated by CCC(Gynae-onc)	As above
	Haematology	Individual- severe depression/anxiety/inability to cope Group- mild depression/anxiety/inability to cope Proposed BMT group intervention in conjunction with Westmead Hospital	As above

<b>Profession</b>	<b>Major Tumour Groups</b>	<b>Examples of Cancer related Interventions/Activities</b>	<b>Outcomes Targeted</b>
Psychology cont'd	Palliative Care	Individual- severe demoralisation/depression/anxiety/inability to cope Family group intervention re supporting patients with above conditions	As above
	Paediatric Oncology	Specialist paediatric psycho-oncology service JHH (Clin Psych .3FTE) for inpatient and outpatient individual and family intervention Bi-monthly bereavement support group	As above
Social Work	All tumour groups – all cancer patients in the AHS	Psychosocial screening and assessments Counselling (bereavement etc) Family counselling End of life decision making Financial assistance Advocacy Community referrals and supports Crisis intervention Group work – general cancer and tumour group specific, eg, brain tumour, prostate Facilitating a 'Living with Cancer' group Education Mediation Multidisciplinary team work Service enhancement Participate in policy development	Psychosocial support to all cancer patients and their families Plan appropriate and timely discharge for inpatients

<b>Profession</b>	<b>Major Tumour Groups</b>	<b>Examples of Cancer related Interventions/Activities</b>	<b>Outcomes Targeted</b>
Speech Pathology	Head and Neck	Education of patients and carers re possible side effects of radiotherapy, advise on relevant support groups, equipment contact list	Quality of Life
	“	Screening and assessment of Head and Neck radiotherapy patients for swallowing and communication difficulties	Minimise difficulties experienced
		Pre and post surgical counselling	Quality of life Rehabilitation of speech and swallowing function
	“	Management of swallowing and communication problems for IP's and OP's post surgery, eg, laryngectomy, and during and post radiotherapy	Improved swallowing and communication function
	“	Pall Care – management of end of life feeding options	Quality of Life
		Insertion and changing of the voice prosthesis post laryngectomy	
	“	Speech and swallowing assessment and therapy for hemiglossectomies and hemi mandibulectomies	
	“	Assessment and management of patients with permanent trachy tubes secondary to cancer eg, supraglottic laryngectomy	

## APPENDIX FOUR: STRATEGIC AND SERVICE ISSUES

### Appendix 4.1 Key Strategic Issues – Ranked

Strategic Area	Rank	Issue
Capacity/Workforce	1	Identification of workforce requirements and succession planning for prevention, diagnosis, treatment, supportive care and palliation services (medical, radiology, nursing, allied health, pharmacy)
Organisational indicators	1	Area-wide data indicators for monitoring quality, patient safety, waiting times and outcomes
Care/Management/Coordination	2	Improved communication with GPs in the management of patients with cancer
	3	Development of standardised protocols for the management of specific tumour types and for diagnostic workups by GPs
Access	3	Establishment of linkages with rural areas for access to evidence based care
	4	Transition issues of paediatric patients as they move to adult cancer services
	4	Review of care coordination model(s)
Access	4	Specific target group needs eg Aboriginals, rural and remote
	4	Clinic appointments for rural patients
	4	Assessment of accommodation and transport requirements
Carer/Patient support	5	Referral to palliative care
Care/Management/Coordination	7	Roll-out of MST/MDT* approach to patient management
Prevention/Screening	7	Prevention
Technology	7	Technology in the broad sense
Care/Management/Coordination	8	Establishment of 13 tumour groups with Tumour Leads
Research	8	Research
Training/Accreditation	9	Identification of professional development needs and ongoing training of staff
Carer/Patient support	10	Identification of survivor needs
Access	10	Assessment of availability for after-hours assistance and point of contact
	10	Assessment of current referral practices including rural referrals to Sydney
Care/Management/Coordination	10	Effective liaison and integration with Surgical Oncology to establish clinical and management links with the surgical stream

Strategic Area	Rank	Issue
Access	11	Opportunities for linkages with private sector and community health
Care/Management/Coordination	12	Introduction of clinical streaming for Medical and Radiation Oncology
Carer/Patient support	12	Identification of rehabilitation services available for patients with cancer
	13	Carer and patient support
Care/Management/Coordination	13	Routine assessment for anxiety and depression
Prevention/Screening	14	Monitoring of screening rates in the HNE area
Capacity/Workforce	14	Assessment of the impact of bowel cancer screening on associated services
Access	14	Uniform approach to the distribution of patient education and patient consent
Research	15	Development of a register of patients in clinical trials
Training/Accreditation	16	Assessment of patterns of care to ensure appropriate volume is maintained for professional accreditation

\*Multispecialty Teams/Multidisciplinary Teams

## **Appendix 4.2 Hunter New England Cancer Proposed Tumour Groups**

Site-specific tumour groups are to be established under the strategic direction of the Cancer Management Committee to implement the strategies outlined in the HNE Cancer Services Plan. The Tumour Groups will comprise:

- lung
- breast
- head & neck
- upper gastro-intestinal
- skin
- colorectal
- paediatric
- neurology/ neurosurgery
- haematology
- urology
- gynaecology
- bone & soft tissue
- familial

**APPENDIX FIVE: ABORIGINAL IMPACT STATEMENT**

**ABORIGINAL HEALTH IMPACT STATEMENT AND CHECKLIST**

**Please complete:**

Have all items of the checklist been reviewed and answered?

Yes     No

If not, give reasons:

Will this policy, program or strategy significantly affect the health\* of Aboriginal people? (the checklist may assist you to answer this question)

Yes     No

If so, how:

***The strategies in the Plan aim to improve access to prevention, detection, treatment and support services for cancer for Aboriginal people. If cancer is prevented or detected at an early stage and timely access to treatment services and support is available then significant health improvements can be gained.***

Is this policy, program or strategy likely to lead to a change in the nature or level of resources or health services available for Aboriginal Health?

Yes     No

If so, specify:

***If identified as required and appropriate, specific funding will be sought for an Aboriginal Health Worker/Educator/Care Coordinator(s).***

**Statement**

The health needs and interests of Aboriginal people have been considered, and where relevant, incorporated and appropriately addressed in the development of this health policy, program or strategy.

**Head of Unit Name: Scott McLachlan**

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**Unit Name: Director Primary and Community Networks**

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\*For Aboriginal people, health is defined as not just the physical well-being of the individual but the social, emotional and cultural well-being of the whole community.

## Development of the Policy, Program or Strategy

1. Has there been appropriate representation of Aboriginal stakeholders in the development of the policy, program or strategy?

Yes       No       N/A

*Aboriginal Health Worker from HNE Aboriginal Health Unit*

2. Have Aboriginal stakeholders been involved from the early stages of policy, program or strategy development?

Yes       No       N/A

Please provide a brief description

*Aboriginal Health Worker from HNE Aboriginal Health Unit*

3. Have consultation/negotiation processes occurred with Aboriginal stakeholders:

Yes       No       N/A

4. Have these processes been effective?

Yes       No       N/A

5. Have links been made with relevant existing mainstream and/or Aboriginal-specific policies, programs and/or strategies?

Yes       No       N/A

*NSW Cancer Plan, 2004 – 2006*

*NSW Chronic Disease Strategy*

*National Cancer Prevention Policy, 2004 - 2006*

*NSW Aboriginal Chronic Conditions, Area Health Service Standards*

6. Has the policy, program or strategy been endorsed by the NSW Aboriginal Health Partnership/Local Aboriginal Health Partnership where required?

Yes       No       N/A

### **Contents of the Policy, Program or Strategy**

7. Does the policy, program or strategy clearly identify the effects it will have on Aboriginal health outcomes and health services?

Yes       No       N/A

Comments

***The strategies in the Plan aim to identify the key issues and assist in providing resources to meet the needs of Aboriginal people in the prevention, detection and treatment of cancer.***

8. Have these effects been adequately addressed in the policy, program or strategy?

Yes       No       N/A

9. Are the identified effects on Aboriginal health outcomes and health services sufficiently different for Aboriginal people (compared to the general population) to warrant the development of a separate policy, program or strategy?

Yes       No       N/A

Explain

***A combination of cultural, rural and remote requirements for the large population of Aboriginal people in Hunter New England warrants specific attention to Aboriginal patients to ensure equitable access to prevention, screening, treatment and support networks.***

**Implementation and Evaluation of the Policy, Program or Strategy**

10. Will implementation of the policy, program or strategy be supported by an adequate allocation of resources specifically for its Aboriginal health aspects?

Yes  No  N/A

**Describe**

***There are general strategies that are culturally and linguistically appropriate that will benefit Aboriginal people, as well as specific strategies targeting Aboriginal, rural, remote and at risk groups of people. If identified as required and appropriate, specific funding will be sought for an Aboriginal Health Worker/Educator/Care Coordinator(s).***

11. Will the policy, program or strategy be implemented in partnership with Aboriginal stakeholders?

Yes  No  N/A

**Briefly describe the intended implementation process**

***In conjunction with HNE Aboriginal Health Unit***

12. Does an evaluation plan exist for this policy, program or strategy?

Yes  No  N/A

***In conjunction with the overall evaluation of the HNE Cancer Services Plan. If funding is sought externally eg Cancer Institute NSW there would be monitoring and evaluation criteria attached to the funding***

13. Has it been developed in conjunction with Aboriginal stakeholders?

Yes  No  N/A

**Briefly describe Aboriginal stakeholder involvement in the evaluation plan**

## **APPENDIX SIX: ETHNIC AFFAIRS PRIORITY STATEMENT**

*“In the development of the Cancer Services Plan, the health needs and interests of people from culturally and linguistically diverse groups have been considered. HNE Health is committed to delivering services that best meet their needs and there are specific strategies included in the Strategic Action Plan demonstrating that commitment.”*