

Area Cancer Services Plan 2006 - 2010

December 2006



HNE Health Area Cancer Services Plan-2006-2010

December 2006

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Appendices are presented as a separate document.

1. EXECUTIVE SUMMARY

The purpose of this Plan is to outline the strategic directions for cancer services development over the next five (5) years and to identify strategies that will enable cancer prevention, screening and treatment services to achieve the Plan's objectives, which are:

- to improve cancer outcomes;
- to improve the patient's experience of care; and
- to improve the efficiency of cancer service delivery for adults.

The Plan will guide the development of a cohesive, integrated, Area-wide approach to cancer control that is founded on the best available evidence, articulates national and state directions, and utilises international benchmarks of effectiveness¹. The overarching goal of the Plan is to ensure that people in Hunter New England will have access to a range of high quality services and best practice care irrespective of where they enter the health system. The scope of the Plan covers adults accessing screening, diagnostic, treatment, palliative care and supportive care services within Hunter New England and the whole population for prevention activities. Paediatric oncology services will be addressed in the Children and Young People's Service Plan.

The Plan was developed through consultation with a range of internal and external stake holders representing the interests of both metropolitan and rural areas. This included utilising community feedback provided as part of the Area Health Care Services Plan 2006-2010. Further gaps and needs in cancer service delivery were identified as part of three separate community forums conducted by the Cancer Council and the Cancer Institute, NSW. In addition to these consultations three (3) surveys were conducted which provided information from a wide range on people on workforce, technology requirements and general issues surrounding cancer treatment delivery. An extensive literature search both nationally and overseas was also undertaken^{2, 3, 4}.

The impact of the changes proposed in this plan will be evident over the short, medium and long term. Immediate efforts will be put into strategies that can promote an Area-wide, integrated approach to cancer service delivery. Improvements in the short-term will include streamlining services to ensure that there are linkages and improved movement across services, access to best practice care in a timely fashion, changes in models of care and clinical practices and the provision of culturally and linguistically appropriate secondary prevention information to all adult cancer patients currently undergoing treatment. In the medium term strategies will focus on identifying at risk patient populations and target specific interventions. While in the longer term strategies will identify where research evidence can be translated into a change in clinical practice.

Diversity in the management structures, quality of facilities, public/private service mix and coordination of cancer services in the Hunter New England reflects historical patterns where cancer treatment has been principally discipline driven with limited interaction, coordination or formal involvement between professional disciplines. This discipline-centred approach has impacted on the ability of Hunter New England Health to ensure that consistent optimal care is being provided to all cancer patients across the whole Area. There is now substantial evidence that patient outcomes could be improved substantially if everyone received optimum treatment. Whilst it is recognised that individually, professional groups provide good care, there is room for improvement by

treating people consistently and uniformly, using evidence based protocols to ensure best outcomes. Hunter New England Health is currently addressing the diversity in the provision of care in a number of ways including identifying as a key priority strategy, the development of the Cancer Clinical Network.

The Cancer Clinical Network will coordinate the development of clinical and non-clinical protocols to facilitate the availability of best practice management across Hunter New England Health, thus ensuring equity of access to an Area-wide, integrated approach to cancer service delivery. The objectives of the Cancer Clinical Network, include:

- placing the consumer at the centre of care;
- driving the strategies identified by the planning process and outlined in the Strategic Directions and Strategic Action Plan for the next five years;
- strengthening relationships between the Newcastle Mater Misericordiae Hospital and other cancer service providers to ensure an Area-wide, coordinated and standardised approach to the delivery of best practice care; and
- enabling linked groups of health professionals and organisations to work together in a coordinated manner to shift the emphasis from buildings and organisations towards services.

Some of the key positions required to meet these objectives and drive the initiatives identified in the Strategic Directions are currently funded by the Cancer Institute NSW and include:

- three lead clinicians appointed to provide strong clinical leadership for the establishment of thirteen tumour groups and the introduction of multispecialty teams to provide a forum for the evidence based management of patients with cancer;
- eight cancer care coordinators appointed to provide a central point of contact for patients with cancer once they enter the health system;
- a Development Manager to promote an Area focus to service development and assist the Director of Cancer Services to roll-out projects funded by the Cancer Institute; and
- recruitment of a Director of Area Cancer Services to oversee the coordination and strategic direction of cancer service development.

These positions will assist in addressing the strategic issues identified in the Plan:

- identification of workforce requirements and succession planning for prevention, diagnosis, treatment, supportive care and palliation services (medical, radiology, nursing, allied health, pharmacy);
- Area-wide data indicators for monitoring quality, patient safety, waiting times and outcomes;
- improved communication with GPs in the management of patients with cancer;
- establishment of linkages with rural areas for access to evidence based care;

- radiotherapy capacity and waiting times;
- monitoring of clinical activity to respond to periods of increased demand quickly and effectively;
- a more 'whole of service' approach to service enhancement to ensure that infrastructure and resource requirements are aligned with service need;
- the need for increased emphasis at a population health level that focuses on culturally and linguistically appropriate opportunistic interventions across the lifespan to identify risk factors, reduce health disadvantage and promote behavioural changes to reduce the risk of a future cancer diagnosis;
- coordinating and disseminating research;
- the inclusion of allied health staff as a major treatment contributor to cancer patients who must be included in the initial care planning as an important and integral part of the treatment team;
- pharmacy in the management of cancer patients and the need for appropriate space and compliance with OH&S guidelines in relation to cytotoxic drugs;
- establishing linkages with HNE Health and Sydney hospitals to facilitate the coordinated transfer of patients utilising the cancer care coordinators to facilitate that linkage;
- improved linkages with the private sector to ensure that transition from one sector to the other is coordinated;
- continuing to improve and expand MDTs whilst acknowledging core membership constraints in radiology, histopathology, medical and radiation oncology;
- developing psycho-oncology/social work services and establishing linkages with rural sites;
- developing psycho-oncology services and establishing linkages with rural sites;
- establishing clinical links with the relevant surgical specialty groups;
- reviewing the long-term plans of Sydney Visiting Medical Officers for servicing rural areas;
- increasing the focus on disease prevention and health promotion across Hunter New England;
- providing patients who have completed treatment with referral links to physical and psychological rehabilitation services currently available to other patient groups;
- improving access to and the development of cancer genetic services through the Hunter and New England Family Cancer Service;
- appropriate support and information for persons from culturally and linguistically diverse backgrounds;
- adequate infrastructure to support future development and integration of IT services; and
- establishing links to comprehensive web-based information on complementary therapies currently being developed by the Cancer Institute, NSW.

2. INTRODUCTION

Cancer control was identified in 1996 as one of six National Health Priority Areas. Cancer is the second most common cause of disease burden in males and females in NSW and accounts for just under one fifth of years of healthy life lost due to premature death, disease and injury. There has been a 25% increase in incidence rates between 1980 and 2000 (20% in males and 25% in females – Public Health Division, 2002) and in 2000 there were 28,889 new cases of cancer diagnosed and 12,185 deaths. In the Hunter New England Area in 2003 there were an estimated 4,439 new cases of cancer (based on 2003 Cancer Registry data) and 1,818 deaths.

The key stages of cancer control and management include prevention, screening, diagnosis, treatment, rehabilitation, survivorship and palliative care. In NSW cancer services are delivered by public, private and community organisations in a range of settings including hospitals, doctors' rooms, general practice, community health centres and the home environment. There are often insufficient links between diverse service providers in cancer care, which can compromise coordination, continuity, convenience, and cost-effectiveness of patient care.

Change in relation to cancer service delivery has been gathering momentum for some time. Cancer policy and service development have traditionally been incorporated under a broader portfolio that has included a range of service areas. NSW Health recognised some years ago that systemic challenges to improving the coordination and integration of cancer services required that cancer be removed from under an umbrella of services and identified as a clinical entity requiring specific attention. These challenges were first addressed through the development of a 'Cancer Care Model for NSW', which formed part of the "Optimising Cancer Management Initiative" released in 1999⁵. This document outlined an organisational framework for the optimal delivery of cancer services in NSW to support best practice for cancer patients across the continuum of care. The model highlighted the need for the networking of cancer and support services to provide a more integrated, patient-centred approach to care. The Plan uses this model as the framework for establishing processes and utilising clinical redesign to promote an Area-wide, approach to cancer service delivery.

This model was further developed as part of the "Clinical Service Framework for Optimising Cancer Care in NSW" released in 2003⁶. The Clinical Service Framework sets clear standards for cancer service delivery and provide further detail of the Cancer Care Model at an Area Health Service level to optimise care for all cancer patients. The Clinical Service Framework complements the recommendations of the recent national consultative report "Optimising Cancer Care in Australia"⁷ and the National Service Improvement Framework⁸, which address issues surrounding quality, access and resourcing of cancer services at a national level.

These policy documents were formed against a backdrop of change towards how cancer should be managed within the health system. The establishment of the Cancer Institute, NSW in 2003 as a separate entity reporting to NSW Health, ensured that the focus remains exclusively on cancer policy, service delivery, education and research rather than being diluted within traditional structures competing for priority and resources. The Cancer Institute has further built on the initiatives of NSW Health and released the NSW Cancer Plan 2004-2006⁹. A central philosophy of the Plan supports the fundamental principles of the early initiatives involving a patient-centred approach which recognises

the important role of patients, carers, consumers and families and making services more responsive to their needs.

The Cancer Institute has been instrumental in providing Hunter New England Health (HNE Health) with the financial resources to establish the basic infrastructure to meet these objectives. Current Cancer Institute funding is available until the 30 June 2007 which makes the issue of recurrent funding an important one if HNE Health is to continue to progress towards a cohesive and integrated cancer service.

2.1 Hunter New England Cancer Services Plan

The overall intent of the Hunter New England Cancer Services Plan is to guide the development of a cohesive, integrated, Area-wide approach to cancer control that is founded on the best available evidence, and which articulates national and state directions and utilises international benchmarks of effectiveness.

The specific objectives of the Plan are to improve cancer outcomes, the patient's experience of care and the efficiency of cancer service delivery by:

- promoting opportunistic interventions across the lifespan to reduce the risk of future cancer diagnosis;
- reviewing existing levels of cancer service provision in the public and private sector and establishing links between providers;
- examining current and future demand for cancer services;
- identifying gaps in service provision;
- identifying strategies for reducing health disadvantage;
- recommending developments to address the gaps and meet projected demands;
- identifying processes to ensure that resources are provided, coordinated and managed to fulfil needs and requirements in the most cost effective way;
- developing a governance structure to ensure that insofar as is clinically feasible, high-quality cancer services are unimpeded by cultural, structural, geographical and disciplinary boundaries; and
- implementing the standards outlined in the Clinical Service Framework for Optimising Cancer Care and programs in the NSW Cancer Plan 2004-2006.

2.2 Plan Scope

- Adults accessing prevention, screening, diagnostic, treatment, palliative care and supportive care services within the Hunter New England area. Children undergoing the transition from paediatric to adult services will be reviewed in the "Children and Young People Services Plan" to be developed.
- The whole population and specific target groups for prevention activities.

2.3 Plan Goal

The over-arching goal of the Plan is to ensure that people in Hunter New England will have access to a range of high quality services and best practice care irrespective of where they enter the health system.

2.4 Plan Outcomes

The impact of the changes proposed in this plan will be evident over the short, medium and long term. Immediate efforts will be put into strategies that can deliver improvements in the short-term and include:

Short-term

- finalising the development of the Cancer Managed Clinical Network;
- streamlining services to ensure there are linkages and improved movement across services;
- access to best practice care in a timely fashion;
- changes in models of care and clinical practices; and
- providing culturally and linguistically appropriate secondary prevention information to cancer patients currently undergoing treatment.

Mid-term

- Identifying at risk patient populations and target for specific interventions.

Long-term

- Identifying where research evidence translates into a change in clinical practice.

2.5 Cancer Services Planning Group

HNE Health Area Executive prioritised that a Cancer Services Plan would be completed early in 2006. A Cancer Services Planning Group was established to identify the strategic direction for the development of an integrated and coordinated management approach to cancer services and identify priorities for action. The NSW Cancer Plan 2004-2006 and the Clinical Services Framework for Optimising Cancer Care in NSW, form the framework of the Area Cancer Plan. Professor Allan Spigelman the then Director of Area Cancer Services chaired the Planning Group. Membership of the Cancer Services Planning Group is included in Appendix 1.1.

2.6 Key Stakeholders

A range of internal and external stakeholders (included in Appendix 1.2) were consulted throughout the course of the development of the Plan and included:

- rural/urban, acute/community, specialist /generalist service providers;
- health promotion, disease prevention, palliative care and migrant health service providers;
- health service managers, medical, nursing and allied health disciplines;
- consumers (patients, carers and community members);
- general practitioners, staff specialists and visiting medical officers; and
- external and non-government agencies.

2.7 Consultation Strategies

Extensive consultations have been undertaken as part of the development of the HNE Area Healthcare Services Plan 2006-2010¹⁰. In addition information from separate community forums run by the Cancer Council and the Cancer Institute have been included. Gaps and needs in cancer services featured prominently in these consultations. In addition to these consultations three (3) surveys were conducted which provided information from a wide range on people on workforce, technology requirements and general issues surrounding cancer treatment delivery. An extensive literature search both nationally and overseas was also undertaken. The resultant draft Plan was distributed widely and a summary of the feedback is included in Appendix 1.3.

2.8 Clinical Networks

HNE Health has endorsed the implementation of Clinical Networks (CN) across the Area and the Cancer Services CN will be one of the first networks established. CNs will enable linked groups of health professionals from primary, secondary and tertiary care to

work together in a coordinated manner unconstrained by professional and organisational boundaries.

The Cancer Services CN will strengthen relationships between the Newcastle Mater Misericordiae Hospital (NMMH) and other cancer service providers to ensure a coordinated and standardised approach to the delivery of best practice care. Specific links will be developed with the Chronic Disease, Aged Care and Rehabilitation, and Children, Young People and Families CNs. This approach will complement the strategic direction of this Plan. The development of the CN for Cancer Services is a priority and will be finalised under the leadership of the new Director of Area Cancer Services who will take up the position at the end of 2006.

2.9 Complementary Therapies

There has been growing interest over the past few years in the role of complementary therapies in the management of patients with cancer. To date there has been little evidence based information about these therapies and as such they are not addressed as part of this plan. The Cancer Institute NSW however will undertake a systematic review of the literature seeking evidence about the benefits and risks of massage, exercise, nutrition/nutritional supplements and meditation for cancer patients. In the interim it is important that health professionals initiate discussions with their patients about complementary therapies, in the context of their overall management approach. "

3. POLICY CONTEXT

The strategic direction of the Plan is articulated from the HNE Area Healthcare Services Plan 2006-2010. In addition the Plan is built on a number of state, national and international initiatives in cancer control which include:

- Optimising Cancer Care in Australia, National Cancer Control Initiative 2002;
- National Service Improvement Framework for Cancer (2004);
- NSW Cancer Plan, 2004-2006;
- NSW Health, Optimising Cancer Management Initiative, 1999
- A Clinical Service Framework for Optimising Cancer Care in NSW (2003);
- The NHS Cancer Plan, UK (2000);
- NSW Chronic Disease Prevention¹¹ Strategy, 2003-2007;
- National Cancer Prevention Policy, 2004-2006¹²; and
- NSW Aboriginal Chronic Conditions, Area Health Service Standards (2005)¹³.

Each of these policy initiatives focuses attention on the patient's experience of care and the need for systems and processes to be established that will provide opportunities to improve the patient's experience.

3.1 Strategic Principles for Better Cancer Control

HNE Health will adopt the strategic principles of the NSW Cancer Plan 2004-2006 listed below.

1. Coordination of cancer control
2. Cancer Prevention and Early Detection
3. Cancer Service Provision – The Patient's Journey incorporating:
 - Patient/consumer-centred practices

- Coordination and Integration of health care professionals
 - Evidence based clinical practice
 - Multidisciplinary care and peer review
 - Sub-specialisation and optimal caseload
 - Evaluation of practice outcomes
 - Research-driven clinical practice
4. Cancer Information
 5. Cancer Education and Workforce
 6. Cancer Research
 7. Quality and Accreditation

This plan articulates the need to establish an organizational framework through the Cancer Services CN that facilitates systemic change and the establishment of mechanisms to support linkages across professional individuals, units and groups. The formalization of cancer service networking and the formation of strategic alliances and partnerships at an inter- and intra-Area Health Service level will facilitate this.

Financial resources are required to ensure that these systemic changes are embedded and sustained. To date the Cancer Institute has provided funding to HNE Health to establish a number of key infrastructure positions to support this framework. These positions, which are recognized as pivotal to achieving the objectives outlined in the Strategic Directions, will be evaluated to support the need for ongoing funding.

3.2 Key Challenges

A review of the literature (including the NSW Clinical Services Framework and The NSW Cancer Plan 2004-2006) and existing service structures across HNE Health identified the following issues as key challenges for cancer service development.

- The complexity of delivering comprehensive cancer control across multiple sites, disciplines and geographic distances.
- Moving the focus from discipline or institution based care to patient focused care.
- Planning for an increasing ageing population and the projected increase in cancer incidence.
- Reviewing inter- and intra- Area referral linkages.
- Poor integration between and across services resulting in poor coordination of treatment.
- Recurrent funding of key infrastructure positions funded by the Cancer Institute, NSW.
- Under use of standardised treatment protocols to ensure evidence based treatment irrespective of setting.
- Timely access to diagnostic and treatment services.
- Workforce and succession planning issues to ensure there are adequate resources available to meet increased demand.
- Lack of outcome measures to determine effective treatments and processes for the management of patients.
- Inadequate IT, support services and booking systems to provide coordinated and integrated care.
- Cultural issues across the disciplines and institutions.
- Poorer outcomes for Aboriginal and socially disadvantaged groups.
- Cultural attitudes to cancer in some migrant and Aboriginal communities.

These challenges will be met through the Strategic Directions and Strategic Action Plan presented later in this document, which outline the initiatives and actions that will be required to meet the objectives of the Plan.

The following two sections (3 and 4) present a summary of information on the burden of illness, current and projected service provision, and the key considerations from the information and how they relate to the Strategic Directions. Key Directions and Strategic Directions have not been included in sections 4.7, 4.8, 4.9 and 4.11 as limited information is available to identify issues.

4. BURDEN OF ILLNESS

This section provides a summary of the population, incidence (number of new cases), prevalence (number of existing cases at any given time period) and mortality (number of deaths) data associated with cancer for residents of Hunter New England.

- Hunter New England has an estimated population in 2006 of 837,670.
- The proportion of the Hunter New England population aged 50 years and over will increase from 32% in 2001 to 46% in 2026
- The number of new cases of cancer (incidence) is expected to increase from 4,439 in 2003 to 5,533 in 2011, which represents a 25% rise. The prevalence is about three times the incidence (NSW Cancer Plan 2004-2006) and suggests there will be approximately 14,538 people with cancer in Hunter New England in 2006 rising to 18,951 in 2016 as illustrated in Fig 3.1.

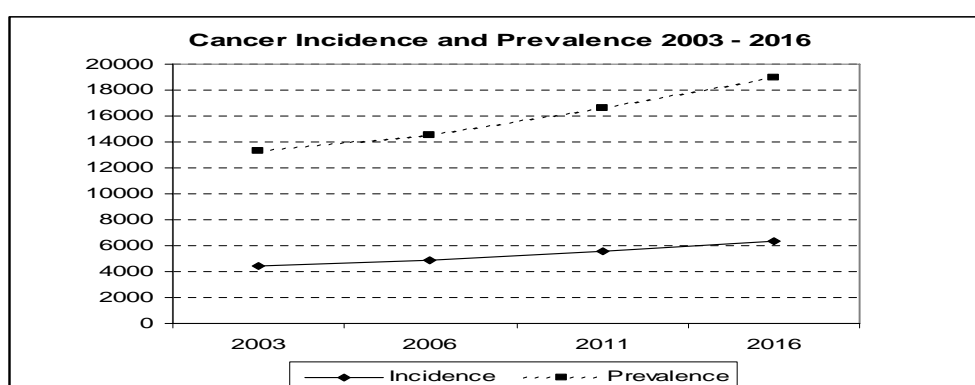
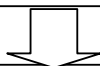


Fig 3.1 Incidence and Prevalence Hunter New England 2003 - 2016

- The projected increase in incidence for each cancer type to 2011 varies from 15% for lung cancer to 34% for prostate cancer. Details are provided in Appendix 2.
- The top five reported cancers between 1999-2003 were Breast, Prostate, Melanoma, Colon and Lung cancers.
- HNE has a higher age standardised incidence rate compared to NSW as a whole for Melanoma (males), Lip (males) and Unknown Primary (males) cancers. (1999-2003).
- In 2003 there were 1,818 cancer deaths. The top five causes of cancer deaths for 1999-2003 were Lung, Indefinite & Unspecified, Colon, Prostate and Breast cancers.
- HNE has a higher mortality rate compared with NSW as a whole for, All Cancers (males) and Prostate cancer. (1999-2003).

Key Considerations

*Increasing incidence and prevalence as the population ages
Higher incidence and mortality rate for some cancers
Need for health promotion and prevention across the lifespan*



Strategic Directions

*Improved equity of access to services
Improved screening and prevention programs for all*

5. CURRENT AND PROJECTED SERVICE PROVISION

Cancer services are provided primarily on an outpatient basis for chemotherapy, radiotherapy and diagnostic investigations and on an inpatient basis for surgery. It is expected that the demand for services will increase with an ageing population.

5.1 Inpatient and Non Inpatient Activity

Inpatient Activity

Table 4.1 provides a summary of the current demand for and supply of inpatient cancer services and indicates HNE Health had a self-sufficiency of 94% in 2003/04. Self-sufficiency indicates the extent to which HNE Health can meet the demand by the resident population for public hospital services within Hunter New England. However, due to the significant outflows to the private sector, in 2003/04 HNE Health supplied 63% of the total resident population demand for cancer services. Further details are available in Appendix 3.

	Seps	Beddays	ALOS
*HNE residents treated in HNE public hosp	9042	49893	5.5
**Outflows - to public hospitals outside HNE	717	3219	4.5
- to private sector in/outside HNE	4614	11877	2.6
Total HNE resident utilisation (demand)	14,373	79,362	5.5
Inflows – from residents outside HNE	388	2365	6.1
Total services by HNE public hospitals (supply)	9430	52,258	5.5
HNE Self sufficiency (9042/9759)	94%		
Overall Self sufficiency (9042/14373)	63%		

(Source: *HNE - HIE¹⁴ 20/7/05, **Flowinfo V6¹⁵ by Cancer DRGs only, not available by principal diagnosis.)

Projected Inpatient Activity

There is currently no rigorous methodology for projecting demand and supply of cancer related services. This is due partly to the inability to clearly identify the full scope of cancer related activity and the multiple data sets available. However, a crude indication of activity for 2011 can be obtained by using the 2003/04 activity in Table 4.1 and the expected average increase in incidence of 25%. This would suggest the following activity for 2011 of:

- 11,302 separations for HNE Health public hospitals (currently 9,042)
- 896 separations for non HNE Health public hospitals (currently 717)
- 5,767 separations to the private sector (currently 4,614)

Table 4.2 provides a summary of the top ten cancers by primary diagnosis, which accounts for approximately 40% of cancer related activity in HNE Health hospitals.

Cancers	2002/03	2003/04	*2004/05
Lung	570	640	616
Breast	493	592	453
Colon	430	525	473
Non-Hodgkin's lymphoma	465	407	400
Bladder	367	389	380
Multiple myeloma	252	311	362
Prostate	323	310	341
Head and Neck	235	289	245
Melanoma of skin	227	286	253
Rectal	205	257	251
Total top ten	3567	4006	3774
All others	4929	5424	5359
Total	8496	9430	9133
Source: HIE 20/7/2005			*incomplete

Non-Inpatient Activity

Non-inpatient data (occasions of service) for cancer related services reported through DOHRS¹⁶ is summarised by cluster in Table 4.3. Due to inconsistent interpretation and counting of occasions of service these data are qualified in terms of reliability.

Cluster	Chemo therapy	Radio therapy	⁽¹⁾ Med oncology	⁽²⁾ Rad oncology	⁽³⁾ All Palliative Care	⁽⁴⁾ Cancer Surgical Services	Breast screen	Total
Greater Ncle	7835	23391	23491	17454	14656	2574	16338	105739
Lower Hunter					6574			6574
Upper Hunter	374		405		80			859
Peel	4027		253	2159	742		11772	18953
Tablelands	4544		330		1105			5979
LMNC	1519		1027		7945			10491
Mehi			194		417			611
McIntyre			142		134			276
Total OOS	18299	23391	25842	19613	31653	2574	28110	149482
⁽¹⁾ Includes all Haematology (16,681) at the Mater ⁽²⁾ Includes, mould room, simulator, superficial, Radiation Oncology clinics ⁽³⁾ Refers to all palliative care activity (estimated 60-90% are patients diagnosed with cancer) ⁽⁴⁾ Only surgical oncology at the Mater is presented								

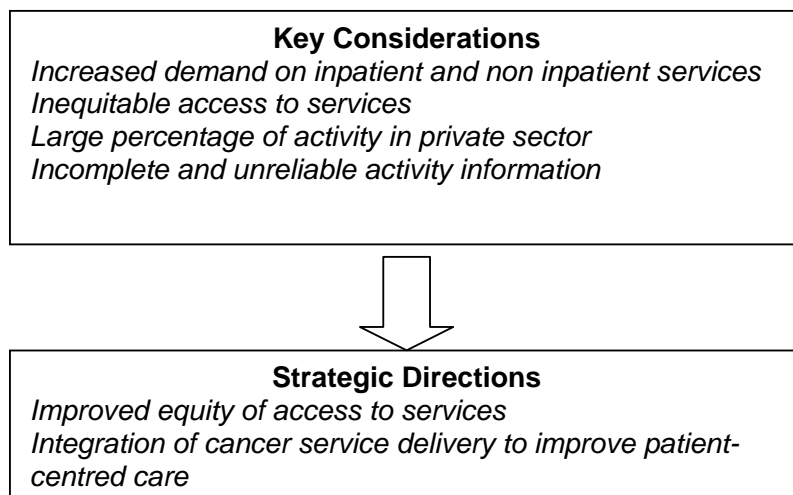
Projected Non Inpatient Activity

Under-reporting and inconsistent reporting between services and units makes projecting non-inpatient activity problematic. Using the projected 25% increase in incidence as a guide, it is expected there will be a corresponding increase in the demand for outpatient services. Projections for some services based on benchmarks and incidence will be presented in the next section.

5.1.1 Rural Referral Patterns

Armidale, Tamworth and Taree have established historical (prior to amalgamation/merger) referral patterns outside HNE Health for cancer services to public hospitals in Sydney and Brisbane. These referral patterns are influenced by the established transport links to capital cities and the range of accommodation available at major treatment facilities. Any change in referral patterns to treatment facilities in Newcastle would require improvement in these factors together with an increase in workforce and support services to enable a comparable level of service to be offered to these residents. Access to services by rural patients will be continually reviewed over the life of this Plan.

The transport needs of cancer patients are a significant issue that can influence access. It is an issue that affects not just cancer patients and as such will be given consideration through the development of the Area Transport Plan.



5.2 Prevention

A number of preventable risks are associated with the major causes of cancer. For example, 12.5% of all cancers are caused by smoking, and 25% of all cancers are attributed to overweight and obesity, physical inactivity, poor diet and drinking alcohol.

Prevalence of Hunter New England cancer risks

- 24% of males and 21% of females smoke
- 27% of infants are exposed to tobacco smoke
- 63% of males and 45% of females are overweight or obese
- 88% of males and 73% of females do not consume sufficient vegetables
- 55% of males and 48% of females do not consume sufficient fruit
- 51% of males and 56% of females are not sufficiently active

Risk Reduction Services

The prevention of cancer risks is undertaken by various clinical services including HNE Population Health and non-government organisations such as the Cancer Council. Limited data are available regarding the provision of cancer preventive care by HNE clinical services. In the former Hunter Area Health Service, 52% of inpatient smokers received some form of smoking cessation care, and 18% were provided best practice cessation care in the form of nicotine replacement therapy.

Current population health service provision is focused on monitoring and enforcing the supply of tobacco products, school-based programs, enhancing smoking cessation care provision by clinical services, and promoting the uptake of smoking cessation services by smokers. Due to resource constraints, delivery of such services does not occur on an area wide basis but in identified priority areas and settings.

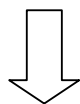
Future Prevention Services

HNE Health has identified the provision of preventive care by clinical services as one of its priority objectives for the next 5 years. Further, HNE Health has identified that CNS will be responsible for the delivery of preventive care services to patients and clients. A Clinical Services Redesign program is proposed to facilitate the achievement of these objectives.

NSW Health has identified tobacco control and the prevention of child obesity as priority areas for disease prevention. HNE Health has been awarded significant funding from NSW Health for the prevention of child obesity. The major long-term consequence of childhood obesity is its continuation into adulthood and the increase in obesity related conditions such as certain forms of cancer (AIHW)¹⁷.

Key Considerations

High rates of cancer risks: smoking, exposure to environmental tobacco smoke, overweight and obesity, inadequate fruit/vegetable consumption and physical inactivity
Limited preventive care provision by clinical services
Incomplete data on clinical preventive care provision
Limited area-wide access to preventive care services



Strategic Directions

Improved screening and prevention programs for all
Disease prevention and health promotion across all service areas
Prioritisation and allocation of resources to best meet cancer service needs
Developing competence, capability, individual accountability and performance

5.3 Screening and Detection

Early detection has been associated with improved treatment and mortality rates in cancer.

Screening

- Biennial cervical screening rates – Hunter New England has an overall rate between 61.3–65.6 (based on old Areas Health Services) for women aged 20-69, with a Local Government Area range from 43.9% to 79.8%. NSW rate is 61%.
- Biennial breast screening rates – Hunter New England rate was 50.4% for women aged 50-69 yrs with a Local Government Area variation from 30.8% to 77%. NSW rate is 51.8%. (See Appendix 3.3 for detailed LGA rates)
- Bowel screening will be introduced in 2006
- Increased screening results in increased demand for radiology, pathology, anaesthetic and surgical services.

Detection

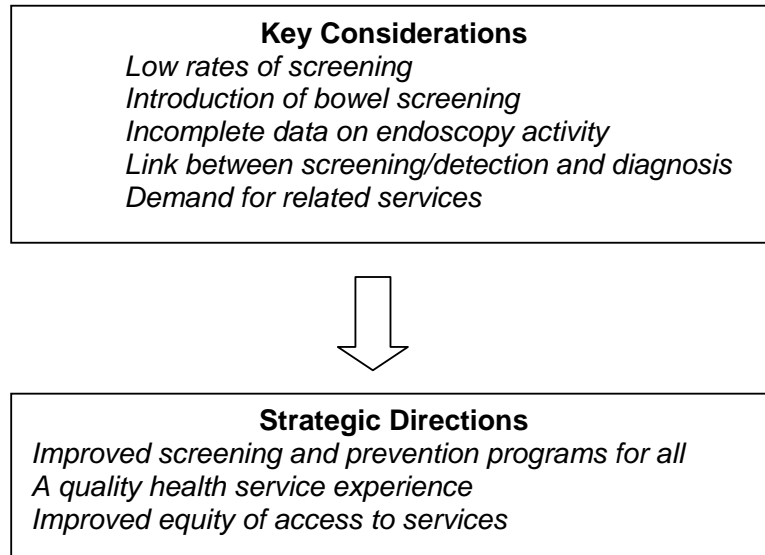
Services involved in the detection of cancer include histopathology, radiology, endoscopy and surgery. Limited data is available on the supply of these services (inpatient and non inpatient) specifically for the diagnosis of cancer as the services are also utilised by non cancer diagnosed patients. NSW Health projects that inpatient diagnostic gastro-intestinal endoscopy in HNE Health hospitals will increase from 7102 separations in 2003/04 to 8518 by 2011(20% increase). There will be a further 10% increase by 2016.

It is anticipated however that the expected increase in incidence and the introduction of bowel screening will increase the demand for diagnostic services. The Commonwealth expects approximately 19,000 Hunter New England residents aged 55 and 65 years will take part in bowel screening with a 45% participation rate which is expected to result in an additional 707 colonoscopies. Whilst NSW Health estimates approximately 137-229 colonoscopies will be performed in HNE Health hospitals, local service pattern distribution estimates a 50% split between the public and private sectors. Any increase in detection will increase the demand for associated staffing including radiologists, surgeons, pathologists, anaesthetists and nurses as well as infrastructure.

Genetic Testing/Screening

Between 1% and 5% of people in the general population are at risk of inheriting cancer from a single gene mutation. Modification of known environmental influences for these people will not prevent recurrence of cancer, which often occurs at a young age. Reducing risks requires focused cancer surveillance, prophylactic surgery or medical treatment. National familial cancer guidelines have been distributed to primary care physicians to encourage appropriate referrals of high-risk families to familial cancer services. In HNE Health, the Hunter Family Cancer Service provides this type of cancer genetic counseling to residents of Hunter New England and Northern NSW. In selected families it is possible to focus preventative methods on those who carry a known gene change, by testing DNA of affected relatives for mutations in genes for breast, ovarian and colon cancer families. An increasing number of families are being referred for genetic counseling resulting in increased waiting times (3 months locally and 12 in

outreach centres outside Hunter New England in 2005), and increased costs associated with genetic testing (\$200,000 in 1997/98 to \$750,000 in 2002/03).



5.4 Medical Oncology Services

Medical oncology services are primarily provided at the Newcastle Mater Misericordiae Hospital (NMMH) and on an outreach basis at Manning and Muswellbrook Hospitals. Services are also provided at John Hunter Hospital for gynaecological cancers, John Hunter Children's Hospital for paediatrics and Lingard Private Hospital. Visiting specialists from Prince of Wales and Royal North Shore provide services at Armidale and Tamworth Hospitals.

5.4.1 Chemotherapy

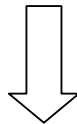
- Primarily provided as an outpatient service at NMMH, Royal Newcastle, Tamworth, Armidale, Manning and Muswellbrook Hospitals. Some smaller hospitals and John Hunter Children's Hospital provide chemotherapy as an inpatient service. Chemotherapy is also provided at Lingard Private Hospital.
- Linking activity with incidence by geographical area using occasions of service indicates that overall 59% of Hunter New England residents diagnosed with cancer may be receiving chemotherapy. However, the range is from 33% for Lower Mid North Coast residents to 100% for Armidale/Tamworth residents. This disparity in the data supports the need for a comprehensive data collection system. Additional information is included in Appendix 3.4
- Currently only the NMMH has a comprehensive data collection system that allows actual patient numbers (as distinct from occasions of service), patient residential locations and tumour type to be collected.
- There is no standardised collection of chemotherapy waiting time information across HNE Health. Therefore it is unknown whether the Clinical Services Framework benchmark of two (2) weeks between decision to treat and commencing treatment is being achieved.

Future Chemotherapy requirements

- NSW Health has indicated that 50% of all new cases will require chemotherapy and a quarter of those treated will require retreatment.
- This equates to 2,775 residents (including retreatments) requiring chemotherapy now, increasing to 3,459 by 2011.
- Using NSW Health methodology, to meet 100% of the demand would require 22 chairs increasing to 28 chairs in 2011 (see Appendix 3.4 for further details).
- HNE Health currently has 34 chairs. However the NSW Health methodology used to determine the number of chairs required by HNE Health (28 by 2011), needs to be adapted to factor in longer treatment times and greater complexity of treatment resulting in decreased throughput as well as the non chemotherapy use of chairs in rural areas. If chairs are not adequately resourced, by qualified chemotherapy staff they cannot be effectively utilised for chemotherapy treatment.

Key Considerations

Increasing demand for medical oncology and associated services
Increasing demand for treatment resources eg chairs and drugs
Access to timely quality service
Information to monitor and drive the above



Strategic directions

Improved equity of access to services
A quality health care experience
Integration of cancer service delivery to improve patient centred care

5.5 Radiation Oncology Services

Radiation oncology services are provided at the Newcastle Mater Misericordiae Hospital (NMMH) and at Tamworth Hospital. Visiting specialists from The Prince of Wales Hospital currently provide services at Tamworth.

5.5.1 Radiotherapy

Radiotherapy services are provided by three linear accelerators at NMMH. There is a comprehensive data collection system (RMIS)¹⁸, which provides for detailed reporting as per Appendix 3.4. In summary:

- Attendances have increased from 19,924 in 2000 to 25,570 in 2004.
- In 2004, 1,118 residents of Hunter, New England and Mid North Coast (former Area Health Services) accessed treatment at NMMH.
- HNE Health self sufficiency in 2004 (exc Lower Mid North Coast residents) was 80%.
- The proportion of new cancers receiving radiotherapy treatment in 2003 is estimated at 30% for Hunter residents and 42% for New England residents. The benchmark is approximately 52% of new cases. Information on Lower Mid North Coast residents is not readily available until all information systems are mapped to the new AHS boundaries.
- Information on radiotherapy to the various tumour treatment sites indicates that all are below the general 52% benchmark and all are below the optimum individual tumour site benchmark.
- Waiting times for radiotherapy in 2004 indicated an average wait time for non-urgent treatment of 14 – 28 days. The Clinical Service Framework benchmark is 21 days between decision to treat and commencing treatment.

Future Radiotherapy Services

NSW Health has indicated that approximately 52% of all new cases would benefit from radiotherapy. Based on the 2003 incidence (number of new cases of cancer) this equates to 2308 residents requiring radiotherapy now and increasing to 2877 by 2011.

Based on the accepted throughput of 331 new courses (excluding re treatments) per linear accelerator per year and the 52% benchmark for treatment HNE Health would require between eight (8) and nine (9) linear accelerators to meet the 2011 projected demand. The current development of the NMMH will increase the number of linear accelerators from three (3) to five (5) in 2007.

There is no further space capacity on the NMMH site to increase the number of linear accelerators beyond five (5). Other mechanisms to increase throughput (eg. extended hours) will need to be investigated during the life of this plan.

The new radiotherapy services at Coffs Harbour and Port Macquarie will have networking links with the NMMH. This network will include a teaching and research partnership between the sites as the North Coast moves to full machine service in radiotherapy by 2011. Networking arrangement will also ensure that more specialised radiotherapy services will be undertaken at the NMMH. This approach supports the assumptions made by NSW Health "Planning for Radiotherapy Services in NSW to 2006"¹⁹. Planning for services to 2011 has recently commenced by NSW Health, in conjunction with the Cancer Institute, NSW. Local service plans for both the Hunter New England and North Coast Area Health Services will need to consider this planning as

part of the context for local service development. Inter Area patient flows will be considered at the statewide level, in conjunction with the relevant Area Health Services.

Key Considerations

*Increasing demand for Radiation Oncology and associated services
Increasing demand for resources eg Linear Accelerators
Access to timely quality treatment
Information to monitor and drive service provision*



Strategic Directions

*Improved equity of access to services
A quality health service experience*

5.6 Cancer Surgical Services

Information on surgery for cancer patients is integral to understanding issues related to access, accreditation and future resource requirements. However the identification of cancer related surgery is not readily available at an Area or State level. To assist Area Health Services considerable work at a state level is needed to ensure the availability of consistent data across all AHS.

It is important to recognise the breadth of surgical involvement with cancer patients. Surgical input includes diagnosis, treatment, reconstructive and palliative surgery. Any increase in the need for surgery has a flow on effect before and after and includes increased demand for radiology, pathology, operating theatres, nursing, allied health, administration staff and beds.

While Medical and Radiation Oncology are relatively unified specialties in identity and function, the involvement of surgery in cancer diagnosis and treatment is far more difficult to describe. Planning and evaluating surgical services requires awareness of this involvement, which is summarised in the following table.

Alphabetical listing of Tumour Group*	Diagnostic	Therapeutic
Bone & Soft tissue	Orthopaedics, General Surgery, Surgical Oncology	Orthopaedics, General Surgery, Surgical Oncology
Breast	General Surgery, Surgical Oncology	General Surgery, Surgical Oncology, Plastic surgery
Colorectal	General Surgery, Colorectal Surgery, Gastroenterology	General Surgery, Colorectal Surgery
Familial	Counselling, Genetic Testing, Surveillance	Various as required
Gynaecology	General Gynaecology, Gynaecological Oncology Surgery	Gynaecological Oncology Surgery
Haematology	General Surgery, Haematology	General Surgery, Specialty Surgery Vascular Surgery
Head & Neck	General Surgery, OMF, Plastic Surgery, ENT	General Surgery, Neurosurgery, OMF, Plastic Surgery, ENT Surgery
Lung	Cardio Thoracic Surgery, Respiratory Medicine	Cardio Thoracic Surgery
Neurological	Neurosurgery, Orthopaedics	Neurosurgery, Orthopaedics
Paediatrics	Paediatric Medicine (General & Specialist) Paediatric Surgery	Paediatric Surgery, Specialty Surgery
Skin	General Surgery, Dermatology, Plastic Surgery, OMF	General Surgery, Dermatology, Plastic Surgery, OMF
Upper GI	General Surgery, UGI/HPB Surgery, Gastroenterology	General Surgery, UGI/HPB Surgery, Thoracic Surgery
Urology	Urology, Renal Medicine	Urology

* See Appendix 4.2

Most of the activities listed above result in very significant and specific demands on other services including anaesthetics, organ imaging, histopathology and allied health services.

Current and future activity

There is a need to identify both surgery undertaken as a result of a cancer diagnosis and surgery to confirm and/or exclude a cancer diagnosis. To gain an indication of this and the possible impact of increased surgical activity on cost and operating theatre time, an estimate was obtained based on the top five cancers for 2003/04 and their top five surgical procedures (see Appendix 3.6 for further details).

Cancer group	Total cost \$M		Total OT time (hrs)	
	2003/04	2011	2003/04	2011
Breast	\$1.6	\$2.2	512	630
Colon	\$2.3	\$3.4	474	817
Lung	\$1.2	\$1.5	331	380
Melanoma	\$2.4	\$3.3	822	1011
Prostate	\$4.9	\$7.4	135	180
Total	\$8.1	\$11.3	2273	3019

The above table indicates the cost and operating theatre time for the identified procedures will increase by \$3.2M and 745 hours for patients with a primary cancer diagnosis. This group represents 33% of all patients who had these procedures and 46% of the funding for these procedures in HNE Health hospitals in 2003/04. An unknown proportion of the remaining 67% of patients will have had these procedures to confirm or exclude a cancer diagnosis. The following table indicates these proportions for each of the five groups. (see Appendix 3.6 for further details)

Cancer group	% total group procedures	% total group funding
Breast	59	71
Colon	12	36
Lung	42	45
Melanoma	54	59
Prostate	17	22
Total	33	46

Key Considerations

Increasing demand for cancer surgery and associated services
Inability to identify the breadth of surgical involvement
Impact of increased surgery on waiting times and resource availability
Diagnostic surgery generated by screening programs
Breadth of proceduralists involved in cancer interventions



Strategic Directions

Improved equity of access to services
Integration of cancer service delivery to improve patient centred care
Prioritisation and allocation of resources
A quality health service experience
Improved screening and prevention programs for all

5.7 Palliative Care

Palliative care services include designated inpatient units at Newcastle Mater Misericordiae Hospital (NMMH), Manning Base Hospital and Tamworth Hospital as well as community-based services in all clusters. Data for palliative care services is inconsistent across the Area making accurate assessment of current issues and future requirements difficult.

- In 2003/04 palliative care inpatient services were provided to approximately 650 patients with a cancer diagnosis generating 778 separations and 10,683 beddays (see Appendix 3.7 for further details).
- The greatest demand for admissions was from Greater Newcastle residents (55%) followed by Lower Mid North Coast residents (15%).
- On the supply side the NMMH provided 54% of the beddays followed by Tamworth (11%) and Manning Base Hospital (9%).
- Palliative care services are also provided in each cluster as a non-inpatient service and in 2004/05 generated 31,653 occasions of service.
- Available waiting times indicate a delay in outreach patients being seen by a Visiting Medical Officer and urgent patients being contacted by the Outreach Team. The Clinical Service Framework inpatient benchmark is 48 hours for palliative care physician consultation and for non-inpatients; 24 hours for initial contact and 48 hours for home nursing visit.

5.8 Cancer Services to Aboriginal people

In 2001, 21.6 percent of the State's Aboriginal population resided in Hunter New England. The highest number resides in Greater Newcastle (7,167), however the Mehi cluster with 3,891 Aboriginals has the highest proportion of the total cluster population (13%).

In general the identification of Aboriginality on information systems is poor resulting in under reporting. Some available information includes:

- During the five year period 1998 – 2002, there were 170 cases in Hunter New England where Aboriginality was registered with the NSW Cancer Registry, i.e. average 34 new cases per year;
- The main reason for admission to HNE Health hospitals in 2003/04 was for Lymphoma and Non Acute Leukaemia 23% (28), followed by Lung cancer 16% (19) and Breast cancer 11% (13) (see Appendix 3.8 for further details);
- Breast cancer accounted for 21% (144) of beddays, followed by Lung cancer 13% (87); and
- Outflows in 2003/04 were mainly to Queensland (20 seps) from Moree Plains Local Government Area.

4.9 Cancer services to Paediatrics

A range of paediatric medical oncology services is provided at John Hunter Children's Hospital. Radiotherapy is provided by Sydney hospitals.

- In NSW in 2003 there were 203 new cases in children (0-14yrs);
- Leukaemia's accounted for 35%, tumours of the Central Nervous System 16% and 9% were lymphomas;
- In 2003/04 there were 404 admissions for Hunter New England children aged 0-19 years to HNE Health hospitals with an average length of stay of 2.9 days (see Appendix 3.9 for further details);
- Approximately 77% of these admissions were for children from Greater Newcastle and Lower Hunter clusters;
- Chemotherapy accounted for a third of separations;
- Outflows were mainly to Prince of Wales Hospital (73) and Westmead (48) for Chemotherapy (42), Connective Tissue Malignancy (34) and Nervous System Neoplasms (20);
- A comprehensive analysis of Paediatric Oncology Services will be undertaken in the Children and Young People's Plan to be completed in 2006.

5.10 Psycho Oncology

Psycho-Oncology services are provided for all cancer types at the NMMH and for Gynae-Oncology and Paediatric Oncology at the John Hunter Hospital. General Consultation-Liaison Psychiatry services are available at both sites. Clinical Psychologists and Consultant Psychiatrists provide multidisciplinary care in the key cancer management stages of: patient treatment, rehabilitation, survivorship and palliative care. Additional information on this service is provided in Appendix 3.10.

- The provision of psycho- oncology services has demonstrated improvement in psychological health and quality of life and reduction in Emergency Department presentations after 6-8 sessions of evidence based intervention (Cognitive Behaviour Therapy).
- The Cancer Institute recently provided funding to progress a limited application of computerised screening for psychological distress and common psychopathology evident in patients diagnosed with cancer.

Future Psycho-Oncology Services

- There is a need to develop and expand psycho-oncology services to other facilities in HNE Health to allow increased access for Hunter New England residents.
- Based on 5% of Hunter New England cancer patients (prevalence) having significant concurrent psychological illness this would increase demand from 727 patients in 2006 to 948 in 2016. In 2004/05 the current service at NMMH received 161 referrals of which 138 attended for treatment. The average waiting time to see the clinical psychologist was approximately five weeks for initial assessment and a further five weeks before beginning therapy. Therefore any additional referrals to the current service will require additional resources (space, psychologists etc)

- As well, there is a need to develop and expand computerised psychosocial screening. The screening process could be modified for other areas of allied health and nursing and for other diagnoses such as Chronic Obstructive Pulmonary Disease, Heart Disease and Diabetes.

Key Considerations

Increased demand for psycho-oncology services
Limited access to psycho-oncology services
Proven positive impact on mental health, quality of life, compliance and emergency presentations



Strategic Directions

Improved equity of access to services
Improved screening and intervention programs for all
Integration of cancer service delivery to improve patient centred care

5.11 Services Provided by Allied Health Professionals

It is important that patients have access to timely, appropriate allied health services including rehabilitation services. However very little cancer specific allied health data is available, as generalist allied health departments usually provide these services.

Appendix 3.10 outlines some of the key activities provided by allied health disciplines. These activities are critical to ensuring that cancer patients progress through their medical treatment to resume as much function as possible. Without the input of the allied health disciplines the side-effects of treatment can have a deleterious impact on the patient's overall well-being and physical capabilities.

6. STRATEGIC AND SERVICE ISSUES

6.1 Overview of current significant issues

Diversity in the management structures, quality of facilities, public/private service mix and coordination of cancer services in Hunter New England reflects historical patterns where cancer treatment has been principally discipline driven with limited interaction, coordination or formal involvement between professional disciplines. This discipline-centred approach has impacted on the ability of HNE Health to ensure that consistent optimal care is being provided to all cancer patients across the Area. There is now substantial evidence from the United Kingdom, United States and Australia that patient outcomes could be improved substantially if everyone received optimum treatment. Whilst it is recognised that individually, professional groups provide good care, there is room for improvement by treating people consistently and uniformly, using evidence based protocols to ensure best outcomes.

HNE Health is currently addressing the diversity in the provision of care in a number of ways including the recent appointment of key positions to drive change. These positions, funded by the Cancer Institute NSW, include the appointment of:

- three lead clinician positions to provide strong clinical leadership for the establishment of thirteen tumour groups and the introduction of multispecialty teams to provide a forum for the evidence based management of patients with cancer;
- eight cancer care coordinators to provide a central point of contact for patients who experience complex care needs such as multi modality treatment; patients where access to treatment is difficult; patients with complex psycho social issues; and patients who experience difficulty navigating the system regardless of complexity;
- a Development Manager to promote an Area focus to service development and assist the Director of Cancer Services to roll-out projects funded by the Cancer Institute; and
- the active recruitment nationally and internationally for a new Director of Cancer Services who will oversee the coordination and strategic direction of cancer service development.

These key positions are critical to the implementation of initiatives identified in the Strategic Action Plan (see Part C). A key risk for HNE Health is that these positions, currently funded by the Cancer Institute until 30 June 2007, will not receive further funding. This will impact on the Area's ability to fulfil the objectives of the plan and implement the strategies identified to progress change.

In addition to the above it is proposed that an Area Cancer Management Committee be established to ensure that policy and protocol development for the management of cancer patients is implemented consistently across the Hunter New England Area. This committee will underpin the proposed Cancer Services Clinical Network (CN) to be established in late 2006.

The Cancer Services CN will coordinate the development of clinical and non-clinical protocols to facilitate the availability of best practice management across HNE Health. The Cancer Services CN will enable linked groups of health professionals and organisations to work together in a coordinated manner and will shift the emphasis from

buildings and organisations towards services and will put the consumer at the centre of care.

6.2 Key Strategic Issues

An analysis of the existing service profile identified strengths and gaps in current cancer service provision. The Planning Group undertook a process of issue generation and ranking of the key strategic issues identified. The strategic issues identified included the standards and programs outlined in the Clinical Service Framework for Optimising Cancer Care in NSW and the NSW Cancer Plan 2004-2006. In all, thirty-one strategic service issues were identified and ranked by the Planning Group according to their level of importance in supporting the delivery of more coordinated care. In addition three (3) surveys were conducted to obtain information and feedback on workforce, technology requirements, and current and future requirements of cancer service delivery.

If 'best practice' services are to be delivered in a systematic way then a key task for HNE Health is to establish an organisational framework with operational processes that enable clinicians to provide the treatment and management required. The challenge is to develop a model that achieves this and integrates the complexities of existing structures.

These challenges require systemic change and the implementation of mechanisms to support linkages between professional individuals, units and groups. The foundation underpinning this change includes the development of an area-wide approach to support the delivery of clinical services through the establishment of a Cancer Services CN. This will encourage cooperation and the sharing of knowledge and information across the Area. The following sections 5.2.1 to 5.6 provide additional discussion/information on strategic service issues identified.

6.2.1 Priority Issues

Of the 31 issues identified and ranked, the top three priorities were:

Priority 1

Workforce & Data (equal ranking)

- Identification of workforce requirements and succession planning for prevention, diagnosis, treatment, supportive care and palliation services (medical, radiology, nursing, allied health, pharmacy)
- Area-wide data indicators for monitoring quality, patient safety, waiting times and outcomes

Priority 2

Communication with GPs

- Improved communication with GPs in the management of patients with cancer

Priority 3

Access for rural areas

- Establishment of linkages with rural areas for access to evidence based care

A full list of the issues and their rankings is included as Appendix 4.1.

The importance of each of the priority issues is discussed below.

Workforce

Articulation of the workforce issues has been achieved through a Workforce Survey, which has ranked the major issues in terms of risk to the viability of services and patient care. The four major issues identified through this process were:

- Recruitment and retention;
- Workforce planning;
- Succession planning; and
- Education and Training.

The Workforce Survey provides a baseline for the ongoing monitoring of workforce requirements. The business planning process needs to ensure workforce issues are included and issues are monitored and resolved.

Recruitment and retention issues were identified across all disciplines working with cancer patients and reinforced the importance of a coordinated approach to cancer service planning. This acknowledges the cross discipline involvement in cancer service delivery and the need to manage the flow-on effect of changes and difficulties in one area and the impact it has on other services and service providers.

The need for comprehensive and coordinated workforce planning again reinforces the inter-dependence of service providers and the flow-on effect of additional recruitment in one area and the impact on other service providers. The appointment of additional medical or nursing staff results in the management of more patients, which flows on to other staff, in particular allied health and technical staff. To circumvent the impact of this, business case development for funding of additional positions should include an impact analysis on other services and providers.

Succession planning is a significant issue for HNE Health due to the large cohort of service providers who will retire in the next five to ten years. This issue will be further exacerbated by the projected increase in the incidence of cancer over the next five years. Failure to address this issue will result in a reduction in capacity to provide treatment resulting in an expansion of waiting lists and a corresponding reduction in best practice care.

There is a need to ensure that there are adequate opportunities to foster training and skill development for all staff and processes in place to ensure the workforce is exposed to career development opportunities and ongoing professional development.

Data availability and quality

Cancer patients are treated in public and private hospitals, both as inpatients or outpatients and in the community. Data systems for capturing all these interactions are disparate, inadequate and lack information related to outcomes of treatment. Data capture where available is not indicative of the breadth of involvement of specialties in cancer diagnosis and treatment. It is difficult for example to obtain data on the role of surgery not only in the diagnosis of cancer but in the treatment, which can include diagnostic, curative, reconstructive, and palliation surgery. The data is also deficient in identifying which patients undergoing diagnostic surgery actually result in a cancer diagnosis. This problem is not only confined to surgery but all endoscopic and imaging diagnostic procedures. This is important particularly in relation to enhancement funding because the extent of cancer related surgery is currently not identifiable. There is a need

to identify both surgery undertaken as a result of the cancer diagnosis and surgery to confirm and/or exclude a cancer diagnosis.

These deficiencies result in a paucity of meaningful data and the inability to ensure service development planning and decision-making is information driven. The proposed collection of key indicators for waiting times, access to treatment, tumour type, treatment regimes and outcomes of treatment will enable services to be more responsive to their patients and manage them more effectively by monitoring trends, effectiveness of treatments and outcomes of clinical regimes.

The ongoing refinement and analysis of existing data will be further enhanced through the implementation of an Area Clinical Cancer Registry. The introduction of Clinical Cancer Registries in Area Health Services is strongly supported by the Cancer Institute, NSW which is funding the development of a business case to support the implementation of a clinical cancer registry across HNE Health.

Communication with General Practitioners

General practitioners are recognised as a pivotal link in the management of patients with cancer. Improved communication between health facilities and general practitioners is seen as an important priority to ensure that GPs are aware of what services are available in the health system and how to access them. Communication has typically been via mail which given the time demands and volume of information GPs need to read, has been a relatively inefficient method of communication. To enable GPs to access this information more easily it is proposed that the AHS develop a cancer website where information related to service availability, referral protocols, medical specialists with interests in specific tumour types and linkages with other useful sites is available. Cancer services will also work with the Divisions of General Practice to establish a feasible process to ensure GPs have a mechanism to communicate with HNE Health about issues related to the management of their cancer patients.

Access for rural areas

Access to evidence based cancer treatment is an important priority across HNE Health. However access does not imply that services are available at all sites. Tertiary level services such as radiation and medical oncology cannot be provided without a critical mass of patients to support the need for capital infrastructure, highly skilled staff and support services in a particular location. The challenge is therefore to implement processes to ensure that as many patients as possible have equity of access to these services. Cancer services are committed to providing outreach services where possible and the improved scheduling of appointments including coordination with transport availability. In addition, improvements in technology will enable the increasing use of telehealth facilities to provide linkages between sites and improve access to specialist consultations and advice.

In addition to access issues, patients and general practitioners in rural areas need to know that the specialists providing treatment operate in an environment where the latest evidence relating to various treatments is available and supported. This information needs to be available to all general practitioners so that their patients can be appropriately referred. The development of tumour specific referral protocols for GPs outlining minimum workup requirements, the introduction of multispecialty teams to identify the most appropriate evidence based treatment for specific tumour types and the introduction of cancer care coordinators to act as a central coordinating point for

appointments, information and advice will assist with this. Keeping GPs informed about these issues and ensuring the information they have is current will be a challenge.

6.2.2 Other Significant Issues

Issues for Radiotherapy Services

Consideration of the impact of radiotherapy waiting times needs to be addressed in the light of overall capacity constraints. Whilst it is acknowledged that delays in starting radiotherapy may lead to poorer outcomes this needs to be assessed against the capacity of the system to overcome these delays. Extending operating hours of the linear accelerators is one possible solution, however this has limitations due to the required maintenance and 'downtime' required for each linear accelerator. Other clinical redesign options also need to be considered.

Increasing demand due to a rise in incidence and increasing awareness as to the benefits and effectiveness of radiotherapy in some solid tumours will result in a disparity between demand and capacity availability. If we cannot remedy the shortfalls in radiotherapy treatment capacity then HNE Health needs to consider patient management strategies accordingly. Current projections indicate HNE Health would need between eight (8) and nine (9) linear accelerators by 2011 to respond to projected demand based on incidence alone. The Newcastle Mater Misericordiae Hospital (NMMH) currently has three (3) linear accelerators, which will increase to five (5) with the redevelopment of the hospital in 2007.

Current evidence indicates that 52% of patients with cancer would benefit from radiotherapy treatment. In Hunter New England 30% of Hunter patients and 42% of New England patients receive treatment. The NMMH currently provides treatment services to approximately 75% Hunter New England patients referred for radiotherapy (preliminary report 2005). To obtain a clearer understanding of the Lower Mid North Coast flows, an analysis of possible flow reversal of Taree/Forster residents to Port Macquarie will be undertaken.

The Area will promote the benefits of radiotherapy and encourage more referrals to meet target utilisation. This will require the ongoing monitoring of waiting times and patient referrals.

The networking of the NMMH as a teaching and research link for radiation oncology services at Port Macquarie and Coffs Harbour as they commission their new linear accelerators, will be further developed with North Coast Area Health Service. NSW Health and the Cancer Institute will need to be involved in this process.

Issues for Haematology Services

Recent unexplained increases in young acute leukaemic admissions to the Newcastle Mater Misericordiae Hospital and the flow-on effects in terms of bed requirements, drugs, the impact on access block, and staffing and budgetary implications have highlighted the need for a monitoring process that provides an "alert" to increases in activity that have implications for other services. Whilst there is the potential for this situation to arise in any service, the management of acute leukaemic patients is resource intensive which suggests the need for a contingency plan to manage these unexpected increases in activity levels and implement alternative arrangements.

The monitoring of clinical activity will enable services to respond to periods of increased demand quickly and effectively if contingencies have been developed. Given the projected increase in cancer incidence will impact on all cancers, future funding submissions should include projected demand and the impact this will have on resource requirements, asset maintenance, and capital funding. A more 'whole of service' approach to service enhancement will ensure that infrastructure and resource requirements are aligned with service need.

Focus on Prevention

The focus of this Plan is to provide an integrated and coordinated approach to the management of patients diagnosed with cancer and to increase prevention activities to reduce longer-term cancer incidence and mortality levels. There is a need for increased emphasis at a population health level that focuses on culturally and linguistically appropriate opportunistic interventions across the lifespan to identify risk factors and promote behavioural changes to reduce the risk of a future cancer diagnosis.

Focus on Research

HNE Health is committed to promoting and supporting ongoing cancer research across the area and to establishing mechanisms to facilitate the translation of this research into clinical practice. Clinical trials constitute an important component of this research program and equity of opportunity to participate in such trials should be available for all patients. At the present time this does not occur due to logistical issues in conducting clinical trials in the private and rural sectors. This problem may be partially addressed by the Cancer Institute's proposal to streamline the ethics approval process for trials conducted at multiple clinical sites thus increasing both the portfolio of active trials available and the time devoted to patient recruitment and management at rural sites.

The Cancer Institute NSW Clinical Trial Unit Establishment Grant funding opportunity aims to provide the support needed to achieve an increase in patient participation in cancer clinical trials at rural hospitals attended by Visiting Medical Officers and strengthen the capacity to utilise the existing local medical skills and available resources. HNE Health recognises it must also play a part in this process to provide tangible and uniform support of clinical trials. Increasing our capacity to enrol patients into clinical trials will increase the efficiency and effectiveness of cancer treatment, improve patient quality of life and cancer survival.

In addition to clinical trials, cancer related research studies including quantitative and qualitative studies are conducted throughout HNE Health. There are presently strong relationships with clinicians working with the University of Newcastle and Hunter Medical Research Institute, and other national and international affiliated research groups.

An assessment of the needs of research will be undertaken within HNE Health to address the following:

- current strengths and weaknesses;
- workforce needs;
- infrastructure requirements;
- opportunities to attract funding;
- ability to maximise enrolment in clinical trials; and
- need for of a comprehensive register of research studies.

6.3 Other Service Issues

To improve the coordination of services and provide more patient centred care is a multifaceted challenge. The diversity of types of cancer, multiple service providers over a large geographic area, differing referral patterns, inadequate transport links to treatment centres, a service or discipline centred approach, growing demand and rapid advances in technology have all impacted on the ability of the Area Health Service to provide coordinated cancer care. Some issues lack prominence in the overall planning of care, however their impact is important. Examining the whole landscape in relation to coordinated service delivery has identified a number of areas where improvements could be made. The cancer service planning approach has recognised the importance of:

- allied health staff as a major treatment contributor to cancer patients who must be included in the initial care planning as an important and integral part of the treatment team;
- biomedical engineering staff in the maintenance of radiotherapy equipment; if sufficient staff are not recruited to maintain essential equipment then the operational capacity of the machines is compromised which then impacts on patient access and safety;
- pharmacy in the management of cancer patients and the need for appropriate space and compliance with OH&S guidelines in relation to cytotoxic drugs;
- establishing linkages with HNE Health and Sydney hospitals to facilitate the coordinated transfer of patients utilising the cancer care coordinators to facilitate that linkage;
- allocating appropriate appointment times for rural patients;
- identifying appropriate after hours assistance and point of contact for patients and GPs;
- improved linkages with the private sector to ensure that transition from one sector to the other is coordinated;
- continuing to improve and expand MDTs whilst acknowledging core membership constraints in radiology, histopathology, medical and radiation oncology;
- developing psycho-oncology/social work services and establishing linkages with rural sites;
- establishing clinical links with the relevant surgical specialty groups;
- reviewing the long-term plans of Sydney Visiting Medical Officers for servicing rural areas;
- increasing the focus on disease prevention and health promotion across Hunter New England;
- providing patients who have completed treatment with referral links to physical and psychological rehabilitation services currently available to other patient groups;
- improving access to and the development of cancer genetic services through the Hunter and New England Family Cancer Service;
- issues facing paediatric patients when they move from the paediatric environment to adult treatment centres. This issue will be referred to the Children and Young People's Planning Committee where paediatric oncology will be addressed in detail;
- adequate infrastructure to support future development and integration of IT services; and
- establishing links to comprehensive web-based information on complementary therapies currently being developed by the Cancer Institute, NSW.

6.4 Issues for Aboriginal people

Cultural issues related to the treatment of Aboriginal people with cancer present additional challenges to service providers to ensure that the respect and dignity of the individual is preserved whilst ensuring access to evidence based treatment. Initial consultation with Aboriginal Liaison Officers highlighted issues associated with the long distances to treatment facilities, which often takes the patient away from their support networks. Once treatment is completed there is often insufficient support in the local community for follow-up assistance. The provision of support once the person returns to their community needs to be examined with the relevant stakeholders to advise HNE Health on the most effective way to meet the needs of our Aboriginal patients with cancer. The employment of Aboriginal cancer care coordinators may be a viable option to explore. As part of the planning process preliminary consultation has commenced and will continue through the appropriate Aboriginal representatives to identify the key issues and potential solutions. Issues facing Aboriginal people accessing cancer prevention, screening and treatment services will be referred to the Aboriginal Health Planning committee for inclusion in the HNE Aboriginal Health Plan due for completion in 2006. An Aboriginal Health Impact Statement is included as Appendix 5. This Impact Statement ensures that the needs of Aboriginal people have been considered and specific strategies have been included in the Strategic Action Plan.

6.5 Issues for people from Culturally and Linguistically Diverse backgrounds

The provision of cancer services to patients from culturally and linguistically diverse backgrounds provides additional challenges for service providers to ensure that these patients receive appropriate information about their disease, understand the treatment options and provide informed consent for the treatment. The Cancer Council of NSW has developed a range of pamphlets and information books for cancer patients and their relatives in a most languages. In addition they provide an information service where patients have access to counselors from a variety of backgrounds. This information together with the availability of interpreters ensures cancer patients from culturally and linguistically diverse backgrounds have the same access to information and advice as other cancer patients. An Ethnic Affairs Priority Statement is included as Appendix 6. This Priority Statement ensures that the needs of culturally and linguistically diverse groups have been considered and specific strategies have been included in the Strategic Action Plan.

7. REFERENCES

- ¹ Centre for Disease Control and Prevention, "Guidance for Comprehensive Cancer control Planning" Vol. 1: Guidelines, Atlanta, March 2002
- ² National Health Service, Cancer Services Collaborative, HNS Modernisation Agency, UK, 2002
- ³ National Health Service, The NHS Cancer Plan, United Kingdom (2000)
- ⁴ NHS Cancer Services Collaborative, HNS Modernisation Agency, UK, 2002
- ⁵ NSW Health, Optimising Cancer Management Initiative, 1999
- ⁶ NSW Health, A Clinical Service Framework for Optimising Cancer Care in NSW (2003)
- ⁷ Clinical Oncological Society of Australia, the Cancer Council Australia and the national Cancer control Initiative 2002: "Optimising Cancer Care in Australia", National Cancer Control Initiative, Melbourne
- ⁸ National Health Priority Action Council 2004, "National Service Improvement Framework for Cancer"
- ⁹ Cancer Institute NSW, NSW Cancer Plan, 2004-2006
- ¹⁰ HNE Health, HNE Area Healthcare Services Plan 2006-2010
- ¹¹ NSW Health, NSW Chronic Disease Prevention Strategy, 2003-2007
- ¹² National Cancer Prevention Policy, 2004-2006
- ¹³ NSW Health, NSW Aboriginal Chronic Conditions, Area Health Service Standards (2005)
- ¹⁴ HNE Health, Health Information Exchange (HIE)
- ¹⁵ NSW Health FlowInfo V6
- ¹⁶ HNE Health, Department of Health Reporting system (DOHRS)
- ¹⁷ Australian Institute of Health and Welfare, A rising epidemic: obesity in Australian children and adolescents (2004)
- ¹⁸ NSW Health, 2004 Radiotherapy Management Information System Report, October 2005
- ¹⁹ NSW Health, Planning for Radiotherapy Services in NSW to 2006, (June 2003)

8. STRATEGIC OBJECTIVES AND STRATEGIC ACTION PLAN

The following pages present HNE Health's Cancer Services Strategic Objectives and Strategic Action Plan for the next five years. The Plan details the Strategic Initiatives that will be implemented to achieve the Strategic Objectives.

Cancer Services Strategic Objectives

THE CANCER SERVICES' VISION, PURPOSE, KEY FOCUS AREAS AND STRATEGIC OBJECTIVES ARE PRESENTED AS A ONE-PAGE SUMMARY.

The Key Focus Areas are those areas that are considered critical to achieving the Cancer Services' Vision. For each Key Focus Area, Strategic Objectives are identified to ensure the Cancer Services remain focussed on the most important issues and needs.

Cancer Services Strategic Action Plan

The Strategic Action Plan identifies performance measure/s for each of the strategic objectives and presents the strategic initiatives (the actions, activities or projects) that will be implemented over the next five years to improve performance, reach targets and achieve key objectives.

Each objective is risk-rated using the HNE Health Risk Matrix, which is based on the NSW Health Severity Assessment Code (SAC). In rating the strategic objectives the consequences and likelihood of not achieving an objective and the impact on service provision and outcomes for the community were considered. The risk ratings identified for each strategic objective signify the priority placed on achieving each objective and indicate where Cancer Services want to be in relation to the objective in five years time. A current risk rating (based on what we are doing now) and a target risk rating (what the risk will be once we have implemented the strategic initiatives) is assessed for each objective.

Cancer Services Strategic Directions and Strategic Action Plan

OUR VALUES

TEAMWORK

HONESTY

RESPECT

ETHICS

EXCELLENCE

CARING

COURAGE

COMMITMENT

VISION: Healthier communities: Excellence in healthcare
PURPOSE: Working with our communities to deliver quality health services

Focus Area: Communities and Patients

To achieve our vision, the key outcomes we must deliver are:

- ❖ Communities that feel empowered in relation to cancer service development & delivery
- ❖ Improved screening and prevention programs for all
- ❖ Reduced gap in health and well being between Aboriginal and non-Aboriginal people
- ❖ Reduced health disadvantage
- ❖ A quality health service experience
- ❖ Improved equity of access to services

Focus Area: External Partners

To deliver the required community outcomes, we need to excel in:

- ❖ Engaging our GPs and other external partners (including NSW Health, Cancer Institute NSW, The Cancer Council, private hospitals and other Area Health Services) in improving the management of cancer

Focus Area: Internal Networking and Processes

To deliver the required community outcomes, we need to excel in an Area -wide:

- ❖ Integration of cancer service delivery to improve patient centred care
- ❖ Effective communication between staff, patients and their carers
- ❖ Disease prevention and health promotion across all service areas

Focus Area: Resource Accountability

To deliver the required community outcomes, we need to excel in:

- ❖ Prioritisation and allocation of resources to best meet cancer service needs

Focus Area: Our People, Culture and Capability

(Employees and Contracted)

To achieve the desired community outcomes and sustain our ability to change and improve, we need to excel in:

- ❖ Recruiting and retaining high quality staff
- ❖ Developing competence, capability, individual accountability and performance
- ❖ Demonstrating innovative cancer care

Cancer Services Strategic Directions and Strategic Action Plan

ABBREVIATIONS:

Aboriginal Health	Abor Hlth	Radiation Oncology	Rad Onc
Area Cancer Care Coordinator	A CCC	Tamworth Base Hospital	TBH
Cancer Allied Health Working Party	Canc AH WP	Tumour Group Leads	TumGr Lds
Cancer Council	CC	Tumour Groups	TumGr
Cancer Management Committee	CMC	Workforce Planning	Wkfce PI
Cancer Services	Canc Serv		
Chair MSTs	Ch MSTs		
Chief Executive	CE		
Cluster Managers	Clust Mans		
Communications Unit	Comms Unit		
Department of Surgery	Dept Surg		
Director of Area Cancer Services	DACS		
Division of General Practice	Div GPs		
Division of Palliative Care	Div Pall Care		
General Practice Advisory Committee	GPAC		
Greater Newcastle Cluster Manager	GNC Man		
Human Resources	HR		
Hunter Medical Research Institute	HMRI		
Information Technology Services	IT		
John Hunter Hospital	JHH		
Lead Clinicians	Lead Clins		
Lower Hunter Cluster Manager	LHC Man		
Lower Mid North Coast Cluster Manager	LMNC Clust Man		
Clinical Network	CN		
Manning Base Hospital	MBH		
Medical oncology	Med Onc		
Medical Recruitment	Med Recruit		
Migrant Health	Mig Hth		
MSS Project Officer	MST Proj Off		
Multidisciplinary Teams	MDTs		
Multispecialty Teams	MSTs		
Newcastle Mater Misericordiae Hospital	NMMH		
Nursing and Midwifery	Nurs & Midw		
Ongoing Care	Ong Care		
Out Patients Departments	OPDepts		
Peel Cluster Manager	Peel Clust Man		
Population Health	Pop Hlth		

◆ **Funding Key:** 1. Initiative/Action to be implemented without funding 2. Initiative/Action to be implemented with funding from existing resources 3. Enhancement funding required Page 39 of 58
 note: multiple initiatives covering multiple objectives may be included in a single position requiring funding.

★ **Priority Key:** Strategic Initiatives/Actions that require “Enhancement Funding” (3) are to be prioritised as either **Low**, **Medium** or **High**, based on their contribution to achieving the objective

Cancer Services Strategic Directions and Strategic Action Plan

FOCUS AREA:	Communities and Patients							
OBJECTIVE:	To achieve our vision, a key outcome we must deliver is: Communities that feel empowered in relation to cancer service development & delivery						Risk Rating	
							Current	Target
						J	L	
DESTINATION STATEMENT:	<i>People in our communities have confidence in working with us on cancer service issues and in managing their own health</i>							
Measure:	Target	Reporting Timeframe	Strategic Initiatives/Actions	Responsibility	Time frame	◆ Funding 1,2,3	★ Priority L, M, H	
To be developed	TBD	Annual	• Promote consumer representation on cancer committees and develop effective consultation mechanisms with consumer, carer groups and other interested stakeholders	Members of CMC	Dec 07	1		
			• Ensure consumer, carer and family perspectives are reflected in individual service planning and strategic service development	Members of CMC	Jun 07	1		
			• Assess the needs of cancer survivors	Members of CMC/CC	Dec 06	2		
			• Promote the use of the Cancer Institute website	Members of CMC /Comms Unit	Jun 07	1		
			• Develop a HNE Area Cancer Website & broadbased communication strategy to inform stakeholders	Members of CMC/IT/ Comms Unit	Jun 08	3		L

◆ **Funding Key:** 1. Initiative/Action to be implemented without funding 2. Initiative/Action to be implemented with funding from existing resources 3. Enhancement funding required
 note: multiple initiatives covering multiple objectives may be included in a single position requiring funding.

★ **Priority Key:** Strategic Initiatives/Actions that require “Enhancement Funding” (3) are to be prioritised as either **Low**, **Medium** or **High**, based on their contribution to achieving the objective

Cancer Services Strategic Directions and Strategic Action Plan

FOCUS AREA:	Communities and Patients							
OBJECTIVE:	To achieve our vision, a key outcome we must deliver is: Improved screening and prevention programs for all						Risk Rating	
							Current	Target
							D	H
DESTINATION STATEMENT:	<i>People in our communities are healthier and have few health risks</i>							
Measure:	Target	Reporting Timeframe	Strategic Initiatives/Actions	Responsibility	Time frame	◆ Funding 1,2,3	★ Priority L, M, H	
% Mammogram screening within the last 2 years (females 50 – 69 years)	49.9% South 66% North	Biannual	<ul style="list-style-type: none"> Monitor screening rates across HNE for breast, cervical and bowel cancer screening Promote prevention & screening for risk factors associated with colorectal, cervical, breast and skin cancer 	Members of CMC/Pop Hlth	Ongoing	3	M	
% Pap tests within last 2 years (females 20 – 69 years)	61%	Biannual	<ul style="list-style-type: none"> Assess the impact of the increase in population aged 50-69 utilising screening services Assess the impact of bowel screening on associated services 	Members of CMC/Pop Hlth	Dec 07	3	M	
				Members of CMC/Pop Hlth	Dec 07	3	M	

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★ **Priority Key:** Strategic Initiatives/Actions that require “Enhancement Funding” (3) are to be prioritised as either **Low**, **Medium** or **High**, based on their contribution to achieving the objective

Cancer Services Strategic Directions and Strategic Action Plan

FOCUS AREA:	Communities and Patients						
OBJECTIVE:	To achieve our vision, a key outcome we must deliver is:					Risk Rating	
	Reduced gap in health and well being between Aboriginal and non-Aboriginal people					Current	Target
						A	D
DESTINATION STATEMENT:	<i>The health and well being of Aboriginal people, relative to non-Aboriginal people, is improved</i>						
Measure:	Target	Reporting Timeframe	Strategic Initiatives/Actions	Responsibility	Time frame	◆ Funding 1,2,3	★ Priority L, M, H
Gap between screening rates for Abor. & non Abor. people	Decrease by 5%	Biannual	<ul style="list-style-type: none"> Identify specific prevention, screening, treatment and palliative care needs of Aboriginal communities Review the need for an Aboriginal Health Worker/Cancer Care Coordinator(s) 	Abor Hlth	Dec 07	3	M
				Abor Hlth	Jun 07	3	M

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★ **Priority Key:** Strategic Initiatives/Actions that require “Enhancement Funding” (3) are to be prioritised as either **Low**, **Medium** or **High**, based on their contribution to achieving the objective

Cancer Services Strategic Directions and Strategic Action Plan

FOCUS AREA:	Communities and Patients							
OBJECTIVE:	To achieve our vision, a key outcome we must deliver is:						Risk Rating	
	Reduced health disadvantage						Current	Target
							A	D
DESTINATION STATEMENT:	<i>The gap in health and well being of disadvantaged groups is improved compared to the general population</i>							
Measure:	Target	Reporting Timeframe	Strategic Initiatives/Actions	Responsibility	Time frame	◆ Funding 1,2,3	★ Priority L, M, H	
Percent gap in potentially avoidable deaths due to cancer between low SES and high SES	Decrease by 5%	Biannual	<ul style="list-style-type: none"> Identify specific needs of identified disadvantaged groups, including low socioeconomic status, culturally and linguistically diverse, rural and remote patients Ensure the initiatives relevant to Aboriginal health are implemented 	Mig Hlth / Members of CMC	Dec 07	3	M	
				Abor Hlth/ Members of CMC	Ongoing	3	M	

◆ **Funding Key:** 1. Initiative/Action to be implemented without funding 2. Initiative/Action to be implemented with funding from existing resources 3. Enhancement funding required note: multiple initiatives covering multiple objectives may be included in a single position requiring funding.

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Cancer Services Strategic Directions and Strategic Action Plan

FOCUS AREA:	Communities and Patients							
OBJECTIVE:	To achieve our vision, a key outcome we must deliver is: Improved equity of access to services						Risk Rating	
							Current	Target
							B	K
DESTINATION STATEMENT:	<i>Within our Area, people with a clinical need have access to the appropriate services that meet their needs within a reasonable timeframe</i>							
Measure:	Target	Reporting Timeframe	Strategic Initiatives/Actions	Responsibility	Time frame	◆ Funding 1,2,3	★ Priority L, M, H	
% Patients receiving radiotherapy (by tumour group)	52%	Annual	<ul style="list-style-type: none"> Review the feasibility and increased capacity of extending the operating hours for the linear accelerators Increase awareness of benefits of radiotherapy to management of different types of cancer 	Rad Onc/CMC	Jun 07	2		
				RadOnc/TumGr	Dec 08	1		
% Patients receiving chemotherapy (by tumour group) –(uses NSW Health methodology)	50%	Annual	<ul style="list-style-type: none"> Increase awareness of benefits of chemotherapy to management of different types of cancer Review the location of chemotherapy services in relation to future population distribution 	Med Onc/TumGr	Dec 08	1		
				Med.Onc/CMC	Jun 08	3	M	
waiting time against benchmarks	Decrease by 10%	Monthly	<ul style="list-style-type: none"> Develop & monitor appropriate waiting time indicators for specific tumour groups and treatment regimes Adopt policies that prioritise patient appointment times according to their need Develop triage categories within waiting time parameters to identify & manage more urgent cases appropriately Identify the key cancer related surgical procedures and monitor waiting times for each sub specialty Review the need for an additional head and neck surgeon at John Hunter Hospital Review the need for after hours support for oncology patients at Taree Assess requirements for establishing a Radiation Oncology outreach clinic in Muswellbrook Identify rehabilitation services that are suitable and establish referral linkages with Chronic Disease and Aged Care and Rehabilitation Services 	Members of CMC	Dec 07	3	M	
				Members of CMC/OP Depts	Jun 07	2		
				TumGr/Med Onc /RadOnc	Jun 07	2		
				DACS	Jun 08	3	H	
				Dept Surg/ Wkfce	Jun 08	2		
				MBH	Jun 08	2		
				Rad Onc	Jun 08	2		
Members of CMC	Jun 07	3	H					

◆ **Funding Key:** 1. Initiative/Action to be implemented without funding 2. Initiative/Action to be implemented with funding from existing resources 3. Enhancement funding required
 note: multiple initiatives covering multiple objectives may be included in a single position requiring funding.

★ **Priority Key:** Strategic Initiatives/Actions that require “Enhancement Funding” (3) are to be prioritised as either **Low**, **Medium** or **High**, based on their contribution to achieving the objective

Cancer Services Strategic Directions and Strategic Action Plan

Continued - Improved equity of access to services

Measure:	Target	Reporting Timeframe	Strategic Initiatives/Actions	Responsibility	Time frame	◆ Funding 1,2,3	★ Priority L, M, H
TBA pending rollout of "Draft Screening Tool for referral to Specialist Palliative Care Service" project team aiming for 2007.	TBD	TBD	<ul style="list-style-type: none"> • Adopt the National Referral criteria to ensure patients with advanced cancer have access to palliative care services 	Div Pall Care	Dec 07	1	H
			<ul style="list-style-type: none"> • Disseminate information in relation to types of services palliative care provides 	Members of CMC/Div Pall Care	Jun 07	1	
			<ul style="list-style-type: none"> • Review the need for after hours support for community palliative care & GP training issues in the Southern region of HNE 	Div Pall Care/ GNC Man	Dec 07	3	
			<ul style="list-style-type: none"> • Undertake needs assessment of palliative care requirements for HNE Northern region residents (Tamworth/Taree) 	Ong Care/ Peel Clust Man/ LMNC Clust Man	Dec 06	2	
			<ul style="list-style-type: none"> • Review palliative care staffing levels at Maitland, Dungog, Cessnock & Singleton 	LHC Man	Dec 07	2	
			<ul style="list-style-type: none"> • Identify priorities of the Family Cancer Service for future service direction 	Members of CMC/DACS/Family Cancer Service	June 08	3	

◆ **Funding Key:** 1. Initiative/Action to be implemented without funding 2. Initiative/Action to be implemented with funding from existing resources 3. Enhancement funding required note: multiple initiatives covering multiple objectives may be included in a single position requiring funding. Page 45 of 58

★ **Priority Key:** Strategic Initiatives/Actions that require "Enhancement Funding" (3) are to be prioritised as either **Low**, **Medium** or **High**, based on their contribution to achieving the objective

Cancer Services Strategic Directions and Strategic Action Plan

FOCUS AREA:	Communities and Patients							
OBJECTIVE:	To achieve our vision, a key outcome we must deliver is:						Risk Rating	
	A quality health service experience						Current	Target
							L	N
DESTINATION STATEMENT:	<i>People who come into contact with us are confident that we consistently deliver safe, effective, appropriate services</i>							
Measure:	Target	Reporting Timeframe	Strategic Initiatives/Actions	Responsibility	Time frame	◆ Funding 1,2,3	★ Priority L, M, H	
% Patients screened for psycho-social issues	Increase by 5%	Annual	<ul style="list-style-type: none"> Further develop the role of psycho-oncology services across the Area & establish linkages across sites 	Members of CMC	Jun 10	3	M	
% Complex cancer patients seen by care coordinator (as per Cancer Institute requirements)	Increase by 5%	Monthly	<ul style="list-style-type: none"> Rollout MSTs/MDTs including support for: <ul style="list-style-type: none"> - Developing programs & activities to increase area-wide compliance of standards; - Review of clinical outcomes, QoL and satisfaction surveys - Recruitment of data managers to support MSTs 	Lead Clins/ ACCC / MST Proj Off	Jun 08	3	H	
Number adverse events relating to cancer patients	Decrease by 10%	Annual	<ul style="list-style-type: none"> Apply best practice principles in the development of clinical and non clinical protocols, to drive and promote evidence-based, innovative and sustainable models of care through a managed clinical network Establish tumour groups to oversee the evidence based management of specific tumour types Develop a checklist to prompt hospital staff to monitor that information has been provided to patients at different stages of their treatment 	Members of CMC	Dec 07	2	H	
				Members of CMC/ Lead Clins	Jun 08	3		
				Members of CMC	Dec 07	2		

◆ **Funding Key:** 1. Initiative/Action to be implemented without funding 2. Initiative/Action to be implemented with funding from existing resources 3. Enhancement funding required note: multiple initiatives covering multiple objectives may be included in a single position requiring funding. Page 46 of 58

★ **Priority Key:** Strategic Initiatives/Actions that require “Enhancement Funding” (3) are to be prioritised as either **Low**, **Medium** or **High**, based on their contribution to achieving the objective

Cancer Services Strategic Directions and Strategic Action Plan

FOCUS AREA:	External Partners							
OBJECTIVE:	To deliver the required community outcomes, we need to excel in: Engaging our GPs and other partners (including NSW Health, Cancer Institute NSW, The Cancer Council, private hospitals and other Area Health Services) in improving the management of cancer						Risk Rating	
							Current	Target
							B	K
DESTINATION STATEMENT:	<i>Our partnerships deliver benefits to Hunter New England people through shared goals, clearly agreed responsibilities and effective outcomes</i>							
Measure:	Target	Reporting Timeframe	Strategic Initiatives/Actions	Responsibility	Time frame	◆ Funding 1,2,3	★ Priority L, M, H	
GP Satisfaction Score	Increase by 5%	Annual	<ul style="list-style-type: none"> Establish formal linkages with GPs through the cancer care coordinators and tumour group leads. Adopt CI standard protocols for the management of specific tumour types Develop protocols & clear referral guidelines for diagnostic workups by GPs for specific tumour types 	GPAC/ACCC/ TumGr Lead Clins/ TumGr Lds Lead Clins/ TumGr Lds/Div GPs	Dec 08 Jun 07 Dec 07	2 2 2		
Number of referral protocols established with external partners	Increase by 10%	Annual	<ul style="list-style-type: none"> Promote relationships with the private sector & visiting specialists to ensure patient transition between the public and private sector is coordinated Establish teaching and research links with Port Macquarie and Coffs Harbour for radiotherapy services. 	Lead Clins/ ACCC DACs/Rad Onc	Jun 09 Jun 07	2 2		

◆ **Funding Key:** 1. Initiative/Action to be implemented without funding 2. Initiative/Action to be implemented with funding from existing resources 3. Enhancement funding required note: multiple initiatives covering multiple objectives may be included in a single position requiring funding. Page 47 of 58
 ★ **Priority Key:** Strategic Initiatives/Actions that require “Enhancement Funding” (3) are to be prioritised as either **Low**, **Medium** or **High**, based on their contribution to achieving the objective

Cancer Services Strategic Directions and Strategic Action Plan

FOCUS AREA:	Internal Networking and processes							
OBJECTIVE:	To deliver the required community outcomes, we need to excel in:						Risk Rating	
	Integration of cancer service delivery to improve patient centred care						Current	Target
							C	H
DESTINATION STATEMENT:	<i>Staff work together to deliver coordinated, consistent healthcare</i>							
Measure:	Target	Reporting Timeframe	Strategic Initiatives/Actions	Responsibility	Time frame	◆ Funding 1,2,3	★ Priority L, M, H	
% Identified Tumour Groups established	100%	Annual	<ul style="list-style-type: none"> Establish an Area Cancer Management Committee to drive the planning, implementation, monitoring and evaluation of Cancer BSC strategies Implement and evaluate the cancer care coordination model across the metropolitan and rural sectors Ensure multispecialty/discipline team meetings develop linkages with rural sites where appropriate Develop and implement a Cancer Managed Clinical Network across HNE to facilitate professional linkages across cancer service providers and other CNs Undertake a comprehensive analysis of available data to address current deficiencies caused by inadequate information available to assist in the planning and management of cancer service development and delivery Establish formal clinical links between relevant surgical specialty groups Improve the availability of after hours support and central point of contact for patients 	DACS/Cancer CN ACCC/Nurs & Midw ACCC/Ch MSTs Members of CMC/DACS Members of CMC/ DACS Members of CMC/Lead Clins/ Div Surg Members of CMC/LeadClin s/Hospital sites	Jun 07 Mar 07 Jun 07 Dec 07 Jun 08 Jun 08 Dec 07	2 2 3 3 3 3 2	 H H L M	

◆ **Funding Key:** 1. Initiative/Action to be implemented without funding 2. Initiative/Action to be implemented with funding from existing resources 3. Enhancement funding required note: multiple initiatives covering multiple objectives may be included in a single position requiring funding. Page 48 of 58
 ★ **Priority Key:** Strategic Initiatives/Actions that require “Enhancement Funding” (3) are to be prioritised as either **Low**, **Medium** or **High**, based on their contribution to achieving the objective

Cancer Services Strategic Directions and Strategic Action Plan

Continued - Integration of cancer service delivery to improve patient centred care							
% Cancer outflow separations	35%	Annual	• Monitor flows for cancer treatment both within HNE and out of area	Members of CMC/DACS	Ongoing	3	L
			• Map the options for radiotherapy flows from the Manning area when Port Macquarie comes on line	Members of CMC/Rad Onc	Jun 07	3	L
			• Review long term plans for servicing rural areas and include discussion with VMOs from Sydney regarding future service provision	CE/DACS	Jun 07	2	
			• Develop linkages between metropolitan & rural clinical staff and GPs to ensure that all patients have access to best practice clinical care	Members of CMC/Lead Clins	Jun 08	3	H
			• Review patient and carers accommodation and transport requirements	Members of CMC/ACCC	Jun 07	2	
• Provide cancer carers with access to supportive care	Members of CMC/CC	Dec 07	2				

◆ **Funding Key:** 1. Initiative/Action to be implemented without funding 2. Initiative/Action to be implemented with funding from existing resources 3. Enhancement funding required note: multiple initiatives covering multiple objectives may be included in a single position requiring funding.

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Cancer Services Strategic Directions and Strategic Action Plan

FOCUS AREA:	Internal networking and processes							
OBJECTIVE:	To deliver the required community outcomes, we need to excel in: Effective communication between staff, patients and their carers						Risk Rating	
							Current	Target
							D	H
DESTINATION STATEMENT:	<i>We have structures and communication systems that effectively involve staff in decision-making and ensure that knowledge is shared</i>							
Measure:	Target	Reporting Timeframe	Strategic Initiatives/Actions	Responsibility	Time frame	Funding 1,2,3	★ Priority L, M, H	
Patient Satisfaction Score	Increase by 5%	Annual	<ul style="list-style-type: none"> Establish a Cancer Communication Strategy for the CN Establish communication pathways to ensure effective interfaces between: <ul style="list-style-type: none"> - all cancer service providers across the acute, non inpatient, community and palliative care sectors - Cancer Services CN and other CNs eg Aged Care and Rehabilitation, Children and Young People, Chronic Disease 	Members of CMC/Comm Unit	Jun 07	3	H	
Level of Clinician Satisfaction by tumour group	Increase by 5%	Annual	<ul style="list-style-type: none"> Promote an Area wide understanding of cancer services available including appropriate referral processes & maintain currency of information on websites Develop a standardized approach to the distribution of patient information to ensure all patients have access to the Cancer Council/ CI Information Pack and supplementary local information 	Members of CMC/Cancer Website	Dec 07	3	L	
				Members of CMC/ACCC	Jun 07	2		

◆ **Funding Key:** 1. Initiative/Action to be implemented without funding 2. Initiative/Action to be implemented with funding from existing resources 3. Enhancement funding required note: multiple initiatives covering multiple objectives may be included in a single position requiring funding. Page 50 of 58
 ★ **Priority Key:** Strategic Initiatives/Actions that require “Enhancement Funding” (3) are to be prioritised as either **Low**, **Medium** or **High**, based on their contribution to achieving the objective

Cancer Services Strategic Directions and Strategic Action Plan

FOCUS AREA:	Internal Networking and processes							
OBJECTIVE:	To deliver the required community outcomes, we need to excel in: Disease prevention and health promotion across all service areas						Risk Rating	
							Current	Target
							D	H
DESTINATION STATEMENT:	<i>We embrace all opportunities to prevent disease and promote healthy lifestyle choices</i>							
Measure:	Target	Reporting Timeframe	Strategic Initiatives/Actions	Responsibility	Time frame	◆ Funding 1,2,3	★ Priority L, M, H	
% Patients with at risk behaviours provided risk reduction care	Increase by 10%	Annual	<ul style="list-style-type: none"> Increase the focus on disease prevention and health promotion through service resourcing strategies Continued involvement with health promotion & prevention strategies aimed at smoking cessation, sensible sun exposure and adequate diet and exercise Incorporate health promotion and prevention across the lifespan in all service plans and business initiatives Monitor smoking behaviour and exposure to tobacco products 	Pop Hlth/Acute services/DAC S/CN Clust Mans/Pop Hlth/Acute Services/DAC S/CN Clust Mans/Pop Hlth/Acute Services/DAC S/CN Pop Hlth	Ongoing Ongoing Ongoing Ongoing	2 2 2 2		

◆ **Funding Key:** 1. Initiative/Action to be implemented without funding 2. Initiative/Action to be implemented with funding from existing resources 3. Enhancement funding required note: multiple initiatives covering multiple objectives may be included in a single position requiring funding. Page 51 of 58
 ★ **Priority Key:** Strategic Initiatives/Actions that require “Enhancement Funding” (3) are to be prioritised as either **Low**, **Medium** or **High**, based on their contribution to achieving the objective

Cancer Services Strategic Directions and Strategic Action Plan

FOCUS AREA:	Resource Accountability							
OBJECTIVE:	To deliver the required community outcomes, we need to excel in: Prioritisation and allocation of resources to best meet cancer service needs						Risk Rating	
							Current	Target
							A	D
DESTINATION STATEMENT:	<i>Staff and communities are confident that resources are allocated to meet identified health needs according to agreed priorities</i>							
Measure:	Target	Reporting Timeframe	Strategic Initiatives/Actions	Responsibility	Time frame	◆ Funding 1,2,3	★ Priority L, M, H	
% Expenditure spent on identified cancer services	13%	Annual	<ul style="list-style-type: none"> Lobby the Commonwealth for a license for a rebatible PET/CT scanner in Newcastle Lobby the CI for funds for a new PET/ CT scanner for the NMMH Develop a robust methodology to determine future resource requirements & associated demand and capacity constraints Submit the Business Case & submission for funding to the Cancer Institute to pilot an Area Clinical Cancer Register including recruitment of data managers to support tumour groups Lobby for equitable share of NSW Cancer Institute and NSW Health Department funding²⁰ Obtain recurrent funding from CI for Round 1 infrastructure positions currently funded until 30/6/07 Allocate sufficient resources to maximize the benefit of the CN Develop a process to manage unexpected increases in demand for resources Budget for leave relief to maintain regular flow of services Monitor selected inpatient activity eg haematology 	<p>CE</p> <p>DACS</p> <p>Members of CMC</p> <p>Members of CMC</p> <p>DACS</p> <p>DACS/CI</p> <p>Members of CMC/AET</p> <p>DACS/CN/Units</p> <p>Clin Serv</p> <p>DACS/CN</p>	<p>Ongoing</p> <p>Ongoing</p> <p>Dec 08</p> <p>Jan 07</p> <p>Ongoing</p> <p>Jun 07</p> <p>Dec 07</p> <p>Dec 07</p> <p>Ongoing</p> <p>Jun 07</p>	<p>1</p> <p>3</p> <p>3</p> <p>2</p> <p>1</p> <p>3</p> <p>3</p> <p>3</p> <p>1</p> <p>2</p>	<p></p> <p>H</p> <p>M</p> <p></p> <p>H</p> <p>H</p> <p>M</p> <p></p> <p></p>	

◆ **Funding Key:** 1. Initiative/Action to be implemented without funding 2. Initiative/Action to be implemented with funding from existing resources 3. Enhancement funding required note: multiple initiatives covering multiple objectives may be included in a single position requiring funding. Page 52 of 58

★ **Priority Key:** Strategic Initiatives/Actions that require “Enhancement Funding” (3) are to be prioritised as either **Low**, **Medium** or **High**, based on their contribution to achieving the objective

Cancer Services Strategic Directions and Strategic Action Plan

Continued - Prioritisation and allocation of resources to best meet cancer service needs							
Measure:	Target	Reporting Timeframe	Strategic Initiatives/Actions	Responsibility	Time frame	◆ Funding 1,2,3	★ Priority L, M, H
			<ul style="list-style-type: none"> • Adopt the HNE framework that links service planning, asset maintenance, capital funding and resource allocation • Identify changes in clinical practice that will require new technology • Identify IT resources to support patient information systems and associated cancer related data bases • Establish a methodology that identifies the breadth of cancer related surgery & associated costs & O/T time • Prepare annual priority list for submission for funding 	Members of CMC/ Wkfce	Jun 08	2	
				DACS/Units	Ongoing	2	
				Members of CMC/IT/Units	Jun 07	3	M
				DACS/Surgery	Dec 08	3	M
				DACS	Dec 07	2	

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★ **Priority Key:** Strategic Initiatives/Actions that require “Enhancement Funding” (3) are to be prioritised as either **Low**, **Medium** or **High**, based on their contribution to achieving the objective

Cancer Services Strategic Directions and Strategic Action Plan

FOCUS AREA:	Our people, culture and capability							
OBJECTIVE:	To achieved the desired outcomes and sustain our ability to change and improve, we need to excel in: Recruiting and retaining high quality staff						Risk Rating	
							Current	Target
						C	H	
DESTINATION STATEMENT:	<i>We have the right people with the right skills, in the right place, at the right time</i>							
Measure:	Target	Reporting Timeframe	Strategic Initiatives/Actions	Responsibility	Time frame	◆ Funding 1,2,3	★ Priority L, M, H	
Vacancy rate for cancer specific positions	Decrease by 5%	Quarterly	• Appoint a full time Director for Cancer Services to optimise an Area wide approach to service delivery	CE	Dec 06	3	H	
			• Review the workforce recruitment/retention issues as identified in the Workforce Framework	DACS/Wkfce	Ongoing	3	H	
			• Continue to advertise for specialist positions for all clinical disciplines using workforce recruiters	DACS/CN	Ongoing	1		
			• Promote HNE Cancer services to ensure positions are competitive with other services	Med Recruit	Ongoing	1		
			• Undertake assessment and feasibility of supporting medical oncologists in Tamworth and Taree	Med Onc NMMH/ MBH/TBH	Dec 07	3	M	
• Identify deficiencies in operating theatre rostering and requirements to match staff experience to casemix	Dept Surg JHH/NMMH	Jun 07	3	M				
Number (FTEs) of allied health cancer specific positions employed	Increase by 10%	Quarterly	• Ensure allied health staff are recognised as an integral part of the cancer treatment team and identify key areas that require funded positions to support their involvement	Canc AH WP	Jun 07	3	H	
			• Identify career pathways for allied health staff	Canc AH WP	Jun 08	2		

◆ **Funding Key:** 1. Initiative/Action to be implemented without funding 2. Initiative/Action to be implemented with funding from existing resources 3. Enhancement funding required note: multiple initiatives covering multiple objectives may be included in a single position requiring funding.

★ **Priority Key:** Strategic Initiatives/Actions that require “Enhancement Funding” (3) are to be prioritised as either **Low**, **Medium** or **High**, based on their contribution to achieving the objective

Cancer Services Strategic Directions and Strategic Action Plan

Continued - Recruiting and retaining high quality staff							
% Staff exit interviews	100%	6 monthly	<ul style="list-style-type: none"> Continue to support strategies for staff recruitment and retention Recruit to all vacant positions in rural areas Identify workforce issues related to the introduction of bowel screening programs Address workforce issues associated with breast screening Monitor vacancies in key clinical areas and implement strategies to actively recruit Develop a succession planning timetable for each specialty 	DACS/CN	Ongoing	2	
				DACS/CN	Ongoing	3	H
				CMC/Wkfce PI	Jun 07	3	H
				Breastscreen Unit	Jun 06	2	
				Members of CMC/ Wkfce	Ongoing	3	H
TumGr Lds/ Lead Clins	Jun 08	2					

◆ **Funding Key:** 1. Initiative/Action to be implemented without funding 2. Initiative/Action to be implemented with funding from existing resources 3. Enhancement funding required note: multiple initiatives covering multiple objectives may be included in a single position requiring funding. Page 55 of 58

★ **Priority Key:** Strategic Initiatives/Actions that require “Enhancement Funding” (3) are to be prioritised as either **Low**, **Medium** or **High**, based on their contribution to achieving the objective

Cancer Services Strategic Directions and Strategic Action Plan

FOCUS AREA:	Our people, culture and capability							
OBJECTIVE:	To achieved the desired outcomes and sustain our ability to change and improve, we need to excel in:						Risk Rating	
	Developing competence, capability, individual accountability and performance						Current	Target
							K	R
DESTINATION STATEMENT:	<i>Our staff develop their skills, accept responsibility for their decisions and actions, and are supported to optimise their performance</i>							
Measure:	Target	Reporting Timeframe	Strategic Initiatives/Actions	Responsibility	Time frame	◆ Funding 1,2,3	★ Priority L, M, H	
Number (FTEs) of oncology clinical educator roles in cancer services	Increase by 5%	6 monthly	<ul style="list-style-type: none"> Foster training and skill development opportunities for all staff to recognise and utilise the skills and experience available Develop professional career pathways for cancer nursing staff Provide a range of learning opportunities to develop and maintain skills of all staff Identify professional development needs and ongoing training of staff Further develop lead clinician roles and responsibilities Further develop care coordinators roles and responsibilities Work with Newcastle University and the NSW Clinical Education Working Party to enhance clinical educator roles in allied health services 	Units/Depts DACS/CN/Nurs & Midw/ All Depts Units/Depts DACS Nursing/ACCC ACCC/ Nurs& Midwi/New Uni	Ongoing Jun 09 Jun 09 Dec 08 Jun 07 Jun 07 Dec 08	2 2 2 2 2 2		
% Oncology clinical nursing staff with relevant post grad. certificate	Increase by 5%	Annual	<ul style="list-style-type: none"> Secure more training posts for oncology & haematology registrar positions 	DACS/Newc Uni	Dec 08	3	H	
Number Oncology registrars passing higher degree exams	5	Annual	<ul style="list-style-type: none"> Commence program to allow less experienced staff to work with specialized staff in a supernumerary role 	Wkfce Units/ DONs	Dec 07	2		

◆ **Funding Key:** 1. Initiative/Action to be implemented without funding 2. Initiative/Action to be implemented with funding from existing resources 3. Enhancement funding required
 note: multiple initiatives covering multiple objectives may be included in a single position requiring funding.
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Cancer Services Strategic Directions and Strategic Action Plan

Continued - Developing competence, capability, individual accountability and performance							
Allied health TBD	TBD	TBD	<ul style="list-style-type: none"> Allow staff easier access to education programs and additional training e.g. post graduate courses, including financial support and leave Provide opportunities for increased clinical supervision Liaise with relevant parties including the Universities, profession organisations, and DoH re development of specific training/residency programs (including mentoring) for identified areas of need, such as Oncology Pharmacist specialist training 	Wkfce/Units	Jun 07	3	M
				Wkfce/Units	Jun 08	2	M
				Wkfce	Jun 08	3	

Cancer Services Strategic Directions and Strategic Action Plan

FOCUS AREA:	Our people, culture and capability							
OBJECTIVE:	To achieved the desired outcomes and sustain our ability to change and improve, we need to excel in:						Risk Rating	
	Demonstrating innovative cancer care						Current	Target
							N	N
DESTINATION STATEMENT:	<i>We are recognised nationally and internationally for innovation in clinical, organisational and support services</i>							
Measure:	Target	Reporting Timeframe	Strategic Initiatives/Actions	Responsibility	Time frame	◆ Funding 1,2,3	★ Priority L, M, H	
Number of patients in clinical trials	Increase by 5%	Annual	<ul style="list-style-type: none"> Contribute to the evidence base through research Assess the strategic needs of research Compile a register of cancer research studies Record patients in clinical trials and participation and accrual of patients in a clinical trial for ACCR Encourage staff in clinical practice to participate in research opportunities Increase number of clinical trials undertaken Commitment to ongoing clinical redesign Identify examples where research has resulted in a change to clinical practice 	DACS HMRI HMRI DACS/CN/Hosp DACS/CN DACS/CN DACS/CN DACS/CN	Jun 10 Jun 07 Jun 08 Ongoing Ongoing Jun 10 Ongoing Ongoing	3 2 2 3 2 2 2 2	H H	

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