National Cancer Programme Work Plan 2011/12

Overview

Introduction
The National Cancer Programme covers the Ministry of Health’s, district health boards’ (DHBs), and regional cancer networks’ activity to implement the Government’s priorities for cancer and the New Zealand Cancer Control Strategy.

This is a high-level work plan that covers the national priorities for cancer. Ministry business plans, DHB Annual Plans, and Regional Cancer Network Annual Plans include more specific detail on the work these groups are leading. The support of the National Health Board, Health Workforce New Zealand, and the National Health IT Board are critical in achieving these national priorities.

Strategic context
This work plan is organised under four focus areas that align with the Government’s vision of Better, Sooner, More Convenient health care. The work plan spans the cancer continuum from prevention to palliative care, support and rehabilitation. It supports the overall purposes of the New Zealand Cancer Control Strategy to reduce the incidence and impact of cancer, and reduce inequalities with respect to cancer.

Cancer is the leading cause of death
Cancer is the country’s leading cause of death (29 percent) and a major cause of hospitalisation. Most New Zealanders will have some experience of cancer, either personally or through a relative or friend.

More people are developing cancer, mainly because of population growth and ageing. Once people are diagnosed with cancer they are now less likely to die from it. This means that people are being treated for longer and surviving longer.

Health inequalities by ethnicity in New Zealand are stark. The incidence of cancer is 20 percent higher for Māori than for non-Māori, but cancer mortality is nearly 80 percent higher. Māori are more likely than non-Māori to have their cancer detected at a later stage of disease spread. In addition, residents of more socioeconomically deprived neighbourhoods are more likely to develop cancer, less likely to have their cancer detected early, and have poorer survival chances, than residents of less deprived neighbourhoods.

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Overview, Continued

Survival ratios are improving

The most recent cancer survival publication (2010) shows that between 1998 and 2007, the five-year cumulative relative survival ratios improved in adults for males and females, for Māori and non-Māori, for all deprivation groups and for most age groups.

The OECD Health Care Quality Indicators Data 2009 used three cancers as indicators for cancer care (breast, cervical and colorectal cancer). The indicators showed New Zealand’s relative survival rates for all three cancers were above the OECD average. The data also showed improved survival rates for breast and cervical cancer from 1997-2002 compared to 2002-2007 (the data was unavailable for colorectal cancer).

Healthcare costs are rising

Overseas studies indicate that cancer costs are likely to increase at a faster rate than overall health expenditure. As the population ages, the total number of people treated for cancer will increase faster than the overall population. Costs also are likely to increase as new, more advanced, and more expensive treatments are adopted.

In 2008 an estimated $511.5 million was spent on cancer diagnosis and treatment by the New Zealand health system. By 2021 expenditure is estimated to increase by an additional $117 million (23%). This is based on current models of care and projected incidence growth it does not provide any indication of the impacts of new technologies or improved survival, reduced mortality, and earlier detection of some cancers.

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Overview, Continued

**Good progress is being made**

Reducing the burden of cancer in our community is one of the Government’s priority areas. Shorter waits for cancer treatment and helping hospitalised smokers to quit are two of the Government’s health targets.

**Health Targets**

In Quarter 3 of 2010/11 (January to March 2011) 99 percent of patients started their cancer radiation treatment within four weeks and 100 percent started within six weeks.

DHBs have made significant progress towards achieving the current target of 90 percent of hospitalised smokers provided with advice and help to quit. In Quarter 3 of 2010/11 (January to March 2011), nationally 74 percent of hospitalised smokers were offered brief advice and help to quit, up four points on the previous quarter.

**Improved early detection – Bowel Screening Pilot**

In May 2010, the Minister of Health announced Cabinet approval for a four year Bowel Screening Pilot, as a means of determining whether it is feasible for New Zealand to roll-out a national bowel screening programme. No decision on a national roll-out will be made until the pilot has finished and all monitoring and evaluation has been completed.

The pilot, which begins in October 2011, will be held in the Waitemata District Health Board area. About 130,000 people aged 50 to 74 years, including 6000 Māori, will be invited to participate.

**Increasing breast screening rates**

The overall breast screening coverage rates continue their upward trend with coverage for Māori and Pacific women increasing at a greater rate than for ‘Other’ women.

**Reducing the incidence and death rate of cervical cancer**

Cervical cancer mortality for all ethnic groups continues to trend downwards. However, cervical cancer incidence rates remain higher for Māori and for Pacific women.

**Multi-disciplinary work group development**

The regional cancer networks have established regional lung and bowel cancer work groups, and for lung cancer are implementing work group recommendations at a regional level. For example, from January to June 2010, 94 percent of lung cases were presented at multi-disciplinary team meetings in the Northern region, up from 28 percent identified in 2007.

A national lung work group has also been established to drive development and implementation of national level initiatives.
Hospice funding
All eligible DHBs passed on their Boost Hospice Funding allocations to hospices (totalling $14.6 million).

Other Milestones
• Publicly funded chemotherapy clinics increased to just over 57,000 outpatient sessions in public hospitals in the 2009/10 year, up 3746 on the previous year.

The increase in chemotherapy volumes is mainly due to a larger number of people getting extra courses of chemotherapy treatment, and the introduction of new drugs, rather than an increase in the total number of new cancer cases.

• The National Plan for Child Cancer Services in New Zealand was published in November 2010. It addresses the challenges of providing high quality child cancer services nationwide, given the small number of patients and their wide geographic spread. Nearly 200 new cases of child cancer are diagnosed each year, with just over 320 children receiving active therapy at any one time. The plan outlines a national service delivery model that is clinically safe, effective and sustainable.
## National Cancer Programme for 2011/12

### Vision

We want all people to **easily** access the **best** services, in a **timely** way to improve overall cancer outcomes.

### Measures

Success will be measured by five year survival rates, cancer incidence and cancer mortality data.

### Focus Areas

- **Wait Times:** All people get timely services
- **Access:** All people have access to services that maintain good health and independence
- **Quality:** All people receive excellent services wherever they are
- **Financial Sustainability:** All services make the best use of available resources

### Priorities

We have prioritised key areas that will have the biggest impact on populations in the next five years. These are:

- **Radiation and Medical Oncology, Palliative Care** – we want sustainable services that adapt to changing need.
- **Lung & Bowel cancer** – we need to reduce the impact of two of the most significant cancers. We want fewer people to get these cancers. We want more people to survive these cancers.
- **Information systems** – we need high quality and consistent information. We need to measure the difference we make.
National Cancer Programme

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<tr>
<th>Priority areas</th>
<th>The National Cancer Programme’s four focus areas have the following priorities for 2011/12:</th>
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<tbody>
<tr>
<td>Radiation Oncology</td>
<td>The Government expects all DHBs to meet the Shorter Waits for Cancer Treatment Health Target – everyone needing radiation treatment will have this within four weeks. Ongoing capital, service, and workforce planning are critical to ensuring the Health Target is sustainably met.</td>
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<tr>
<td>Medical Oncology</td>
<td>The Government expects all DHBs to meet the Policy Priority of Shorter Waits for Chemotherapy Treatment – everyone needing chemotherapy treatment will have this within four weeks. New models of care are being developed for medical oncology. Implementing these models, particularly around workforce and service configuration will be integral to DHBs meeting the Policy Priority.</td>
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<tr>
<td>Palliative Care</td>
<td>The demand for palliative care services will increase slowly over the next 10 years, but thereafter will increase more rapidly in line with the ageing population. The number of people requiring palliative care will increase by nearly 25 percent over the next 15 years and will nearly double by 2061. Ensuring a sustainable and appropriate workforce is crucial to providing a sustainable palliative care service.</td>
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National Cancer Programme, Continued

Lung & Bowel Cancers

A whole of system approach, via tumour streams, aims to improve access to services and waiting times for patients. Multidisciplinary team approaches and standardised care pathways means patients receive the same care regardless of where they are treated. The National Cancer Programme has agreed to initially prioritise lung and bowel cancers.

Lung cancer is the leading cause of cancer deaths in New Zealand. Its poor prognosis is largely attributed to late diagnosis. The five-year cumulative relative survival ratio for patients with lung cancer is very low (11 percent 1994-2007). Compared with European/Other people the risk of developing lung cancer is:

- twice as high for Māori males
- three times as high for Māori females
- one and a half times as high for Pacific people.

Bowel cancer is the second leading cause of cancer registrations and cancer deaths in New Zealand. The development of bowel cancer is preventable in many cases and highly treatable when identified in the early stages.

Information Systems

Accurate, meaningful and timely cancer data is vital, and underpins all research, reporting and decision-making that needs to be undertaken. However, despite this:

- there is no coherent view across the cancer continuum
- data is not collected in a consistent manner
- data has to be extracted from multiple systems for analysis
- timely access to data is difficult.

The Ministry, the regional cancer networks, and DHBs are working to resolve these problems through the establishment of a national data view for cancer, supported by regional clinical data repositories for cancer and standardised core data definitions for cancer.
### Work Plan 2011/12

**Key work plan initiatives**

Over 2011/12 DHBs, the Ministry of Health and Regional Cancer Networks will deliver the following initiatives in the four focus areas. The lead agency is detailed under each initiative.

### Wait Times: All people get timely services

The Government is committed to Better, Sooner, More Convenient health care. For the cancer programme this means improving access to, and shorter waiting times for, cancer treatment.

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<th>Initiatives</th>
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<td>Everyone needing radiation treatment will have this within four weeks.</td>
<td>Implementation of National Radiation Oncology Plan priorities by June 2012. This Plan will provide national direction to DHBs on future service requirements to ensure DHBs sustainably meet the health target. <strong>Lead: Ministry of Health, DHBs</strong></td>
</tr>
<tr>
<td>Everyone needing chemotherapy treatment will have this within four weeks.</td>
<td>Implementation of the Medical Oncology Models of Care Project priorities by June 2012. New Models of Care are needed to ensure medical oncology services can effectively, equitably and sustainably meet the future demand, given workforce and resource trends. DHBs and the Ministry are currently developing the new models of care. This work will be finished by August 2011. With the assistance of Health Workforce New Zealand, the focus then shifts to implementation. <strong>Lead: Ministry of Health, DHBs</strong></td>
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<td>Advice is provided to the Minister of Health on a wait time standard from suspicion of cancer to first treatment, by July 2011.</td>
<td>Develop advice to the Minister of Health on wait time standards from when a person is suspected of having cancer until cancer treatment is initiated. Specialist cancer treatment and symptom control is essential in reducing the impact of cancer. This advice will examine approaches to expanding the reporting of cancer wait times to the start of the patient pathway. <strong>Lead: Ministry of Health</strong></td>
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Access: All people have access to services that maintain good health and independence

Reducing risk factors and improving early diagnosis contribute to reducing the incidence of cancer and improving survival rates. The National Cancer Programme is focused on ensuring people have access to smoking cessation advice and participate in appropriate screening programmes.

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| 95 percent of hospitalised smokers will be provided with advice and help to quit smoking by July 2012. | Implement the ABC approach for smoking cessation in the hospital setting.  
(Ask all people about their smoking status; provide Brief advice to stop smoking to all people who smoke; offer evidenced based Cessation treatment).  
Lead: DHBs |
| 90 percent of enrolled patients who smoke and are seen in general practice will be provided with advice and help to quit smoking by July 2012. | Implement the ABC approach for smoking cessation in the primary care setting.  
Lead: DHBs and PHOs |
| Commence the bowel screening pilot at Waitemata DHB in October 2011. | Implement and oversee the evaluation of the bowel screening pilot at Waitemata DHB.  
Lead: Ministry of Health and Waitemata DHB |
| Screen 70 percent of the eligible population for breast cancer every two years including underscreened women (Māori and Pacific) aged 50-69. | Monitor BreastScreen Aotearoa provider performance against 46 quantitative targets for women aged 50-69 years.  
Lead: Ministry of Health |
| Increase cervical screening coverage\(^1\) to 80 percent for all ethnic groups by 30 June 2014. | Monitor the National Cervical Screening Programme against national standards, indicators and targets.  
Lead: Ministry of Health |

\(^1\) Women 20-69 years screened in the previous three years.
Quality: All people receive excellent services wherever they are

Differences in access to and quality of health services may generate inequalities in cancer survival. Standardising models of care and treatment pathways can help reduce unnecessary variations in treatment and outcomes. The National Cancer Programme is taking a tumour stream approach with an initial focus on lung cancer and bowel cancer.

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<td>Increase the percentage of lung cancer patients who start treatment within 62 calendar days from receipt of referral into secondary services.</td>
<td>Implement the national lung cancer treatment standards by June 2012. The standards aim to improve the overall care of lung cancer patients. Nationally developed standards will be implemented regionally. The standards will be used to develop key performance indicators that will be audited and used to drive improvements in services.</td>
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<tr>
<td>Increase the percentage of lung and bowel cancer patients reviewed at multidisciplinary team meetings by DHB and by ethnicity.</td>
<td>Support the running of multidisciplinary team meetings. Multidisciplinary team meetings support quality clinical decision-making and identify appropriate treatment options, which ultimately improve patient outcomes.</td>
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<td>Pilot endoscopy quality improvement tool (Global Rating Scale) in four DHBs.</td>
<td>Develop and implement endoscopy quality improvement initiatives by June 2012.</td>
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<td>Models of palliative care developed, with support from Hospice New Zealand, by December 2012.</td>
<td>By December 2012: • develop a palliative care role delineation model (this will describe how different services are delineated) • utilise recommendations from the Health Workforce New Zealand (HWNZ) palliative care service review in the development of the models of palliative care • develop a national funding model (to determine what are the essential palliative care services that should be totally publicly funded) • pilot hospice standards • pilot, with HWNZ Workforce Innovations, hospice education training in palliative care settings such as aged care and secondary / tertiary hospitals.</td>
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Regional Clinical Data Repositories will include a cancer component by June 2012 (as outlined in the National Health IT Plan).

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<th>With the support of the National Health IT Board:</th>
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<td>- pilot a regional oncology data management system by June 2012 (across both public and private services)</td>
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<td>- pilot cancer data standards by November 2011 and publish finalised standards by June 2012.</td>
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The cancer core data definitions standard is intended to ensure that minimum agreed cancer data is collected and stored in a consistent manner wherever it is collected and stored. The associated business process and messaging standards are intended to ensure the safe, secure and accurate exchange of cancer information between systems in New Zealand.

By the end of 2013 the National Cancer Programme and National Health IT Board will deliver a National Cancer Data View, which will be able to be accessed by a wide variety of interested parties, and will provide a consistent and nation-wide view of data relating to the diagnosis, treatment, and outcomes for patients receiving cancer care in New Zealand. In the 2011/12 year we will have completed a high-level design and solution architecture for the National Cancer Data View.

**Lead: Ministry of Health**

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It is widely acknowledged that cancer and palliative care services could easily absorb significant amounts of new funding. However, in a constrained economic environment there is limited new funding available. The National Cancer Programme is focused on improving service delivery within existing funding with a focus on new models of care, patient pathways, and improving the productivity of existing services. Analysis of cost and cost drivers of cancer services is crucial to informing planning and prioritisation decisions.

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<td>Disseminate findings from Phase 1 analysis on the Price of Cancer to DHBs by August 2011</td>
<td>Undertake more detailed analysis into the increase in inpatient costs by December 2011.</td>
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<td>Re-run Phase 1 analysis for 2009 registrations to determine any increase in costs by December 2011.</td>
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<td>Complete the Northern Region Cost of Breast Cancer Study by February 2012.</td>
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<td>Determine additional analysis needed following consultation with DHBs, and information that comes out of the models of care for medical oncology, the national plan for radiation oncology and the national funding model for palliative care by June 2012.</td>
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**Lead: Ministry of Health**