



# A CANCER CONTROL PLAN FOR TAIRAWHITI 2007

*Mahia nga mahi i roto i te kotahitanga  
Kia piki ake te oranga o te Tairawhiti*

*Working together to elevate the wellbeing of Tairawhiti*

Acknowledgements

*E nga iwi, e nga reo, e nga karangatanga maha o te Tairawhiti tenei te mihi atu kia  
koutou katoa.*

*Tena koutou, tena koutou, tena koutou katoa.*

The Tairawhiti Cancer Control Plan has been developed over the past year and thanks are due to the many people who have contributed their time, expertise and advice to put this together.

The experiences shared by cancer patients and their families add extra value to this document and are greatly appreciated. The TDH Cancer Advisory Group must be acknowledged for their continued passion and support to see that this plan is not only completed but will be put into action.

Thanks also to the health professionals, clinicians, nurses, community support workers, managers and staff from the health and community support services in Tairawhiti that contributed to the Cancer Control Plan for Tairawhiti.

This plan will guide the way forward for cancer control in this region and will assist those who work in this area to remain focussed and work collectively to achieve the goals that have been set to reduce the number of people who get cancer and reduce the number of people who die from cancer in Tairawhiti.

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## **Executive Summary**

Cancer is a leading cause of death in New Zealand and its impact on Tairāwhiti continues to grow. Cancer services have developed in a piecemeal way in New Zealand leading to service gaps and the fragmentation of cancer services.

The New Zealand Cancer Control Strategy (MOH, 2003) is the first attempt at taking a comprehensive view of cancer control in New Zealand in order to clearly identify the issues and to develop solutions for them. The overarching goals of the strategy are to:

- Reduce the incidence and impact of cancer.
- Reduce inequalities with respect to cancer.

Tairāwhiti District Health Board (TDH) has used the national framework to create a local picture of cancer control in Tairāwhiti. This became the platform from which we could engage with the key stakeholders to identify areas for improvement and develop ideas for service improvement.

### **Consultation**

The issues identified in this document are a result of consultation with cancer patients and their whānau/family, general practitioners, nurses, clinical specialists, management, allied health professionals and support workers. Cancer patients provided an important perspective that gave an insight into the impact on health services on their lives.

Health professionals described the challenges of working in the cancer field that faces a shortage of specialists, has limited resources and competing health priorities. Despite the shortcomings, the cancer patients interviewed were often full of praise for cancer staff from primary to tertiary levels, from clinicians to community support workers.

However, as the cancer burden continues to grow it will become difficult to sustain quality service provision. Actions have been recommended in this plan that aim to address identified issues. Resource constraints dictate that we must prioritise what we can best achieve from these recommendations and what will make a difference.

### **Issues and Solutions**

It is known that one third of cancers can be prevented; one-third can be successfully treated through early detection and effective treatment and one-third can be managed well through effective support and palliative services.

As outlined in the TDH District Annual Plan 2007/2008, improving access to primary care services continues to be a priority for TDH and this supports the recommendations of the Cancer Control Plan for primary prevention. Improving workforce capability and increasing community-based interventions are key recommendations in this plan. The rates for breast screening must increase to address the high prevalence of this cancer type for women of Tairāwhiti. Specific actions have been recommended to enable this to happen.

Population Health strategies to improve nutrition and physical activity; reduce the uptake of smoking in the region and increase quit rates will impact on breast,

prostate, colorectal and lung cancers, some of the most prevalent cancer types for this region.

Ensuring that people have access to effective diagnostic and cancer treatment services is also a priority and specific projects have been recommended to look more closely at this area to ensure that any interventions are the right interventions.

Improving the integration and coordination of health and support services will improve the journey of the cancer patient providing better health outcomes and quality of life. Recommendations have been made to improve cultural competencies, review clinical staffing configuration and levels and improve access to information.

Information is critical for monitoring efficiencies; and measuring effectiveness is also a priority. A Cancer Information Plan will show us what information is currently being collected, the quality of the information and who is collecting it. This will enable an evidence-based approach to measuring progress and improving service provision. Ethnicity data is important to measure successes and failures of the health system for Maori.

Maori continue to bear the heaviest burden for cancer in this region and nationally. Each of the recommendations must make a difference for Maori cancer patients and this can be achieved by ensuring that each recommended action that is taken is assessed for reducing inequalities. Maori reference groups and consumers have been recommended to input into the development and implementation of actions. Increasing the Maori workforce for cancer control is required.

It is acknowledged that all of the issues and recommendations are of importance and some can be achieved within existing resources and should be followed up. Some of the recommended priorities will require new funding and TDH will be submitting proposals to the Ministry of Health/Cancer Control Council for this purpose.

Tairāwhiti District Health will continue to work with the Cancer Control Advisory Group to progress the actions from this plan and recommendations will be reviewed and updated annually.

## INTRODUCTION

Cancer is the leading cause of premature death amongst New Zealanders (29% of deaths from all causes). In 2002 and 2003 cancer was the leading cause of death for both males and females. National data shows that the Maori male rate of death from cancer was 58% higher than non-Maori male rate of cancer death in 2002 and 63% higher than the non-Maori male rate of cancer death in 2003. The rate of female cancer deaths for Maori women in 2002 was 78% higher than non-Maori women and 79% higher in 2003<sup>1</sup>.

One in three New Zealanders will at some point in their lives be affected by cancer, either personally or through a relative or friend. The burden of cancer is expected to increase significantly, with Maori and people with low socio-economic status more likely to be affected by cancer now and in the future.

At least one third of cancers are preventable, and another third of cancers can be effectively treated if detected at an early enough stage. Lifestyle changes such as improving nutrition and increasing physical activity may reduce the impact of cancer such as colon, breast cancer and prostate cancer (three of the most common cancers in New Zealand). Eliminating smoking would be the single most effective intervention for reducing all cancers.

Reducing the rate and effects of cancer is identified in the Tairāwhiti District Health (TDH) Strategic Plan as one of the top Health Gain Priorities for the region. Female breast cancer, prostate, lung and large bowel were the most common types of cancers registered in Tairāwhiti during 2002 and 2003. The leading causes of cancer deaths between 2002 and 2003 in Tairāwhiti were lung, colorectal, breast and prostate cancers<sup>2</sup>.

Rural isolation, high levels of socio-economic deprivation and a large Maori population places the people of Te Tairāwhiti at greater risk of developing cancer and dying from cancer. Issues of inequality must be addressed as part of the Cancer Control Plan. Fragmented service provision and delivery has led to "inequitable access to services for people who are socially disadvantaged or isolated" (Ministry of Health 2003).

The NZ Cancer Control Strategy (NZCCS) was released in 2003 by the Ministry of Health (MOH) in response to the increasing death rate and prevalence of cancer in New Zealand. The TDH Cancer Control Plan has been developed using the national NZCCS framework.

### ***How To Use This Plan***

This plan is written in four sections: Background; Context Impact; Action.

Section 1 describes the cancer control continuum and the six goals of the NZCCS.

Section 2 sets the context of the plan by linking it to the Treaty of Waitangi and health strategies. Input from cancer patients is introduced in this section and continues throughout the plan to add a personal perspective to the evidence and information

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<sup>1</sup> Sourced from [www.nzhis.govt.nz/mortality.html](http://www.nzhis.govt.nz/mortality.html)

<sup>2</sup> For more details refer section 3, p11, The Impact of Cancer in Tairāwhiti, for more details.

collected used in this plan. This is followed by a demographic and geographical profile of Tairāwhiti to highlight the risk factors for this region and the access barriers to cancer services.

Section 3 provides statistical evidence to identify priority areas in an effort to create an accurate and up to date profile of the impact of cancer in this region. Specific reference is made to the impact of cancer on Māori who are at greater risk at getting cancer and dying from cancer.

Section 4 consists of the *Action Plan* using the six NZCCS goals as a framework. Under each goal heading is a description of current services and related activities for Tairāwhiti. Each goal concludes with a summary of key issues, recommendations and actions.

Following Section 4 is a summary of all recommendations, an appendix and references.

## SECTION 1 - BACKGROUND

### *The New Zealand Cancer Control Strategy*

The New Zealand Cancer Control Strategy was launched by the Ministry of Health in 2003 in response to the increasing rates of incidence and death from cancer. *Reducing the incidence and impact of cancer* is one of the Government's 13 population health objectives identified in the New Zealand Health Strategy (MOH, 2000). This was followed by the release of the *NZCCS Action Plan 2005-2010* to turn the strategy into a reality.

The NZCCS provides a framework to plan and coordinate services across the cancer control continuum. The overall aim of NZCCS is to:

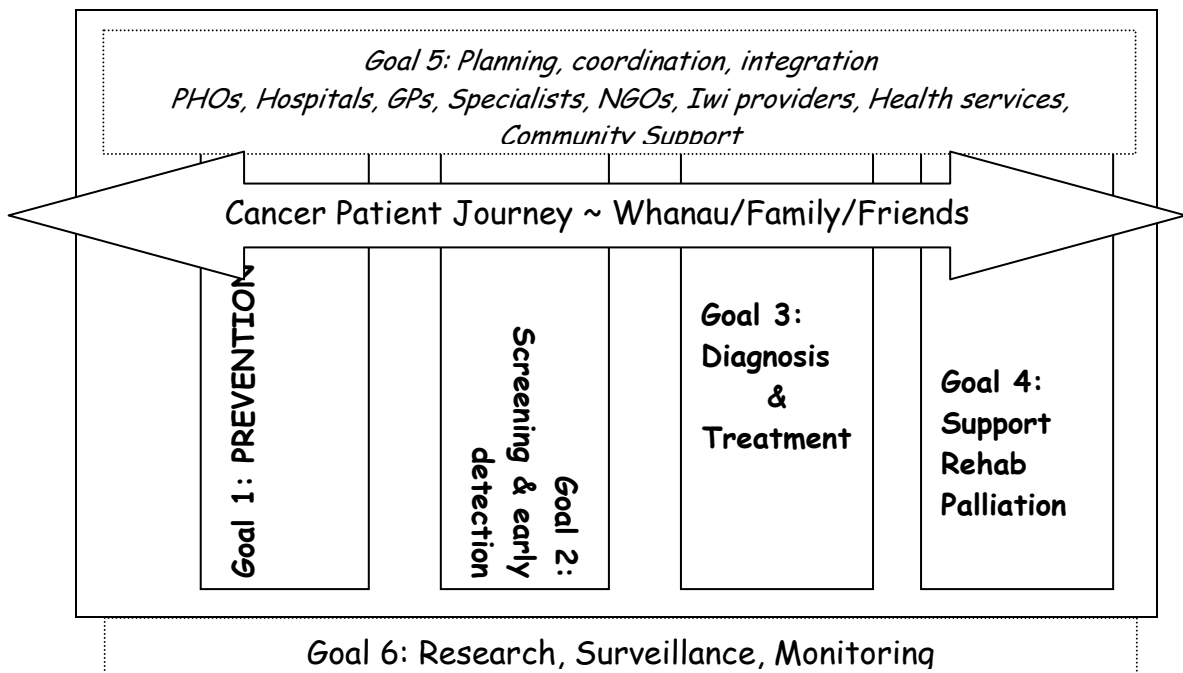
- reduce the incidence and impact of cancer
- reduce inequalities with respect to cancer

The NZCCS identifies six goals to achieve the overall aim:

1. Reduce the incidence of cancer through primary prevention
2. Ensure effective screening and early detection to reduce cancer incidence and mortality
3. Ensure effective diagnosis and treatment to reduce cancer morbidity and mortality
4. Improve the quality of life for those with cancer, their family and whānau
5. Improve the delivery of services across the continuum of cancer control through effective planning, co-ordination and integration of resources and activity, monitoring and evaluation
6. Improve the effectiveness of cancer control in New Zealand through research and surveillance

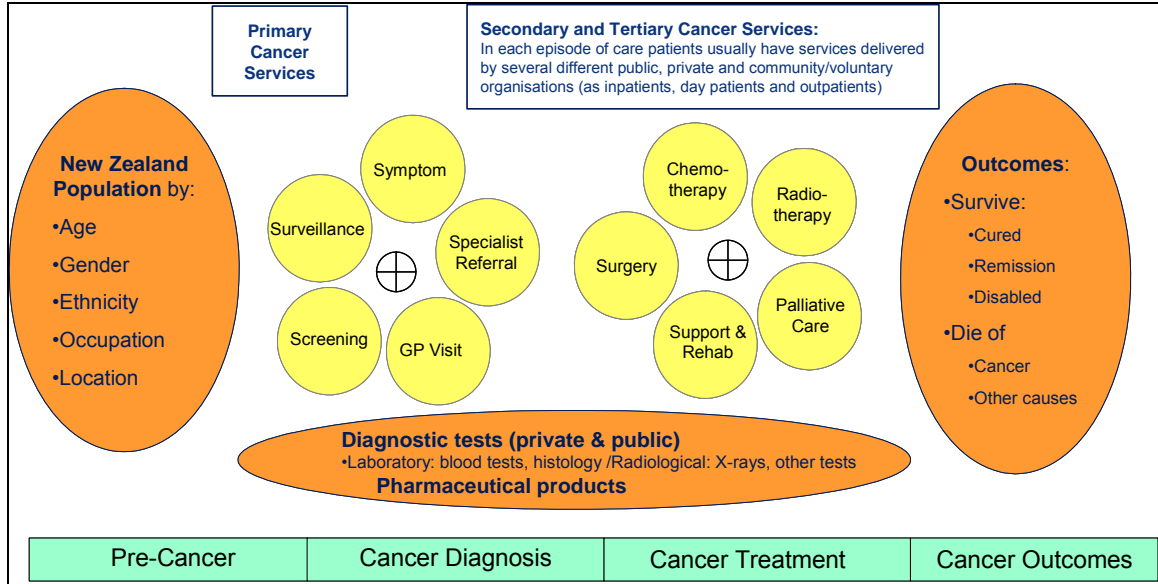
Diagram 1 below depicts the journey of the cancer patient across the continuum of cancer services and Providers that are represented by the six Goals of NZCCS.

Diagram 1: The Cancer Control Continuum



In contrast to Diagram 1, Diagram 2 shows the complexity of the cancer control continuum and highlights the dilemma of the patient, their whānau/family and support, who must navigate the system to receive treatment and support. One of the objectives of the NZCCS is to coordinate services more effectively to improve the journey of cancer patients.

Diagram 2: This diagram highlights the complexity of the cancer control continuum. Progression through the continuum is non-linear, potentially multi-staged and frequently cyclical in nature. There is also potential for remission to pre-cancer status.



Source: Cancer Collections Framework Final Report. Wellington: Ministry of Health, 2006.

## SECTION 2 - STRATEGIC CONTEXT

### ***The Treaty of Waitangi***

TDH recognises the Treaty of Waitangi as this country's founding document and acknowledges the special relationship between Maori and the Crown under the Treaty.

Central to the Treaty relationship and the implementation of the Treaty principles is a common understanding that Maori will have an important role in developing and implementing health and disability strategies for Maori. The Crown and Maori will relate to each other in good faith, with mutual respect, co-operation and trust. This is reaffirmed in He Korowai Oranga (the Maori Health Strategy) which emphasises the relationship must be based on:

- **Partnership:** working together with whānau, hapu and Maori communities to develop strategies for improving health status of Maori. (Article 1)
- **Participation:** Involving Maori at all levels of the sector in planning, development and delivery of health and disability services that are put in place to improve the health status of Maori. (Article 2)
- **Protection:** Ensuring Maori wellbeing is protected and improved as well as safeguarding Maori cultural concepts values and practices (Article 3)

The Treaty of Waitangi Framework sets the pathway for achieving the goals of the TDH Cancer Control Plan across the cancer control continuum for both reducing the prevalence and impact of cancer and reducing health inequalities.

### ***New Zealand Health Strategies***

The NZCCS was written in the context of broader New Zealand health strategies and builds on other cancer control documents such as *Improving Non-surgical Cancer Treatment Services in New Zealand* (Ministry of Health, 2001) and the *DHB Toolkit: Cancer Control* (Ministry of Health, 2001).

There are other strategies in place to support the implementation of the NZCCS including *Healthy Eating - Healthy Action: Oranga Kai - Oranga Pumau* and *Clearing the Smoke: A five-year plan for tobacco control in New Zealand (2004-2009)* (Ministry of Health, 2004) and the *National Maori Tobacco Control Strategy 2003-2007* (ATAK, 2003).

The key national health strategies relevant to this plan are listed in Appendix 1 of this document.

The TDH Cancer Control Plan is consistent with the top health gain priorities identified in the *TDH Strategic Health Plan 2005-2010*, *TDH District Annual Plan 2006-2007* and *TDH Maori Health Plan 2006-2007*.

It is important to note that other district and regional strategic plans have been produced that will overlap, enhance and complement the TDH Cancer Control plan. District plans have been developed by Hawkes Bay DHB (2006) and Central Health

(2006). Regional plans have been completed by Midland Region DHBs (2004) and Central Region (2006). Both regional plans include the Tairāwhiti district.

While each of the plans is guided by the NZCCS they are quite different from each other in focus and depth.

### ***A Patient-Centred Focus***

This plan acknowledges the cancer patient as the central focus of the cancer control continuum and therefore must participate in the planning and monitoring of cancer services. Cancer patients were approached to share their experiences of the cancer treatment pathway for this plan. TPW worked with the Gisborne/East Coast Cancer Society to identify and contact people to participate in interviews. Thirteen cancer patients were invited to participate in interviews, nine accepted and eight attended.

The interviews were not intended in this case to offer a detailed analysis of cancer treatment pathways from a patient perspective (beyond of the scope of this plan), but rather to balance and enhance the clinical data and health service overviews with real life experiences.

Six women and two men were interviewed. Six of the eight people interviewed were Māori. Two of interviewees live in rural coastal areas whereas the remaining six live in the Gisborne city area.

The key themes that emerged from the interviews are consistent with the results of patient journey mapping projects from other regions:

- Information
  - Timing
  - Format
  - Delivery
- Education about cancer – prevention and recognising symptoms
- Coordination of secondary/tertiary health systems
- Understanding financial entitlements and how to access them
- Access to travel and accommodation including for whānau/support
- Treatment options

Responses from patient interviews have been used throughout the plan (italicised in inverted commas) where relevant. The above themes will be revisited under the appropriate Goal in Section 4.

### ***The TDH Cancer Control Plan***

Te Puna Waiora, the funding and planning arm of TDH is responsible for identifying health priorities and setting targets to address priority areas and ensuring the targets are met. It also has a role to monitor performance of providers charged with delivering these services. A cancer control plan for Tairāwhiti will assist with this process and enable TPW to lead changes where necessary to improve services.

For the region of Te Tairāwhiti the cancer continuum stretches across a number of DHB regions encompassing a range of services, disciplines and organisations. The field of cancer services is complex and this plan is the first step towards presenting an overview of the cancer control continuum for Tairāwhiti for further consideration.

The purpose of this plan is to describe cancer services for the Tairāwhiti DHB region using the NZCCS framework. The plan will highlight issues across the cancer control continuum relevant to Te Tairāwhiti and make recommendations to address them.

This plan may be used to inform decision-making to plan and coordinate future cancer services and improve the effectiveness and efficiencies of existing cancer services.

### ***The Population of Tairāwhiti***

Tairāwhiti's population shown in the latest 2006 Census was 44,460 (a slight increase from 2001 census of 43,974). Te Tairāwhiti has the greatest proportion of Māori (46.4%) than any other region in New Zealand. The impact of cancer on Māori is discussed in more detail in Section 3 of this plan. Pacific people make up 2.9% of the population, a significant increase from 1.1% in 1996. The total population of this district is projected to fall by 3.5% over the next 12 years.

The population age structure of Te Tairāwhiti shows a large proportion of young people (29% of males and 26% of females aged 0-14yrs) whilst the proportion aged 30-44yrs remains low. Te Tairāwhiti has the largest youth population nationally and also has a high level of people aged 65+ compared to New Zealand as a whole. Age profiles for the region show that Māori still have a younger population structure than non-Māori. This can be attributed to a higher birth rate and lower life expectancy. By 2026, the number of people over 65 years of age will have doubled with one in four people in the 65+ age group by then.

The changing age-structure is important to note as cancer is said to be a disease of the aged. Not only does an aging population increase the risk of cancer for this region but those who get cancer are more likely to be living longer in future due to advances in cancer treatment and cancer drugs. As cancer treatment services improve and cancer patients live longer with the disease there will be greater demand on drug supply, support, rehabilitation and palliative care services.

One-parent families comprised 27.5 percent of all Te Tairāwhiti families, the highest percentage for any district. While the unemployment rate in Tairāwhiti is currently less than 5%, the unemployment rate for Māori is 9%. Tairāwhiti had the third lowest median income in the country at \$15,000 per annum.

Tairāwhiti still experiences higher levels of deprivation than New Zealand as a whole, with almost half (47.5%) of the population living within deciles 9 and 10. This trend is exacerbated when split by ethnicity. Seventy-eight percent of Māori in Tairāwhiti live within deciles 9 and 10, while this figure reaches 86% for Pacific peoples. Tairāwhiti is one of the most isolated regions in the country which has implications for access to health and other services for rural residents.

Socioeconomic position, ethnic identity, gender and place of residence influence health outcomes and create inequalities among New Zealanders (MOH, 2002). These factors need to be considered to ensure equitable funding and planning decisions at all levels of health service delivery.

### ***Pacific Peoples***

Similarly to Māori Pacific Peoples are at greater risk of getting cancer than other New Zealanders. Nationally, Pacific men have higher rates of lung cancer and primary

liver cancer, and Pacific women have higher rates of breast and cervical cancer than other New Zealand women (check website again).

The Pacific population of Tairāwhiti is small but growing with 2.9% (approximately 1290) of the population of the Gisborne region identifying as Pacific in the 2006 Census. TDH has recently signed a Memorandum of Understanding with the Pacific Islands Community Trust (PICT) to formalise a working partnership to support the health of Pacific peoples in this region. A Pacific Health Plan is to be developed for Tairāwhiti that will offer a strategic approach to Pacific health in Tairāwhiti.

## SECTION 3 – THE IMPACT OF CANCER IN TAIRAWHITI

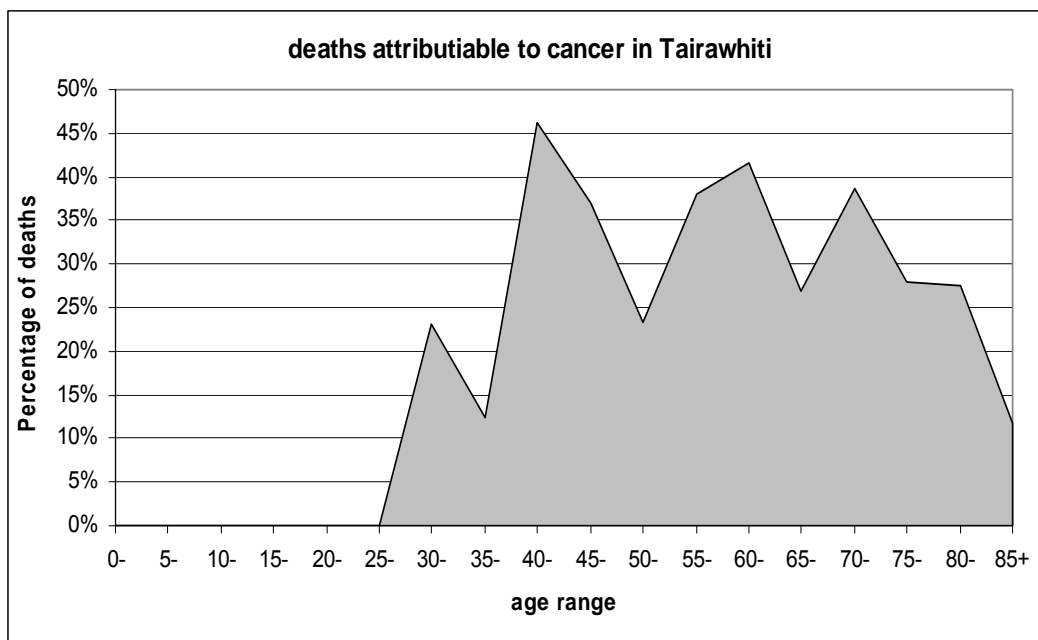
### **Cancer Rates**

Cancer is the biggest killer in New Zealand accounting for 27.5% of all deaths in 2002.

Within Tairawhiti in 2002 cancer was responsible for 111 deaths (27.6%) of the total 401 people who died. Of the 207 males who died in 2002, 29% (61 deaths) were attributed to a cancer, 194 females died during 2002, 50 attributed to a cancer (26%).

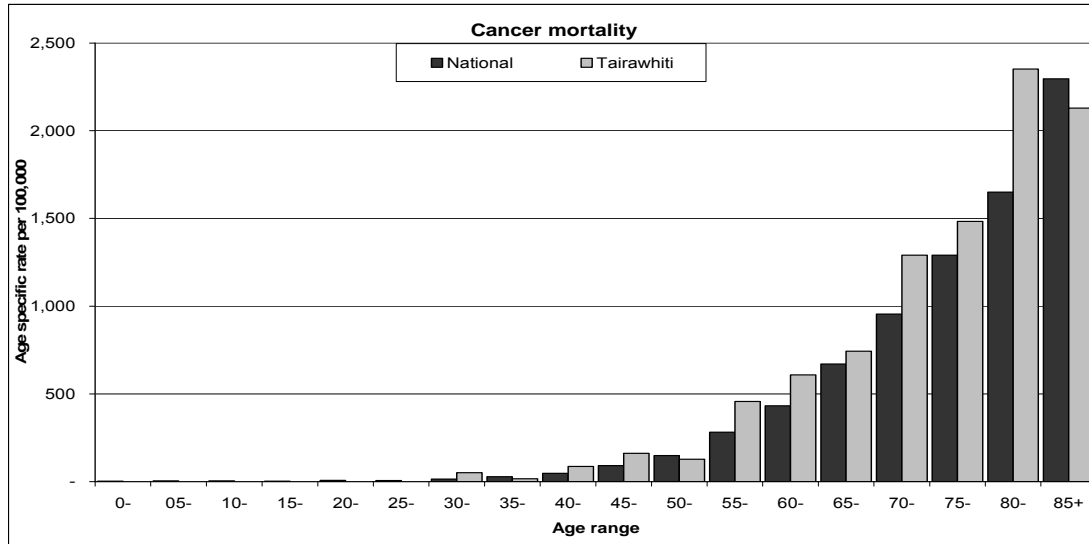
Cancer is a disease related to aging, Graph 1 shows the percentage of deaths attributed to cancer in 2002 and 2003 at different ages, with the small numbers in Tairawhiti's small number can result in significant swings and peaks and troughs are common, but graph 1 shows that as we get older our risk of dying from cancer greatly increases.

Graph 11111111: Cancer mortality in Tairawhiti in 2002 and 2003 as a percentage of total deaths.



Data source: NZHIS.

Graph 22222222: Comparison of age specific rates of cancer in Tairawhiti and New Zealand. Tairawhiti mortality figures are from the 2002 and 2003, while national figures are for 2002 only.



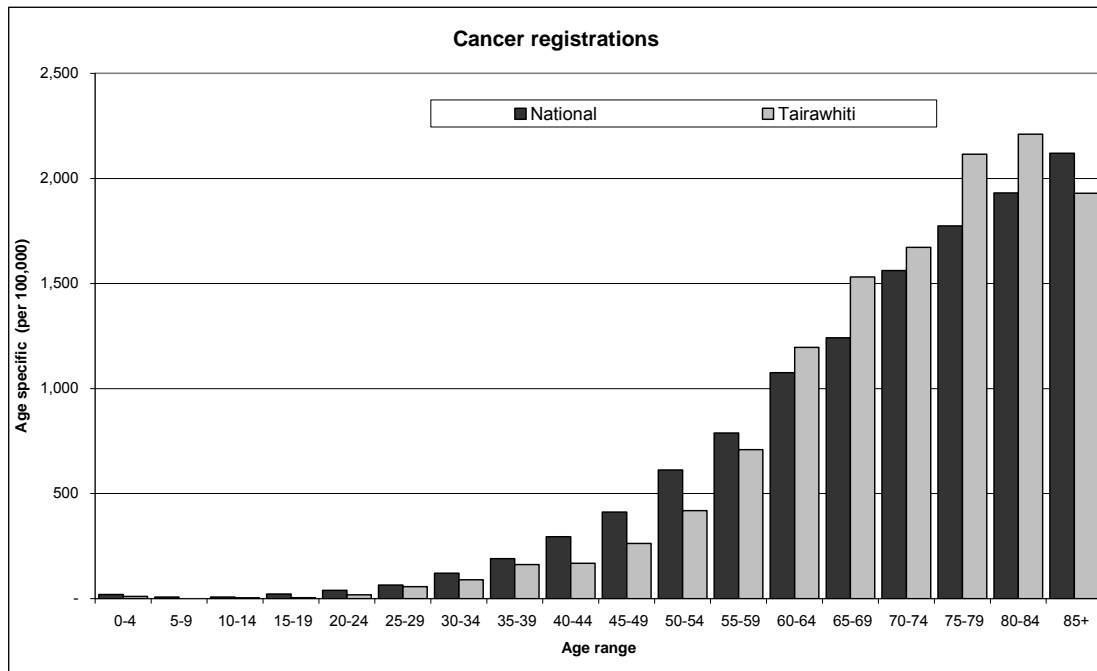
Source: NZHIS cancer registrations and deaths.

To allow us to examine differences within a population we calculate an age specific rate which is the number of people with/or who have died of cancer over the number of people within that specific portion of the population. Graph 2 shows age specific mortality per 100,000 for Tairawhiti against that of New Zealand.

Firstly we can see the increase in the risk of cancer as people age, and specifically once people are over 65 years. Secondly we can see that from 55 to 85 years Tairawhiti has a higher rate than would be expected from national figures, this gap is particularly large for those between 80 and 85. For those over 85 years the national and local rate are reversed; while the reasons for this reversal are many and complex, life expectancy for Tairawhiti being significantly below of the national average may contribute in some way as may the aging within the Maori community who make up 42% of the Tairawhiti population.

Graph 3 shows the age specific rate of cancer registration for Tairawhiti and New Zealand. While registration in Tairawhiti is under the national rate for those under 60 and over 85 years, between 60 and 84 years the rates of registrations are above national rates, but the differences were not as large as found in the mortality rates. For those aged between 80 and 84 years the mortality rates are above the rate of registration.

Graph 33333333: Comparison of age specific rates of cancer in Tairawhiti and New Zealand. Tairawhiti registrations are from the 2000 to 2002, while national figures are for 2002 only.



Source: NZHIS cancer registrations and deaths.

To take into account differences in population structures, features affecting a population have been standardised before being superimposed on to the population structure of Tairawhiti to allow us to examine differences between populations in tables 1 to 5 age specific rates below.

The SEGI world population model was used to standardise the populations examined. In tables 1 to 3 the actual mortality rate refers to the annual average for 2002 and 2003, while in tables 4 and 5 the actual registration refers to Tairawhiti annual average rate of cancer registration for the period 2000 to 2002. The expected rate is the national rate for 2002. All are superimposed onto the 2002 Tairawhiti population. As these are rates superimposed onto the Tairawhiti population the numbers will tally.

Table 1 shows that the total cancer mortality burden in Tairawhiti is 47% greater than would be expected if our mortality rates reflect the national rates, as this is statistically significant at the 95% confidence level, we can rule out chance accounting for the difference. We can also see that the mortality burden for lung and colorectal cancers are above the national average and that the Maori specific rate in Tairawhiti is 23% higher than we would expect from the national Maori specific mortality rates. For Non Maori (56% of the population in 2002) we experience rates comparable to the national non Maori rates and chance cannot be ruled out for any of the differences seen.

Table 11111111: Comparison of the annual average number of deaths in Tairawhiti due to cancer from local and national rates of cancer mortality<sup>3</sup>.

<sup>3</sup> \* Significant to 95% CI

+ not significant at 95% CI

TDH population obtained from 2002 Statistic NZ population projection

| ALL               | Total population |          | Maori          |          | Non Maori       |          |
|-------------------|------------------|----------|----------------|----------|-----------------|----------|
| CAUSE OF DEATH    | Actual           | Expected | Actual         | Expected | Actual          | Expected |
| Total Cancer      | 62*              | 42       | 37*            | 30       | 21 <sup>+</sup> | 22       |
| lung cancer       | 14*              | 8        | 9 <sup>+</sup> | 11       | 4 <sup>+</sup>  | 4        |
| Colorectal cancer | 10*              | 6        | 5*             | 2        | 4 <sup>+</sup>  | 3        |
| breast cancer     | 9*               | 4        | 8*             | 3        | 2 <sup>+</sup>  | 2        |
| stomach cancer    | 3 <sup>+</sup>   | 2        | 3*             | 2        | 0 <sup>+</sup>  | 1        |

Source NZHIS, Age standardisation based on SEGI population.

For males the actual rates were 37.5% above the expected, lung, colorectal and prostate making up over 50% of the cancer mortality in males. Again the total cancer burden on Maori within Tairawhiti is higher than what national figures for Maori would lead us to expect, as are colorectal and stomach specific cancers. Again the Non Maori rates are similar to those we could expect if national rates were superimposed on our Non Maori male population.

Table 22222222 - comparison of the annual average number of male deaths in Tairawhiti due to cancer from local and national rates of cancer mortality<sup>1</sup>.

| Male              | Total population |          | Maori          |          | Non Maori       |          |
|-------------------|------------------|----------|----------------|----------|-----------------|----------|
| CAUSE OF DEATH    | Actual           | Expected | Actual         | Expected | Actual          | Expected |
| Total Cancer      | 33*              | 24       | 19*            | 15       | 12 <sup>+</sup> | 13       |
| lung cancer       | 8*               | 5        | 4 <sup>+</sup> | 5        | 3 <sup>+</sup>  | 2        |
| Colorectal cancer | 5 <sup>+</sup>   | 4        | 4*             | 1        | 1 <sup>+</sup>  | 2        |
| prostate cancer   | 5 <sup>+</sup>   | 3        | 1 <sup>+</sup> | 2        | 2 <sup>+</sup>  | 2        |
| stomach cancer    | 2 <sup>+</sup>   | 1        | 2*             | 1        | 0 <sup>+</sup>  | 1        |

Source NZHIS, Age standardisation based on SEGI population.

For females the total cancer mortality burden is 63% above the expected rate. Lung, Colorectal and Breast cancer account for 68% of the local cancer mortality burden, compared to 47% nationally. For Maori females the local rate 27% above the expected rate with lung and breast cancers making up 63% of the mortality burden, compared to an expected 53%. Again the Non Maori rates are similar to those we could expect if national rates were superimposed on our Non Maori female population.

Table 33333333 - Comparison of the annual average number of female deaths in Tairawhiti due to cancer from local and national rates of cancer mortality<sup>1</sup>.

| Female            | Total population |          | Maori          |          | Non Maori       |          |
|-------------------|------------------|----------|----------------|----------|-----------------|----------|
| CAUSE OF DEATH    | Actual           | Expected | Actual         | Expected | Actual          | Expected |
| Total Cancer      | 31*              | 19       | 19*            | 15       | 10 <sup>+</sup> | 9        |
| lung cancer       | 7*               | 3        | 5 <sup>+</sup> | 6        | 2 <sup>+</sup>  | 1        |
| Colorectal cancer | 5 <sup>+</sup>   | 3        | 1 <sup>+</sup> | 1        | 2 <sup>+</sup>  | 1        |
| breast cancer     | 9*               | 3        | 7*             | 2        | 2 <sup>+</sup>  | 2        |
| stomach cancer    | 1 <sup>+</sup>   | 0        | 1 <sup>+</sup> | 1        | 0 <sup>+</sup>  | 0        |

Source NZHIS, Age standardisation based on SEGI population.

Cancer registrations within Tairawhiti are significantly below what we would expect from the national rates, with an all cancer male rate of 277.7 per 100,000 compared to a 2002 national rate of 348.2 and for females a local rate of 266.0 compared to a national rate of 287.0. As with mortality rates the difference between the local male and female rates are lower than what is found nationally.

The difference in registration between local Maori (221 per 100,000) and Non Maori (278 per 100,000) male registrations is higher than the national figure, with local Maori males are a quarter less likely to be registered than Non Maori males. For both Maori and Non Maori male prostate cancer is the most common type of cancer, but in Maori Lung is ranked second, fourth for Non Maori. The cancer with the second largest impact on Non Maori was Melanoma, which along with lung were the only cancers above the national rate of registration.

Table 44444444 – Comparison of the average annual for selected male cancer registration in the period 2000 to 2002 within Tairawhiti<sup>4</sup>.

| Male Cancer registrations | Maori             |          | other             |          |
|---------------------------|-------------------|----------|-------------------|----------|
|                           | Actual            | Expected | Actual            | Expected |
| Prostate                  | 5.1 <sup>+</sup>  | 5.3      | 8.5 <sup>*</sup>  | 9.2      |
| Lung                      | 3.1 <sup>+</sup>  | 4.8      | 3.1 <sup>*</sup>  | 2.8      |
| Colorectal                | 1.6 <sup>+</sup>  | 1.9      | 4.3 <sup>*</sup>  | 4.6      |
| Stomach                   | 1.5 <sup>+</sup>  | 1.1      | 0.6 <sup>+</sup>  | 0.8      |
| Pancreas                  | 1.3 <sup>+</sup>  | 0.5      | 0.3 <sup>+</sup>  | 0.5      |
| Leukaemia                 | 0.1 <sup>+</sup>  | 0.8      | 1.4 <sup>+</sup>  | 1.5      |
| Melanoma                  | -                 | 0.1      | 5.1 <sup>*</sup>  | 3.7      |
| <i>All</i>                | 15.6 <sup>+</sup> | 22.5     | 24.6 <sup>*</sup> | 32.6     |

Source NZHIS: Age standardisation based on SEGI population. TDH population obtained from 2002/03 Statistic NZ population projection.

Unlike Male registrations the rate of Maori female registration (273 per 100,000) is higher than the Non Maori females (266). For Maori females breast cancers are significantly higher than are found in the national Maori population, with the other Maori rates showing little difference between local and national. For Non Maori breast cancer registrations are significantly under the national rate, while melanoma and colorectal significantly above the national rate. Cancers of the reproductive organs, uterus, cervical and ovary, together have high incidences of registration.

Table 55555555: Comparison of the average annual for selected female cancer registration in the period 2000 to 2002 within Tairawhiti.

| Female Cancer registrations | Maori             |          | other             |          |
|-----------------------------|-------------------|----------|-------------------|----------|
|                             | Actual            | Expected | Actual            | Expected |
| Breast                      | 9.1 <sup>*</sup>  | 6.2      | 7.7 <sup>*</sup>  | 8.5      |
| Lung                        | 3.8 <sup>+</sup>  | 3.9      | 1.6 <sup>+</sup>  | 1.9      |
| Uterus                      | 2.3 <sup>+</sup>  | 2        | 1.3 <sup>+</sup>  | 1.7      |
| Colorectal                  | 1.1 <sup>+</sup>  | 1.3      | 4.0 <sup>*</sup>  | 3.8      |
| Cervical                    | 1.0 <sup>+</sup>  | 1        | 1.9 <sup>+</sup>  | 1.7      |
| Ovary                       | 1.0 <sup>+</sup>  | 0.8      | 1.2 <sup>+</sup>  | 1.1      |
| Melanoma                    | 0.2 <sup>+</sup>  | 0.4      | 4.7 <sup>*</sup>  | 3.6      |
| <i>All</i>                  | 21.6 <sup>+</sup> | 21.1     | 24.5 <sup>+</sup> | 28.3     |

Source NZHIS: Age standardisation based on SEGI population. TDH population obtained from 2002/03 Statistic NZ population projection.

Graphs 4 and 5 show the age specific rates of cancer registration for Maori and Non Maori in Tairawhiti. In graph 4 we can see that across all but the 70-74 age group

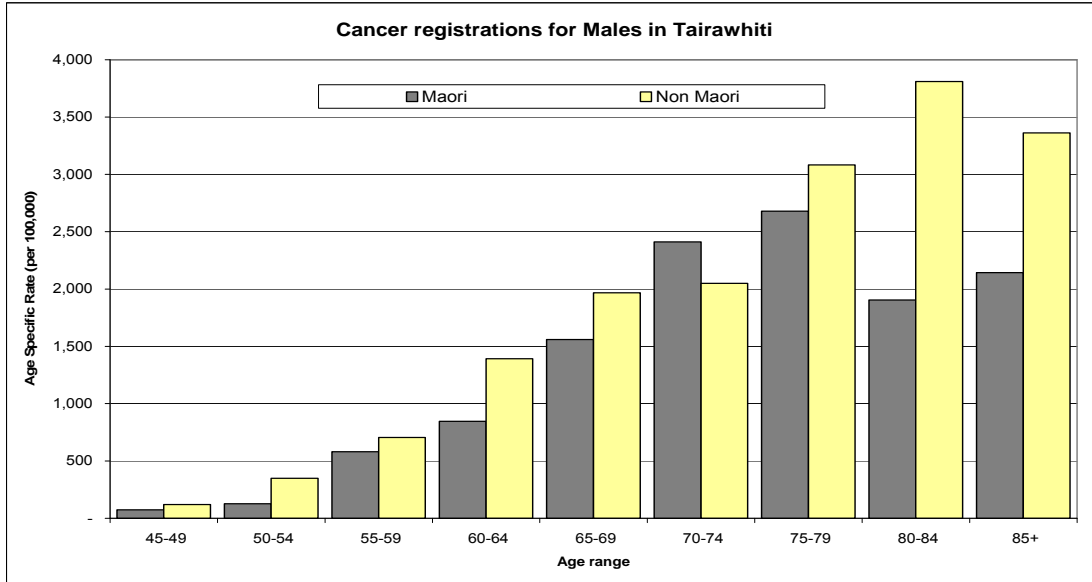
<sup>4</sup> \* Significant to 95% CI

+ not significant at 95% CI

TDH population obtained from 2002 Statistic NZ population projection

Maori male cancer registrations are below those of Non Maori, with the difference become significantly more marked in the 80+ age groups.

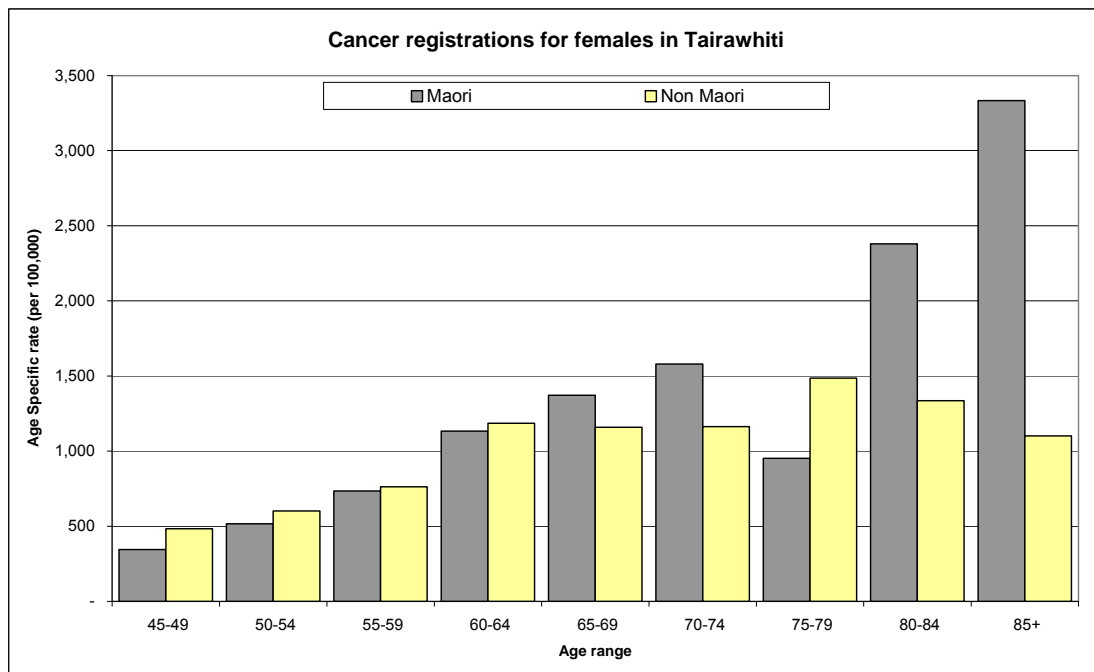
Graph 44444444 – Cancer registrations by age for the male Maori and Non Maori populations of Tairawhiti for the period 2000 to 2002.



Source: NZHIS, Age standardised using SEGI world Population Model.

In graph 5 we see that Maori female cancer registrations are above the Non Maori registrations for the 80+ age groups. While Maori registrations largely increase with age, as would be expected, Non Maori registrations appear to plateau at around 60.

Graph 55555555 – Cancer registrations by age for the female Maori and Non Maori populations of Tairawhiti for the period 2000 to 2002.



Source NZHIS, age standardised using SEGI world Population Model.

Lung cancer is the biggest cancer killer in the district, and given that Tairāwhiti rates of smoking for 15 years and over is above the national rate, this is likely to remain so for some time to come. Particularly within Māori females where the number expected to die from these types of cancers is higher than any of the other groups. Also for Māori women, breast cancer is of concern with both a high rate of mortality and registration.

The lower than expected rate of cancer registration and higher than expected cancer mortality is an area for significant study as it occurs across all ethnicity and sex groups in Tairāwhiti to some extent.

## **Maori and Cancer**

“Maori are more likely to get cancer than non-Maori,  
and of those who get cancer Maori are more likely to die from it than non-Maori”  
*Dr Guy Naden, presentation to Establishing Cancer Networks Seminar, Wellington, 2006.*

### ***Inequalities***

There is no doubt that Maori are affected disproportionately by cancer. The cancer data provided in the previous section highlights the health disparities between Maori and non-Maori both regionally and nationally. Reducing health inequalities is one of the key focuses of the NZCCS and the TDH Cancer Control Plan and a key priority for TDH.

TDH has adopted whanau ora as its pathway forward toward addressing inequalities and Maori health gains in particular. Whanau ora focuses on the individual's health and wellbeing from and in the context of whanau, hapu and iwi. It recognises Maori specific models of health and disability as well as traditional healing practices. Associated strategies adopted by TDH enhancing whanau ora include maintaining community relationships, inter-sectoral relationships and participation in events and activities wherever individuals and whanau congregate.

Maori constitute 46.4% of the total population in Tairāwhiti, almost 3 times the national average. Of this number 80% reside in the most deprived decile areas 9-10. These factors contribute to greater health risks for the population, and poorer access to health services. Add to this the rurality and geographical isolation of the region and it is clear that Te Tairāwhiti requires particular attention for equitable resource allocation and distribution.

Social factors that determine economic, cultural and political status of Maori are key to improving health outcomes. While the health sector alone cannot directly address all of these factors, it can have a role to support Maori development and influence decisions across other sectors that impact on the health of the population, particularly those most at risk. TDH will continue its formal working relationships with Maori and its participation in inter-sectoral fora to ensure a population health perspective on social policies and issues that impact on health.

Planning and funding decisions have a significant influence on access to cancer services by Maori and issues of equality must be recognised in the decision making process (MOH, 2002 and Cormack et al, 2005). There are a number of planning and assessment tools, both Maori and non-Maori models, to assist with this process<sup>5</sup>. TDH also has a responsibility for effective data collection and monitoring of service agreements to ensure that service provision does not increase inequalities.

Relationships with the Ministry of Health Public Health Intelligence Unit (PHI) have been developed and strengthened with PHI leading an information work stream with three other DHBs nationally who have the most significant health inequalities. This data will help TDH better understand what is driving the lowest life expectancy

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<sup>5</sup> For example: MOH Intervention Framework, The Equity Lens and Health Impact Assessment Tool. Tools based on Maori models of health include Te Pae Mahutonga and Te Wheke.

nationally, and inform TDH actions as well as influencing future development of Population Based Funding.

### ***The Unequal Impact of Cancer***

The research reports discussed below provide some insight and action points to assist DHBs and all cancer treatment and support services specifically to reduce the unequal impact of cancer within whanau Maori and broader communities.

The unequal impact of cancer on Maori is reported in the recently published chart book researched by Te Roopu Hauora a Eru Pomare, Wellington School of Medical and Health Sciences, *Unequal Impact: Maori and Non-Maori Cancer Statistics 1996-2001* (Robson et al. 2006).

Researchers analysed how health systems and processes contribute to disparities in health between Maori and non-Maori. The findings were consistent with international research into ethnic disparities in cancer incidence and outcomes.

The chart book emphasises the importance of collecting detailed information for Maori and non-Maori cancer patients to monitor, address and eliminate disparities and shows that:

- The 'type and timeliness of cancer care' have an impact on cancer outcomes of people.
- Maori patients are less likely than non-Maori patients to be diagnosed at an early stage of the cancer, and ...
- ...are therefore more likely to be diagnosed once the cancer has spread.
- Maori are less likely than non-Maori to have 'stage at diagnosis' recorded on the cancer registration data. This raises uncertainty about recording procedures and/or staging procedures.

Similar findings were identified in the report *Access to Cancer Services for Maori* (Cormack et al, 2005). The aim of this project was to research the barriers to accessing cancer services including health system factors and patient factors that lead to poorer outcomes for Maori cancer patients and better outcomes for non-Maori cancer patients. Patients and providers were interviewed for this research project. The report provides useful insight into the barriers to accessing cancer services and proposes a number of interventions to improve Maori access although more work is required to increase this number of interventions e.g. a whanau ora model encourages more community or marae-based health services.

Proposed interventions include:

- Building workforce capacity to increase Maori workforce and improve responsiveness of mainstream services to Maori.
- Enhancing Maori specific services or service components.
- Integrating Maori service options into mainstream services e.g. traditional healing, medicine and expertise.
- Improving access to entitlements for travel and support.

Projects have been carried out by DHBs and Non Government Organisations (NGOs) to further identify barriers to screening, diagnosis and treatment services within their own organisations and services. A number of Maori-specific projects were

undertaken and included patient journey mapping and service improvement projects<sup>6</sup>. The projects were funded in 2005 by MOH as part of its implementation of the *NZCCS Action Plan 2005-2010*.

The emerging themes specific to Maori included:

- The lack of dedicated kaupapa Maori cancer services.
- Development of the Maori cancer workforce.
- More training, information and support in cultural competence for the non-Maori workforce.
- Introduction of whanau ora models of care into diagnosis/treatment pathways.
- Lack of Maori specific information and resources.

Much can be drawn by TDH and other cancer services from the research findings of the projects described above. Each of the projects made consistent findings although it is recommended that TDH carry out its own service reviews to prioritise areas for attention and to ensure that processes are in place for effective and ongoing evaluation and monitoring such as data collection and clear processes and protocols for cancer treatment pathways. Involving Maori consumers and health and social service providers from all levels would be crucial for this process.

**Key Issues to be considered in Section 4 of this plan:**

- Access to cancer services for Maori.
- Equity and equality to reduce health disparities.
- Early detection and diagnosis protocols for Maori.
- Treatment pathways and options for Maori particularly for most prevalent cancer types.
- Collection of ethnicity data by health services in Tairāwhiti.
- Non-Maori workforce cultural competencies.
- Maori cancer workforce development.
- Lack of Maori consumer input into cancer control.

**Recommended Actions:**

- Recommended cancer service review and patient mapping project (Goal 3) to include identification of barriers to accessing cancer services, timeliness of detection, diagnosis and treatment and options for Maori.
- Integrate whanau ora model of care into cancer services.
- Recommended Cancer Information Plan (Goal 6) to include review of ethnicity data collection.
- Developing specific cultural competencies for the non-Maori workforce to assist with improving access. (Goals 1, 3, 4 and 5).
- Ensure TDH funding prioritisation systems incorporate an assessment of health equity so that all funding decisions seek to reduce, not increase, health inequalities. (Goal 5).
- Establish mechanism for Maori consumer input into cancer service development. (Goal 5).

*These issues are addressed under the relevant Goals in Section 4*

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<sup>6</sup> Summaries of the NZCCS Action Plan Implementation Project Reports are available on the Ministry of health website: <http://www.moh.govt.nz/moh.nsf/indexmh/cancercontrol-projectssummaries>

## SECTION 4 – ACTION PLAN

This Section describes cancer services under the relevant NZCCS goal. Each goal has a summary of issues and recommendations to follow. Some of the issues and recommendations may be relevant to more than one goal.

### ***Goal 1: Reduce the incidence of cancer through primary prevention***

#### **Background to Primary Prevention**

Primary prevention has the potential to offer the most effective form of cancer control. The aim of primary prevention is to reduce exposure to potential lifestyle factors, and so to prevent or at least reduce the risk of cancer.

*At least one-third of all cancers could be prevented in this way (WHO 2002).*

Strategies to prevent disease and promote wellness include public health, health promotion, health protection and primary health care. Prevention strategies are implemented by Public Health Units (PHUs), Primary Health Organisations (PHOs), Iwi and community providers and NGOs. The expansion of Local Government responsibilities to include social and community outcomes has also led to collaboration between local councils and the health sector on prevention programmes.

With a growing number of agencies now funding and implementing population health programmes it is becoming more important to coordinate services and monitor the impact of activity against regional objectives and priorities.

The vision of The Primary Health Care Strategy (MOH, 2001b) is to provide a greater emphasis on population health in a community setting that includes health promotion and protection activities as well as preventative care. There are a number of programmes and services delivered by PHOs, TDH PHU and NGOs throughout Tairāwhiti.

The key objectives for primary prevention in the NZCCS are:

- tobacco control
- physical activity and nutrition
- UV radiation exposure
- Infectious diseases
- Alcohol
- Occupational health

#### **Primary Prevention Services in Te Tairāwhiti**

In Tairāwhiti, tobacco control and nutrition and physical activity continue to be key foci for TDH. Population health objectives have been set to curb obesity and smoking rates that lead to the diseases most prevalent in this region such as diabetes, cancer and cardiovascular disease. Smoking is one of the main causes of lung cancer while

obesity and/or a poor diet and lack of physical activity contribute to many cancer types.

The 2005 Year 10 ASH survey<sup>7</sup> reported a drop in ranking for Tairāwhiti region from 20/21 to 17/21 for student 'monthly', 'daily' and 'never' smoking rates by DHB region. Quitline results from January to March 2005 showed that 90 people registered from the Tairāwhiti region and 56% of this group identified as Māori<sup>8</sup>.

The 2002/2003 NZ Health Survey (MOH, 2004) identified that over thirty-five percent of the population aged over 15 years was overweight. The same survey identified that 27% of the population were obese, which is significantly higher than the national average. Fruit and vegetable consumption was below the national average however over seventy-two percent of people aged 15 years and over were physically active and fifty-one percent were regularly physically active.

The prevalence of diabetes in Tairāwhiti was measured at 5.7% which is among the highest rates in the country.

Expanding smoking cessation services and programmes for Māori women and implementing Healthy Eating-Healthy Action are priorities of phase 1 implementation of NZCCS.

The average rates of melanoma for this region are relatively high (1995-2002), particularly for non-Māori male and female. 'Sunsmart' campaigns to protect people from the harmful effects of UV radiation exposure are promoted by PHU and the Cancer Society in collaboration with other agencies such as Sport Gisborne Tairāwhiti and schools. GPs carry out opportunistic mole checks and provide information to patients to protect against sun damage.

Below is a summary of some of the organisations delivering primary prevention services in Tairāwhiti. This list is not exhaustive but gives some indication of the level of activity and resources dedicated to promoting healthy lifestyles as a means to preventing diseases such as cancer.

#### **Primary Health Organisations (PHOs)**

Te Tairāwhiti has two Iwi-mandated PHOs - Turanganui PHO (TPHO) and Ngati Porou Hauora (NPH). Each PHO receives health promotion funding calculated on their enrolled population.

*Turanganui PHO* has invested its health promotion funding into the Green Prescription programme for Healthy Kids Active Families/Whanau and 'E Tipu E Rea' a HEHA Innovative Fund Project to improve nutrition and increase physical activity for children less than 5 years.

*Ngati Porou Hauora* applies a population health approach to much of its whanau and community-based service delivery. Programmes such as Ngati and Healthy, Manaaki Tinana, Whanau Ora and Problem Gambling incorporate health promotion strategies, social marketing, community action and advocacy.

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<sup>7</sup> Source: [http://www.ash.org.nz/factsheets/DHBs\\_Year10survey2005](http://www.ash.org.nz/factsheets/DHBs_Year10survey2005)

<sup>8</sup> Source:

[http://www.moh.govt.nz/moh.nsf/0/24CF104E9314BE41CC256F930078F575/\\$File/phinewsletter3.doc](http://www.moh.govt.nz/moh.nsf/0/24CF104E9314BE41CC256F930078F575/$File/phinewsletter3.doc)

### **GP Services**

There are 8 general practices in the Tairāwhiti region. Health education, promoting healthy lifestyles and improving access to screening/cessation services are a part of the role of a GP in cancer control at primary prevention end of the spectrum<sup>9</sup>.

### **Iwi Health Providers**

*Turanga Health Ltd* is a community-based provider and delivers early intervention and health promotion programmes to the communities of Turanganui a Kiwa as part of its broader primary healthcare service. Programmes include but are not limited to nutrition and physical activity, injury prevention, oral health, tobacco control, smoking cessation, sunsmart, alcohol and drug, sexual health.

*Te Aitanga a Hauiti Hauora*, based in Tolaga Bay, provides a number of public health programmes particularly for the communities of Uawa. Programmes include sexual health, whānau ora, smoking cessation. *Te Aitanga a Hauiti Hauora* delivers the BreastScreen Aotearoa programme (BSA) to Tairāwhiti.

BSA employs a health promoter and kaiāwhina who promote regular breast screening as part of the women's wellness programme. The role of the health promoter for this programme regularly extends to support for women requiring follow-up treatment after a mammogram. This issue of 'support' is discussed further under Goal 5 of this plan.

### **Tairāwhiti District Health**

*The Public Health Unit* (PHU) is made up of a range of public health services including public health nursing, health promotion, health protection, a Medical Officer of Health and a Public Health Physician.

The PHU supports health promotion services in the areas of physical activity and nutrition (including Fruit In Schools), tobacco control, alcohol and drug, health promoting schools, sexual health, tamariki ora and sunsmart. Programmes are delivered in community and school settings. There are currently 5.7 FTE Health Promoters and 3.4 FTE Health Protection Officers.

*The Cervical Screening Unit* based within the PHU employs two full-time health promoters to deliver the 'Healthy Women' programme in Tairāwhiti to encourage women to maintain wellness through regular cervical screening. The National Screening Unit commissioned an evaluation of all its health promotion services. The three year evaluation project is due to be completed in 2007.

*Te Puna Waiora* (TPW), the funding and planning division of TDH, has recently established a partnership with the Health Sponsorship Council and Ministry of Health to work with local and national stakeholders to plan interventions for tobacco control. This will include data collection and evaluation methods to measure the impacts of the interventions.

A Healthy Eating Healthy Action (HEHA) Development role is to be established within TPW to provide strategic direction and coordinate regional activity that contributes to the goals of HEHA. This role will support the newly launched 'Mission On' programme funded jointly by SPARC, MOH and Ministry of Education. Initiatives include the Nutrition Fund, a grant to support school based nutrition and physical activity projects.

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<sup>9</sup> Feedback received from the GP Liaison Group who liaise with TDH hospital specialists and management.

Strategic plans are currently being developed by TDH in the areas of Tobacco Control, Healthy Eating, Healthy Action and Sexual Health. Each plan is relevant to the NZCCS and will support the implementation of the TDH cancer control plan.

***Non-government Organisations***

A growing number of non-government organisations are supporting or providing population health programmes to the community, whanau, hapu and iwi.

The *Gisborne District Council* (GDC) has taken on responsibilities in the areas of smokefree environments, physical activity programmes such as Bikewise and Manaaki Tinana. The Council recently produced the *Active Recreation Strategy 2005-2010* to promote the use of local facilities and encourage activity in the region.

The *National Heart Foundation* (NHF) employs two staff based at Gisborne Hospital. The service provides health promotion and advocacy services in both tobacco control and nutrition and physical activity. The NHF provides national training programmes for smoking cessation.

The *Family Planning Association* (FPA) provides health promotion services in school settings and is planning to expand its services in the region into sexual health consultations in the near future.

*Te Runanga o Turanganui a Kiwa* and *Te Runanga o Ngati Porou* both provide social services and health promotion services including physical activity and nutrition programmes. TDH has a formal relationship with both Runanga for strategic planning purposes. These plans are actioned, monitored and reviewed through regular meetings between Runanga and TDH management. The leadership role of both organisations can enhance population health interventions at both planning and implementation levels.

*Sport Gisborne Tairāwhiti* is a key provider of sports and recreation programmes including the newly established *E Tipu E Rea* programme. *E Tipu E Rea* uses a public health approach in an early childhood education setting to improve nutrition and physical activity for children less than 5 years. *E Tipu E Rea* is funded as part of the national HEHA Innovative Fund programme. The *Healthy Kids Active Families* programme also operates from this organisation.

*The East Coast/Gisborne Cancer Society* provides health promotion services to encourage healthy lifestyles and employs one part-time health promoter. The priority health promotion programmes identified by Cancer Society New Zealand are tobacco control, skin cancer prevention, nutrition and physical activity and health promotion information<sup>10</sup>.

There are many other community organisations not listed here that promote healthy lifestyles through leadership, role modelling and positive messages. Advocates for women's health, breastfeeding and children's health, such as the Maori Women's Welfare League, contribute to the overall impact of health promotion and prevention activity in this region. Schools also have a key role to play in this area.

It will be the role of the TDH HEHA Manager to work with as many stakeholders as possible to develop a HEHA strategic plan that captures this information and sets

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<sup>10</sup> *Three Year Strategic Plan for National Health Promotion 2005-2008*, sourced from [www.cancersociety.org.nz](http://www.cancersociety.org.nz).

targets that can be measured and linked to objectives to prevent and reduce the incidence of cancer, diabetes and cardiovascular disease in Tairawhiti.

### **Collaborative Approach**

With the growing number of primary prevention programmes being delivered in the region TDH supports a collaborative and coordinated approach for the planning and delivery of interventions. This approach can help to avoid duplication and target and evaluate interventions effectively.

Using population health planning models such as Ottawa Charter and Treaty based health promotion practices to address lifestyle factors can enhance these impacts (Ratima, 2002). Effective monitoring and evaluation will assist with decision making to review priorities and plan for future services and programmes.

Population health programmes have drawn the interest of other government agencies such as Ministry of Social Development (MSD) and Te Puni Kokiri. A scoping project was carried out by the Public Health Directorate to help improve the working relationships and align services between MSD and DHBs to address social and health determinants particularly in the area of physical activity and nutrition and mental health<sup>11</sup>. The scoping report concluded that there are potential benefits through greater collaboration between health and social development sectors and provides a useful gap analysis that can assist with planning for primary prevention for cancer control.

GP services and PHOs provide an important role in primary prevention. TDH supports the recommendation made at the national networking hui for Health Promotion in PHOs<sup>12</sup> (June, 2006) for DHBs to help develop health promotion in the PHO environment.

### **Key Issues from Goal 1**

- High prevalence rates of tobacco smoking in Tairawhiti.
- High rates of obesity in Tairawhiti – refer to Inequalities Action
- Increasing health disparities and high levels of deprivation.
- Linking prevention programmes to prevalent cancer types i.e. breast and prostate, lung, colorectal and melanoma.
- The proliferation of health promotion programmes, funding streams and stakeholders.
- Increasing role and interest of PHOs in health promotion.
- Growing number of health promotion roles and activities in health and social sectors.

### **Recommended Actions for Goal 1**

- Implement tobacco control plan to reduce the prevalence and uptake of smoking in Tairawhiti.
- Implement Tairawhiti Healthy Eating-Healthy Action (HE-HA) strategic plan to reduce obesity, improve nutrition and increase physical activity for the population of Tairawhiti.

<sup>11</sup> Health and Social Development Position Paper, LECG Ltd, June 2006.

<sup>12</sup> 'Health Promotion in PHOs, National Networking Hui 19 & 20 June, 2006', discussion paper and summary of discussions prepared by Doone Winnard on behalf of ARPHS, August 2006.

- Implement Sexual Health Strategy to reduce incidence of cancers caused by infectious diseases.
- Work with PHOs to produce an action plan to support development of health promotion in PHO settings.
- Develop joint workforce development programme for the Tairāwhiti health promotion workforce. (Goal 5).
- Encourage health promotion competencies/best practice guidelines to ensure health promotion programme plans to reduce inequalities.

**Goal 2: Ensure effective screening and early detection to reduce cancer incidence and mortality**

**Screening**

Cancer screening is the early detection of cancer, or precursors of cancer, in individuals who do not have symptoms of cancer. These interventions are often directed to entire populations, or to large and easily identifiable groups within the population.

New Zealand has two national cancer screening programmes, the National Cervical Screening Program (NCSP) and BreastScreen Aotearoa (BSA). The National Screening Unit (NSU) within MOH is responsible for the ongoing management and all operational aspects of the programmes.

Screening programmes have the potential to reduce the impact of cancer. For example, breast screening for women can reduce the risk of dying from breast cancer by 20-45% depending on age. Cervical cancer is one of the most preventable cancers and regular cervical screening will reduce a woman's risk of developing cancer by 90% (NSU, 2006).

As screening programmes are offered to people without evident disease, it is crucial that such programmes are demonstrably effective. Early detection efforts must focus on those cancers where reduced cancer mortality and morbidity has been proven such as breast cancer and cervical cancer. National feasibility studies are currently underway to ascertain the benefits of a national screening programme for prostate and colorectal cancers.

**Early detection**

Awareness of cancer is an issue for many, particularly late presentation of relevant symptoms. An excessive delay between the presentation or identification of initial symptoms, and the definitive diagnosis can have a significant psychological effect on those with cancer, their family and whanau<sup>13</sup>. Early recognition of symptoms requires education to increase awareness. Not all cancers have recognisable symptoms and for some cancers early detection does not always mean a better outcome.

Poor access to health services is a barrier to good health. Creating opportunities to carry out symptom checks for the most prevalent cancer types and particularly for those most at risk is required where a national screening programme does not exist.

If early detection can lead to better health outcomes or quality of life for some patients then it is important to enable people to recognise symptoms and take appropriate action. There are a number of factors that could lead to delayed detection and diagnosis. Fear of the unknown could be a barrier to early detection.

*"I don't think there is enough information out there or public knowledge. I would relate cancer with death because that's all I knew."*

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<sup>13</sup> Refer to p34, NZCCS.

*"I find that a lot of men are afraid of tests. I know some guys who won't go near a doctor."*

Communication between patients and health professionals is also critical. One interviewee spoke of frustration at not being able to articulate their concerns to their GP or not being heard by their GP.

*"I was frustrated because when I tried to tell the problem I felt ignored and the fact that they're doctors you trust them and ignore your own concerns and instincts."*

Programmes such as BSA have the benefit of a dedicated person to navigate and support women through the health system. A similar role to raise public awareness about cancer, encourage frequent health checks, and support patients through to diagnosis would be helpful. Collaboration between health promotion/education services, GPs, screening and primary health care services; and consumers appears to be the logical starting point to discuss these ideas. Patient journey mapping would help to identify more clearly the barriers to early detection.

## **Screening Services in Tairāwhiti**

### ***BreastScreen Aotearoa (BSA)***

Health promotion and support services for the BSA programme are delivered in Tairāwhiti by *Te Hauora o Te Aitanga a Hauiti*, based in Tolaga Bay. This service is contracted by BreastScreen Coast to Coast (one of six lead BSA providers) that encompasses Tairāwhiti, Taranaki, Wanganui, Hawkes Bay and Manawatu DHB regions.

For eligible women in Tairāwhiti, the BSA service provides health promotion, recruitment, enrolment, screening, and assessment to a definitive diagnosis, (with support to access travel and accommodation if required).

BSA mammography services are delivered via a mobile unit that visits the region for two weeks every year (initially every two years until 2004). Gisborne Radiology is the fixed mammography service provider in the region. Gisborne Hospital patients who require mammography services are referred to Gisborne Radiology. Gisborne Radiology employs one qualified mammographer. Reliance on one specialist for this service means that there are delays if this person is not available or on leave.

The staff of *Te Hauora o Te Aitanga a Hauiti* BSA service work closely with Iwi health providers to maintain enrolment and coverage rates of women accessing primary health care services.

Although the primary role of *Te Hauora o Te Aitanga a Hauiti* is to promote and support women to undergo breast screening, the current contract limits the amount of funded support and therefore does not meet the known demand. The provider will often continue to support women for further assessments, diagnosis and cancer treatment to ensure that they progress along the cancer control pathway. Women may be required to travel to Hawkes Bay and Palmerston North for these services. BSA patients interviewed claim that they would not have entered the programme or pursued the treatment pathway if not for the encouragement and support of the BSA health promoter.

Tables 6 and 7 below show actual numbers and percentages for coverage of eligible women in Tairāwhiti who utilised the publicly-funded BSA programme for a two-year period from November, 2004 to October, 2006. Rates are low for Maori and Pacific women and Other women within the 45-49 year age bracket.

Table 6: Breast screening coverage rates in Tairāwhiti from Nov 2004 to Oct 2006.

| <b>Ethnicity</b> | <b>Coverage from 1/11/04 to 31/10/06</b> | <b>% Coverage</b> | <b># required to reach 70%</b> |
|------------------|--|-------------------|--------------------------------|
| <i>Maori</i>     | 564                                      | 24%               | 1,109                          |
| <i>PI</i>        | 15                                       | 24%               | 29                             |
| <i>Other*</i>    | 2,093                                    | 55%               | 557                            |
| <b>Total</b>     | <b>2,672</b>                             | <b>43%</b>        | <b>1,695</b>                   |

Data Source: BSA (contains only public funded women between 45 and 69).

Table 7: Age-specific Breast Screening coverage rates in Tairāwhiti for non-Maori and non-Pacific women from Nov 2004 to Oct 2006.

| <b>*Age Band</b> | <b>Coverage from 1/11/04 to 31/10/06</b> | <b>% Coverage</b> | <b># required to reach 70%</b> |
|------------------|--|-------------------|--------------------------------|
| 45-49            | 357                                      | 20%               | 863                            |
| 50-54            | 722                                      | 49%               | 304                            |
| 55-59            | 686                                      | 56%               | 179                            |
| 60-64            | 548                                      | 56%               | 138                            |
| 65-69            | 359                                      | 44%               | 212                            |

Data Source: BSA (contains only public funded women between 45 and 69).

TDH must work with MOH/BSCC and the BSA service provider to improve coverage rates as the incidence and mortality rates for breast cancer are high when compared to both national rates of breast cancer and the rates of other cancers types in this region. It is important that MOH/BSCC recognises the high risk of the Tairāwhiti population and prioritises the region for receiving equitable resource allocation.

Proactive planning is required to ensure community access to radiology for women at risk between 40-45 years and any age 5 years post-breast cancer surgery. These groups or women require annual mammograms.

Once again solutions may be found through analysis of patient processes and health system processes as was done for the *Midland Region Cancer Control Patient Mapping Project* in 2005 that focussed on breast cancer patients (Hewitt. J, 2005). A review of the BSA service specifications against the *Equity Lens*<sup>14</sup> may also be of use to identify gaps/causes specific to the Tairāwhiti region.

The Midland project identified some key themes following patient interviews:

- Waiting times
- Access to services
- Urgency to get underway with treatment
- Lack of continuity of care
- 'Cut adrift' after treatment
- Financial burden
- Information

<sup>14</sup> The Equity Lens is a Ministry of Health assessment tool. For more information visit the MOH website: [www.moh.govt.nz](http://www.moh.govt.nz).

Service improvements have been made by Midland DHBs as a direct result of this project.

The MOH are currently discussing with TDH a project to expand the use of the mobile mammography unit to reach women who are at high risk of breast cancer and living in rural areas. Increasing access to the mobile unit for backup purposes to support the fixed site may also be of benefit. In the past, staff shortages at the fixed site have lead to delays in mammography services for BSA enrolled women.

**National Cervical Screening Programme**

Cervical screening services are provided by the Cervical Screening Unit based in the Public Health Unit of TDH. Staffing includes one manager and two health promoters. There are approximately 30 registered smear taker nurses in the region based in general practice services.

*The Ministerial Inquiry into the Under-Reporting of Cervical Smear Abnormalities in the Gisborne Region* (Duffy et al, MOH, 2001) highlighted a number of quality issues within the screening programme. The report from the inquiry listed 46 recommendations, and the majority have been implemented to bring about the required changes to the programme. The NSU continue to carry out audits to monitor and improve the services of the NCSP.

Waikato DHB currently manages the cervical screening registry while TDH continues the provision of smear taking and health promotion activities relevant to the programme. However, from 1 July, 2007 a new national Register will be in place. The new programme is expected to improve on current quality assurance systems, streamline current business processes; and provide a more efficient electronic interface between the NCSP-Register and providers and key stakeholders.

PHOs are principal providers of smear taking services in Tairawhiti and the table below shows that the participation rates (number of women enrolled on the NCSP-Register) although the rate for Pacific women can be improved. The coverage rate for Maori and Pacific women is lower than those of Other and Asian women.

A national evaluation of NCSP health promotion services is underway to improve planned interventions to reach target audiences and work is being carried out by Tairawhiti NCSP and the Pacific Island Community Trust to improve coverage rates for Pacific women living in Tairawhiti. Other interventions to be considered include payment incentive to GPs for referring women for screening. This has been proven to be successful at Canterbury DHB and is already in the PHO Performance Management Programme.

Table 8: Cervical Screening Participation as at September, 2006 for Tairawhiti DHB region.

| Ethnicity | Population | Actual | % Tairawhiti |
|-----------|------------|--------|--------------|
| Maori     | 5867       | 4731   | 80.6%        |
| Asian     | 223        | 158    | 71%          |
| Pacific   | 203        | 132    | 65%          |
| Other     | 5694       | 6296   | 110.6%       |

Source: National Cervical Screening Unit (NSU), 2007. \*The % rate for *Other* includes some duplication.

Table 9: Cervical Screening Coverage as at September, 2006 for Tairawhiti DHB region.

| Ethnicity | Population | Actual | % Tairawhiti |
|-----------|------------|--------|--------------|
| Maori     | 5867       | 3517   | 59.9%        |

|         |      |      |       |
|---------|------|------|-------|
| Asian   | 223  | 135  | 60.7% |
| Pacific | 203  | 100  | 49.2% |
| Other   | 5694 | 5314 | 93.3% |

Source: NSU, 2007.

### **Colposcopy Clinics**

Colposcopy clinics are held weekly at TDH in an outpatient setting. TDH employs two full-time gynaecologists, one permanent and one locum. Both are skilled colposcopists. The current number of clinics is unable to meet service demands and additional gynaecologists would be required in order to increase this number.

It is uncertain at this point as to what impact this is having on patients seeking diagnosis for possible cancer or receiving treatment for cervical abnormalities. While information systems are in place to capture data from colposcopy clinics, how this data is accessed, for what purpose and by whom, needs to be coordinated and formalised for monitoring purposes. An upcoming audit of colposcopy services by NSU will assist with this process.

The audit of all DHB colposcopy services has been called following a review of colposcopy services in 2006 by MOH. The review identified areas for improvement around waiting times, clinical oversight, assessment and grading of referrals, inconsistencies in documentation and the management of women who fail to attend clinic appointments. An audit of TDH colposcopy services will be a timely intervention particularly in relation to the cancer control plan in order to assess how well TDH is meeting colposcopy standards and identify areas for improvement.

Chelsea Private Hospital also provide colposcopy services, however, this information is not integrated at a regional level. This presents a problem for NCSP who have a monitoring role for women on the screening pathway but are not informed of the outcomes from private clinics and unable to follow up effectively. Information protocols between Chelsea Private Hospital and NCSP will help to eliminate this gap in services for women.

As described screening and early detection involves a number of health services in both private and public health sectors. Improvements to screening and early detection must involve collaboration between all of these services. There are opportunities to improve coverage of national screening programmes as discussed previously and interventions to increase opportunities for non-formal screening and health checks in community settings, particularly for the more prevalent cancer types such as melanoma, should be considered.

### **Prostate Cancer**

Prostate cancer is the most common tumour type for men in Tairāwhiti particularly males over 60 years.

Prostate specific antigen (PSA) testing, as a screening test for prostate cancer in the general population has not been demonstrated to improve outcome (survival) from prostate cancer. There may be sub-groups, e.g. first-degree relatives, who may benefit, though this too is unproven. Therefore, at present there is no recommendation from the National Health Committee for the routine screening of men without symptoms for prostate cancer in New Zealand.

### **Colorectal Cancer**

*The Report of the Colorectal Cancer Screening Advisory Group* (MOH, 2006), says that colorectal cancer is the fourth most common cancer for Maori and the second most common cancer for non-Maori during 1996 to 2001. The mortality:incidence ratio is 57% for Maori (50:85), and 41% for non-Maori (1080:2400). Maori cancer mortality rates have increased between 1980 and 1999, although the rates overall in New Zealand have been declining since the 1970s.

Produced by the Colorectal Screening Advisory Group in 2006, this report discusses the appropriateness and feasibility of population-based screening for colorectal cancer. Screening for colorectal cancer is not recommended at this time by the Advisory Group. However, it will continue to advise NSU as new information comes to hand through international research. Colorectal cancer is among the top 5 types of cancer registrations and deaths in Tairāwhiti. With no formal national screening programme to be approved in the near future there is a need for new interventions to enable early detection of colorectal cancer.

### **Melanoma**

Nationally, the rate of death caused by melanoma is among the highest in the world, and the incidence of melanoma particularly among non-Maori has increased. The Cancer Society and Health Sponsorship Council have developed national health promotion campaigns. The PHU continues to promote 'Sunsmart' campaigns in various settings and GPs provide advice to their patients to protect against UV radiation. There is no formal nationally funded screening programme for this type of cancer.

*MoleMap* services visit Chelsea Private Hospital several times per year. *MoleMap* is a digital imaging procedure that allows specialists to diagnose moles and other suspicious lesions. While *MoleMap* has the ability to identify all skin cancers, its primary focus is on the early detection of melanoma<sup>15</sup>. *MoleMap* is a user-pays service and those patients who cannot afford the service but are concerned about melanoma would need to request a check from their GP.

With the relatively high rates of melanoma for this region perhaps more opportunities for Sunsmart providers and GP services to collaborate on improving access to this type of screening in community settings could be done.

### **Key Issues from Goal 2**

- Low screening breast screening rates for women in Tairāwhiti.
- Late presentation by patients.
- Delays in detection and symptom recognition.
- Communication barriers between patient and health professional
- Increasing melanoma rates for non-Maori.
- Workforce capacity for mammography, colposcopy screening and early detection.
- Limited access to mobile screening unit.
- Tairāwhiti not prioritised by BSCC despite high risks for region.
- Delays in enrolment and screening.

<sup>15</sup> For more information visit [www.molemap.co.nz](http://www.molemap.co.nz).

**Recommendations for Goals 2**

- Work with PHOs, BSA, BSCC and MOH to target breast screening rates for women in Tairāwhiti particularly Māori and women living in rural areas.
- Advocate to MOH/BSCC for high priority status for Tairāwhiti
- Incorporate workforce capacity issues into workforce development plan (Goals 5 and 1).
- Coordinate melanoma screening/early detection plan for the region.
- Integrate screening information between public and private health services.
- Improve patient/professional communication regarding cancer. (Goal 4).

**Goal 3: Ensure effective diagnosis and treatment to reduce cancer morbidity and mortality**

**Background**

Both cancer diagnosis and treatment involve a number of services, disciplines and providers. It is during this time that a patient may require extra support services to assist them through the uncertain period of diagnosis through to the treatment pathway. For some patients, cancer treatment may be a long-term experience, for others it may be a short journey but recurring.

Patients may also choose to engage the use of Complementary and Alternative Medicines (CAM). More often than not extra travel will be required by patients within Tairāwhiti to Gisborne Hospital or to other regions for treatment. The fragmentation and complexity of cancer services becomes more evident from this point onwards and coordinating activities becomes a critical task for health services.

The impact of diagnosis and treatment care on cancer outcomes and health inequalities in Tairāwhiti is difficult to measure without the analysis of reliable data; patient factors, health care processes and health system factors (Cormack et al, 2005). Issues regarding the monitoring and evaluation of services and data collection are described in more detail under Goal 6 of this plan.

**Diagnostic Services**

*“Of prime importance is the timeliness of diagnosis” (NZCCS, 2003)*

*“...disparities in cancer outcome have less to do with the biological aspects of the disease, and much more to do with the type and timeliness of care that people receive”*

*(Unequal Impact: Maori and non-Maori Cancer Statistics 1996-2001)*

Goal 3 of the NZCCS places prime importance on timeliness of diagnosis. Waiting for a diagnosis for cancer can be the start of an emotionally and psychologically stressful period for a patient and their whānau who may be uncertain about the future of their health until test results are complete and an assessment can be made by health specialists. Therefore, delays in diagnosis can affect the quality of life of an individual and their whānau, and lead to delays in treatment which may impact on treatment outcomes.

Diagnostic treatment may take place locally; on an out-patient or in-patient basis. In some cases diagnosis will require a visit to another region such as Hawkes Bay or Waikato depending on the type of cancer. This requires service coordination between hospitals and further support for cancer patients and their whānau/support people to coordinate appointments, travel and in some cases accommodation. The diagnosis period can take up to 6 weeks or longer. This process may or may not result in a cancer diagnosis.

## **Stage at Diagnosis**

“Knowledge of stage of disease spread is vital for deciding treatment options for many cancers.” (Cormack et al, 2005).

This is a significant point, particularly for Maori cancer patients as recent national research (Robson et al, 2006 and Cormack et al, 2005) shows that:

- Maori are less likely to have stage at diagnosis recorded.
- Maori who are ‘staged’ are more likely to be diagnosed at a more advanced stage of disease spread.

The impact of cancer on Maori is discussed further in Sections 3.

A review of TDH cancer services should include the ‘staging’ process for all of its cancer patients and any delays or failures to stage for cancer should be investigated. Timeliness of diagnosis and stage at diagnosis should form part of any diagnosis and treatment protocols.

## **Cancer Treatment Services**

A patient is referred to an Oncology Clinic once a diagnosis is confirmed. Referral and treatment pathways will obviously depend on the cancer. Assessment is generally provided within the designated 6-week timeframe identified in the MOH guidelines. Some patients can be managed locally without the need to travel away and can receive chemotherapy at TDH. Other patients may require the services of a tertiary cancer treatment centre. Non-emergency referrals for diagnosis and treatment are managed through elective services within the Gisborne hospital.

Gisborne Hospital provides a range of general and specialised services for cancer patients including:

- General surgery
- Ear, Nose, Throat Specialist; Orthopaedic specialist
- Medical Physician
- 1.45 FTE Oncology nurse including Breast Care role
- 0.5 FTE Oncology social worker
- Radiology
- Laboratory
- Palliative care hospital beds
- Rehabilitation services
- Pharmacy

Clinics including First Specialist Assessments (FSA) and follow-ups are coordinated by TDH Outpatients Department (OPD). Chemotherapy and other cancer treatments are coordinated by OPD and Day Ward. Patients that cannot be treated locally are referred to one of the tertiary cancer treatment centres. Table 10 below shows the cancer patient flow from TDH to regional cancer treatment centres in 2005/2006.

## **Surgery**

TDH has 4 FTE general surgeon positions with 3 positions full at this time. The types of general surgery for cancers carried out at Gisborne Hospital include skin, thyroid, stomach, gallbladder (uncommon), small and large bowel including rectum, breast, some renal tumours, bladder, prostate and testicular cancers. Liver cancers are referred to Auckland DHB and oesophageal cancer patients are also referred out.

Surgery for pancreatic cancers has been done in Gisborne in the past but may be referred to Auckland or Waikato tertiary centres if necessary.

A concern of clinical services is the lack of clinical specialists required to meet the growing cancer burden. There is a shortage of cancer specialists in New Zealand and examples of how this is impacting on treatment care are described in this section. Issues regarding workforce shortages are being progressed at a national level and TDH will continue to monitor developments against local staffing issues.

### **Oncology Nursing**

The TDH oncology nursing service (1.45 FTE) includes breast specialist nursing care and works within both hospital and community settings. These positions are funded via District Nursing Services and not directly through a Medical Oncology service agreement.

The role of the Oncology Nurse involves care coordination and case management for oncology and haematology patients including patient education and symptom management. TDH Oncology Nurses liaise with patients and their whanau/families; and medical staff from TDH and Regional Cancer Treatment Centres to coordinate services. The breast specialist nursing role is to provide support, information and advocacy services to women with breast cancer from the time of diagnosis to the completion of treatment or treatment related side effects.

Oncology nursing services are supported by Day Ward and OPD nursing staff to facilitate specialist clinics and administer chemotherapy treatment. Day Ward has two fully certified chemotherapy nurses who are qualified to administer cytotoxic chemotherapy treatment and two partially trained nurses. On average there are approximately 12 clients receiving chemotherapy at any given point in time and up to six may receive treatment in a week.

Patient:nurse ratios have been raised as an issue by TDH since 2003. Waikato and Tauranga centres view one nurse to three to four patients per shift as appropriate. Gisborne hospital oncology nursing services are reliant on a limited number of qualified staff and maintaining service levels during leave is an issue. Succession planning and staff relief is an area to be considered for review to ensure continuity and quality of oncology services for TDH cancer patients.

### **Radiology**

Gisborne has two radiology services one based at TDH and another private service - Gisborne Radiology. The radiology department at TDH carries out imaging services for all hospital patients including cancer patients. This department provides Computerised Technology (CT), Medical Resonance Imaging (MRI), general x-ray and interventional radiology e.g. biopsies. Symptom management may be an option but there is no sterile unit at present and upgrades to the service are currently underway.

Procedures that are unable to be carried out at TDH are referred to other DHBs for specialist radiology services such as in the case of lung cancer diagnosis and children's cancer. TDH radiology does not have a mammography service and patients are referred to Gisborne Radiology for this procedure.

Waiting times for TDH radiology services are reported to be low as demands are able to be met within current resources.

### **Laboratory**

Currently there are two Laboratory Providers in Tairāwhiti, the Gisborne Hospital Laboratory which provides hospital laboratory services and a small proportion of community referred testing. TDH also has a contract with a private Provider, MedLab Gisborne, to provide community referred testing.

An independent review of both Providers indicated that significant savings could be achieved by rationalizing the provision of laboratory services in the district. As a result of this conclusion TDH is now engaged in a tendering process seeking the provision of a combined hospital and community referred laboratory service. It is anticipated that this process will be completed with a September 2007 commencement date for the preferred Provider.

### **Pharmacy and Cancer Drugs**

Gisborne Hospital Pharmacy service prepares chemotherapy and other cancer drugs for TDH cancer patients. Chemotherapy drugs are ordered from Hawkes Bay Hospital for delivery to Gisborne.

The costs of cancer drugs vary with newer treatments costing up to \$4000 per cycle. Drug costs for cancer are increasing ahead of inflation, especially with the introduction of new treatments. In 2005/2006 TDH spent a total of \$394,744 on oncology drugs with \$111,188 spent on the first quarter of 2006/2007 compared to \$79,309 spent during the first quarter of the previous year.

New cancer drugs introduced to the market are subject to regular monitoring and approval by the government drug-funding agency PHARMAC. The recent publicity surrounding the breast cancer drug Herceptin highlights the public pressure faced by the government to fund new drugs that may be of high cost yet clinically unproven for long-term benefits and its impact on life expectancy. Population Based Funding (PBF) means that increased costs for drugs need to be met within existing resources, an increasing challenge for health care providers.

Expenditure by TDH on all pharmaceuticals has risen by over 12% in the past year. This represents the fastest rate of increase in drug costs throughout New Zealand when compared to a 5% increase nationally and 7% increase in the Midland region. A joint DHB project is underway to purchase all cancer drugs through Pharmac. This is to improve effectiveness of spend.

### **Tertiary Cancer Treatment Centres**

TDH purchases additional cancer treatment services and specialist care from regional cancer treatment centres:

- **MidCentral DHB (MidCentral Health)** in Palmerston North is the primary treatment service provider for Tairāwhiti cancer patients.
- **Waikato DHB** provides specialised surgical and medical interventions mainly for ear, nose and throat cancers.
- **Auckland Starship Hospital** provides paediatric oncology services for children and adolescent cancer patients referred from Gisborne.
- **Capital and Coast DHB** in Wellington provides treatment for gynaecological cancers.

As the principal provider of cancer treatment services to this region, MidCentral Health (MCH) provides Visiting Specialist services to TDH as follows:

- Medical Oncologist – 18 visits per year

- Radiation Oncologist – 12 visits per year
- Haematologist – Quarterly visits annually (80% oncology)
- Registrar – 12 per year with Medical Oncologist

Clinical meetings are held at TDH to assess and manage patients with malignant tumours. TDH patients who require radiation oncology services are referred to MCH. MCH has three linear accelerators (Linacs) with one due for replacement in 2007/2008.

Waiting times for treatment are monitored by MCH following MOH wait time criteria. Monthly and weekly wait time reports are required by MOH and available to DHBs to assist with patient monitoring and care. Waiting times can be adversely affected by staff shortages, equipment shortages and/or failure and industrial action. This has a direct effect on treatment start times for TDH patients.

As at January 2007, the *waiting time between first specialist assessment and start of radiation treatment* for Tairawhiti cancer patients were as follows<sup>16</sup>:

- No Priority A patients (treat within 24 hours) or Priority B patients (treat within 2 weeks) waiting for first specialist assessments or treatment.
- Priority C patients (treat within 4 weeks) had an average wait time from assessment to treatment **0.6 weeks**.
- Priority D patients (combined chemotherapy & radiation therapy) (treat within 12 weeks) had a wait time from assessment to treatment of **14.5 weeks**.

The waiting time between *receipt of referral and the start of radiation treatment* was as follows:

- No Priority A and Priority B patients from TDH were on the waiting list.
- Priority C patients had a wait time of **1.8 weeks**.
- Priority D patients had a wait time of **17.1 weeks** from referral to treatment.

Treatment delays are managed by MCH within existing resources and contingency plans are regularly communicated to all stakeholders. If necessary, suitable patients are offered treatment in Australia and some TDH patients have taken this option. Any delays or disruption to treatment for cancer patients will have a flow on effect for whanau/family and support services that may be unable to respond at short notice to changes to treatment plans and travel arrangements.

Phase 1 of the NZCCS Action Plan 2005-2010 aims to provide long term solutions to current issues of treatment equipment and workforce capacity. Similar issues exist within other regional cancer treatment centres. Waikato DHB has recently commissioned a fourth bunker and linear accelerator and Capital and Coast DHB currently have two linear accelerators and are seeking an additional one for its Wellington treatment centre. A minimum number of medical radiation technologists are required to operate Linear accelerators in addition to radiation oncologists and physics staff. Both Waikato and Palmerston North hospitals have identified staff shortages in these areas. Workforce issues are addressed in Goal 5 of this plan.

## **TDH Patient Flow To Regional Cancer Treatment Centres**

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<sup>16</sup> Source: Regional Cancer Treatment Service, Palmerston North Hospital, 2007.

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The following table shows the Inter District Flow of Oncology Inpatients from TDH to regional cancer treatment centres and the associated treatment costs for 2005/2006.

Table 10: Inter District Patient Flows from TDH to Regional Cancer Treatment Centres.

| DHB Service  | PU*    | PU name  | Admission Type | Forecast   |                   | Actual     |                   |                  |
|--------------|--------|--|----------------|------------|-------------------|------------|-------------------|------------------|
|              |        |  |                | Client No. | \$ value (GST ex) | Client No. | \$ value (GST ex) | Difference       |
| MidCentral   | M50.01 | Oncology - Acute/Arranged Inpatient Services (DRGs)        |                | 33         | 163,156           | 31         | 153,160           | \$ 9,996         |
| MidCentral   | M50.01 | Oncology - Elective Inpatient Services (DRGs)              |                | 29         | 107,788           | 25         | \$95,169          | \$ 12,619        |
| Otago        | M50.01 | Oncology - Acute/Arranged Inpatient Services (DRGs)        |                | 1          | 4,849             | 1          | \$4,849           | \$-              |
| Waikato      | M50.01 | Oncology - Acute/Arranged Inpatient Services (DRGs)        |                | 1          | 1,456             | 1          | \$1,456           | \$-              |
| Auckland     | M54.01 | Specialist Paediatric Oncology - Inpatient Services (DRGs) | Acute/Arranged | 7          | 29,582            | 6          | \$28,895          | \$ 687           |
| <b>Total</b> |        |  |                | <b>71</b>  | <b>306,830</b>    | <b>64</b>  | <b>283,528</b>    | <b>\$ 23,302</b> |

\*Purchase Unit  
Source: MOH, Inter District Flows, 2005/2006.

Table 11: Oncology treatments funded by TDH for 2005/06.

| 2005/06 actual     | Oncology         |                 |                       |                  |                  |                           |                    |
|--------------------|------------------|-----------------|-----------------------|------------------|------------------|---------------------------|--------------------|
| PU description     | Inpatient        | 1st Attendance  | Subsequent Attendance | Chemotherapy     | Radiotherapy     | Stereotactic radiosurgery | Total              |
| PU code            | M50001           | M50002          | M50003                | M50004           | M50005           | M50006                    |                    |
| Tairāwhiti         |                  | \$60,526        | \$207,065             | \$525,640        |                  |                           | \$793,231          |
| MidCentral         | \$248,329        | \$6,725         | \$71,807              | \$16,380         | \$450,626        |                           | \$793,867          |
| Auckland           | \$28,895         |                 | \$3,095               | \$20,102         | \$12,399         |                           | \$64,491           |
| Other <sup>1</sup> | \$6,305          | \$517           | \$3,715               |                  | \$8,502          | \$11,550                  | \$30,589           |
| <b>Total</b>       | <b>\$283,529</b> | <b>\$67,768</b> | <b>\$285,682</b>      | <b>\$562,122</b> | <b>\$471,527</b> | <b>\$11,550</b>           | <b>\$1,682,178</b> |

<sup>1</sup>Waikato DHB and Otago DHB  
Source: MOH, Inter District Flows, 2005/2006.

Table 12: Paediatric Oncology treatments funded by TDH for 2005/2006.

| <b>Paediatric Oncology<br/>2005/2006 Actual</b> |                  |                           |                                  |              |
|---|------------------|---------------------------|----------------------------------|--------------|
| <b>PU<br/>description</b>                       | <b>Inpatient</b> | <b>1st<br/>Attendance</b> | <b>Subsequent<br/>Attendance</b> | <b>Total</b> |
| <b>PU code</b>                                  | <b>M54001</b>    | <b>M54002</b>             | <b>M54003</b>                    |              |
| <i>Auckland</i>                                 | \$28,895         | -                         | \$26,641                         | \$55,536     |

Source: MoH IDF flows for 2007/08

Additional oncology funding is allocated to associated services including Matched Unrelated Donor (non relative) risk pool (\$29,099) and marrow fee (\$6,611). *Matched Unrelated Donors* (MUDs) are used during transplants to replace bone marrow (stem cells) lost when a person has undergone high-dose chemotherapy, usually appropriate in the early stages of the disease cycle for leukaemia, myeloma or other bone marrow cancers.

TDH spent approximately \$1.8m on oncology treatment during 2005/2006. The following table provides a breakdown of the expenditure by Purchase Unit. This figure is expected to increase by 2.6% in 2007/2008.

### **Private Cancer Treatment Services**

Not all cancer treatment is publicly funded. Chelsea Private Hospital is based in Gisborne and its local and visiting private surgical, gynaecological, ENT, plastic and orthopaedic specialists provide a wide range of health services to the community. These include screening and early interventions such as endoscopic procedures, removal of lesions and biopsies; to more invasive surgical interventions including, bowel resections, mastectomies and breast reconstructions and laparoscopic hysterectomies.

*MoleMap*<sup>17</sup> also visits several times a year and runs its outpatient clinics from Chelsea facilities.

In addition, free respite/palliative nursing care services are available to cancer patients and their families who would benefit from a short stay in the hospital. These are funded by specific fundraising events carried out by the Friends of Chelsea Charitable Trust.

Not all private cancer patients are treated at Chelsea. Specialists may provide some surgical procedures and interventions in their consulting rooms or refer out of district. Hospital data is collected by procedure type rather than diagnosis hence further analysis is required to provide a breakdown by disease-type that could be useful to provide a profile of the cancer patient flows through the private health sector in Tairāwhiti.

One of the cancer patients interviewed had medical insurance and opted for private health care to treat breast cancer. She was still required to travel to Hawkes Bay, Auckland and Palmerston North throughout her diagnosis and treatment pathway.

<sup>17</sup> For more information about MoleMap, refer Goal 2, p32, *Melanoma*.

### **Complementary and Alternative Medicines (CAMs)**

Patients are increasingly seeking the use of traditional therapies and complementary medicines in addition to receiving conventional treatment. Traditional Maori medicines and therapies are now a part of primary health services. Cancer service providers will need to look at how to improve the integration of CAMs with conventional treatments to meet patient demands and increase options for cancer care.

### **Models of Care**

As described in this document the provision of cancer care for patients relies on the coordination of services and processes across a number of disciplines, organisations and regions. Having the right model of care in place to maximise service delivery and ensure a seamless service across the continuum of cancer control is critical.

### **Multidisciplinary Care**

Overseas experience of multidisciplinary treatment planning and care models have shown to improve outcomes for cancer patients (NZCCS, p35) and are increasingly favoured by regional cancer treatment centres such as Waikato DHB<sup>18</sup> and MidCentral DHB<sup>19</sup>. Both Hawkes Bay and Northland DHBs have recommended in their cancer control plans projects to determine the most appropriate Multidisciplinary Team model (MDT) for their respective organisations.

TDH currently uses a multi service team approach for assessing and monitoring cancer patients although this approach is used as required on an ad hoc basis. Teams include visiting specialists, oncology nurses and general surgeons and nurses continue to link patients to other services. Multi service meetings therefore are currently limited to TDH services and do not routinely include external providers and support services.

A more integrated service model would extend participation to include psycho-social services and support agencies, pharmacy, general practitioners, primary health providers, cultural advisors, allied health providers, the patient and whanau/support. Multidisciplinary care models can vary according to patient needs and the capacity of relevant services. The current arrangement is fragile due to limited specialist and nursing levels to meet patient demand.

There is currently no formal arrangement for a multidisciplinary approach specifically for the planning and care of cancer patients at TDH. A project to consider MDT models is required to determine the most ideal model for cancer patients and is recommended in this plan.

Issues to be considered in this process would include patient needs, service capacity to participate effectively in an MDT; operational costs, the availability and use of technology (Waikato DHB has recommended the use of telemedicine to support inter-regional MDTs for the Midland region); appropriate settings for MDT meetings e.g. community or marae-based as opposed to hospital; a multidisciplinary coordinator is also recommended as being essential to the success of MDTs<sup>20</sup>.

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<sup>18</sup> Refer p59, *Non-Surgical Cancer Treatment Service Plan for the Midland Region*, Barber. Jan, Midland DHBs, 2004.

<sup>19</sup> Refer *Central Region Cancer Control Plan*, MidCentral Health. June, 2006.

<sup>20</sup> Refer p59, *Non-Surgical Cancer Treatment Service Plan for the Midland Region*, Barber. Jan, Midland DHBs, 2004.

A cancer patient interviewed felt that a discussion with all specialists and services concerned would save time and place patients in a better position to make informed decisions about their treatment. However, depending on the setting, not all patients may be comfortable in this environment without a suitable advocate or support person.

*"I would recommend a 'buddy system' for those more reticent"*

### **Key Issues for Goal 3**

#### ***Diagnosis***

- The timeliness of diagnosis and stage at diagnosis
- Combined laboratory services

#### ***Treatment***

- The need for tertiary care outside of the district complicates the patient journey
- Access to cancer services for Maori.
- Maori responsiveness i.e. Integration of whanau ora model and improvement of staff cultural competency.
- The use of complementary, alternative and traditional medicines and therapies
- Financial burden for patients and their whanau/family.
- Escalating costs for cancer treatment and drugs.
- Lack of formal referral pathways and diagnosis/treatment protocols for providers and clients.
- Coordination of and access to TDH cancer data and patient information for service monitoring. (Goal 6).
- Accommodation/travel requirement inappropriate. (Goal 5).

### **Recommendations for Goal 3**

A review of cancer services that will involve:

- Scope and propose for a Service Improvement Project to assess current patient management models, patient care processes and health systems to identify gaps, delays and areas for improvement.
- Funding proposal for A Patient Journey Mapping project.
- Review current models of patient management planning and care and formalise agreed model.
- Development of formal protocols for cancer diagnoses and treatment particularly for most prevalent cancers.
- Review current treatment and drug costs against cancer projections and service provider price options.
- Develop formal protocols for pathways for providers and clients.
- Develop and integrate whanau ora plan for cancer services.
- Implement Central Region Cancer Control Plan.
- Implement Midlands Non-surgical Cancer Treatment Plan.

Some of these issues are addressed under Goal 5, Service Integration and Coordination.

**Goal 4: Ensure the quality of life for those with cancer, their family and whanau through support, rehabilitation and palliative care**

**Support, Rehabilitation and Palliative Services in Te Tairāwhiti**

Evidence shows that when people experiencing cancer receive good social, psychological and cultural support, their quality of life improves (MOH, 2003). Care encompasses more than clinical treatment. It includes psychological and physical support for patient and whanau/family. Whether a patient is receiving treatment, has suffered disability or impairment as a result of cancer and/or treatment, or is terminally ill, in order to achieve the best outcome for those with cancer every aspect of treatment needs to recognise their total needs.

**Support**

The needs of one cancer patient to another at any one time can be so diverse that it is not useful to list all of the support services that could be called upon by a cancer patient. The NZCCS recognises that social, psychological, nutritional, information and spiritual needs are all equally important. Support can come in many forms from a range of people, networks, organisations and services.

Whanau/family and friends, The East Coast/Gisborne Cancer Society, Iwi Providers, GPs, Specialists and Oncology staff were often identified during cancer patient interviews in Tairāwhiti and other regional patient journey mapping projects as key support systems. Support systems can link patients to other health services, other cancer patients, and information about their illness, sources of financial support, social services, complementary and alternative therapies and treatment advice.

Support services appear to be crucial for the successful treatment of a cancer patient. There is strong anecdotal evidence that providers (primary and secondary services) often provide informal support services in addition to contracted services. The provision of additional 'support' services is often not formally recognised and therefore not adequately funded. A funded position dedicated to support cancer patients and their whanau/family is recommended.

The need for 'navigators' to assist cancer patients along the treatment pathway are consistently raised throughout cancer networks. A 'navigator' would walk alongside the cancer patient and should enhance and support other services along the cancer continuum. A stock take of current formal and informal support services currently accessed by cancer patients could identify the need and scope for dedicated support roles.

Further investigation is needed to look into care and support available locally specifically for children and adolescents and their whanau/family. Patients spoke of the need for support for whanau who may have difficulties in dealing with cancer in the family as it can have a negative affect on the cancer patient. Support for whanau/families of cancer patients should be considered as part of the stocktake recommended above.

*"With my family I had to keep them at arms length as sometimes they just make me feel depressed. Even if there was a cancer family support group. That would be good. You've got the burden of looking after yourself; you don't have enough energy to look after family too."*

*“It was such a shock on my family too. I coped better with the news than my family.”*

### **The East Coast/Gisborne Cancer Society**

The mission statement of the Cancer Society of New Zealand is to “minimise the impact of cancer in the community through the provision of support services, health promotion, research, advocacy and information services”.

The local office of the East Coast/Gisborne Cancer Society is located on the Gisborne Hospital grounds. The service provides health promotion services, advocacy, information and support services for cancer patients and their whanau. Programmes such as ‘Living with Cancer’ and ‘Look Good – Feel Better’ are run locally by The Cancer Society. This service is available to all cancer patients and their whanau/family and cancer patients should be made aware of this service by health professionals.

The East Coast/Gisborne Cancer Society is staffed by a manager, an administrator and a part-time health promoter. The organisation does not receive government funding. Many of the community events; services and fundraising activities organised by the Society rely on the commitment of the voluntary sector.

The East Coast/Gisborne Cancer Society is a key resource for cancer patients and better integration of this service with primary, public and secondary health care services, particularly Maori providers to improve responsiveness, would be of benefit to patients.

Other organisations that offer support for cancer patients include Iwi Providers, Turanga Health; Te Aitanga a Hauiti Hauora; Ngati Porou Hauora. Patients (both Maori and non-Maori) interviewed for this plan spoke highly of Iwi providers being available to support patients through clinical treatment and therapy. Patients expressed a need to talk to other people with the same type of cancer and people in their age group.

*“When I got sick (provider) transported me to and from hospital – they were amazing! They brought me to all appointments and sometimes (provider) would stay with me and sometimes they’d go and do their thing and come back. Sometimes they would even sit through chemo with me.”*

### **Rehabilitation**

TDH Rehabilitation services consist of a number of health disciplines, which include District Nurses, Physiotherapy, Speech Language Therapy, Occupational Therapy, Social Work, Physiotherapy, Rehabilitation Ward, and Palliative Care Services. The key role of TDH Rehabilitation services is to help cancer patients manage disease symptoms and/or pain. Rehabilitation may be required as a consequence of cancer treatment where a temporary or permanent disability may have occurred.

A 0.5 FTE psycho-oncology social worker role has been established within this service to support cancer patients through the treatment and care system. MidCentral Health also has a similar service available to all patients who are receiving cancer treatment in Palmerston North. The role includes but is not limited to assessment of patients for social, emotional, interpersonal and socio-economic issues. Interventions may include counselling, crisis intervention, cognitive/behavioural therapy and stress management. This role is specialised in

some areas and should not be seen as the solution to the proposed 'navigator' role that will link cancer patients into one of many services including the psycho-oncology social worker service.

### **Palliative Care**

"Palliative care is the care of people who are dying from active, progressive diseases or other conditions that are not responsive to curative treatment. Palliative care embraces the physical, social, emotional and spiritual elements of wellbeing – tinana, whanau, hinengaro and wairua – and enhances a person's quality of life while they are dying. Palliative care also supports the bereaved family/whanau."(MOH, 2001a).

Palliative Care services are provided at a number of points across the cancer control continuum through a Specialist service, primary health care; General Practices; and TDH hospital services.

### **Gisborne Palliative Care Service**

A specialist service has been provided by Gisborne Palliative Care Services since 1981. The primary focus of the service is to meet the needs of the terminally ill and their whanau in the Gisborne/East Coast region. Approximately 85% of referrals to this service are cancer patients. Referrals are received from either Gisborne hospital or a health provider.

Based on the Gisborne Hospital site, Gisborne Palliative Care Service received 133 referrals in 2006 and approximately 164 interventions were provided. Gisborne Palliative Care Service (GPCS) receives up to 40% of its funding from TDH. Further funding is sourced through various grants and fundraising activities.

The services provided by GPCS include medical care and nursing advice; counselling for patients and whanau; pastoral support; grief and bereavement counselling; equipment loans; volunteer support; respite; education and information.

Staffing includes 1 Palliative Care Specialist; 2 part-time GPs; 1 counsellor (part-time); 1 education coordinator; 1 palliative care nurse; a manager and administration staff. GPCS has up to 70 volunteers to support service delivery.

Two Gisborne Hospital beds staffed by TDH are allocated for palliative care. The rooms are furnished and maintained by GPCS. Home nursing care is provided by TDH District Nursing service and by the Public Health Nurse or Practice Nurse in rural areas. There has been a significant increase in the volumes provided by the TDH palliative care nurse in 2006/2007. This increase has been met by District Nurses but has created financial difficulty for the services that are unfunded.

Te Whare Hauora o Ngati Porou Hauora at Te Puia Springs uses its Inpatient Ward to provide hospital beds for palliative care as required.

### **General Practice and Nursing Services in Palliative Care**

GPs are also providers of palliative care to their patients including on-call care. They may offer to manage palliative patients themselves or refer to GPCS, Iwi providers or TDH services. Practice nurses may provide after hours services up to 8pm during weekdays.

A project to increase access to GP support for palliative care was proposed by TPHO in 2004. This was followed by a needs assessment to pinpoint specific gaps and needs for palliative care in Gisborne. The needs assessment involved a review of the

Gisborne Palliative Care Service and a report highlighting gaps, issues and recommendations was produced in August, 2004<sup>21</sup>.

The review looked at both primary and secondary managed palliative care services and made recommendations to reduce access barriers for patients. Gaps and issues identified related to assessments; service coordination; clinical care; support, Maori responsiveness and funding. Fourteen recommendations were made by TPHO following the review to improve palliative care services. The recommendations are linked to four key areas of process coordination, service delivery, integration and workforce development.

Referrals are made by GPCS and GPs to TDH District Nursing services for home visits to patients. Public Health Nurses and practice nurses are also referred to for domiciliary care in rural areas.

Palliative care in Tairāwhiti is another example of efforts by a number of health providers and health professionals to utilise available resources to offer the most comprehensive service possible. Coordination becomes a key issue as the provision of a full palliative care service requires input from a number of health services and disciplines as do many cancer services across the cancer continuum (e.g. screening and diagnosis).

Local palliative care providers are currently working jointly to prioritise funding towards improving cultural competencies and increasing access to palliative services for Maori. Work is being done to integrate Maori models of health palliative care models of practice. This process can be used to support integration of Maori health models into other areas of cancer control for Tairāwhiti.

In 2006 a national body known as Palliative Care New Zealand was established to provide a collective voice for users, providers and funders; and leadership on palliative care in New Zealand.

## Information

Relevant, accurate and up to date information is necessary to enable patients to make informed decisions about their treatment and to seek further support and advice to support treatment. Receiving information at the right time and in the appropriate form is also important. Cancer patients reported that they sourced information from websites to gain an understanding of their disease and treatment options. A number of patient journey mapping projects<sup>22</sup> as well as local interviews have highlighted the need for coordinated approach to the dissemination of information to cancer patients. A comprehensive range of accurate and up to date information would assist patients to:

- Understand treatment options and make informed decisions about their treatment.
- Link with other cancer patients with same cancer type, age group.
- Navigate the health system easily.

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<sup>21</sup> Unpublished Report, Gisborne Palliative Care Services Review, TPHO, August 2004.

<sup>22</sup> Refer to the Sharing The Learning Symposium at Ministry of Health website:

<http://www.moh.govt.nz/moh.nsf/indexmh/cancercontrol-sharingthelearningsymposium>.

- Identify and access other support services and advice as required.

Information should be available and accessible at any point along the continuum. This would require services to identify what information is available, ensure it is up to date and ensure that staff have easy access to information should it be requested by patients. It is uncertain at this point as to how this process would be undertaken and by whom but it would require a coordinated approach to obtaining information and maintaining it. Perhaps this could form part of the 'navigator' role as this person would have regular contact with a range of key services as well as patients to keep abreast of information sources and patient needs.

The Cancer Society carried out a review of consumer cancer information resources. The review found that resources lacked cultural material; information on certain cancer screening was contentious, little consumer feedback mechanisms and no resources for people with disabilities<sup>23</sup>.

How information is communicated is also an issue for patients particularly during the phases of diagnosis and treatment. Interviewees spoke about the language that was used and the volume of information from health professionals.

*"I had all reports printed out by my GP who translated everything into simple English."*

*"Too many pamphlets!"*

*"Felt specialists were trying to rush everything, so I felt like a zombie, you know?.. Trying to remember all of the things he was saying."*

*"At the first stage when the doctor referred me I didn't know what the palliative word was. People asked me why I was going there and I couldn't respond because I didn't know what it was".*

## **Financial Support**

Having Cancer is costly for patients and their whanau/families. The disease impacts on employment; home life; family time and budgets. Financial support is available in some cases, subject to criteria, to assist with inter-district travel and accommodation. However, loss of income and time off work causes added stress.

Families that experience cancer and are most at risk of getting cancer often live below the poverty line and the extra costs on top of normal living expenses is burdensome and distressing. Financial and physical support is available but accessing this support can be cumbersome and may result in further stress.

An issue raised by consumers was the lack of an information/guide sheet that summarises financial support available and the criteria. TDH and agencies such as WINZ have a role to help to alleviate some of the financial tension by streamlining processes and ensuring information about assistance and access to assistance is available and user-friendly.

Opportunities for agencies such as MSD and TDH to collaborate on cancer control issues have been discussed under Goal 1 and can be extended to include the issues of financial support and entitlements.

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<sup>23</sup> More information about this project can be sourced on the Ministry of Health website at <http://www.moh.govt.nz/moh.nsf/indexmh/cancercontrol-projectssummaries>.

## **National Travel Assistance Policy**

National Travel Assistance Policy (TAP) outlines the eligibility criteria and assistance that is available to subsidise accommodation and travel for patients to attend regional centres for treatment. Treatment programmes can last up to 6 weeks and more than one trip may be required. This is also available to Tairāwhiti rural residents who have no transport or access to a driver to travel to Gisborne for treatment.

Patients who wish to travel with their whānau/family may also require assistance for travel and accommodation. Applications for assistance are processed by staff at the Transport Department at Gisborne Hospital. Patients may not be eligible for TAP subsidies but may be eligible for other entitlements from WINZ and will be referred on. The Gisborne/East Coast Cancer Society has been known to provide travel subsidies and the Citizens Advice Bureau also has a small amount of funding available.

Cancer patients may require more than one trip to a treatment centre and as the patient becomes more unwell over time each journey will become less comfortable placing greater demands on systems and support people. In some cases patients are flown to regional centres for treatment at the discretion of a specialist.

TDH held an Agreement in the past with Ozanam House Trust in Palmerston North for block bookings to accommodate Tairāwhiti cancer patients being treated at Palmerston North Hospital. This Agreement was superseded by the implementation of the TAP released by MOH in 2006. Patients are now referred to Ozanam House on an 'as required' basis and bookings are made by TDH hospital staff.

Inter-regional travel for treatment undermines the whānau approach to cancer control. Some accommodation venues do not always allow for more than one or two people and for some centres whānau are not permitted to stay during weekends.

Issues raised by cancer patients with regard to travel and accommodation include weekend access for whānau/family and capacity to accommodate more than one support person. One patient referred to a six hour trip to Hamilton for 15 minute specialist assessment. It is difficult to know if this type of scenario can be avoided without speaking with clinicians but finding alternative options where possible to avoid unnecessary travel would be helpful for patients and their families.

### **Key Issues from Goal 4**

#### ***Support and Information***

- Accommodation services for whānau/family/support people of cancer patients in regional centres.
- Support for children and adolescents.
- Support for whānau/families.
- Access to information by patients.
- Availability of information to staff for patient distribution.
- Need for a dedicated navigator role.
- Communication/language between health professionals and patients. (See also Goal 2).

#### ***Rehabilitation***

- Role definition of psycho-oncology social worker.

***Palliation***

- Access to palliative care for Maori. More Maori want to die at home.
- Lack of home support particularly in rural areas.
- Role of GPs in palliative care.
- Issues raised in Palliative Care Services Review by TPHO.

**Financial Support and Travel/Accommodation**

- Lack of clear guidelines on entitlements and assistance for travel and accommodation.
- Long distance travel for short assessments.

**Recommendations for Goal 4**

- Carry out stocktake of formal and informal support services to inform scope of 'navigator role'; develop information directory for staff/patients; identify gaps in support services.
- Increase palliative care community service volumes to meet demand.
- Continue to support joint palliative service project group to improve non-Maori workforce cultural competencies and access to palliative care by Maori.
- Incorporate priority TPHO recommendations into Tairawhiti palliative care strategic planning.
- Recommended consumer group (Goal 5) to inform development of user-friendly guidelines for patient assistance and entitlements.
- Develop user-friendly information/service directory for staff and patients.
- Develop scope and funding proposal for 'navigator role' for Tairawhiti cancer patients. (May be best to consider this under Service Improvement Project/Patient Journey Mapping Project – Refer Goal 3 recommendations).
- Improve communication/language between health professionals and patients.

***Goal 5: Improve the delivery of services across the continuum of cancer control through effective planning, co-ordination and integration of resources and activity, monitoring and evaluation***

**Background**

The main objective of this goal is to improve the delivery and coordination of cancer services across the cancer continuum within Tairāwhiti. The services described in this plan highlight the absolute necessity for effective planning and coordination of services both within Tairāwhiti and across other DHB regions so that cancer patients receive optimum care and treatment in a timely manner.

Service integration, planning and coordination can happen at many levels within an organisation, a service or between services locally and regionally. Quality improvements in service delivery require cooperation, collaboration, time and effort to consider options, risks, feasibility and benefits. Efforts to streamline and improve services should be informed by reliable data and evidence collected through monitoring and evaluation processes.

The key objectives of Goal 5 in the NZCCS are to coordinate a national cancer workforce strategy, ensure Māori have access to appropriate programmes and services; and to ensure active involvement of consumer representatives across the cancer control continuum.

Māori and consumer representation across the cancer control continuum has to be assessed and considered against the current level of involvement. Māori carry the greatest cancer burden leading to health inequalities in this region. Reducing inequalities has been discussed previously in this plan and cannot be addressed without meaningful input and participation of Māori consumers, and all service providers.

**Service Coordination in Tairāwhiti**

Gisborne Hospital is the principal provider of cancer services in Tairāwhiti however; the benefits of working more collectively with other parts of the health sector could create better coordination and cohesion to ensure a more seamless cancer continuum for the cancer patients and their family/whānau.

The use of a multidisciplinary model of care was discussed under Goal 3 of this plan and is recommended for further consideration. Better integration of a Whānau Ora model of health into cancer services is also recommended in Section 3. The role of Private Health Services in the cancer continuum has been discussed under Goal 3 and it is recommended that private and public funded health services form closer working relationships to identify and bridge service gaps.

All of the previous goals refer to the need for collaborative thinking and planning involving key stakeholders, users of cancer services and Māori. How to achieve this is the challenge although Tairāwhiti has an advisory group that could form the basis of a representative body to assist with developing actions from the recommendations of this plan and to monitor the implementation of those actions.

The Tairawhiti Cancer Advisory Group (TCAG) was established to inform TDH on cancer control issues particularly for the development of a regional cancer control plan that is to be implemented from July 2007. Wider representation will be required for the group to be effective across the cancer control continuum. Careful consideration will need to be given to the issues of representation, mandate, purpose and scope of the Group.

At present TCAG is open to all cancer services and meets bi-monthly in the Cancer Society Rooms at Gisborne Hospital. Meetings are regularly attended by Cancer Society, Cervical Screening Unit, Palliative Care Services, PHOs, Public Health Unit, TPW, and TDH Oncology Services. Positive discussions have been held with a representative from the GP Liaison Group and TDH Clinical Services to involve them in this forum. TCAG does not have input from consumers or Maori advisors and consideration needs to be given to how this can be best achieved.

Participation in advisory groups and committees is an ongoing issue in Tairawhiti given the relatively small pool of health professionals and management that are called upon to attend a number of network meetings; specialist and sub-specialist groups; both locally and regionally.

The development of regional and district cancer control plan is seen as a step towards improved service coordination and delivery.

### **Regional Cancer Networks**

Tairawhiti DHB has participated regularly on the Regional Cancer Treatment Advisory Group (RCTAG) network headed by MidCentral Health and includes DHBs from the Central District region. The network includes clinicians, management and more recently DHB Funding and Planning services and The NZ Cancer Society. The Group had a key role in sourcing MOH funding to develop a regional cancer control plan which was completed in June 2006.

Establishing regional cancer networks was a priority for phase 1 implementation of the NZCCS. RCTAG made a successful proposal to establish a project management role to develop the Central Region Cancer Control Plan that was completed in June 2006. The plan recommends a model for a Regional Cancer Network for Central region. RCTAG sees itself as the basis of the Regional Cancer Network and is aiming to extend its scope to encompass other stakeholders across the cancer continuum. There is no consumer input or Maori advisor to this group but there are plans to address this issue.

Six regional networks have been established nationally around the main cancer treatment sites. Tairawhiti DHB will continue its role in this network due to MidCentral Health being the primary centre for cancer treatment services to Tairawhiti. Linkages with other treatment centres particularly the Midland Regional Network and other regional networks to a lesser extent will be maintained.

There is currently a nation-wide shortage of skilled professionals in the cancer workforce that has been shown to have an impact directly on the treatment of cancer patients (see Goals 2 and 3). This is being addressed by MOH who are undertaking a comprehensive stocktake of the present workforce and future requirements. This will be followed with a workforce development plan that will also aim to increase the Maori workforce capacity in this area. Reference has been made in this plan to shortages in the areas of screening services, oncology staff levels and support

workers. Workforce development in this area will be looked at in context of the TDH workforce development strategy and the national workforce strategy for cancer control.

### **Key Issues from Goal 5**

- Future purpose and role of Tairawhiti Cancer Advisory Group.
- Lack of clinical representation on Cancer Advisory Group
- No formal mechanism for consumer input/feedback
- No formal mechanism for Maori input/feedback
- Workforce capacity of cancer services.
- Need to improve integration of health services and disciplines; and cultural models.
- Tairawhiti representation in regional networks particularly - RCTAG and Midlands.

### **Recommendations from Goal 5**

- Review purpose of TCAG to encompass role to improve service integration and; implement and monitor priority actions of this plan.
- Establish mechanism for consumer involvement in service improvements for cancer control ensuring adequate Maori representation.
- Obtain mandate from management to support service representation on TCAG in recognition that service planning and coordination is an essential component of effective clinical work.
- Define formal representation on RCTAG and report back mechanisms.
- TDH workforce development plan to include cancer service workforce priorities including cultural competency of non-Maori workforce.

## **Goal 6: Improve the effectiveness of cancer control in New Zealand through research and surveillance**

### **Background**

The importance of being able to access accurate, reliable and up to date data is crucial to developing, implementing, evaluating and monitoring cancer control plans and services. It is also critical to identify the causes of health inequalities.

The NZCCS outlines plans to develop an agreed, nationally consistent minimum data set for cancer control. Building and maintaining Maori research capacity is a priority. A five-year rolling research strategy for cancer control is to be developed. The synthesis of knowledge provided through research in these areas will enable the development of evidence-based priorities and actions for cancer control.

*The Cancer Collections Framework Project* (MOH, 2006) was commissioned to achieve this goal and a final report was produced in March 2006. The report provides a 'roadmap' for Ministry of Health and health services to improve the quality, collection and access of cancer information in the future. The report proposes a 5 year plan to achieve its vision for cancer collections.

### **Cancer Information in Tairāwhiti**

TPW the Funding and Planning arm of TDH, as well as other organisations funded to provide cancer services, have a responsibility to ensure information is available to monitor performance and effectiveness of cancer services. It would be useful to identify what information is currently captured by TDH and what needs to be done to enable easy access to information for meaningful analysis and effective monitoring.

At present, information is collected in a piecemeal manner by various services along the pathway. For instance, MidCentral Health records wait times from referral to FSA to the start of treatment, there is no formal data collection for wait times for FSA to the start of chemotherapy treatment at TDH, OPD captures data for referral to medical or radiation oncology to FSA but only captures clinic referrals and not referrals to tertiary centres for surgery or multidisciplinary opinions. Information about diagnosis would need to be retrieved on an individual patient basis.

The collection of ethnicity data is essential in order to monitor health disparities and identify the causes of inequalities in the health system. This must also be reviewed.

Reference to the integration of patient information between services has been discussed previously e.g. Goal 2 regarding private cervical screening services and Tairāwhiti NCSP. A Cancer Control Information Plan to identify information sources and data collection across cancer services is recommended. The Cancer Collections Framework Report provides a useful diagram highlighting information requirements across the cancer control continuum that can help guide the local plan. However, there are gaps in the list of requirements but these have been identified through a gap analysis and are listed in the report. For example there is no reference to information about palliative care and inequalities.

Table 13: Key Information Requirements

|                                   |   |   |   |   |
|-----------------------------------|---|---|---|---|
| <b>Pre-cancer/<br/>prevention</b> | <ul style="list-style-type: none"> <li>• Success of prevention initiatives</li> <li>• Level of exposure to screening initiatives</li> <li>• Level of exposure to risk factors                             <ul style="list-style-type: none"> <li>- Smoking</li> <li>- Obesity</li> <li>- Alcohol</li> <li>- Occupational exposure</li> <li>- Sun exposure</li> <li>- Nutrition</li> </ul> </li> <li>• Familial surveillance</li> <li>• Success of relevant screening initiatives</li> </ul> | Linkages between the stages of the cancer continuum (pre-cancer/risk through to access to services, treatment and outcomes) also need to be understood. | Differential outcomes from stage at diagnosis | Effectiveness of specific treatment(s) and treatment combinations |
| <b>Diagnosis</b>                  | <ul style="list-style-type: none"> <li>• Success of relevant screening initiatives</li> <li>• Disease specific incidence</li> <li>• Disease specific prevalence</li> <li>• Disease specific stage at diagnosis</li> </ul>   |   |   |   |
| <b>Treatment</b>                  | <ul style="list-style-type: none"> <li>• Access to interventions</li> <li>• Speed of access to interventions</li> <li>• Intervention volumes</li> <li>• Intervention/treatment type</li> <li>• Intervention/treatment mix</li> </ul>  |   |   |   |
| <b>Outcomes</b>                   | <ul style="list-style-type: none"> <li>• Differential outcomes from stage at diagnosis</li> <li>• Effectiveness of specific treatment(s) and treatment combinations</li> <li>• Total cancer mortality rate</li> <li>• Disease specific mortality rate</li> <li>• Complications and co-morbidities</li> <li>• Surveillance of survivors for new cancer</li> <li>• Equivalency with international outcomes</li> </ul>   |   |   |   |
| <b>Workforce/<br/>resources</b>   | <ul style="list-style-type: none"> <li>• Resource utilisation</li> <li>• Resource forecasting</li> </ul>  |   |   |   |

Source: Cancer Collections Framework Final Report, 2006.

### **Key Issues from Goal 6**

- The collection and availability of cancer data and information.
- Access to cancer data and information.
- Use of information to monitor and evaluate cancer services.
- Use of information to identify causes of health inequalities.

### **Recommendations for Goal 6**

- Stocktake of cancer information collection by TDH and treatment centres.
- Review/audit ethnicity data collection by TDH.
- Develop Cancer Information Plan for Tairāwhiti.
- Ensure TDH funding prioritisation systems and service planning incorporate an assessment of health equity so that all funding decisions seek to reduce, not increase, health inequalities. (Goal 5).
- All TDH funding and service planning decisions to incorporate a HEAT tool evaluation to prioritise actions and to demonstrate that decisions will improve equality for those most disadvantaged.

## SUMMARY OF RECOMMENDED ACTIONS

ALL ACTIONS TO BE REVIEWED AND UPDATED ANNUALLY

Goal 1: Reduce the incidence of cancer through primary prevention

| Objectives   | Actions   | Measures/Milestones  | Timeframe     | Existing, Increase or New Resources | Stakeholders   |
|--|---|--|---------------|-------------------------------------|--|
| 1.1 Reduce the prevalence and uptake of smoking in Tairawhiti.   | Continue to work with joint Tobacco Control Working Group (HSC/MOH/TDH) in consultation with Taki Tahī Toa Mano to develop Tairawhiti Tobacco Control Plan. | Tairawhiti Tobacco Control Plan complete and ready for implementation.                       | 30 June 2007. | New.                                | Tobacco Control Working Party<br>Taki Tahī Toa Mano<br>Runanga<br>GDC<br>NGOs<br>Other community organisations<br>National SF stakeholders<br>e.g. Te Reo Marama, Te Hotu Manawa Maori, ASH. |
| 1.2 Improve nutrition and increase physical activity for population of Tairawhiti particularly those most disadvantaged. | Appoint HE-HA Project Manager   | Appointment made.  | March 2007.   | New.                                | TPW<br>PHU<br>Maori Health Manager   |
|  | Develop and implement Tairawhiti HE-HA Strategic Plan.  | Tairawhiti HE-HA plan or Ministry Approved Plan (MAP) complete and ready for implementation. | 30 June 2007. | New.                                | TPW<br>PHU<br>PHOs<br>Primary health providers<br>Runanga<br>GDC<br>MOE<br>SPARC   |

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|  |   |   |                        |                   | Sport Gisborne Tairawhiti<br>MSD<br>Tairawhiti HEHA Regional<br>Network<br>National stakeholders            |
|  | Continue to support E Tipu E Rea – HEHA to improve nutrition and increase physical activity for tamariki less than 5 years. | Funding contribution.   | July 2006 – June 2009. | Existing.         | Sport Gisborne<br>TPHO<br>NPH<br>TPW<br>Early Childhood Centres<br>Kohanga reo<br>National Heart Foundation |
| 1.3 Reduce Infection-disease related cancers                                       | Develop Tairawhiti Sexual Health Strategy.  | Strategy complete for implementation.   | 30 June 2007.          | Existing.         | PHU<br>NPH<br>TPHO<br>Schools<br>Family Planning Association  |
| 1.4 Reduce the incidence of cancer caused by UV radiation exposure.                | Refer 2.2.  |   |                        |                   | The Cancer Society<br>PHU<br>Sport Gisborne Tairawhiti  |
| 1.5 Support the development of health promotion in PHO setting.                    | Develop joint action plan to meet identified objectives.  | Action plan complete with clear goals and objectives, timeframe, key stakeholders and responsibilities. | Dec 2007               | New and existing. | TPHO<br>NPH<br>PHU<br>TPW   |
| 1.6 Support the development of health promotion workforce across all work sectors. | Complete and/or collate stocktake of current health promotion workforce capacity in Tairawhiti.                             | Stocktake updated/completed.  | Nov 2007               | New.              | PHOs<br>GP services<br>PHU<br>Primary Health services<br>Runanga<br>Cancer Society                          |

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|   |   |   |                               |                   | Iwi providers<br>NGOs<br>Schools<br>Local government   |
|   | Produce joint regional Workforce Development Plan based on stock take results and consultation with key stakeholders. | Workforce Development Plan complete for implementation from 1 July, 2008. | June 2008.                    | New and existing. | PHOs<br>GP services<br>PHU<br>Primary Health services<br>Runanga<br>Cancer Society<br>Iwi providers<br>NGOs<br>Schools<br>Local government |
| 1.6 Encourage health promotion competencies/best practice guidelines within health promotion field. | Identify training needs through stocktake/needs assessment (1.5).   | Relevant training initiatives identified in Workforce Development plan.   | June 2008 with annual review. | New and existing. | As above.<br>Training providers.<br>Health Promotion Forum.  |

**RECOMMENDED ACTIONS**

Goal 2: Ensure effective screening and early detection to reduce cancer incidence and mortality.

| Objectives   | Actions  | Measures/Milestones   | Timeframe   | Existing, Increase or New Resources | Key Stakeholders  |
|--|--|---|---|-------------------------------------|---|
| 2.1 Improve breast screening rates of high risk women in Tairawhiti.                               | Tairawhiti region prioritised as high risk by MOH/BSCC.  | Current service specifications and targets reviewed against Equity Lens and demographic profile to identify service gaps and ensure equitable resourcing.       | *TBC<br>* 'To be confirmed'.<br>Timeframe needs to be considered by stakeholders during planning. | Existing.                           | MOH<br>BSCC<br>BSA – Te Aitanga a Hauiti Hauora<br>Gisborne<br>Radiology<br>TPW<br>Cancer Society<br>NCSP |
|  | Address risk and incidence of backlogs for women requiring mammograms in Tairawhiti.   | Develop initiative to provide backfill during mammographer absence from fixed mammography site as required.   | TBC   | New and existing.                   |   |
| 2.2 Improve melanoma screening rates/health checks in Tairawhiti for vulnerable population groups. | Carry out stocktake of current melanoma screening and Sunsmart programmes and identify opportunities to increase screening and promotion activities in most targeted settings. | Stocktake complete.<br><br>New joint initiatives identified with action plan and evaluation component in place.<br><br>Long term reduced incidence of Melanoma. | TBC   | New.                                | GPs<br>PHU<br>Cancer Society<br>GDC<br>Sport Gisborne<br>Primary Health Providers                         |
| 2.3 Increase other opportunistic health  | Identify community-based interventions to increase   | No. of targeted interventions.  | TBC   | New and existing.                   | GPs<br>PHU  |

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| checks/screening for most prevalent cancers in Tairawhiti.   | awareness about early detection and symptom recognition and encourage cancer/health checks.   | No. of referrals for follow up.   |     |      | PHOs<br>Cancer Society<br>GDC<br>Sport Gisborne<br>Primary Health Providers |
| 2.4 Improve health professional/patient communication regarding early detection and symptom recognition. | Provide communication training for clinicians/specialists/GPs/health professionals and engage consumer reference group to develop communication protocols to improve early detection. | No. of training programmes implemented.<br><br>Consumer reference group participation and feedback.<br><br>Communication protocols complete and in use. | TBC | New. | TDH<br>PHOs<br>GPs<br>Cancer  |

**RECOMMENDED ACTIONS**

Goal 3: Ensure effective diagnosis and treatment of cancer to reduce morbidity and mortality.

| Objectives   | Actions   | Measures/milestones            | Timeframe                       | Existing, Increase or New Resources | Key stake-holders  |
|--|---|--------------------------------|---------------------------------|-------------------------------------|--|
| 3.1 To ensure appropriate referral and timely access to diagnosis and treatment for those with recognised disadvantages such as Maori, who have lower cancer survival. | Develop proposal for Service Improvement Project to assess current patient management models, patient care processes and health systems to identify causes of inequalities, gaps, delays and areas for improvement. | Proposal ready for submission. | MOH RFP deadline – March, 2007. | New.                                | TPW<br>Cancer diagnostic and treatment providers and professional groups<br>GPs                          |
|  | Develop proposal for Patient Mapping Project focussing on inequalities and Maori experience of diagnosis and treatment options.   | Proposal ready for submission. | MOH RFP deadline - March, 2007. | New.                                | TPW<br>Consumer Advisory Group<br>Cancer diagnostic and treatment providers<br>Screening Services<br>GPs |

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| Objectives  | Actions  | Measures/milestones   | Timeframe | Existing, Increase or New Resources | Key stake-holders   |
|---|--|---|-----------|-------------------------------------|---|
|   | Develop/Revise formal protocols for diagnoses, treatment and best practice based on Service Improvement and Patient Mapping project outcomes particularly for most prevalent cancers.                                | Formal protocols completed and in use.<br><br>Evidence of monitoring.   | TBC       | New and existing.                   | TPW<br>Cancer diagnostic and treatment providers and professional groups<br>GPs   |
|   | Develop a whanau ora plan for cancer services.   | Whanau ora Plan for cancer services complete.                           | TBC       | New and existing.                   | TPW<br>Cancer diagnostic and treatment providers and professional groups<br>GPs<br>Maori Consumer group<br>TDH Maori Health Manager |
| 3.2 Improve referral processes for timely access to diagnostic and treatment service. | Create referral guidelines and template for primary health practitioners to use when referring people with a suspected cancer for diagnosis or treatment, prioritising the most prevalent cancer types. (Refer 3.1). | Referral guidelines and template in use.<br><br>Evidence of monitoring. | TBC       |                                     | PHOs<br>GPs<br>Secondary cancer services  |

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| Objectives   | Actions  | Measures/milestones  | Timeframe  | Existing, Increase or New Resources | Key stake-holders   |
|--|--|--|------------|-------------------------------------|---|
|  | Review timeframes within which those with suspected cancer should be able to see a specialist for diagnosis, or for treatment. | Evidence that waiting times for appointment are being monitored.<br><br>Appropriate and transparent prioritisation procedures.<br><br>Regular monitoring of waiting times. | TBC        | New and existing.                   | TPW<br>Cancer diagnostic and treatment providers and professional groups<br>GPs |
|  | Monitor waiting times for all cancer treatments.   | MCH Wait Time Reports.<br><br>Evidence of regular monitoring by TDH/TPW.   | June 2007. | Existing.                           | TPW<br>Secondary Health services<br>GPs<br>TCAG                                 |
| 3.6 Develop a person-centred, multi-disciplinary and coordinated approach to cancer diagnosis and treatment that targets Maori, and other people at risk of poor outcomes. | Review current TDH models of patient management planning and care and formalise agreed model.                                  | Formalise MDT model with documented procedures for the development and operational of a multidisciplinary team approach to diagnosis and treatment.                        | June 2008. | New and existing.                   | DHBs, Cancer Treatment providers.   |

**RECOMMENDED ACTIONS**

Goal 4: Ensure the quality of life for those with cancer, their family and whanau through support, rehabilitation and palliative care.

| Objectives  | Actions   | Measures/Milestones  | Timeframe                      | Existing, Increase or New Resources | Key Stakeholders  |
|---|---|--|--------------------------------|-------------------------------------|---|
| 4.1 Ensure that all people with cancer are aware of what support services are available to enable informed choices, and to promote access the services. | Develop scope for a 'navigator role' to support/advocate for cancer patients and their family/whanau to link primary, secondary, tertiary and support services.         | Scoping project complete with funding proposal.                          | MOH RFP Deadline (March 2007). | New.                                | Cancer Advisory Group<br>All cancer support services across cancer continuum<br>Consumer advisory group |
|   | Write proposal to carry out stocktake of formal and informal support services available to patients and their whanau/family and produce and maintain Service Directory. | Proposal complete – include as component of proposal for Navigator Role. | MOH RFP Deadline (March 2007). | New.                                | TCAG<br>All cancer services across cancer continuum<br>Consumer Advisory Group                          |
|   | Develop referral protocols for staff to link cancer patients needing support and rehabilitation services with the available services.                                   | Protocol complete and use is monitored.                                  | TBC                            | New and existing.                   | TCAG<br>All cancer services across cancer continuum<br>Consumer Advisory Group                          |
|   | Consumer reference group to inform development of user-friendly guidelines for  | Guidelines complete and in use.  | TBC                            | New.                                |   |

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|  | patient assistance and entitlements.   |   |                   |                   |  |
| 4.2 Improved capacity and capability of cancer nursing workforce.              | Adequate Oncology staffing level in place.<br><br>Adequate levels of Certified Chemotherapy nurse to manage patient case loads.                        | Review current oncology nursing funding configuration (e.g. District Nursing vs. Oncology Nursing) and staffing levels against (national guidelines?) and clinical demand.<br><br>Implement review recommendations.<br><br>Develop succession plan for both Oncology and Chemotherapy nursing services. | TBC               | New and existing. | TDH Clinical Services<br>Director of Nursing<br>Oncology staff                               |
| 4.3 Ensure that Palliative Care services are responsive to the needs of Maori. | Continue to support joint palliative care service project to improve non-Maori workforce cultural competencies and access to palliative care by Maori. | Palliative Care Service Project progress reports.   | June 2007.        | Existing.         | Palliative Care Services<br>TPW<br>Maori Consumer Advisory Group<br>TDH Maori Health Manager |
| 4.4 Improve cultural competencies of non-Maori workforce in cancer services.   | Develop proposal to undertake stocktake of cultural competencies of non-Maori workforce across the cancer control continuum.                           | Proposal complete.  | MOH RFP deadline. | New.              | All cancer services across cancer continuum  |

**RECOMMENDED ACTIONS**

Goal 5: Improve the delivery of services across the continuum of cancer control through effective planning, coordination and integration of resources and activity, monitoring and evaluation.

| Objectives  | Actions   | Measures/Milestones                   | Timeframe  | Existing, Increase or New Resources | Key Stakeholders  |
|---|---|---------------------------------------|------------|-------------------------------------|---|
| 5.1 To achieve improved coordination of cancer care and support services, and reduce disparities between Maori and non Maori relating to access to cancer services. | Establish appropriate mechanism to receive input from Maori advisors and consumers.   | Appropriate mechanism established.    | Dec 2007.  | New and existing.                   | Maori consumers.<br>Maori advisors.<br>Iwi Providers.<br>TCAG<br>The Cancer Society |
| 5.2 Develop and support local and regional cancer networks.   | Review role, purpose and representation of TCAG to encompass role to improve service integration and implement and monitor priority actions of this plan. | Review complete with recommendations. | June 2007. | Existing.                           | TCAG<br>TPW<br>Cancer Services<br>Service management.                               |

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|--|---|--|-------------------------------------|-----------------------------------|---|
|  | <p>Formalise/coordinate Tairawhiti representation on Central Region Cancer Network and report back protocols.</p> <p>Maintain links with Midland Regional Cancer Network and formalise report back protocols.</p> | <p>Representation and role confirmed.</p> <p>Report back protocols agreed and implemented.</p> <p>Communication protocols with Midlands formalised and maintained.</p>                 | <p>June 2007.</p> <p>June 2007.</p> | <p>Existing.</p> <p>Existing.</p> | <p>TCAG<br/>TPW<br/>Cancer Services<br/>Service<br/>management.</p> |
|  | <p>Formalise/coordinate Tairawhiti representation on Central Region Cancer Network and report back protocols.</p> <p>Maintain links with Midland Regional Cancer Network and formalise report back protocols.</p> | <p>Representation and role confirmed.</p> <p>Report back protocols agreed and implemented.</p> <p>Communication and report back protocols with Midlands formalised and maintained.</p> | <p>June 2007.</p> <p>June 2007.</p> | <p>Existing.</p> <p>Existing.</p> | <p>TCAG<br/>TPW<br/>Cancer Services<br/>Service<br/>management.</p> |

**RECOMMENDED ACTIONS**

Goal 6: Improve the effectiveness of cancer control in New Zealand through research and surveillance.

| Objectives  | Actions  | Measures/milestones  | Timeframe                       | Existing, Increase or New Resources | Key stake-holders                                      |
|---|--|--|---------------------------------|-------------------------------------|--|
| 6.1 Develop regional data set (aligning to national framework for information collection) that provides up to date and meaningful information for monitoring cancer services for this region. | Develop proposal to carry out stocktake of cancer information collected in Tairāwhiti to produce a Cancer Information Plan for Tairāwhiti.   | Proposal complete.   | MOH RFP deadline – March, 2007. | New.                                | TPW<br>All cancer services in Tairāwhiti.              |
| 6.2 Improved and consistent collection of ethnicity data.   | Ethnicity data to be reported on all Cancer Service Agreements.  | Ethnicity data reported.   | June 2007.                      | Existing.                           | TPW<br>All cancer services in Tairāwhiti.              |
| 6.3 Ensure service funding and planning decisions lead to reduced inequalities for those most disadvantaged.  | All TDH cancer services including funding and planning decisions to incorporate a HEAT tool evaluation to prioritise actions and to demonstrate that decisions will improve equality for those most disadvantaged. | Evidence that HEAT Tool has been applied to ALL decision making (including those for cancer services) by management and governance bodies. | June 2007.                      | Existing.                           | TDH management teams.<br>TPW.<br>TDH governance teams. |

## Appendix 1

Some of the key health strategies relevant to this plan:

- The New Zealand Health Strategy (Minister of Health, 2000).
- The Palliative Care Strategy (Minister of Health, 2001).
- The NZ Disability Strategy (Minister for Disability Issues, 2000).
- The New Zealand Palliative Care Strategy (Minister of Health, 2001).
- The Primary Health Care Strategy (Minister of Health, 2001).
- He Korowai Oranga – Maori Health Strategy (Minister of Health and Associate Minister of Health, 2002)
- Whakatataka: Maori Health Action Plan 2002-2005 (Minister of Health and Associate Minister of Health, 2002).
- Healthy Eating – Healthy Action: Oranga Kai – Oranga Pumau, A Strategic Framework 2003 (Ministry of Health, 2003).
- National Maori Tobacco Control Strategy 2003-2007 (ATAK – Maori Smokefree Coalition, 2003).
- Clearing the Smoke: A five-year plan for tobacco control in New Zealand 2004-2009 (Ministry of Health, 2004).
- Whakatataka Tuarua: Maori Health Action Plan 2006-2011 (Minister of Health and Associate Minister of Health, 2006).

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Winnard, D. 2006. Health Promotion in Primary Health Organisations: National Networking Hui 19 & 20 June, 2006. Discussion paper prepared on behalf of ARPHS. Not published.

Further references:

Summaries of the NZCCS Action Plan Implementation Project Reports are available on the Ministry of Health website: <http://www.moh.govt.nz/moh.nsf/indexmh/cancercontrol-projectssummaries>

Molemap: [www.molemap.co.nz](http://www.molemap.co.nz)