Northern
Territory
Government

Northern Territory
Cancer Plan

2013 –2016

Australian Government
Cancer Australia

Northern Territory
Cancer Plan
2013 - 2016

This NT Cancer Plan was developed by the Northern Territory Department of Health, supported by Cancer Australia and in partnership with key stakeholders in the Northern Territory (including clinicians, cancer patients, carers, researchers, administrators, health managers and professionals, non-government organisations and Aboriginal Medical Services) over the period 2008-2012.

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Department of Health is a Smoke Free Workplace

Contents

NT Cancer Plan

Cancer places a heavy burden on both the people diagnosed with this disease and their families and carers. *The NT Cancer Plan* is intended to minimise this burden by guiding developments and improvements in cancer services in the Northern Territory. This *Plan* includes the key elements of a cancer service network and the underpinning principles, as well as identifying priority action areas for each of these elements in the Northern Territory.

Purpose

The *NT Cancer Plan* provides a focus for people and organisations involved in cancer prevention, detection, treatment, care and support to work together to improve health outcomes for Territorians.

Top Priorities

The top priority areas for 2012 - 2015 are:

- Improving point-of-diagnosis consumer education and information (particularly through more culturally secure resources and communication)
- Further developing and supporting multidisciplinary team discussion and care
- Establishing a formal multidisciplinary clinical leadership within a structured NT Cancer Service
- Further developing allied health services to support the development of cancer services in the Northern Territory
- Developing integrated data capture systems to inform quality improvement strategies
- Building cancer care coordination capacity within the health system and its providers.

Consumers include cancer patients, people living with cancer, cancer survivors, carers and family members.

Governance – introducing the Cancer Care Optimisation Group

- For a network approach to work, partnerships must be developed and nurtured across organisational, professional and cultural boundaries.
- To promote this network approach, and in response to the need for multidisciplinary leadership, the Cancer Care Optimisation Group (CCOG) was established in 2010.
- The CCOG is represented by oncology, haematology, surgery, palliative care, cancer nursing, remote/community health, allied health, Aboriginal Health Workers, the Cancer Council NT, General Practice, Aboriginal Medical Services Alliance NT and consumers.
- Members come from across the Northern Territory, and their collective expertise and experiences in cancer care is intended to provide balanced leadership in the development of holistic patient-centred care.
- Part of the role of the CCOG is to guide and promote the implementation of the *NT Cancer Plan*.

Overview of the NT Cancer Plan

Goal

Promote the prevention and timely detection of cancer amongst Northern Territory residents and, where patients require treatment for cancer, work collaboratively across all cancer service providers with patients to facilitate a seamless journey.

Cancer Network Model

The NT Cancer Plan is based on the Cancer Australia Cancer Services Network model (Figure 1).

This model links key elements that promote improved cancer services and patient outcomes based on person centred care, equitable access, better coordinated cancer services and best available evidence for practice.

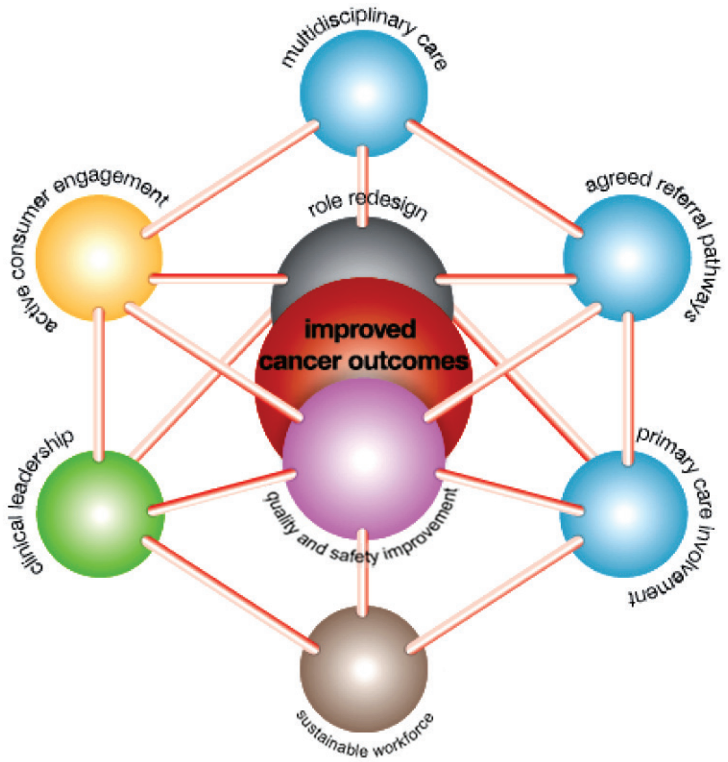


Figure 1: Key Elements of the Cancer Services Network

The specific strategies contained in the *NT Cancer Plan* are presented against these key elements.

Priorities

Key Elements	Principles	Priority Action Areas in the Northern Territory
1. Active consumer engagement	Engaging consumers in service planning, delivery, education and evaluation.	*Ensure all patients are provided with the appropriate support and information at the time of diagnosis (particularly through more culturally secure resources and communication for Indigenous cancer patients and their families).* *[Initiative 2]*
2. Needs based cancer care	Providing safe and quality treatment to patients as close to home as possible • Clinicians and patients working together to decide agreed referral pathways. • Multidisciplinary cancer assessment and cancer care planned at multidisciplinary team meetings (MDT) (face to face or via teleconference). • Primary care involved in prevention, diagnosis, referral and shared care. Strong investment in these areas can reduce expenditure on treatment of cancer and improve patient outcomes.	*Further develop and support multidisciplinary team discussion and care (particularly through improved engagement with and involvement of the primary care sector).* *[Initiative 14]*
3. Clinical leadership	Supporting clinical champions to lead operational and clinical improvements based on best practice and up-to-date evidence.	*Establish a formal multidisciplinary clinical leadership within a structured NT Cancer Service that includes medical, nursing and allied health care providers.* *[Initiative 26]*
4. Sustainable workforce	Investing in the development of the cancer care workforce through continuing resource development and professional learning. Continually develop the specialist cancer workforce to achieve self sufficiency in the diagnosis and treatment of most cancers in the NT.	Further develop allied health services to support the development of cancer services in the Northern Territory. *[Initiative 28]*
5. Quality & safety improvement	Using evidence-based protocols and guidelines for safe care and service delivery, and collecting and using data through systematic clinical audits for system improvement.	*Develop integrated data capture systems to inform quality improvement strategies.* *[Initiative 30]]*
6. Role redesign	Role clarity in a complex health system underpins successful and effective patient management and shared care. This is particularly important in a health system transitioning to a more fundamentally patient-centred care approach.	*Build cancer care coordination capacity within the health system and its providers to ensure patients experience smooth, integrated care from diagnosis through to survivorship or palliation.* *[Initiative 31]*

How to use this document

This document is designed to be a focal point through which concerted and collaborative efforts can be made towards improving cancer care and control in the NT.

It is intended that this document will be used by health care providers, community groups, Aboriginal Community Controlled Organisations, research institutes, consumers, Government Departments, non-government organisations (NGOs) and the private sector. To achieve successful outcomes, it is envisaged that the Cancer Plan will guide efforts across sectors.

If you want to see improvements in cancer care and control in the NT, you should use:

- The priorities to focus your efforts
- The network elements to identify where you can best make (or influence) improvements
- The initiatives to guide specific service delivery improvements
- The principles as a foundation for all actions.

The *NT Cancer Plan* may also be used to support funding submissions for grants, as well as identify and encourage joint initiatives or collaboration across stakeholder groups.

Maximum benefit is usually achieved by collaborating with others to implement multi-strategy programs rather than focusing on a single activity or action area in isolation.

If you are focussing on a particular initiative, take a moment to check for other potentially related areas within the *Plan* and, if applicable, read the related NT Chronic Conditions Prevention and Management Strategy (CCPMS) Key Action Area (KAA). This may help you to build a broader view of the context within which your strategy or activity will be implemented and provide an opportunity to link with other relevant stakeholders. It may also provide an avenue for you to pursue funding options.

If there is a “KAA” next to a Cancer Plan initiative, check out the relevant Key Action Area in the Implementation Plan of the Chronic Conditions Prevention and Management Strategy

Building a bigger picture of effort and achievements

You are encouraged to provide copies of any reports you receive (or write) describing initiatives undertaken in the NT and progress made against key action areas to the Chronic Conditions Strategy Unit (www.health.nt.gov.au/Chronic_Conditions/Chronic_Conditions_Strategy_Unit/index.aspx).

This information will be collated and made available publically via the Chronic Conditions website so that all key stakeholders will be able to identify where and what progress is being made against the various key action areas and learn what is successful in other workplaces or communities. This will support a comprehensive Territory-wide knowledge-base and could underpin the growth of cross sectoral communities of practice in chronic disease.

The CCPMS framework will also support the monitoring of progress against related action areas in the Cancer Plan.

A network effort CAN make a difference

Cervical cancer rates have dropped markedly in recent years through improved community awareness, increased participation in screening, clinical professional development relating to pap smears and effective follow up treatment of abnormalities. Rates are expected to fall even further in the future as a result of the implementation of the Human Papillomavirus (HPV) vaccination.

This is a good example of the health system making a concerted effort across multiple areas and providers to make a tangible difference in a particular area.

Development Process

The development of this document was coordinated through the Cancer Service Networks National Demonstration Program (CanNET) which was jointly funded by the Northern Territory Department of Health and Cancer Australia.

The development process involved:

- An analysis of service demand
- A review of research, policies and relevant literature
- Consultations with stakeholders.

Demand analysis - An overview of demand characteristics for cancer services in the NT was prepared. This examined the incidence of cancers in the NT by tumour type (1991–2005) and characteristics of cancers for NT residents treated in hospital, including primary place of residence of patients, Indigenous status, and place of treatment (NT hospital or interstate).

Literature Review - A literature review to identify relevant existing policies and current good practices for cancer service delivery was undertaken.

Stakeholder consultations - Consultations were undertaken with stakeholders in Alice Springs, Bathurst Island, Darwin, Tennant Creek, Katherine, Nhulunbuy, Hermannsburg and Santa Theresa and included a combination of face-to-face and telephone consultations. Meetings were also undertaken with clinicians involved in providing care to NT patients at Royal Adelaide Hospital. Consultations with patients and service providers identified further development needs for cancer services in the NT.

An issues paper was formulated based on the demand analysis, literature review and consultations. This paper outlined proposed approaches for the future development of cancer services and was considered by Regional Cancer Group members and relevant health service providers at a CanNET Symposium in Alice Springs in early October 2008. The Symposium reviewed the questions identified through the consultation process and commented on draft strategies to assist in the subsequent formulation of the NT Cancer Plan. Directions that emerged from the Alice Springs CanNET Symposium were documented and considered in the formulation of the NT Cancer Plan.

Cancer has been recognised by the World Health Organisation as a chronic condition.

To support the achievement of the *Northern Territory Cancer Plan*, the initiatives have been mapped to the key action areas of the *Northern Territory Chronic Conditions Prevention and Management Strategy (CCPMS)*.

The Australian Government, through Cancer Australia, is working with jurisdictions to establish and strengthen cancer networks as a best practice model of cancer service development and care.

Strengthening networks involves improving links between cancer services across Australia to ensure more people with cancer can access the most appropriate treatment, care and support.

Part of this work is being progressed through the Cancer Service Networks Project (CanNET), initiated by Cancer Australia, in partnership with each state and territory health department.

The aim of cancer networks is to improve access to quality cancer services throughout Australia, particularly for people living in rural and regional areas, and Aboriginal and Torres Strait Islander peoples, who currently have poorer cancer outcomes.

CanNET NT facilitated the development of this Northern Territory Cancer Plan over the period 2008-2011.

Both the *Cancer Plan* and the *CCPMS* are informed by the *National Chronic Disease Strategy 2006*, as well as the *National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003-2013* and the *Northern Territory Aboriginal Health and Families: A Five Year Framework for Action*.

In order to finalise the NT Cancer Plan, and in response to a key strategy to create a peak multidisciplinary cancer body to guide the implementation of this document, the Cancer Care Optimisation Group (CCOG) was established. The CCOG is made up of stakeholders representing clinical and non-clinical, Top End and Central Australia, government and non-government, Indigenous and non-Indigenous, and urban and remote health service delivery areas.

The CCOG was instrumental in reviewing and prioritising the initiatives within this document.

1 Active Consumer Engagement

Background

Ensuring active consumer engagement underpins a more holistic development of a cancer network. The interaction of consumers with service providers presents different perspectives on problems, generating more responsive services and promoting a culture of change in service delivery towards more patient-centred care.

Consumer engagement can occur at the individual, program/departmental level, health service/organisational level and jurisdiction level. It can entail the provision of information to consumers, consultation to seek their views, partnerships in developing policy direction research and priority setting, and delegation of decision making. Access to clinical trials is another characteristic of good practice consumer engagement in the area of cancer care.

1.1 Consumer consultation on future service development

The NT Department of Health (DoH) has embraced consumer involvement in service development through the inclusion of consumers in the formation and prioritisation of the NT Cancer Plan, as well as on the peak advisory body overseeing the implementation of the NT Cancer Plan – the Cancer Care Optimisation Group.

Initiative 1 – KAA 1.3

Identify and provide opportunities for consumers to engage with NT wide cancer planning activities.

1.2 Support for patients at the time of diagnosis

During consultations some patients described personal traumatic experiences they encountered when being told they had cancer. Patients emphasised the need for timely support when being told of their diagnosis and would appreciate assistance in understanding what the diagnosis means, information on the treatment options available and the pros and cons of those treatments.

Initiative 2 – KAA 5.1

Ensure all patients are provided with the appropriate support and information at the time of diagnosis, particularly through more culturally secure resources and communication for indigenous cancer patients and their families.

1.3 Culturally sensitive cancer services

For Indigenous people there are added complexities to treatment planning and provision related to culture, family and kinship structure as well as English and health literacy challenges. The diagnosis of cancer for Indigenous people often occurs at a later stage when prognosis is less positive. The mortality rates for some cancers are higher amongst Indigenous people. Fear of cancer and its association with death, as well as possible negative experiences in hospital, can act as a deterrent to some Indigenous people seeking treatment in hospitals. For a number of Indigenous people, decisions around treatment require extensive involvement of their family and broader community. Health workers report that many Indigenous patients need to return to their community, unless key community members are in town, to discuss the proposed treatment with family before a commitment can be made to undergo treatment.

Other people from culturally and linguistically diverse (CALD) backgrounds face similar challenges in accessing appropriate and timely services.

Initiative 3 – KAA 4.2, 4.3, 5.1, 5.3, 6.1

Strengthen the cultural sensitivity and security of cancer services and information resources.

Initiative 4

Ensure all patients are provided with the appropriate support and information at the time of diagnosis.

1.4 **Access to clinical trials**

Clinical trials involve the testing of new clinical procedures and treatments for the management of cancer. There is evidence that patients treated on trials have a better outcome. Patients benefit from participating in clinical trials in several ways:

- They can access new procedures and treatments for treating particular types of cancer
- Participants may be subject to closer monitoring by the trial team than occurs for standard treatment
- There are altruistic benefits from participation because trials can potentially lead to improved treatment planning for all cancer patients in the longer term.

Royal Darwin Hospital (RDH) has been building capacity for the conduct of cancer clinical trials since 2006, and received a boost in trial capability in 2010 through funding from Cancer Australia.

Skilled and dedicated clinical trials nurses, supported by quality data management tools, underpin the successful operation of clinical trials.

Initiative 5

Further build clinical trials capacity in the NT.

2 Needs Based Cancer Care

Ensuring that patients have access to cancer care that is responsive to their needs is the second key element that supports the development of a cancer service network model. The network model assumes that patients with cancer will have access to:

- Cancer care that is evidence-based and includes discussions by multidisciplinary care teams
- As much of their treatment as close to home as possible
- Relevant specialist diagnostic and treatment-related cancer services
- Primary care involvement in prevention, diagnosis, referral and shared care along the cancer journey.

Ultimately patients should experience easy access to adequate and appropriate information, timely diagnostic services, quality and safe treatment and comprehensive support services as they move along the cancer care pathway (Figure 2).

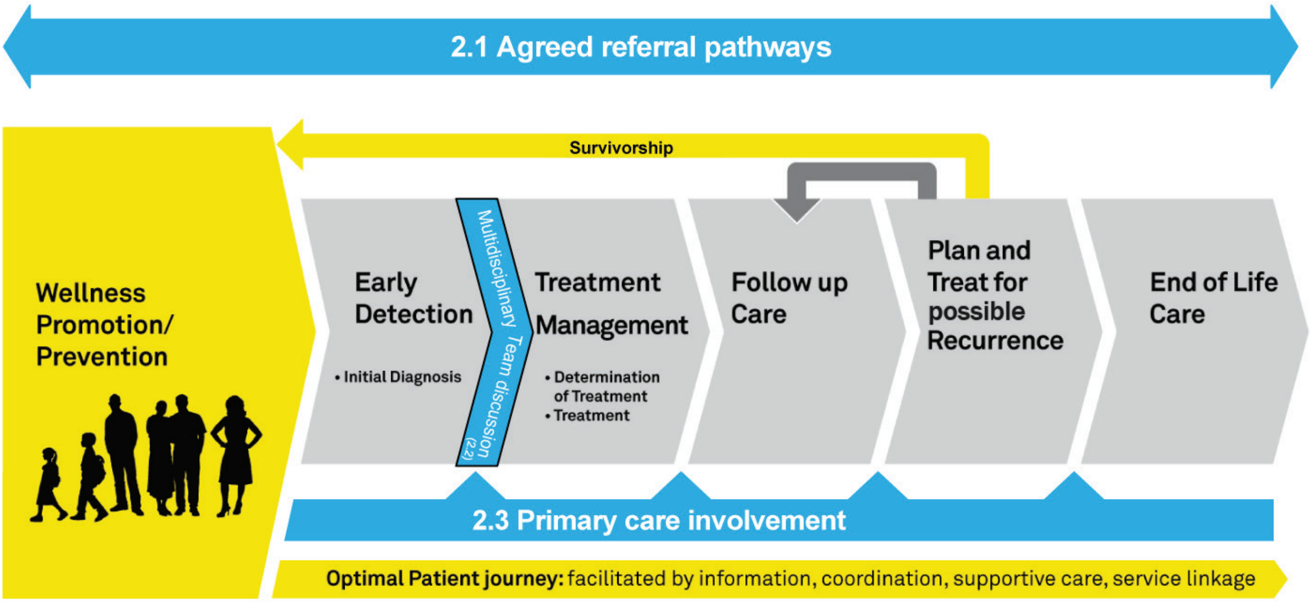


Figure 2: Patient Cancer Care Referral Pathway – Ensuring a Smooth Transition

The complex suite of cancer care treatment services should be tailored to the person’s type of cancer, the stage of its development and personal circumstances.

2.1 **Agreed referral pathways**

Clearly defined referral pathways are determined by the model of care for prevention, early detection, treatment management (including initial diagnosis, investigations, treatment planning and treatment delivery) and follow-up care.

Initiative 6

Strengthen clinical and workforce support through a formal NT cancer network.

Initiative 7

Expand care coordination to support the management of paediatric and Adolescent and Young Adult (AYA) patients with cancer.

Initiative 8

Maintain and further develop self-sufficiency in the diagnosis and treatment of the most common types of cancers experienced by NT residents.

Management of patient pathways typically focuses attention on actions around cancer diagnosis, treatment planning and treatment delivery. The NT Cancer Plan applies a broader view which includes actions in:

- Strengthening access to psychosocial cancer care
- Expanding accommodation facilities for people travelling for treatment
- Developing follow up care services to support cancer survivors
- Increasing culturally secure palliative care.

Strengthen access to psychosocial cancer care

During the consultation process patients emphasised the importance of a positive mental attitude whilst undertaking treatment and during the recovery process. The importance of referral to psychosocial support services was demonstrated in the literature. Many patients expressed how referrals to support groups provided an important “life line” for coming to terms with their diagnosis.

However, patient groups and NGOs reported current referrals for psychosocial support were limited. This may be due in part to the lack of appropriate psychosocial services. Access to psychosocial services should be available to both inpatients and outpatients.

Initiative 9 – KAA 4.1, 4.2. 4.3

Strengthen the psychosocial support network and services for cancer patients.

Initiative 10 – KAA 5.4

Strengthen the responsiveness of the service system to meeting the psychosocial needs of people who are Indigenous or from a CALD backgrounds, including the use of traditional supports.

Expand accommodation facilities for people travelling for treatment

Many people in the NT have to travel significant distances from their homes to see a specialist, undergo surgery, undertake chemotherapy or receive radiation oncology treatment. Depending on the nature of the treatment plan, patients and their carers may need to remain away from home for lengthy periods. For many people the costs associated with living away from home pose a significant financial burden. Patients and their carers identified the importance of low cost accommodation being available when required to travel to access treatment.

The establishment of the Alan Walker Cancer Care Centre in early 2010 was supported by a low cost accommodation facility for cancer patients in Darwin (Barbara James House). However, Alice Springs continues to experience a shortage of low cost accommodation to support patients travelling from remote areas to Alice Springs for treatment or specialist appointments.

Initiative 11

Expand the availability of low cost accommodation services to support patients who must travel for treatment.

Develop follow up care services to support cancer survivors

Patients with cancer face the challenges of a life threatening disease and undergo demanding treatment. Patient groups discussed the need for support for cancer survivors in re-establishing their lives following treatment. Some patients, as a consequence of their illness, have to give up their jobs, relocate closer to treatment and require the support of family members and friends to care for their children whilst they are in treatment or recovering.

Patients can become reliant on support for many months because of the debilitating treatment sometimes involved. Patients detailed the challenges they faced in getting their lives back on track after treatment and expressed a need for psychosocial support services to assist them in re-establishing their lives.

Initiative 12

Develop survivorship awareness and support services to help cancer survivors re-establish their lives.

Increase culturally secure palliative care

Health workers observed that the quality of end of life care could be improved if there was enhanced service integration between cancer and palliative care service systems. This includes early referral to palliative care or early involvement of palliative care services in the treatment discussion and planning.

Initiative 13 – KAA 5.6

Build on the renal palliative care program for Indigenous patients, enabling them to discontinue treatment, ‘return to country’ with palliative care support and ‘finish up on country.’

2.2 Multidisciplinary care

Multidisciplinary teams (MDTs) are integral to best practice cancer treatment planning and coordination. Treatment planning and coordination for many cancer patients at RDH is currently planned and managed by MDTs. A small MDT operates regularly at the Alice Springs Hospital (ASH). Specialists wanting to discuss cancer patients with more specialised treatment requirements are able to liaise with interstate MDTs to facilitate this.

Continuing growth in the volume of patients is projected over the coming three years placing increased demand on MDTs. Rapid changes in understanding of cancer biology and new therapeutic options developed through research also increases the demand for quality cancer services which MDTs work to provide.

Initiative 14 – KAA 5.3

Further develop and support multidisciplinary team discussion and care (particularly through improved engagement with and involvement of the primary care sector).

Use information management and technology to facilitate care coordination

Information technology (IT) can facilitate the linkage of patients with care delivery systems across highly dispersed geographies like the NT. The NT is especially well placed to use IT to enhance the care of patients with cancer via the shared health record system and eHealthNT.

Initiative 15 – KAA 7.3

Strengthen information management systems to enable service providers to share, monitor and report on patient care effectively.

Initiative 16

Increase electronic accessibility to reference and educational materials available to the public.

Initiative 17

Enhance pathology reporting systems.

FREE Online Cancer resources

The following national online resources have been created for health professionals wanting to increase their knowledge in cancer care and control.

Australian Government
Cancer Australia

www.cancerlearning.gov.au - national online hub
The Cancer Learning online hub is designed for health professionals working in cancer care. It includes learning activities, resources and information in cancer care. It also supports people undertaking, building or planning professional development programs and activities in cancer care.

eviQ Cancer Treatments Online

www.eviq.org.au – point-of-care resource
eviQ Cancer Treatments Online provides accurate, current, evidence based information for use at the point of care. It is a valuable tool for clinicians caring for patients with cancer. This Australian resource is intended to support clinicians, cancer carers and patients at the point of care. All content development complies with a rigorous data governance model. Registration is free.

EdCaN National Education Framework Cancer Nursing

www.edcan.org – cancer education for nurses
EdCan includes a National Professional Development Framework for Cancer Nursing and a suite of learning resources targeted at building capacity of the nursing workforce in cancer control. Registration is free.

2.3 **Primary Care Involvement**

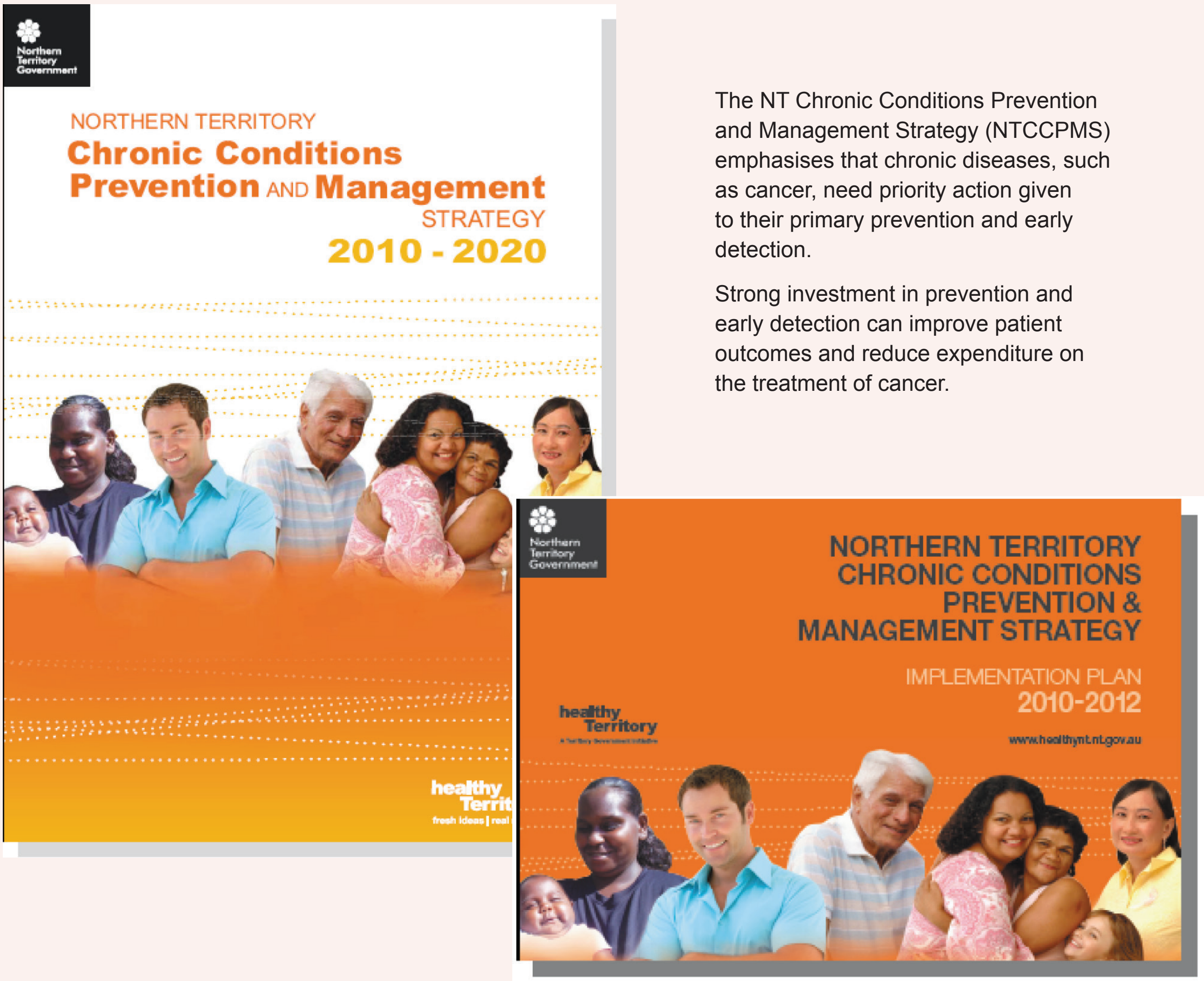
General Practitioners (GPs) have a recognised role in the prevention and early detection of cancer, including ordering preliminary drug tests, referral to specialists and designated roles in cancer screening programs (the precise roles vary according to the screening program type – cervical, bowel and breast). There is increasing acknowledgment that GPs should receive greater recognition for their roles in prevention, early detection, treatment after care, including support in the post treatment surveillance period, and the management of complications such as lymphoedema.

The Australian Government has introduced cancer care conferencing items into the Medical Benefits Schedule (Items 871 and 872) to encourage GP participation in treatment planning and delivery. This can involve coordination of work-up tests to assist with staging, participation in relevant parts of MDT meetings (especially to provide advice on a patient’s psychosocial context), pre-chemotherapy/biochemical checks and management of chemotherapy side effects.

In the NT, many patients with cancer have no GP involved in their care. This is particularly unsafe for vulnerable patients, such as those without funds or family or community support networks.

Initiative 18 – KAA 7.1

Expand the support for and involvement of GPs and primary care providers in cancer prevention strategies, diagnosis, treatment planning and follow up care.



The NT Chronic Conditions Prevention and Management Strategy (NTCCPMS) emphasises that chronic diseases, such as cancer, need priority action given to their primary prevention and early detection.

Strong investment in prevention and early detection can improve patient outcomes and reduce expenditure on the treatment of cancer.

Strengthen primary healthcare cancer prevention programs

Cancer prevention programs related to lifestyle need further development that is consistent with the NT Chronic Conditions Prevention and Management Strategy. Common smoking related cancers such as trachea, bronchus and lung cancer account for more deaths from cancer in NT men and women than any other cancer site. The incidence of breast and bowel cancers, which are common in the NT, are positively linked to obesity and poor diet. Addressing poor lifestyle factors by promoting and supporting healthy living is likely to lead to reductions in cancer incidence.

Initiative 19 – KAA 2.2

Actively support the implementation of the Nutrition and Physical Activity Action Plan 2007–2012 and the continued development of healthy lifestyle and behaviour programs.

Initiative 20 – KAA 2.2

Encourage the development of NT-wide evidence-based public health promotion programs that are responsive and adaptable to community needs, and incorporate systemic approaches to changing behaviour and providing opportunities for people to live healthy lives.

Initiative 21 – KAA 1.3, 2.1

Further develop culturally appropriate health promotion programs and information resources with a focus on reducing the levels of preventable cancers amongst Indigenous and CALD populations.

Initiative 22 – KAA 2.2

Strengthen the capacity of regional hospitals and remote health services (including Aboriginal Medical Services – AMS) to undertake active roles in cancer health promotion and prevention strategies at the local level.

Increase early detection activities

Many people fear cancer and associate its diagnosis with death, prompting a reluctance to participate in cancer screening programs. During consultations, health workers reported that men, in particular, were often reluctant to participate in screening programs. It is vital to change the perceptions and experiences of people with cancer. The most effective way to do this is through the promotion of early detection screening programs within general health and wellbeing promotion programs.

A major barrier for participation in screening programs in the NT is the rural and remote localities of people, making access to timely screening services problematic. Innovative ways to maximise access to screening programs need to be developed to overcome this problem.

Initiative 23 – KAA 3.1, 3.2

Strengthen the promotion of the early detection of cancer within the context of general health and wellbeing promotion programs to promote the message that many cancers are preventable and that cancer survival is greatly improved if the cancer is detected early.

Initiative 24 – KAA 3.1

Increase participation rates of Indigenous and CALD people in early detection programs.

Initiative 25 – KAA 3.2

Further develop the delivery of cancer screening programs to remote communities (both Indigenous and non-Indigenous).

3 Fostering Clinical Leadership

Fostering clinical leadership needs clinical champions to be identified and supported. These clinical champions liaise with stakeholders to identify resource requirements, lead operational and clinical governance, and oversee the implementation of clinical best practice based on the best available evidence.

The growing size of NT cancer service capability, combined with the complex network of service providers that contribute to service delivery, means there would be benefits from a more coordinated approach to management, planning, resource allocation and service development for ongoing cancer service development and delivery.

Clinicians, particularly those involved in service delivery from NT hospitals and interstate providers, also highlighted the need for careful consideration in future resource planning with specific attention paid to the coordination around managing patients across different treatment modalities and between the range of service providers involved in cancer care.

Background

The coordination of the evolving and complex network of cancer services in the NT has warranted the establishment of a high level cancer specific reference group: the Cancer Care Optimisation Group (CCOG).

The role of the CCOG is to:

- Provide high level advice and direction on a range of issues and activities impacting on cancer care in the Northern Territory
- Advise on likely impacts of proposed options for action
- Identify strategies to achieve consistent evidence based approaches to clinical standards, quality and monitoring across both the acute and primary sectors as they relate to cancer
- In consultation with the Department of Health, establish working parties to progress specific issues or guide the implementation of particular projects
- Guide the implementation of the *NT Cancer Plan*.

Achieving the initiatives within this *Plan* will be greatly facilitated by the establishment of a formal Cancer Service. This Service would have a multidisciplinary leadership with operational responsibilities for delivering cancer services in the Northern Territory, as well as linkages across the primary and prevention areas of the health sector.

The leader of the Cancer Service is expected to have a defined senior role in the delivery of cancer services in the NT, a comprehensive knowledge of current trends in cancer care, an understanding of health service delivery in the NT and be well respected by the medical, nursing and allied health professions.

Initiative 26

Establish a formal multidisciplinary clinical leadership within a structured NT Cancer Service that includes medical, nursing and allied health care providers.

4 Sustainable Workforce

Delivery of quality cancer services requires specialist expertise, including medical and specialist oncologists, surgeons working in cancer, haematologists, nurses and allied clinicians with experience covering the complex needs of patients with cancer. There must be a focus on workforce enhancement to expand and up skill the cancer professional workforce to ensure high quality patient outcomes.

During the consultation process, members of the NT cancer workforce emphasised the importance of ensuring that:

- Their skills and knowledge keep pace with the rapid changes that occur in cancer clinical practice, technology and guidelines
- There are opportunities for professional development; there are adequate arrangements in place to allow staff to take their leave entitlements
- Their academic and research roles are supported as key elements of workforce growth and sustainability.

A broader concern raised was the need to develop the specialist cancer workforce in line with increased underlying demand for cancer treatment services and new service developments.

Access to specialist cancer workforce expertise is problematic in most jurisdictions. These difficulties are compounded in the NT, as in other areas of specialist health care, because of the distances from the major Australian cancer diagnostic and treatment centres and the need to maintain a critical mass of staff with expertise.

Initiative 27

Develop sustainable clinical capability to address current and expected limitations in self sufficiency.

Initiative 28 – KAA 5.3

Further develop allied health services (including social work, counselling, psychosocial support, occupational therapy, physiotherapy, dietetics, pharmacy, pathology, radiology and Aboriginal Health Workers) to support the further development of cancer services.

Initiative 29 – KAA 6.1

Support the professional learning and development of practitioners to achieve the objectives of the NT Cancer Network.

5 Quality and Safety Improvement

Measuring, monitoring and improving cancer services is a challenge given the complexity of cancer care and the range of providers involved in service delivery. During the consultation process clinicians acknowledged that careful attention to safety and quality processes is needed to enhance patient outcomes.

As cancer services in the NT develop there will be a growing need to embed service development and evaluation as key components of the emerging quality culture. A culture of quality that incorporates monitoring, review, feedback and performance measurement will influence the decisions of individual service providers about how and what changes are made to cancer services and service delivery.

The range of organisations involved in cancer care planning and delivery presents a challenging environment. Capturing the voice of patients to measure where their needs and expectations are being met and/or not met will be essential to ensure improvement opportunities are identified.

Initiative 30

Develop integrated data capture systems to inform quality improvement strategies.

The CCOG will lead activities which underpin quality improvement in cancer service delivery including:

- Developing a Cancer Clinical Registry
- Increasing references about the screening, early identification, investigation, treatment and follow up care of cancer in primary health care manuals and contexts
- Advocating for peer reviews and regular re-assessments of the credentialing and scope of practice processes for medical, nursing and allied health professionals providing cancer care.

The CCOG will support activities which underpin quality improvement in cancer service delivery including:

- Using NT Cancer Registry reports on incidence and mortality to inform longer term health service planning
- Promoting a consistent standard of care
- Encouraging the use of patient surveys, key performance indicators, case and peer review processes and clinical audits
- Addressing patient feedback and identified clinical improvement opportunities.

Cancer Registry

Records cancer diagnosis and death. It is part of a national Cancer Registry system. Data collection is mandated through legislation. Data is derived from positive pathology results (diagnosis) and Births, Deaths and Marriages registrations (deaths). This information can be used to inform health policy development and identify trends for service planning.

Cancer Clinical Registry

Records cancer details including staging, risk factors, pathology, treatment activity, interventional effectiveness and outcomes. Data could be derived from a combination of existing and expanded or new sources. Once established, it is expected that data collection will be mandated through policy and practice. This information can be used to understand patterns of disease and outcomes of care to monitor and improve safety and quality of cancer care and control.

6 Role Redesign

Role clarity is fundamental to effective shared care. If each care provider is clear about what their role is in relation to each patient, then the 'wholeness' of care that the patient experiences can be improved.

The consultation process and literature scan reinforced the importance of care coordination to quality outcomes for patients with cancer.

Patients discussed the importance of having someone who could assist them to plan and coordinate their cancer journey and support them in accessing the services they required. At times, arrangements have not occurred as planned, however the aim of a plan is to improve the patient journey.

Allied health staff reported that they spent significant amounts of their time providing support for patients in their cancer journey, rather than in the direct provision of care. This support included explaining treatment options, providing encouragement and linking patients with the Non Government Organisations who could best assist them.

Initiative 31

Build cancer care coordination capacity within the health system and its providers to ensure patients experience smooth, integrated care from diagnosis through to survivorship or palliation.

Please see these important documents

Chronic Conditions Prevention and Management Strategy 2010 - 2020

- www.health.nt.gov.au/Chronic_Conditions/NT_CCPMS/

Chronic Conditions Prevention and Management Strategy – Implementation Plan 2010 - 2012

- www.health.nt.gov.au/library/scripts/objectifyMedia.aspx?file=pdf/50/64.pdf&siteID=1&str_title=NT%20Implementation%20Plan.pdf

NT Tobacco Action Plan 2010 - 2013

- www.health.nt.gov.au/library/scripts/objectifyMedia.aspx?file=pdf/48/20.pdf&siteID=1&str_title=Northern%20Territory%20Tobacco%20Action%20Plan.pdf

Nutrition and Physical Activity Program Action Plan 2007 - 2012

- www.health.nt.gov.au/Nutrition_and_Physical_Activity/index.aspx

Acronyms

ACCHO	Aboriginal Controlled Community Health Organisations
ASH	Alice Springs Hospital
CanNET	Cancer Service Networks National Demonstration Program
CALD	Culturally and Linguistically Diverse
CCOG	Cancer Care Optimisation Group
CCPMS	Chronic Conditions, Prevention and Management Strategy
DoH	Department of Health (Northern Territory)
IT	Information Technology
GP	General Practitioner
KAA	Key Action Area
MDT	Multidisciplinary Team
NT	Northern Territory
RDH	Royal Darwin Hospital