Tairawhiti DHB:
Review of adult tertiary cancer treatment services for Tairawhiti residents

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03 February 2011
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Acknowledgements

We acknowledge the support of TDH clinicians and staff in the preparation of this report, and particularly thank Dr John Childs (Clinical Advisor, MOH) for his expert guidance in the analysis of the options.
Executive Summary

This review explores the future provision of tertiary cancer treatment services for Tairawhiti residents with a focus on reducing clinical risk and improving the cancer patient journey.

Current provision of cancer services in Tairawhiti is characterised by a multitude of providers. This creates unnecessary risks associated with multiple handovers, potential for provision of incomplete assessment and treatment information, inconsistent treatment advice to patients, unnecessary travel, and inadequate use of multidisciplinary teams.

We developed a set of options for future provision of services to address the identified clinical risk issues. This was achieved through a participative process involving a Steering Group representative of key stakeholders. The options considered were:

- continuing with multiple providers, with tertiary oncology provided mainly be MidCentral (status quo);
- centralising services at Capital and Coast DHB;
- centralising services at Waikato DHB;
- centralising services at Auckland DHB.

The options were tested against a set of key considerations including:

- **Comprehensiveness**: what range of cancer services are available to patients? (i.e. to what extent does this proposed option site provide a comprehensive solution?)
- **Capacity risks**: what capacity / availability risks exist?
- **Convenience**: how convenient is it for patients and relatives to travel to the proposed option site?
- **Support services**: what support services are available for out of town patients?
- **Quality outcomes**: what would be the impact on patient outcomes / quality of service provision?
- **Clinical interface**: how well would services at this site interface clinically with those provided by Gisborne?
- **Costs**: what is the impact on costs to TDH?
Other strategic considerations – to recognise that this decision needs to be taken within an overall strategic context.

Auckland DHB indicated at an early stage that they did not have capacity to provide services to Tairawhiti, and were removed from further consideration. At the time of writing, Capital and Coast DHB also did not appear a strong contender. This may be partly due to the recent turnover in senior management roles making strategic decision making more difficult.

The realistic options for tertiary cancer services for Tairawhiti at this stage are the status quo (MidCentral augmented by other DHBs), or consolidation at Waikato DHB.

If there were no current service in place, Waikato DHB would be the obvious choice for tertiary cancer services for the following reasons:

- Waikato can provide a more comprehensive range of clinical services, hence simplifying the cancer journey for patients and reducing handover risks;
- the Government’s increasing emphasis on regional planning makes straddling two regions more difficult as time goes by;
- it would consolidate more clinical relationships at Tairawhiti around a single major tertiary provider;
- regional information systems development will in future allow easy access to clinical records with Waikato;
- Tairawhiti District Health’s ability to provide local acute services in future may well depend on access to a strong supportive tertiary provider to provide clinical back up – hence it is in TDHs long term interest to build capacity and relationships at Waikato.

However, there are two important reasons why moving from MidCentral would be difficult:

1. the existing clinical relationships are highly valued by some key clinical staff;
2. Ozanam house is highly valued by the TDH community, who have donated substantial sums of money to the building over the years.

Further, the local branch of the Cancer Society is affiliated with the central region and would find switching to the Midland region disruptive.

Nonetheless, from an overall strategic perspective, a stronger alliance with Waikato DHB and the Midland region makes sense, and should deliver a better patient journey at the same or lower cost, provided the services can be
assured to be as good as, or better than, the current arrangements. The key assurances required are set out in the recommendations below.

We recommend that the TDH Board:

a) **endorse** further discussions with Waikato DHB involving both senior management and TDH clinicians to explore in more detail the option of consolidating tertiary cancer services at Waikato;

b) **agree** that the following service parameters would need to be guaranteed to the satisfaction of management and clinicians prior to agreeing to switch services to Waikato:

i) reliable onsite visiting clinics at the same or higher frequency than current (medical and radiation oncology 18 or more clinics per year, haematology 6 or more clinics per year);

ii) improved access to consultants between clinics through telehealth solutions;

iii) the provision of comprehensive clinical support services (training, advice, policies, protocols and other resources) to maintain local nursing, medical and allied health skills and capability in chemotherapy, medical oncology and other cancer related services;

iv) support accommodation services at Hamilton which are conveniently located, available 7 days a week, whanau friendly and are welcoming to Tairawhiti patients; and

v) that Waikato clinical services & support accommodation services are culturally appropriate;

c) **agree** to consult with the Tairawhiti community prior to taking a final decision on this matter;

d) **agree**, that if the discussion with Waikato DHB do not result in a set of services being offered that are at least of equal quality to current arrangements, to discuss with MidCentral DHB the feasibility of the following:

i) arrangements to achieve joint MDT meetings between Waikato, TDH and MidCentral clinicians for single clinical view as to the best treatment plan for TDH patients;

ii) the ability to increase the frequency of clinics to reduce delays (including through telehealth);

iii) flexibility for travelling to centres for assessment in between clinics;
iv) the ability to provide mutual remote access to each patients’ clinical record; and

v) ensuring succession planning is in place for current long standing oncology staff.
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1 Introduction

This section provides contextual information on cancer rates in Tairawhiti and current cancers services for the region’s population. It also describes the purpose of the review and the approach taken.

1.1 Cancer registrations

The table below shows a summary of TDH cancer registrations for the period 2002 to 2006. It shows that breast and digestive tract cancers are the most common, followed by lung cancer. There are some 200 new registrations per year, but the actual number receiving treatment in any year is likely to be considerably higher – since some people will have treatment spanning a number of years.

Table 1 New cancer registrations 2002 - 2006

<table>
<thead>
<tr>
<th>Description</th>
<th>5 year total</th>
<th>Annual average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Digestive organs (inc bowel)</td>
<td>227</td>
<td>45</td>
</tr>
<tr>
<td>Breast</td>
<td>126</td>
<td>25</td>
</tr>
<tr>
<td>Respiratory and intrathoracic organs</td>
<td>120</td>
<td>24</td>
</tr>
<tr>
<td>Lymphoid, haematopoietic</td>
<td>112</td>
<td>22</td>
</tr>
<tr>
<td>Skin – melanomas</td>
<td>98</td>
<td>20</td>
</tr>
<tr>
<td>male genital organs</td>
<td>72</td>
<td>14</td>
</tr>
<tr>
<td>female genital organs</td>
<td>52</td>
<td>10</td>
</tr>
<tr>
<td>Uncertain or unknown</td>
<td>47</td>
<td>9</td>
</tr>
<tr>
<td>Urinary tract</td>
<td>42</td>
<td>8</td>
</tr>
<tr>
<td>Unspecified sites</td>
<td>33</td>
<td>7</td>
</tr>
<tr>
<td>Eye, brain and other central nervous system</td>
<td>24</td>
<td>5</td>
</tr>
<tr>
<td>Mouth and throat</td>
<td>19</td>
<td>4</td>
</tr>
<tr>
<td>Mesothelial and soft tissue</td>
<td>16</td>
<td>3</td>
</tr>
<tr>
<td>Bone</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>Grand Total</td>
<td>992</td>
<td>198</td>
</tr>
</tbody>
</table>

27% of all deaths in Tairawhiti for 2006 were caused by cancer. Of the 118 who died, lung cancer (23), colorectal (17) and breast cancer (10) were the main causes.
1.2 Current services to Tairawhiti patients

Local services
Local surgeons perform the majority of surgery for breast cancer, bowel cancer and skin cancer.

Chemotherapy patients are generally able to be managed at TDH within the day ward setting. Treatment is overseen by a local physician, and by nurses who receive chemotherapy training at Palmerston North.

Cancer nurse specialists at TDH provide overall coordination of services.

Palliative care is provided locally either through community services or as an inpatient.

Services from MidCentral
TDH has received tertiary oncology services from MidCentral DHB for at least 25 years, possibly since the inception of MidCentral as a regional tertiary cancer treatment centre. The services provided consist of visiting specialist services provided at Tairawhiti (medical oncology, radiation oncology and haematology) and provision of external beam radiation therapy and complex chemotherapy at Palmerston North Hospital. MidCentral oncologists also provide support by telephone and email to local nurses and physicians.

Hawke’s Bay DHB
Hawke’s Bay DHB provides sentinel node biopsies for breast cancer, and breast cancer screening services at Hastings Hospital.

Radical prostatectomy for prostate cancer is currently delivered at Hastings Hospital for Tairawhiti patients. HBDHB pharmacy produces the chemotherapy doses for Tairawhiti patients.

Waikato DHB
Waikato DHB clinicians provide a range of tertiary medical and surgical services for Tairawhiti residents, including: neurosurgery for those with brain cancers; thoracic surgery for lung cancer; head and neck cancer surgery; tertiary bowel and gastric cancer surgery; intensive care for the acutely unwell, and some multi-disciplinary team (MDT) services. Some private (e.g. breast MRI) services are also sourced from Waikato.
Auckland DHB
Auckland DHB provides paediatric oncology services and gynae-oncology surgical services to Tairawhiti patients.

ADHB is also the provider of quaternary services nationally. Some patients elect to receive private services in Auckland.

Capital and Coast DHB
Capital and Coast provides brachytherapy services to Tairawhiti patients in Wellington, and a private radiology provider in Wellington provides PET scans.

1.3 Why review tertiary cancer services?

Issues identified through previous work
The critical issues relating to tertiary cancer services for Tairawhiti were identified in the 2008 Cancer Patient Mapping Study by Dr Emma Davidson. These are:

- Waiting times for the following were all outside NZ and UK guidelines:
  - First referral to first specialist contact (FSC);
  - First referral to diagnosis; and
  - GP referral and FSC to first treatment.
- Poor evidence of staging of cancer early during investigation. This can lead to inappropriate treatment and/or inconsistent treatment regimes.
- Little evidence of a multidisciplinary approach. This is also identified as a general theme in the New Zealand Cancer Control Strategy (Ministry of Health 2003) and the New Zealand Cancer Control Strategy Action Plan 2005-2010 (Ministry of Health 2005).
- The extremely complex nature of cancer services provision with its multitude of services and health professionals led Emma Davidson to suggest that TDH should undertake a service review with the goal of rationalising the current number of tertiary referral centres and then should work on improving coordination, information provision and support. (Tairawhiti Cancer Service Mapping Project 2008, p.97).

In short, the multitude of providers creates unnecessary risks associated with multiple handovers, potential for provision of incomplete assessment and
treatment information, inconsistent treatment advice to patients, unnecessary travel, and inadequate use of multidisciplinary teams.

Our brief
The key objectives for this review were:

• to critically consider whether and how the current range of tertiary cancer services provided to Tairawhiti could be rationalised to ensure a more integrated pathway of care for cancer patients in Tairawhiti; and

• to recommend and provide options for the future long term provision of tertiary cancer treatment services.

The scope was limited to adult tertiary oncology services; i.e. excluding paediatric oncology and primary/community services.
2 Approach

2.1 Project process

LECG were commissioned to work closely with a Tairawhiti DHB steering group in conducting this review. The process used included:

- a request for information from the relevant DHB tertiary cancer service providers;
- interviews with key informants (patients/advocates, clinicians, senior management, cancer network representatives, GPs);
- review of available information on cancer services performance;
- development of high level generic patient journeys for Tairawhiti’s most frequent cancers (to understand the overall patients flows);
- a review at random of actual representative patient journeys (to understand how the generic pathways impact on individual patients);
- development of specific options to test;
- development of key considerations to test options against; and
- analysis of the options against the key considerations.

This study did not attempt to duplicate the 2008 cancer mapping project, but rather looked at options for centralising services, as recommended by that project.

Steering group

The steering group members included:

- Dr. Nassar Sheikh (CD Medical Services and ASMS Representative, TDH)
- John Childs (Tertiary Oncology Clinician & Clinical Advisor MOH)
- Te Pare Meihana (Medical Services Clinical Care Manager, TDH)
- Lynne Gray (Nursing Representative, TDH Oncology Nurse)
- Helene Carbonatto (GM Funding and Planning, TDH)
- Maaka Tible (GM Maori Health, TDH)
- Jacqui Thomas (Consumer Representative)
• Dr. Moira Cunningham (Primary Care Representative)
• Kiri Pardoe (Cancer Society Trustee)
• Naomi Whitewood (Portfolio Manager, TDH)
• Dr. Andrea Muller (General Surgeon, TDH)
• Dr. Jason Ward (Surgical Services Clinical Care Manager, TDH)
• Dr. Chris Duffy (Physician, TDH)

DHB request for information
A request for information document was sent to Auckland DHB, Waikato DHB, MidCentral DHB, and Capital and Coast DHB, asking for details of their current capacity and potential interest in future provision for the Tairawhiti population. All four supplied a response to the RFI.

Auckland DHB not considered further
Auckland DHB indicated that it did not have capacity to provide tertiary cancer services to Tairawhiti and was therefore not consider further as an option.
2.2 Options considered

We assessed the following three options.

Option 1: MidCentral / status quo

Under this option MidCentral would continue to provide radiation therapy, medical oncology and haematology services to Tairawhiti DHB. Waikato would continue to provide tertiary surgery for lung cancer, head and neck, some complex gastric, hepatic and rectal cancers, and brain cancers. Auckland DHB would provide gynae-oncology services, and Hawke’s Bay would continue to provide radical prostatectomy services. Capital and Coast would continue to provide brachytherapy services and some bone marrow transplants. PET scans would still be sourced from Wellington, endoscopic bronchial ultrasounds from Auckland and breast MRI imaging from Hamilton. Most bowel cancer, breast cancer and melanoma removal surgery, and chemotherapy delivery, would continue to be done at Gisborne Hospital.

Option 2: Centralise services at Capital and Coast DHB

Under this option CCDHB would provide the full range of tertiary adult cancer services, including radiation therapy, medical oncology, haematology, surgery, and imaging and staging services. Most bowel cancer, breast cancer and melanoma removal surgery, and chemotherapy delivery would continue to be delivered at Gisborne Hospital.

Option 3: Centralise services at Waikato DHB

Under this option Waikato DHB would provide nearly the full range of tertiary adult cancer services, including radiation therapy, medical oncology, haematology, surgery, and imaging and staging services. Most bowel cancer, breast cancer and melanoma removal surgery, and chemotherapy delivery would continue to be done at Gisborne hospital. Some services not available at Waikato would be obtained from Wellington or Auckland, including, in the short term, gynaeoncology and endoscopic bronchial ultrasounds.

Option of multiple pathways discounted

An option suggested by some key informants was splitting tertiary service provision according to cancer type. This would involve sending, for instance, breast cancer patients to Palmerston North, brain cancer patients to Waikato for surgery and oncology services, gynae-oncology patients to Capital and Coast for surgery and oncology services, etc. The Steering Group considered that this would result in further fragmentation of treatment and would not be a safe option. It was therefore discounted from further analysis.
2.3 Key considerations

The steering group approved the following as the key considerations against which the future options should be analysed.

- **Comprehensiveness**: what range of cancer services are available to patients? (i.e. to what extent does this proposed option site provide a comprehensive solution?)
- **Capacity risks**: what capacity / availability risks exist?
- **Convenience**: how convenient is it for patients and relatives to travel to this proposed option site?
- **Support services**: what support services are available for out of town patients?
- **Quality outcomes**: what would be the impact on patient outcomes / quality of service provision?
- **Clinical interface**: how well would services at this proposed option site interface clinically with those provided by Gisborne?
- **Costs**: what is the impact on costs to TDH?
- **Other strategic considerations** – to recognise that this decision needs to be taken within an overall strategic context.
3 Assessing the options against the key considerations

This section reviews each of the three options against the key considerations developed by the steering group.

We adopted a ten point rating scale to allow a numerical comparison of the options. However, we emphasise first, that we have not weighted these criteria, and second, in some cases the overall score for a ‘key consideration’ masks important variation in assessed performance against the subcomponent within that criteria. We do not recommend adding the scores as a useful approach to reaching a decision on this matter. However the individual scores give a sense of where the options appeared stronger or weaker to the group.
3.1 Extent to which each centre provides a comprehensive range of adult tertiary cancer services

The more services patients can receive in one place, the less fragmented their journey will be. A more comprehensive service can also avoid some trips by combining some investigations and treatments in a single visit.

<table>
<thead>
<tr>
<th>Service</th>
<th>Option 1: MidCentral</th>
<th>Option 2: Capital &amp; Coast</th>
<th>Option 3: Waikato</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Radiation therapy</strong></td>
<td>Provides a comprehensive range of external beam therapies. Does not provide brachytherapy. (Impacts on a small number of gynaecology and prostate patients.)</td>
<td>Provides a comprehensive range of external beam therapies. Provides high dose brachytherapy.</td>
<td>Provides a comprehensive range of external beam therapies. Provides high dose brachytherapy.</td>
</tr>
<tr>
<td><strong>Medical oncology</strong></td>
<td>Provides a comprehensive range of medical oncology services.</td>
<td>Provides a comprehensive range of medical oncology services.</td>
<td>Provides a comprehensive range of medical oncology services.</td>
</tr>
<tr>
<td><strong>Haematology</strong></td>
<td>Provides a comprehensive range of haematology services (except some Bone marrow transplants)</td>
<td>Provides a comprehensive range of haematology services including bone marrow transplants</td>
<td>Provides a comprehensive range of haematology services (except some Bone marrow transplants)</td>
</tr>
<tr>
<td><strong>Tertiary surgery</strong></td>
<td>Does not provide tertiary surgery.</td>
<td>Provides a comprehensive range of tertiary surgery (when fully staffed – gynaecology oncology for instance, now obtained from Auckland because of vacancies at CCDHB)</td>
<td>Provides a comprehensive range of tertiary surgery except urology and gynaecology, which are in development.</td>
</tr>
<tr>
<td><strong>Diagnostic &amp;staging investigations</strong></td>
<td>Does not provide PET scanning or endoscopic bronchial ultrasound (EBUS).</td>
<td>PET scans available through local private provider. EBUS not currently available.</td>
<td>PET scanning and EBUS not currently available. Intended developments in 2011/12.</td>
</tr>
<tr>
<td><strong>Comment</strong></td>
<td>MidCentral cannot provide a broader range of surgical or diagnostic services. A significant proportion of those with cancer will continue to travel to more than one centre. No simplification of the patient journey.</td>
<td>Capital and Coast can provide a comprehensive range of tertiary cancer services including radiation therapy, medical oncology, surgery and diagnostics. Would simplify the patient journey considerably for many patients.</td>
<td>Waikato can provide a fairly comprehensive range of tertiary cancer services including radiation therapy, medical oncology, radiation therapy, most surgery and some diagnostics. Would simplify the patient journey considerably for many patients.</td>
</tr>
</tbody>
</table>

**Rating**

1 = poor, 10 = excellent

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>rating</td>
<td>6</td>
<td>9</td>
<td>8</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### 3.2 Clinical service capacity risks at each site

TDH requires this information in order to assess the sustainability of the services in each area, and hence the risk that TDH patients will not receive timely treatment in future. While the future risks cannot be known with certainty, we can assess the risks based on current and past performance and organisational context.

<table>
<thead>
<tr>
<th>Service</th>
<th>Option 1: MidCentral</th>
<th>Option 2: Capital &amp; Coast</th>
<th>Option 3: Waikato</th>
</tr>
</thead>
<tbody>
<tr>
<td>Radiation therapy</td>
<td>No significant capacity risks – current provider</td>
<td>No significant capacity risks – have excess capacity</td>
<td>No significant capacity risks – have excess capacity</td>
</tr>
<tr>
<td>Medical oncology</td>
<td>Moderate capacity risks in medical staffing – recruiting to fill vacancies</td>
<td>Moderate to high capacity risks in medical staffing – recruiting to fill vacancies, and would need extra resource on top</td>
<td>Low risks in medical staffing - well staffed now, but would need extra resource.</td>
</tr>
<tr>
<td>Haematology</td>
<td>No significant capacity risks – able to increase clinic numbers with current capacity.</td>
<td>RFI flags moderate capacity risk – require additional medical staff to provide outreach services.</td>
<td>RFI flags minor risk – would need additional FTE to provide outreach services.</td>
</tr>
<tr>
<td>Tertiary surgery</td>
<td>Not applicable – not a tertiary surgery provider.</td>
<td>RFI flags moderate capacity risk – but little detail provided.</td>
<td>Low risk - current tertiary volumes included in current staffing.</td>
</tr>
<tr>
<td>Comment</td>
<td>The service already has TDH volumes built into its oncology capacity – hence limited risk – though note that they have a long standing shortage of medical oncologists and difficulty recruiting. Surgery risk not applicable.</td>
<td>Medical oncology staffing shortages probably precludes switching to CCDHB in the next few years (given the lead time to recruit SMOs). Insufficient detail to establish surgical risk.</td>
<td>Overall staffing has greater critical mass than MidCentral or CCDHB. Have excess rad onc capacity. Current surgical provider.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rating 1 – 10</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 = poor, 10 = excellent</td>
</tr>
<tr>
<td>6</td>
</tr>
</tbody>
</table>
### 3.3 Clinical interface

The ability to establish effective clinical working relationships is vital for Tairawhiti. Local physicians and nurses need to have confidence in the tertiary provider, and vice versa, to allow them to work to their full scope.

<table>
<thead>
<tr>
<th>Aspect</th>
<th>Option 1: MidCentral</th>
<th>Option 2: Capital &amp; Coast</th>
<th>Option 3: Waikato</th>
</tr>
</thead>
<tbody>
<tr>
<td>Willingness to support local clinical delivery</td>
<td>Have demonstrated willingness to support local delivery over many years. Indicated superior responsiveness and willingness to customise services to meet TDH needs.</td>
<td>No track record in supporting delivery of oncology services at a distance.</td>
<td>Have demonstrated willingness to support local delivery satellite settings (e.g. Thames, BOP). Able to support local delivery of surgical services.</td>
</tr>
<tr>
<td>Ability to access the clinical record at each site electronically</td>
<td>Laboratory Information system integrated. Other clinical record information and PACs not integrated.</td>
<td>Clinical information not able to be accessed across sites.</td>
<td>Clinical information not able to be accessed across sites easily at this stage – but regional project underway to enable this.</td>
</tr>
<tr>
<td>Linkages with other clinical services</td>
<td>Have linkages with pathology services at MidCentral through TLab/Medlab. Linked via the Central Cancer network, and Cancer society.</td>
<td>Have linkages with mental health services. Linked via the Central Cancer network</td>
<td>Have linkages with ICU, tertiary surgery, and some tertiary medical services. Linked for regional planning purposes.</td>
</tr>
<tr>
<td>Comment</td>
<td>Linkages other than cancer services are minor. But track record in supporting local delivery is important.</td>
<td>Linkages are minor. Responsiveness is unknown. Track record unknown.</td>
<td>The other regional linkages with Waikato are important. Waikato does support local delivery of chemotherapy at Thames, and other services at TDH.</td>
</tr>
<tr>
<td>Rating</td>
<td>8</td>
<td>5</td>
<td>7</td>
</tr>
</tbody>
</table>

*1 = poor, 10 = excellent*
3.4 Quality of service

We looked for differences in patient satisfaction, survival rates, and waiting times. A major difference in any of these would aid in discriminating between the options. No major differences were found.

<table>
<thead>
<tr>
<th>Service</th>
<th>Option 1: MidCentral</th>
<th>Option 2: Capital &amp; Coast</th>
<th>Option 3: Waikato</th>
</tr>
</thead>
<tbody>
<tr>
<td>5 year survival</td>
<td>Data on five year survival was reviewed, but clinical advice is that the fluctuations cannot be attributed to the difference in practice at the centres and therefore this data is not presented.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Voices of experience</td>
<td>98% overall positive rating. <strong>Better than average ratings for:</strong> - radiation waiting times - RCTS environment - care coordination - treating people with dignity and respect - privacy during care - providers doing everything they could to treat the cancer <strong>Below average ratings for:</strong> - providing enough information to patients - explaining treatment delays - parking - putting patients in touch with other support providers / counselling services - talking about complementary therapies</td>
<td>99% overall positive rating. <strong>Better than average ratings for:</strong> - radiation waiting times - care coordination - Cancer centre environment - privacy during care - providers doing everything they could to treat the cancer - treating people with dignity and respect <strong>Below average ratings for:</strong> - providing enough information to patients - explaining treatment delays - chemo therapy waiting times - putting patients in touch with other support providers / counselling services - talking about complementary therapies - taking living situations into account</td>
<td>96% overall positive rating. <strong>Better than average ratings for:</strong> - radiation waiting times - care coordination - Cancer centre environment - privacy during care - providers doing everything they could to treat the cancer - treating people with dignity and respect - trustworthy staff <strong>Below average ratings for:</strong> - providing enough information to patients - explaining treatment delays - putting patients in touch with other support providers / counselling services - talking about complementary therapies</td>
</tr>
<tr>
<td>Waiting times</td>
<td>Radiation: All patients treated within 6 week target in the last year. 75-80% treated within 4 weeks. Noted that the interval between clinics at TDH contributes to a delay in overall treatment times for haematology.</td>
<td>Radiation: Less than 6 six weeks</td>
<td>Radiation: Priority one - 24 hours Priority two - 8.7 working days Priority three - 23.1 working days (Best waiting times statistics at present)</td>
</tr>
<tr>
<td>Comment</td>
<td>The available information does not provide any information suggestive of differences in quality of clinical care between the centres.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rating</td>
<td>8</td>
<td>8</td>
<td>8</td>
</tr>
</tbody>
</table>

**Rating**

1 = poor, 10 = excellent
3.5 How convenient is it for patients and relatives to travel to this centre?

Cancer is a long term condition with many factors impacting on treatment success – difficulty getting to treatment being one of those factors. Hence ease of travel is an important consideration. Unfortunately, Gisborne’s geographic isolation means that no option is ideal from a travel perspective.

<table>
<thead>
<tr>
<th>Service</th>
<th>Option 1: MidCentral</th>
<th>Option 2: Capital &amp; Coast</th>
<th>Option 3: Waikato</th>
</tr>
</thead>
<tbody>
<tr>
<td>Distance</td>
<td>393 kms</td>
<td>538 kms</td>
<td>394 kms</td>
</tr>
<tr>
<td>Travel time by car</td>
<td>5 hrs:35 mins</td>
<td>7 hrs: 40 mins</td>
<td>5 hrs: 40 mins</td>
</tr>
<tr>
<td>Air links</td>
<td>Via Wellington or Auckland (AirNZ) Frequency: 6x day well spread. Flight duration 2&amp;1/2 to 5 hours. Reliability of flights: good</td>
<td>Direct Frequency: 5 direct flights a day Flight duration 1&amp;1/2 hours Reliability of flights: good</td>
<td>2x direct flights day (am and pm) (small plane – described as bumpy and uncomfortable) 3x AirNZ flights via Auckland. Flight duration 2hrs to 4.40 hrs Reliability: 4% direct flights cancelled AirNZ direct flight being canvassed.</td>
</tr>
<tr>
<td>Comment</td>
<td>Both Hamilton and PN are a long drive with similar duration. Flight links to PN are good but are indirect, making travel time long. Hospital close to airport and easy to navigate.</td>
<td>Very long driving time to Wellington, making it difficult for Whanau to travel with patient, or to visit. Flight links are much better. Hospital close to airport but hard to navigate by car. Some trips may be avoided through more comprehensive service.</td>
<td>Both Hamilton and PN are a long drive with similar duration. Flight links to Hamilton are better than to PN and will improve if AirNZ commence direct flights. Hospital is some distance from the airport, and can be challenging to navigate by car. Some trips may be avoided through more comprehensive service.</td>
</tr>
<tr>
<td>Rating 1–10</td>
<td>5</td>
<td>3</td>
<td>6</td>
</tr>
</tbody>
</table>

1 = poor, 10 = excellent
3.6 What support services are available for out of town patients?

Tairawhiti patients may spend weeks at the tertiary cancer centre. Stakeholders indicated that the support services available for Tairawhiti residents make a large difference in their experience of the cancer journey.

The Voices of Experience report noted that many patients’ expectations were not met in aspects of care relating to provision of emotional support and provision of information on daily living. Stakeholders identified that improvements in supportive and psychosocial aspects of care were essential to improve the cancer patient experience regardless of the tertiary provider chosen.

<table>
<thead>
<tr>
<th>Service</th>
<th>Option 1: MidCentral</th>
<th>Option 2: Capital &amp; Coast</th>
<th>Option 3: Waikato</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accommodation</td>
<td>Ozanam house available 24/7, Whanau friendly, well situated and well accepted by Maori. Partly funded through Gisborne fund raising.</td>
<td>Margaret Stewart House available and on hospital campus. Open 24/7. Whanau unit also available.</td>
<td>Cancer Society’s newly rebuilt Lion Lodge is available and well situated. Closed during the weekends. Not considered a family friendly accommodation to date, but includes some family units. Not considered friendly to Maori. A new lodge is currently being built that will increase capacity. Hoping 5 family units will become available during the weekend. Waikato is willing to consider how to make support accommodation more family friendly, and is supporting a bid to local Council to open 7 days. local motel option considered family friendly by stakeholders.</td>
</tr>
<tr>
<td>Comment</td>
<td>Community has strong emotional ties to Ozanam House, clearly a superior service. A major barrier to shifting services.</td>
<td>Considered to be a good service. Capacity may be an issue as Margaret Stewart House was described as often full.</td>
<td>Not well regarded by stakeholders. Would need to change services to meet Gisborne patients concerns.</td>
</tr>
<tr>
<td>Rating 1 – 10</td>
<td>9</td>
<td>6</td>
<td>5</td>
</tr>
</tbody>
</table>

1 = poor, 10 = excellent
3.7 Cost to TDH

This review is driven by concerns about patient experience and outcomes, not cost. But financial considerations are always relevant given the opportunity cost involved – if more is spent in one area it reduces services in another.

<table>
<thead>
<tr>
<th>Service</th>
<th>Option 1: MidCentral</th>
<th>Option 2: Capital &amp; Coast</th>
<th>Option 3: Waikato</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Other cost implications</strong></td>
<td>None – current cost structure continues.</td>
<td>Unknown – probably lower cost through consolidation of trips</td>
<td>Unknown – probably lower cost through consolidation of trips</td>
</tr>
<tr>
<td><strong>Comment</strong></td>
<td>Current cost structure would continue.</td>
<td>Transport cost would increase marginally if more patients decided to fly - say $60,000 per annum if 300 trips cost and extra $200 each.</td>
<td>Current cost structure – or possibly less if more staging and treatment can be done in one trip.</td>
</tr>
<tr>
<td><strong>Rating 1 – 10</strong></td>
<td>5</td>
<td>4</td>
<td>6</td>
</tr>
</tbody>
</table>

\(^1\) Based on national travel assistance policy (28 cents per km)
3.8 Other strategic considerations

Other strategic considerations noted by the steering group are set out below.

- TDH has a growing relationship with Hawke’s Bay – which implies a continued link to the Central Region – but the group noted that HBDHB will not in the foreseeable future be able to supply tertiary services to TDH.

- The impact on MidCentral: TDH equates to some 10% of the MidCentral’s volumes – an important component, but not likely to be one whose loss they could not accommodate. MidCentral is planning to buy another LINAC – a purchase which could be delayed some years if TDH volumes were no longer coming to Palmerston North. Within five years, given the expected increase in cancer volumes regionally, MidCentral oncology and radiation therapy volumes could be expected to have grown by more than the current TDH volumes.

- Taranaki DHB intentions – Taranaki indicated that travel to PN for their population is easier than to Hamilton and they provide much more surgery and diagnostics locally at Taranaki – hence their cancer journeys are less complicated, and they are unlikely to switch from MidCentral.

- Regional clinical services plan – the growing importance of regional planning means that Tairawhiti may find it more difficult over time to ‘sit on the fence’ between two regions.

- Regional information systems – the National Health IT board has endorsed regional solutions to information sharing and hence Tairawhiti will increasingly have good information links with the Midland region rather than the Central region.

3.9 Summary

Each of the alternate sites has both advantages and disadvantages in terms of travel, capacity, integration of clinical relationships, historical ties and availability of support services, making a choice between them a complex multi-criteria decision. A summary of scores are shown below, but have not been added to a total; as stated previously, the steering group did not consider a simple unweighted addition of scores as useful input to the decision process. The individual scores should be seen more as in indication of relative areas of strength and weakness of the options.
Table 2: Summary scoring against key considerations

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Option 1: MidCentral</th>
<th>Option 2: Capital and Coast</th>
<th>Option 3: Waikato</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comprehensiveness</td>
<td>6</td>
<td>9</td>
<td>8</td>
</tr>
<tr>
<td>Capacity risks</td>
<td>7</td>
<td>6</td>
<td>8</td>
</tr>
<tr>
<td>Clinical interface</td>
<td>8</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td>Quality</td>
<td>8</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>Convenience</td>
<td>5</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>Support services</td>
<td>9</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>Cost</td>
<td>5</td>
<td>4</td>
<td>6</td>
</tr>
</tbody>
</table>

The MidCentral and Waikato options have different strengths and weaknesses.

MidCentral has the advantage of being the incumbent provider, having established effective clinical relationships, a strong track record and excellent support services. However, MidCentral will never be a one-stop-shop for Tairawhiti patients.

The Waikato option would provide a more comprehensive service for Tairawhiti patients, and would integrate better with other clinical services. It may also be more sustainable in the long run, and would provide a better strategic fit. However, the accommodation support service provided by the Cancer Society is less well regarded than Ozenam House, and Waikato would need to show how it would address this, and how it would develop a strong clinical interface with Gisborne based clinicians involved in cancer treatment.

At the time of writing, Capital and Coast DHB did not appear a strong contender. The range of services they provide is only slightly more comprehensive than Waikato, travel times are longer, and the clinical interface is not as well established. It is likely that recent turnover in senior management roles at CCDHB meant that this option may not have been as well presented by CCDHB as it might have been under more stable leadership with a clearer longer term strategic vision.
4 Conclusions

4.1 Reflections

The realistic options for the provision of tertiary cancer services for Tairawhiti at this stage are the status quo (MidCentral augmented by other DHBs), or consolidation at Waikato DHB. Auckland and Capital & Coast DHBs are not currently viable options.

If the decision could be taken from a greenfields perspective, i.e. if there was not already a set of service arrangements in place, it would make sense to choose Waikato DHB, for the following reasons:

- Waikato can provide a more comprehensive range of clinical services, hence simplifying the cancer journey for patients and reducing handover risks;
- it would consolidate more of Tairawhiti’s key clinical relationships around a single major tertiary provider;
- regional information systems development will in future allow easy sharing of clinical records with Waikato;
- Tairawhiti District Health’s ability to provide local acute services in future may well depend on access to a strong supportive tertiary provider to provide clinical back up in times of constrained workforce supply. Hence it is in TDHs long term interest to build capacity at and relationships with Waikato;
- the Government’s increasing emphasis on regional planning has the potential to make straddling two regions more difficult as time goes by – Tairawhiti will be better served by choosing a predominant regional planning affiliation and building on it.

However, there are two very strong reasons why moving from MidCentral would be difficult:

1. The existing clinical relationships are highly valued by some key clinical staff; and
2. Ozanam house is highly valued by the TDH community, who have donated substantial sums of money to the building over the years.

Further, the local branch of the Cancer Society is affiliated with the central region and would find switching to the Midland region difficult.
Nonetheless, from both an overall strategic perspective, and a patient journey perspective, a stronger alliance with Waikato DHB and the Midland region makes sense, provided the services to be put in place can be guaranteed to be of equal quality, or better than, the current arrangements.

4.2 Recommendations

As indicated by our analysis and reflections, a decision such as this requires a careful weighing of the pros and cons of the options. We put forward the following recommendations, endorsed by the Steering Group, for consideration by the TDH Board:

a) **endorse** further discussions with Waikato DHB involving both senior management and TDH clinicians to explore in more detail the option of consolidating tertiary cancer services at Waikato;

b) **agree** that the following service parameters would need to be guaranteed to the satisfaction of management and clinicians prior to agreeing to switch services to Waikato:

   i) reliable onsite visiting clinics at the same or higher frequency than current (medical and radiation oncology 18 or more clinics per year, haematology 6 or more clinics per year);

   ii) improved access to consultants between clinics through telehealth solutions;

   iii) the provision of comprehensive clinical support services (training, advice, policies, protocols and other resources) to maintain local nursing, medical and allied health skills and capability in chemotherapy, medical oncology and other cancer related services;

   iv) support accommodation services at Hamilton which are conveniently located, available 7 days a week, whanau friendly and are welcoming to Tairawhiti patients

   v) that emotional support and provision of information on daily living is improved; and

   vi) that Waikato clinical services & support accommodation services are culturally appropriate;

c) **agree** to consult with the Tairawhiti community prior to taking a final decision on this matter;

d) **agree** that if the discussion with Waikato DHB does not result in a set of services being offered that are at least of equal quality to current
arrangements, to discuss with MidCentral DHB the feasibility of the following:

i) arrangements to achieve joint MDT meetings between Waikato, TDH and MidCentral clinicians for single clinical view as to the best treatment plan for TDH patients;

ii) the ability to increase the frequency of clinics to reduce delays (including through telehealth);

iii) flexibility for travelling to centres for assessment in between clinics;

iv) the ability to provide mutual remote access to each patients’ clinical record; and

v) ensuring succession planning is in place for current long standing oncology staff.