

Cancer Control Programme Work Plan 2009/10

Overview

Introduction This document provides an overview of the Cancer Control Programme and the work plan for 2009/10, including planning signals for 2010/11 and 2011/12. The Cancer Control Programme is a national programme that covers Ministry of Health, District Health Boards, and regional cancer networks activity to implement the Government's priorities for cancer and the New Zealand Cancer Control Strategy.

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Purpose of the Cancer Control Programme

What is cancer control?

Cancer Control is one of the Government’s priority areas. Cancer Control is an organised approach to reducing the burden of cancer in our community. It recognises that the disease cannot be completely eradicated in the foreseeable future, but that its effects can be reduced. The control of cancer requires a planned, systematic and co-ordinated approach. It also requires resources, which are always likely to be limited.

Cancer Control Programme

In 2008, the Ministry of Health, District Health Boards (DHBs), and regional cancer networks decided that an integrated National Cancer Control Programme needed to be established to:

- provide a national strategic focus for cancer control, and
- undertake system wide improvement across the cancer continuum.

The Cancer Control Programme is an integrated national programme that covers Ministry of Health, DHBs, and regional cancer networks activity across the cancer continuum to implement the Government’s priorities for Cancer and the Cancer Control Strategy. The Programme is led by the Ministry of Health working with DHBs and regional cancer networks on the Programme’s strategic direction and implementation.

Cancer Control Strategy

The Cancer Control Strategy was published in 2003. The six goals of the Strategy are to:

- Goal 1: Reduce the incidence of cancer through primary prevention.
- Goal 2: Ensure effective screening and early detection to reduce cancer incidence and mortality.
- Goal 3: Ensure effective diagnosis and treatment to reduce cancer morbidity and mortality.
- Goal 4: Improve the quality of life for those with cancer, their family and whānau through support, rehabilitation and palliative care.
- 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.
- Goal 6: Improve the effectiveness of cancer control in New Zealand through research and surveillance.

The Cancer Control Strategy provides the strategic framework for the Cancer Control Programme.

Aspects of the Cancer Control Programme

Programme objectives

The objectives of the Cancer Control Programme are to:

- Reduce the incidence of cancer
 - Reduce the impact of cancer
 - Reduce inequalities with respect to cancer
 - Ensure there is nationally consistent access to cancer services
 - Fairly and equitably prioritise and plan service improvement and new investment to achieve the Programme's objectives and deliver value for money.
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Programme scope

The Cancer Control Programme covers the following areas:

- **The publicly funded cancer continuum, from prevention to palliation.** The Programme covers all aspects of the cancer continuum:
 - Prevention
 - Screening
 - Early detection
 - Diagnosis
 - Treatment
 - Rehabilitation and support, and
 - Palliative care.

It also addresses problems associated with equity of access to services; workforce development; research, monitoring and evaluation of services; data collection and analysis.

- **The work programmes of the Ministry of Health, DHBs, and the regional cancer networks.** The Ministry, DHBs, and regional cancer networks are the key organisations responsible for implementing the Programme. Their work programmes cover:
 - Strategic direction
 - Policy development, and
 - National and local implementation.

The private and voluntary sectors also contribute to the implementation of the Programme. Communication links have been established with these sectors.

Links to other programmes

Other programmes that have wider impacts than just cancer (eg tobacco control, obesity prevention, national screening programmes) are linked into the Programme through regular reporting to the Cancer Control Steering Group and through representation on the Ministry's Internal Reference Group for Cancer and via regional cancer networks.

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Aspects of the Cancer Control Programme, Continued

Programme activity

Key national Cancer Control Programme tasks include:

- Leading and coordinating a strategic prioritisation process to provide a longer term view on how the Programme will achieve the overall purposes of the Cancer Control Strategy – to reduce the incidence and impact of cancer and to reduce inequalities with respect to cancer.
- Overseeing an annual planning and prioritisation process. This includes running a prioritisation process for new investment and areas for targeted improvement, and ensuring the Ministry, DHBs, and regional cancer networks annual plans align with the priority areas of the Programme.
- Informing the government’s annual budget cycle for Vote Health with the Cancer Control Steering Group making decisions on which services/initiatives are recommended to funders for investment.
- Ongoing identification and planning for projected service delivery volumes and funding requirements, based on trends in incidence, impact, and treatment.
- Systematically scanning the horizon to identify future developments in treatment and care including ‘new’ technologies and drugs.
- Setting clear performance targets/outcomes for the Programme and monitoring achievement of these targets/outcomes by the Ministry, DHBs, and regional cancer networks to show how the Programme has impacted on specific programme outcomes and the broader outcomes set out in the Cancer Control Strategy.
- Monitoring the ongoing implementation of the Action Plan 2005-2010 and reviewing the priority implementation of specific actions in the Cancer Control Action Plan.

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Aspects of the Cancer Control Programme, Continued

Programme principles

The Cancer Control Programme operates according to the following principles:

- **National consistency with local flexibility**

The Programme provides national leadership on strategic and annual priorities across the cancer continuum (this includes 'enabling' activity such as IT and workforce development). This is to ensure national consistency in planning and prioritisation whilst maintaining flexibility at a local level to deliver services in a way that is suited to the district's population.

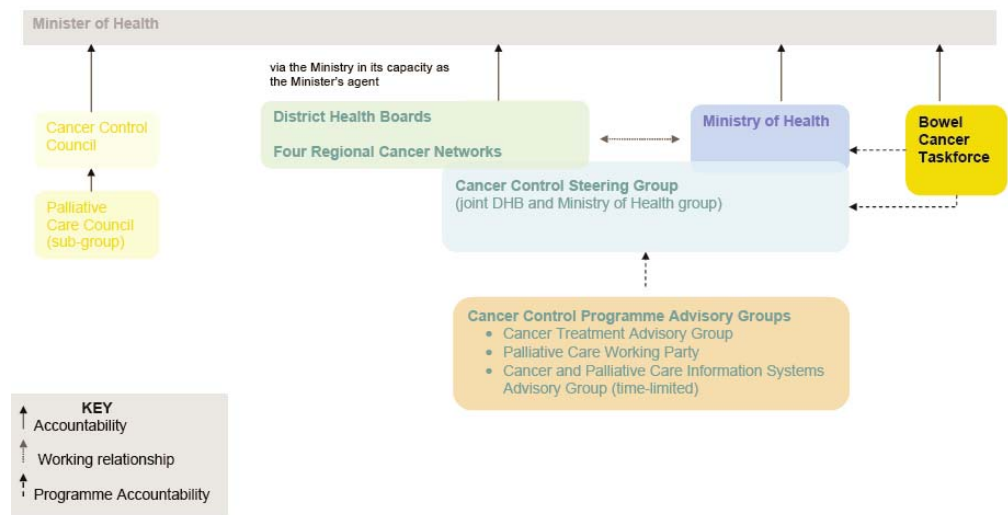
- **Collaboration and cooperation**

There are a number of organisations involved in the area of cancer control. The Programme supports active collaboration and cooperation between groups on cancer control initiatives. Programme participants collaborate to achieve the overall objectives of the Programme.

Roles and Relationships in the Cancer Control Programme

Programme governance

The Cancer Control Programme is led by the Ministry of Health working closely with DHBs and regional cancer networks on its strategic direction and implementation. To maintain these close working relationships, the Programme is governed by a joint Ministry and DHB Steering Group. Steering Group representatives are mandated by their organisation or sector to make decisions on their behalf. The Steering Group operates across the Ministry, DHBs, and regional cancer networks. The Steering Group's terms of reference are provided in Appendix I. The Programme governance structure is outlined below.



Governance Structure for the Cancer Control Programme

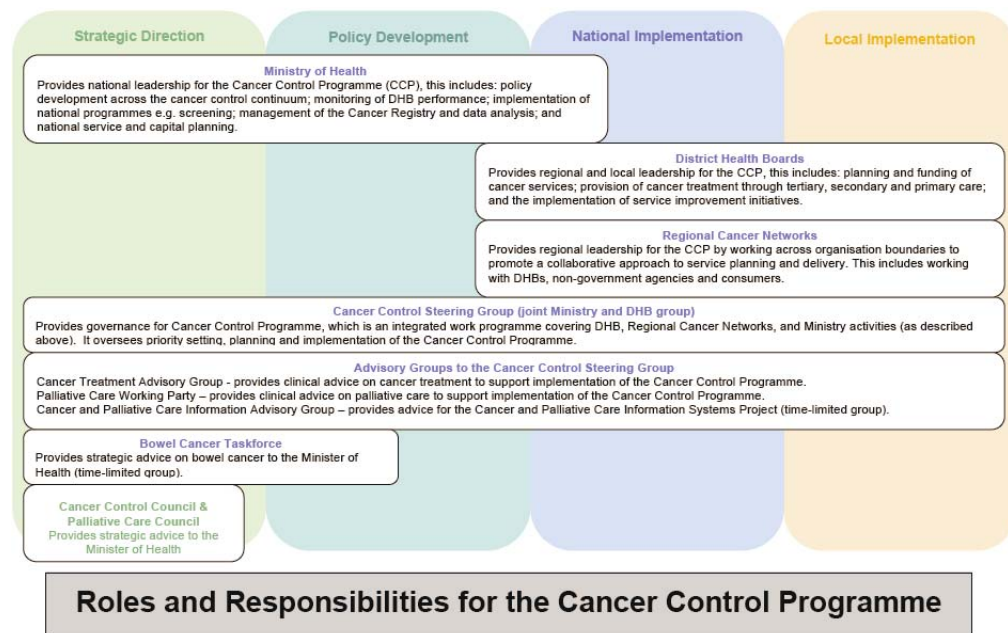
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Roles and Relationships in the Cancer Control Programme, Continued

Roles and responsibilities

As mentioned above, the Ministry of Health, DHBs, and regional cancer networks are the key groups responsible for implementing the Cancer Control Programme. Expert advisory groups have been established to provide clinical and specialist advice to the Cancer Control Steering Group and contribute to implementation, where appropriate.

The diagram below outlines the roles and responsibilities of the various groups involved in the Programme. Terms of Reference are provided in the appendices 2-4.



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Roles and Relationships in the Cancer Control Programme,

Continued

Advisory groups

The priorities of the Cancer Control Programme determine the need for advisory or expert groups. The configuration of the advisory groups will change over time to reflect the priorities of the Programme. Advisory groups are either time-limited (providing advice for specific projects) or a standing group, where the role and membership is regularly reviewed to ensure ongoing relevance to the Programme. All advisory groups have agreed terms of reference.

The current advisory groups to the Programme are listed below. Some advisory groups have also established specialist work groups.

Advisory Group	Work Groups
Cancer Treatment Advisory Group	Adolescent and Young Adults
	Haematology
	Medical Oncology
Palliative Care Working Party	Radiation Oncology
	Specialist Palliative Care Service Specification
	Palliative Care Medications
Cancer and Palliative Care Information Advisory Group	Syringe Driver
	Cancer Data Definitions
	Palliative Care Data Definitions

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Roles and Relationships in the Cancer Control Programme,

Continued

Advisory groups work plans

Each year the advisory and work groups agree a work plan and identify priority areas of focus. The priorities for 2009/10 are listed below.

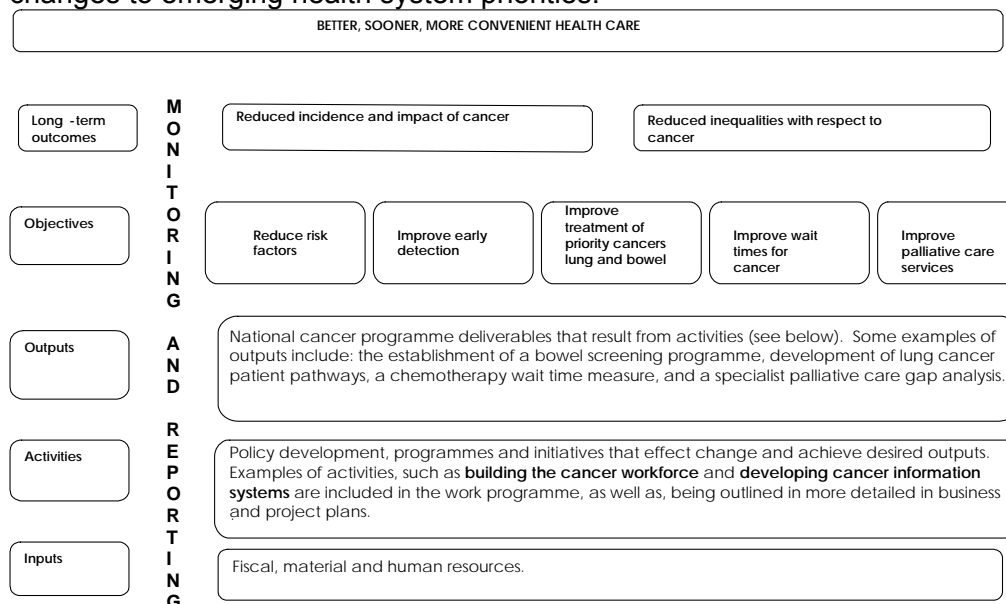
Advisory/Work Group	Priority focus
Cancer Treatment Advisory Group	<ul style="list-style-type: none"> • Quality improvement – with an initial focus on the national approach to lung cancer • Sector Capacity – analysis of future demand • Workforce
Adolescent and Young Adults Work Group	<ul style="list-style-type: none"> • Advice on the implementation of the Adolescent and Young Adults service specification
Haematology Work Group	<ul style="list-style-type: none"> • Development of clinical access priority criteria for Bone Marrow Transplant • Haematology workforce
Medical Oncology Work Group	<ul style="list-style-type: none"> • Finalisation of clinical access prioritisation criteria for medical oncology • Model projected demand and workforce requirements for medical oncology for the next 5 – 10 years
Radiation Oncology Work Group	<ul style="list-style-type: none"> • Advice on Health Target and indicators for radiation oncology • Updated modelling and planning of projected demand, capital and workforce requirements for radiation oncology for the next 5 – 10 years
Palliative Care Working Party	<ul style="list-style-type: none"> • Palliative care service development
Specialist Palliative Care Service Specification Work Group	<ul style="list-style-type: none"> • Finalisation of the specialist palliative care service specification
Palliative Care Medications Work Group	<ul style="list-style-type: none"> • Work with Pharmac on improving access to medications for palliative care
Syringe Driver Work Group	<ul style="list-style-type: none"> • Advice and support for the phase out of the Graseby Syringe Driver
Cancer and Palliative Care Information Advisory Group	<ul style="list-style-type: none"> • Advice on core cancer and palliative care data definition sets to Health Information Standards Organisation (HISO) standard • Improved access to cancer information
Cancer Data Definitions Work Group	<ul style="list-style-type: none"> • Develop cancer data definition sets
Palliative Care Data Definitions	<ul style="list-style-type: none"> • Develop palliative care data definition sets

Planning Framework

Outcomes hierarchy

The framework below sets out an outcomes hierarchy for the national Cancer Control Programme. The framework is intended to ensure that all service and policy related activities and outputs contribute to the overall outcomes and objectives of the Programme, by way of a clear intervention logic. Indicators and/or measures to monitor progress towards (or away from) the overall outcomes will be developed for each level of the framework.

The framework is intended to be a living framework that can accommodate changes to emerging health system priorities.



Focus on lung cancer and bowel cancer

The Cancer Control Steering Group has decided there will be a priority focus on lung cancer and bowel cancer for the objective on improving treatment of priority cancers. There are significant inequalities for these cancers.

The five year survival for lung cancer in New Zealand of 10 percent is below that of a number of OECD countries where rates of 15 percent to 17 percent are reported. In New Zealand there are significant ethnic inequalities with 5 year survival rates of 5 percent for Māori. Māori men have over twice the incidence of lung cancer compared to non-Māori and non-Pacific males. Māori women have over three times the incidence of lung cancer compared to non-Māori and non-Pacific women (Cancer: New Registrations and Deaths 2005, Ministry of Health).

Although five year survival for bowel cancer of 60 percent in New Zealand compares favourably to other OECD countries the high incidence, frequently advanced disease at presentation and high death rates in New Zealand mean that further improvements need to be made.

The Cancer Control Programme is taking a system-wide approach to reducing inequalities with its focus on lung cancer and bowel cancer.

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Planning Framework, Continued

Long-term outcomes

The long-term outcomes for the Cancer Control Programme are to:

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

Age-standardised mortality and five year survival rates will be monitored on a regular basis by the Ministry of Health to assess whether the long-term outcomes of the Programme are being met.

Links to Cancer Control Strategy goals

The five objectives identified in the outcomes hierarchy above link to the six goals in the Cancer Control Strategy (see page 2 for the description of the goals).

Goal no	Links to objective
1: prevention	Reduce risk factors
2: screening and early detection	Improve early detection
3: diagnosis and treatment	Improve treatment of priority cancers, lung and bowel
4: support, rehabilitation, palliative care	Improve treatment of priority cancers, lung and bowel; Improve palliative care services
5: delivery of services	Improve wait times for cancer
6: research and surveillance	Links to all objectives.

Cancer Control Programme Work Plan 2009/10

Work Plan 2009/10

A high-level work plan for 2009/10 is outlined in the following table (see page 14). The work plan reflects the high-level activities that will be monitored at the programme level by the Cancer Control Steering Group. Planning signals are also identified for 2010/11 and 2011/12. Activities for out years will be reviewed and prioritised through the annual Cancer Control Programme prioritisation process that occurs over October – December and following discussion with the Minister of Health.

Links to other work plans

Sitting behind this high-level work plan are the individual business plans for the Ministry, DHBs, the regional cancer networks, and the Cancer Programme Advisory Groups as outlined in the table below.

Organisation	Type of plan	Covers
Ministry of Health	Statement of Intent	High-level plan describing key areas of focus, including reducing cancer treatment wait times, national breast and cervical screening programmes.
	Directorate business plans	Detailed plans describing activities of specific teams e.g. the Cancer and Tobacco teams.
Regional Cancer Networks	Annual Plans	Detailed plans describing annual priorities for each regional cancer network.
	Strategic Plan	Five year plan describing strategic priorities for each regional cancer network.
District Health Boards	District Annual Plans (Statement of Intent)	Annual plans describing local DHB priorities, including cancer control.
	District Strategic Plans	Five to ten year plan describing strategic priorities for the district.
	Local Cancer Plans	Detailed plans describing specific activities for cancer control at a local DHB level.
Cancer Programme Advisory Groups	Annual work plans	Annual work plan describing the areas of focus for each advisory group.

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Cancer Programme Work Plan 2009/10, Continued

What this work plan means for people

The actions being taken over 2009/10 aim to provide people with better, sooner, more convenient cancer services at every point of the cancer pathway.

What will be done	Led by
<p>More will be done to help people stop smoking:</p> <ul style="list-style-type: none"> • Advice will be given to people when they are in hospital or visiting the doctor on how to stop smoking. 	DHBs
<p>There will be an increased likelihood of cancer being detected earlier:</p> <ul style="list-style-type: none"> • Primary care doctors will be given more guidance on how to identify suspected cancer • Planning will occur for a national bowel cancer screening programme • More people will be screened through the cervical and breast screening programmes. 	Ministry of Health
<p>There will be better access to high quality treatment:</p> <ul style="list-style-type: none"> • More patient cases for lung and bowel cancer will be discussed at multidisciplinary team meetings • Waiting time and treatment standards will be developed for lung and bowel cancer patients • The lung and bowel cancer treatment pathways will be improved so people are diagnosed sooner and have better access to treatment • Capacity for colonoscopy services will be reviewed to improve access to this service. 	Regional cancer networks, DHBs, Ministry of Health
<p>Wait times for cancer treatment services will be improved:</p> <ul style="list-style-type: none"> • Further action will be taken to reduce wait times for radiotherapy through meeting the national wait time target • Wait time standards will be developed for chemotherapy and some cancer surgical areas • A national approach to defining and collecting information on cancer treatment will be developed, enabling assessment of performance. 	DHBs, Ministry of Health
<p>Patients will be supported in their end of life care so that the care is delivered in the most appropriate setting:</p> <ul style="list-style-type: none"> • More funding will be provided to hospices to improve the services they provide to patients and their families • Service specifications for specialist palliative care services will be finalised. 	DHBs, Ministry of Health

A high-level work plan for 2009/10 is outlined below that follows the outcomes framework described on page 10. The work plan reflects the high-level activities that will be monitored at the programme level by the Cancer Control Steering Group. Planning signals are also identified for 2010/11 and 2011/12. Activities for out years will be reviewed and prioritised through the annual Cancer Control Programme prioritisation process that occurs over October – December and following discussion with the Minister of Health.

Objective	Indicator or measure (measure of progress against output/activities undertaken)	Output/Activities (work undertaken to contribute to the objective)	Timeframe			Lead Responsibility
			2009/10	2010/11	2011/12	
Reduce risk factors	80% of hospitalised smokers will be provided with advice and help to quit by July 2010.	Implement the ABC Approach for Smoking Cessation (A sk all people about their smoking status; Provide B rief advice to stop smoking to all people who smoke; Offer evidenced based C essation treatment).	July 2010	90% by July 2011	95% by July 2012	DHBs

Objective	Indicator or measure (measure of progress against output/activities undertaken)	Output/Activities (work undertaken to contribute to the objective)	Timeframe			Lead Responsibility
			2009/10	2010/11	2011/12	
Improve early detection	Implementation Plan for Suspected Cancer Guideline published by December 2009.	Develop an implementation plan for the Guideline for Suspected Cancer in Primary Care to improve access to health services for people with suspected cancer. Implement phase 1 priorities.	Plan published by Dec 2009 Phase 1 priorities implemented by June 2010	Phase 2 priorities supported and implemented (subject to funding) by June 2011	Evaluate effectiveness of programme by June 2012	Ministry of Health
	Screening pathway and quality standards for the Bowel Cancer Screening Programme agreed by June 2010.	Develop the screening pathway and quality standards for the Bowel Cancer Screening Programme.	June 2010	Develop screening programme information system June 2011	Implement first screening sites (subject to funding)	Ministry of Health
	Breast Screen Aotearoa: Screen 70% of the eligible population every two years including women from priority groups (Māori and Pacific) aged 50-69.	Monitor Breast Screen Aotearoa (BSA) provider performance against 46 quantitative targets for women aged 50-69 years. Monitor provider performance reports for women aged 45-49. ¹ Undertake routine audits of BSA services against quality standards. Undertake issues-based audits in response to identified problems.	June 2010 June 2010 June 2010 June 2010	Ongoing provider performance monitoring to June 2011 Quality improvements of providers and BSA programme to June 2011	Ongoing provider performance monitoring to June 2012 Quality improvements of providers and BSA programme to June 2012	Ministry of Health

¹ There is insufficient international data from which to derive local cancer detection targets for biennial screening of women under 50 years

	<p>National Cervical Screening Programme:</p> <ul style="list-style-type: none"> • increase coverage² to 75% target (for all ethnic groups) by 2011 • reduce incidence in cervical cancer to 7.5³ (for all ethnic groups) by 2011 • reduce mortality in cervical cancer to 2.0⁴ (for all ethnic groups) by 2011 	<p>Implementation of National Cervical Screening Programme Strategic Plan.</p> <p>Monitoring and evaluation against national standards, indicators and targets.</p>	<p>Ongoing monitoring and evaluation to improve service delivery June 2010</p>	<p>Ongoing monitoring and evaluation to improve service delivery June 2011</p>	<p>Ongoing monitoring and evaluation to improve service delivery June 2012</p>	<p>Ministry of Health</p>
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² Women 20-69 years screened in previous 3 years.

³ Per 100,000 age standardised to Segi's world population

⁴ Per 100,000 age standardised to Segi's world population

Objective	Indicator or measure (measure of progress against output/activities undertaken)	Output/Activities (work undertaken to contribute to the objective)	Timeframe			Lead Responsibility
			2009/10	2010/11	2011/12	
Improve treatment of priority cancers	Establishment of multidisciplinary lung cancer and bowel cancer work groups in the Regional Cancer Networks by June 2010	Promote clinical governance through the establishment of multidisciplinary tumour stream work groups and work with them to undertake the outputs/activities listed below.	Lung and bowel cancers by June 2010	Ongoing Breast and prostate cancers by June 2011	Ongoing Ongoing Upper GI Head & Neck Gynae by June 2012	Regional Cancer Networks
	Wait times from referral to first treatment for lung cancer patients (excludes inpatient and acute admissions) will be collected by DHB and ethnicity for quarter 4 2009/10	Develop a lung cancer patient management framework. This will include: <ul style="list-style-type: none"> • Wait time indicators for lung cancer from referral to first treatment • National standards for multidisciplinary teams. 	June 2010	Additional patient mgmt framework (tumour stream to be identified)	Additional patient mgmt framework (tumour stream to be identified)	Ministry of Health
		Gather baseline information and identify existing waiting times from primary care referral to treatment for patients with suspected lung cancer.	Quarter 4	Monitor wait times on an ongoing basis	Monitor wait times on an ongoing basis	Regional Cancer Networks
		Identify the percentage of suspected lung cancer patients that meet the 2 week standard from General Practitioner (GP) referral to First Specialist Assessment (FSA) respiratory (elective services standard).	Dec 2009	Approach to be replicated for other tumour streams	Approach to be replicated for other tumour streams	Regional Cancer Networks

	Identify the current percentage of lung cancer patients presented at multidisciplinary team meetings by DHB and by ethnicity.	Dec 2009	June 2011		Regional Cancer Networks
	Facilitate streamlining referral processes to reduce the number of steps in the treatment pathway.	June 2010	Approach to be replicated for other tumour streams	Approach to be replicated for other tumour streams	Midland Cancer Network
	Facilitate the adoption of a 'straight to test' approach for suspected lung cancer patients prior to specialist FSA, where clinically appropriate, with the aim to reduce the number of steps in the treatment pathway.	June 2010	Approach to be replicated for other tumour streams	Approach to be replicated for other tumour streams	Northern Cancer Network
	Facilitate the development of a lung cancer multidisciplinary team meeting framework and implement the framework within available resources that will lead to multidisciplinary team effectiveness for decision making to achieve timely and appropriate treatment for increased number of lung cancer patients.	June 2010	Breast Prostate	Upper GI Head & Neck Gynae	Central Cancer Network
Wait times from referral to first treatment for bowel cancer patients (excludes inpatient and acute admissions, and those people not diagnosed with bowel cancer) will be collected by DHB and ethnicity for quarter 4 2009/10	Develop a bowel cancer patient management framework. This will include: <ul style="list-style-type: none"> • Wait time indicators for bowel cancer from referral to first treatment • National standards for multidisciplinary teams. 		June 2011	Additional patient mgmt framework (tumour stream to be identified)	Ministry of Health
	Develop and implement initiatives to enhance colonoscopy workforce capacity and capability	June 2010	Monitor and review take-up of initiatives	Monitor and review take-up of initiatives	Ministry of Health

		Gather baseline information for wait times from referral to first treatment for bowel cancer patients.	June 2010	Monitor wait times on an ongoing basis	Monitor wait times on an ongoing basis	Regional Cancer Networks
		Identify the current percentage of bowel cancer patients presented at multidisciplinary team meetings by DHB and by ethnicity.	June 2010	Approach to be replicated for other tumour streams	Approach to be replicated for other tumour streams	Regional Cancer Networks
		Develop and adopt bowel cancer multidisciplinary team meeting framework and implement the framework within available resources that will lead to multidisciplinary team effectiveness for decision making to achieve timely and appropriate treatment for increased number of bowel cancer patients.	June 2010	Approach to be replicated for other tumour streams	Approach to be replicated for other tumour streams	Central Cancer Network
		Facilitate the development and implementation of a histology reporting proforma for colorectal cancer across the South Island.	June 2010	Approach to be replicated for other tumour streams	Approach to be replicated for other tumour streams	Southern Cancer Network

Objective	Indicator or measure (measure of progress against output/activities undertaken)	Output/Activities (work undertaken to contribute to the objective)	Timeframe			Lead Responsibility
			2009/10	2010/11	2011/12	
Improve wait times for cancer treatment	Everyone needing radiation treatment will have this within 6 weeks by the end of July 2010 and within 4 weeks by December 2010.	Manage throughput to meet the health target	Ongoing	Ongoing	Ongoing	DHB Cancer Centres
		Monitor wait times and regularly report to the Minister of Health on wait times	Quarterly	Quarterly	Quarterly	Ministry of Health
		Finalise clinical access prioritisation criteria for medical oncology	February 2010	Implement criteria by December 2010		Ministry of Health
		Develop Cancer Surgery Wait Time Indicator(s)	Lung cancer indicator February 2010	Additional cancer indicator/s November 2010	Additional cancer Indicator/s November 2011	Ministry of Health
		Develop core cancer data definitions to HISO standard	Data elements and definitions agreed June 2010	Pilot/s of core data set completed December 2010	Implement core data set	Ministry of Health
		Improve access to cancer information	June 2010	Ongoing	Ongoing	Ministry of Health

Objective	Indicator or measure (measure of progress against output/activities undertaken)	Output/Activities (work undertaken to contribute to the objective)	Timeframe			Lead Responsibility
			2009/10	2010/11	2011/12	
Improve palliative care services	DHBs will pass the Boost Hospice funding directly to hospices.	Implement and monitor <i>Boosting Hospice Funding Initiative</i>	Implementation completed by December 2009	Ongoing monitoring of initiative	Realign palliative care funding, where possible to support specialist palliative care implementation	Ministry of Health
		Finalise Specialist Palliative Care Service Specification	Finalise gap analysis of specialist palliative care specialist service specification by February 2010	Agree implementation process for finalised Specialist Service Specification	Realign specialist service specification within wider context to include generalist palliative care	Ministry of Health
		Develop core palliative care data definitions to HISO standard	Data elements and definitions agreed by June 2010	Pilot/s of core data set completed by December 2010	Implement core data set	Ministry of Health

Research, Monitoring and Evaluation

Research A cancer research partnership has been established between the Ministry of Health and the Health Research Council. Three million dollars has been allocated to this partnership. The partnership will manage a cancer research agenda that seeks to:

- Identify and evaluate ways to reduce cancer morbidity and mortality
- Improve the quality of life of people living with, recovering from, or dying from cancer
- Improve the quality and cost–benefit ratio of cancer control services and activities
- Link research with policy and practice needs.

This research partnership will complement the other research activities within cancer.

Modelling Over 2009/10 an overview on cancer will be published that summarises existing information on cancer, with a particular emphasis on the context provided by time series and international comparisons, and including information on treatment volumes and cost estimates that have not previously been publicly available.

Specific modeling and analyses will also be done for:

- Bowel cancer screening
- Radiation therapy
- Medical oncology
- Haematology
- Palliative care.

The Cancer Control Steering Group's prioritisation and resource decisions will be informed by these models and analyses.

Monitoring The 2009/10 work plan will be monitored by the Cancer Control Steering Group. A programme update report is prepared for each Steering Group meeting. The 2009/10 performance indicators for the Cancer Programme will be reviewed in December 2009 and July 2010.

Monitoring of the Health Targets is undertaken quarterly and results are available on the Ministry of Health's website.

Evaluation An evaluation of the regional cancer networks will be undertaken over 2010/11. Over 2009/10 the scope of the evaluation will be developed.

Resourcing

Programme funding

Funding for the Cancer Control Programme is largely devolved to DHBs through Population Based Funding (PBF). The regional cancer networks are funded through a Crown Funding Agreement variation. The Ministry holds a Departmental Expenditure budget for its work programme and a Non-Departmental Expenditure budget for projects or services funded at a national level.

As the Programme develops there may be further opportunities to adapt how funding models feed into the Programme. For example, how DHBs' PBF links to the Programme.

Ministry of Health funding

The following table outlines Ministry of Health resourcing of the Tobacco, Cancer, BreastScreen Aotearoa, and National Cervical Screening Programmes:

Programme area	Departmental expenditure	FTEs	Non-departmental expenditure
Tobacco	\$1.35 million	10	Approx. \$57 million
Cancer Group ¹	\$3.45 million	22	Approx. \$50 million ²
BreastScreen Aotearoa	\$0.88 million	8.0	\$41.49 million
National Cervical Screening Programme (excludes NCSP register)	\$1.05 million	9.6	\$35.13 million

¹ Includes resourcing for the development of a bowel cancer screening programme

² Includes funding for all Herceptin drug costs and the Boosting Hospice Initiative

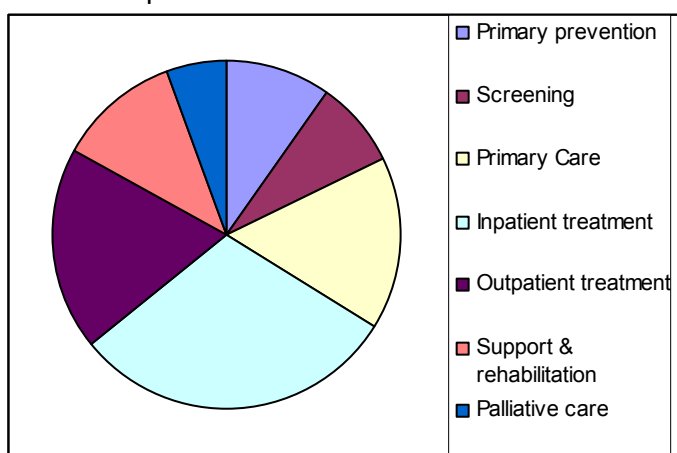
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Resourcing, Continued

Health system funding

In 2006/07, an estimated \$800 million⁵ was spent on cancer control by the public health system (see diagram below), and although the analysis is not yet complete, this is believed to have increased to around \$900 million in 2007/08. This represents about seven percent of total public health expenditure, which is in line with estimates from the United States and Australia. The estimates provided here do not include:

- Travel and accommodation costs (either publicly funded or borne by individuals)
- Insurance-funded or out-of-pocket expenditure in the private system (including primary care)
- Expenditure by NGOs supported by charitable funding
- The value of volunteer contributions
- Expenditure on research.



	\$ millions	% of total
Primary prevention	77.9	9.7%
Screening	65.4	8.1%
Primary Care	129.4	16.1%
Inpatient treatment	243.9	30.3%
Outpatient treatment	152.4	18.9%
Support & rehabilitation	90.6	11.3%
Palliative care	44.8	5.6%
Total	804.4	

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⁵ Notes: does not include NGO, private insurer or out-of-pocket expenditure; does not include expenditure on research.

1. Primary prevention – total Ministry of Health national budgets for tobacco control, physical activity and nutrition. Does not include DHB expenditure.

2. Screening – NSU budgeted expenditure.

3. Primary care – indicative 5% of PHO, community laboratories and community pharmaceuticals expenditure plus expenditure on community cancer drugs, based on information provided by PHARMAC. Does not include community-referred radiology.

4. Inpatient treatment – actual case-weighted discharges from the National Minimum Data Set with cancer diagnosis, multiplied by base inpatient price. Does not include tertiary or other adjusters.

5. Outpatient treatment – actual price/volume schedules from Personal Health Non Case Weight database for oncology and haematology purchase units; actual BreastScreen Aotearoa invoiced outpatient expenditure. Does not include non cancer-specific purchase units.

6. Support & rehabilitation – extrapolation to national level of 2003/04 Capital & Coast DHB study which calculated community care expenditure on patients identified by NHI as having received cancer treatment. Expenditure adjusted by DHB funding pathway (average 6.5% per annum) for out years.

7. Palliative Care – actual DHB funder expenditure from general ledger reporting.

Resourcing, Continued

Programme resources - Ministry of Health

The Cancer Control Programme is led by the Ministry of Health working closely with DHBs and regional cancer networks on the Programme's strategic direction and implementation.

The Ministry's Cancer Team leads and coordinates the national Programme. Accountability for the Cancer Team is jointly held by the National Clinical Director for Cancer, Dr John Childs who provides clinical leadership for the Programme and the National Programme Manager for Cancer, Deborah Woodley, who is responsible for team management. The Bowel Cancer Team reports into the Cancer Team. The Deputy Director-General of the Sector Capability & Innovation Directorate, Margie Apa, provides executive leadership for the Programme and co-chairs the joint DHB and Ministry Cancer Control Steering Group.

District Health Boards

DHBs have appointed a lead Chief Executive Officer for Cancer, Garry Smith (CEO of Auckland DHB) to provide national leadership for cancer. Garry Smith co-chairs the joint DHB and Ministry Cancer Control Steering Group.

A consolidated DHB funding and planning perspective is provided at the Steering Group level via a General Manager Planning and Funding representative and a DHB provider arm perspective is given via a Chief Operating Office representative at the Cancer Treatment Advisory Group.

Strong clinical leadership is provided at all levels of the programme. There are range of clinical advisory and work groups. At a governance level the Chair of the Cancer Treatment Advisory Group sits on the Steering Group.

Regional cancer networks

There are four regional cancer networks in New Zealand who work across organisational boundaries to promote a collaborative approach to service planning and delivery.

Continued on next page

Resourcing, Continued

Geographic regions

The four regional networks cover the following DHB geographical coverage areas and the patient flow to the regional cancer centres:

- Northern Cancer Network - Auckland, Waitemata, Counties Manukau, Northland
- Midland Cancer Network - Waikato, Bay of Plenty, Lakes
- Central Cancer Network - Taranaki, Whanganui, MidCentral, Hawke's Bay, Tairāwhiti, Wairarapa, Hutt Valley, Capital & Coast
- Southern Cancer Network – Nelson/Marlborough, Canterbury, Otago, West Coast. South Canterbury, Southland.



Continued on next page

Resourcing, Continued

Network support

The regional networks are supported by a network manager and clinical director(s) as listed below:

Maree Pierce (Northern Network Manager), Dr Richard Sullivan (Northern Clinical Director)

Jan Hewitt (Midland Network Manager), Dr Charles De Groot (Midland Clinical Director)

Jo Anson (Central Network Manager), Dr Andrew Simpson (Central Clinical Director), Dr Simon Allan (Central Clinical Director)

Annie Bermingham (Southern Network Manager), Dr Shaun Costello (Southern Clinical Director), Dr Bernie Fitzharris (Southern Clinical Director).

Appendix 1 Cancer Control Steering Group Terms of Reference

Purpose

1. The purpose of the Cancer Control Steering Group (the Steering Group) is to provide governance for the Cancer Control Programme. It oversees priority setting, planning and implementation of the Cancer Control Programme. The Steering Group also provides governance for the palliative care work programme.
2. The Cancer Control Programme is a national programme that covers Ministry of Health (the Ministry), District Health Boards (DHBs), and regional cancer networks activity to implement the Government's priorities for cancer and the New Zealand Cancer Control Strategy.
3. The objectives of the Cancer Control Programme are to:
 - Reduce the incidence and impact of cancer
 - Reduce inequalities with respect to cancer
 - Ensure there is nationally consistent access to cancer services
 - Fairly and equitably prioritise and plan service improvement and new investment and deliver value for money.

Role

4. The role of the Steering Group is to provide leadership and oversight over the strategic direction of the Cancer Control Programme. This will be achieved by:
 - a. Setting the strategic direction for the Cancer Control Programme
 - b. Leading and coordinating a strategic planning and prioritisation process to provide a longer term view on how the Cancer Control Programme intends to achieve the overall purposes of the Cancer Control Strategy (which includes operational 'business as usual' activity)
 - c. Overseeing an annual planning and prioritisation process to inform the government's annual budget cycle for Vote Health and the annual work plan for the Cancer Control Programme. This includes:
 - i. Providing guidance to the Ministry, DHBs, and regional cancer networks on priority areas for new investment, service development, and work planning to achieve alignment across the Ministry, DHBs and regional cancer network work programmes
 - ii. Seeking expert clinical advice on services/initiatives for prioritisation from advisory groups to the Cancer Control Programme
 - iii. Overseeing work to aid medium-term planning for cancer treatment in New Zealand and ensuring this information is disseminated to the appropriate organisations to inform planning processes
 - iv. Making decisions on which services/initiatives are recommended to funders for investment. This relates to new services/initiatives and areas for targeted improvement across the whole system.

- d. Setting clear performance target/outcomes for the Cancer Control Programme and monitoring achievement of these targets/outcomes by the Ministry, DHBs, and Regional Cancer Networks (including the national health targets for cancer control).
- e. Monitoring the ongoing implementation of the Cancer Control Strategy Action Plan 2005-2010 (including operational 'business as usual' activity) and reviewing the implementation priority of specific actions in the Action Plan.
- f. Providing strategic oversight of projects across the Cancer Control Programme. This includes:
 - i. Approving (in consultation with mandating groups) specific project work
 - ii. Providing guidance on risks and issues arising for the Cancer Control Programme and where necessary managing specific risks/issues.
- g. Overseeing the implementation of a communication strategy for the Cancer Control Programme.
- h. Setting clear expectations about the roles and responsibilities of the groups tasked with providing advice to the Steering Group. This includes requesting and receiving advice, and approving specific projects.
- i. Ensuring the Cancer Control Programme operates according to the following principles:
 - i. National consistency with local flexibility
 - ii. Collaboration and cooperation
 - iii. Openness and transparency.

Membership

5. The Steering Group is comprised of the following members and will be co-chaired by the Deputy Director-General Sector Capability and Innovation and the Lead DHB Chief Executive Officer for Cancer. Steering Group members are on the Steering Group as representatives of their organisation or sector.

Name and Job Title	Programme Role
Margie Apa Deputy Director-General Sector Capability and Innovation	Co-Chair Ministry of Health programme sponsor Provides the link between the Cancer Control Steering Group and the Long Term System Framework Steering Group
Deborah Woodley National Programme Manager for Cancer	Ministry of Health programme manager
John Childs National Clinical Director for Cancer	Clinical advice for cancer control
Ashley Bloomfield Chief Advisor Public Health/National Director Tobacco Control	Population Health advice for cancer control
Teresa Wall Deputy Director-General Māori Health	Inequalities advice for cancer control
DHB Chief Executive Officer	Co-Chair Lead DHB CEO for cancer

DHB General Manager Funding & Planning	DHB funder and planner
Regional Cancer Network Clinical Director and Manager	Represents the four regional cancer networks
Garry Forgeson Chair of the Cancer Treatment Advisory Group	Provides a link between the Steering Group and the Cancer Treatment Advisory Group

6. Depending on the agenda items other people may attend Steering Group meetings to present papers or issues and participate in the discussion.

Meeting Arrangements

7. Meetings will take place on a bi-monthly basis. In general meetings will be face-to-face. Teleconferences will be used as appropriate.

Quorum

8. A quorum will be 4 members of the Steering Group, including one DHB and one Ministry representative as a minimum.

Decision-making

9. Decision-making at the Steering Group will be by consensus, with Members ensuring that they have a mandate from their relevant organisation/sector.

Group Processes

10. The co-Chairs will be responsible for:

- a. Managing meeting processes
- b. Ensuring they have an appropriate mandate to participate in the Steering Group's consensus decision-making processes
- c. Acting as spokespeople for the Steering Group.

11. Steering Group members will be responsible for:

- a. Keeping their respective organisations/groups updated
- b. Ensuring they have an appropriate mandate to participate in the Steering Group's consensus decision-making processes
- c. Promoting the Cancer Control Programme and its processes. This includes keeping the Cancer Control Council informed of progress to support the Council's role in providing independent advice to the Minister of Health and Associate Minister of Health and monitoring the implementation of the Cancer Control Strategy.

12. The Ministry will provide secretariat support to the Steering Group. This includes distribution of the agenda and recording of the minutes. The agenda will be circulated at least ten days prior to meetings. Minutes will be circulated no later than a fortnight following the meeting date.

13. Continuity of membership is preferable and generally, substitutes will not be nominated to attend in the absence of another member, unless it is considered helpful to co-opt colleagues with particular expertise to provide advice on specific agenda items. In these

14. Minutes of the Steering Group meetings will be provided to the following groups for information:

- Ministry of Health Executive Leadership Team
- Cancer Treatment Advisory Group and its work groups
- New Zealand Palliative Care Working Group and its work groups.

Appendix 2 Cancer Treatment Advisory Group Terms of Reference

Purpose

1. The Cancer Treatment Advisory Committee (CTAG) provides clinical advice on cancer treatment to the Cancer Control Steering Group.
2. The Cancer Control Steering Group provides governance for the Cancer Control Programme, which is a national programme that covers Ministry of Health, District Health Boards (DHBs), and regional cancer networks activity to implement the New Zealand Cancer Control Strategy and New Zealand Cancer Control Strategy Action Plan. The Cancer Control Steering Group also provides governance for the palliative care work programme.
3. The objectives of the Cancer Control Programme are to:
 - Reduce the incidence and impact of cancer
 - Reduce inequalities with respect to cancer
 - Ensure there is nationally consistent access to cancer services
 - Fairly and equitably prioritise and plan service improvement and new investment and deliver value for money.

Role

4. The role of the CTAG is to provide clinical advice on cancer treatment to the Cancer Control Steering Group. This will be achieved by providing expert clinical advice on:
 - a. specific areas that relate to cancer treatment e.g. existing clinical effectiveness, service improvement, service development, treatment guidelines, service standards
 - b. technology change for cancer treatment as part of the Cancer Control Programme's horizon scanning function
 - c. services/initiatives for prioritisation to be considered as part of a strategic planning and prioritisation process to provide a longer term view on how the Cancer Control Programme intends to achieve the overall purposes of the Cancer Control Strategy, as requested by the Steering Group
 - d. services/initiatives for prioritisation to be considered as part of an annual planning and prioritisation process to inform the government's annual budget cycle for Vote Health and the annual work plan for the Cancer Control Programme, as requested by the Steering Group
 - e. any other specific areas as requested by the Cancer Control Steering Group
 - f. cancer treatment matters to the Cancer Control Council (where appropriate). All requests for advice will be facilitated via the Ministry of Health.

Membership

5. CTAG members are on the CTAG as recognised experts nominated by their organisation, sector or speciality group. The CTAG is comprised of the following members.
 - Cancer Control Steering Group Co-Chairs (attendance at their discretion)
 - Appointed Chair

- National Clinical Director Cancer Programme
- Chief Operating Officer
- Clinical Directors from each regional cancer network
- Radiation Oncologist (Chair or representative of the work group)
- Medical Oncologist (Chair or representative of the work group)
- Paediatric Oncologist (Chair or representative of the paediatric oncology steering group)
- Oncologist (Chair or representative of the adolescent and young adult work group)
- Palliative care (Chair or representative of the New Zealand Palliative Care Working Party)
- Haematologist (Chair or representative of the work group)
- Surgeon (Chair or representative of the work group)
- Oncology nurse
- Primary care clinician.

Appointment Process

6. The Co-Chairs of the Cancer Control Steering Group will nominate the Chair of the CTAG with agreement by the CTAG. The Chair will hold office until:
 - a. he or she vacates
 - b. the Co-Chairs appoint a chair in his or her place with agreement by the CTAG.
7. The Ministry will seek nominations for the clinical and other representatives through the relevant college or professional/organisational body as appropriate.
8. Where specialist sub-groups of the CTAG have been established the work group Chair or work group representative may represent the relevant specialty area. Appointees may represent several categories, for example a speciality area and a clinical director role.
9. Representatives will be appointed for three years and may be reconfirmed by their nominating bodies for a further period of three years.

Work Groups

10. The CTAG establishes and co-ordinates work groups to provide advice on specialist areas within cancer control. The work groups are multidisciplinary in composition as appropriate. Clinically focused groups will be chaired by a clinician and the role of the group should be clear by its title. The standing work groups are:
 - Radiation oncology
 - Medical oncology
 - Adolescent and Young Adults oncology
 - Haematology
 - Surgical.
11. Other work groups may be established by the CTAG, on a time limited basis, as required by the work programme and with the agreement of the Ministry of Health. Work groups may be disbanded by the CTAG to reflect changes in work programme priorities and/or if specific projects have reached completion.
12. Each work group develops terms of reference, annual objectives, and a supporting workplan in consultation with the CTAG.

13. The work groups report to the CTAG and can be delegated to provide advice directly to the Cancer Control Steering Group.

Support for CTAG and Work Groups

14. The Ministry of Health will provide secretariat and administrative support to the CTAG and its work groups. This includes distribution of the agenda and recording of the minutes. The agenda will be circulated at least five days prior to meetings. Minutes will be circulated no later than a fortnight following the meeting date. The Ministry will provide rooms and refreshments for the meetings.
15. Travel and time will be funded through the representative's employer for DHB employees. The Ministry will fund travel for people not employed by DHBs.

Meeting arrangements

16. Meetings will take place on a quarterly basis and align with Cancer Control Steering Group meetings (preferably four weeks before a Steering Group meeting).

Quorum

17. Eight members will constitute a quorum.

Group Processes

18. The Chair will be responsible for:
 - a. Managing meeting processes
 - b. Acting as a spokesperson for the CTAG.
19. CTAG members will be responsible for keeping their respective organisations/groups updated on the CTAG's work programme.
20. Continuity of membership is preferable and generally, substitutes will not be nominated to attend in the absence of another member, unless it is considered helpful to co-opt colleagues with particular expertise to provide advice on specific agenda items. In these circumstances, it is the responsibility of the CTAG member to ensure the substitute is fully briefed and understands their responsibilities.

Reporting

21. The CTAG reports to the Cancer Control Steering Group through the Chair. Minutes of the CTAG meetings will be provided to the Steering Group for information.
22. At the beginning of each financial year, the CTAG will provide a high-level workplan for the CTAG and its work groups to the Cancer Control Steering Group. It is acknowledged that the CTAG is an advisory group and its workplan is flexible and subject to change based on requests from the Steering Group for advice and the need for the CTAG to respond to emerging issues.

Appendix 3 New Zealand Palliative Care Working Party Terms of Reference (currently under review)

NB: the terms of reference are being updated and will be made available on the Ministry's website once finalised.

Appendix 4 Cancer and Palliative Care Information Advisory Group

Purpose

The National Cancer and Palliative Care Information Systems (CCIS) Advisory Group is being set up to provide advice to the Cancer Control Implementation team, the Cancer Control Steering group, Ministry of Health and DHBs.

The role of the Advisory Group is to support the project by providing advice on work produced by the Cancer Control Implementation team.

The Advisory Group will review and make recommendations to support the two workstreams within the National Cancer and Palliative Care Information Systems project (CCIS):

- Non-Surgical Cancer and Palliative Care Patient Management Systems (CPMS)
- Cancer and Palliative Care Data and Code sets (Data and Code sets).

Responsibilities

The responsibilities of the Advisory Group include:

- Providing advice on the development of CPMS from a national perspective
- Providing technical and clinical advice on the proposed Data and Code sets
- Provide advice on the options for the next steps to operationalise data and code sets
- Provide advice on options for changes in access to data in the Cancer Registry (if this is confirmed as a possibility).

Membership

The CCIS Advisory Group will have a sufficient membership to be able to represent and/or liaise with all relevant stakeholders.

Membership would normally include representatives of:

- Oncologist
- Non-Surgical Cancer Treatment
- Public Health and Research
- Surgical
- Regional Clinical Network Director
- Clinical Information
- Primary Health Care
- Palliative Care
- Pathologist
- Chief Information Officer
- New Zealand Cancer Treatment Working Party (NZCTWP)
- New Zealand Palliative Care Working Party (NZPCWP)
- New Zealand Health Information Service (representing both the operational and strategic view of the Cancer Registry)
- National Systems Development Programme

The Advisory Group can provide advice about the development of the membership of the group or inviting participation at specific meetings to widen skills available in the group if and when necessary.

If a member is unable to attend a meeting they may nominate an appropriate substitute by notifying the Project Manager. It is the responsibility of the member to ensure the substitute is fully briefed and understands their responsibilities.

Roles and Relationships

Dr John Childs, National Clinical Director Cancer Programme, is the sponsor of the National Cancer and Palliative Care Information Systems.

Professor Tony Blakely is the Chairperson of the CCIS Advisory Group.

The Cancer Control Steering Group will provide governance of the project and is the project's decision-making body.

The Project Manager will report to the Advisory Group and to the Steering Group on progress and liaise with the Cancer Control Implementation team.

Advisory Group members are able to and encouraged to liaise with the groups they represent on progress of the project as appropriate.

Communication

Advisory Group meetings will be held on approximately a quarterly basis and interim teleconferences will be arranged if appropriate.

Advisory Group meetings will be rescheduled if a quorum of five full (ie non ex officio) members is not available (exclusive of Ministry of Health personnel).

The project manager will ensure an up to date contact list is available to all.

The Ministry of Health will set up meetings, provide secretarial services for the meetings and manage circulation of documentation to members.

Fees

Attendance fees and Travel costs will be met in accordance with Ministry of Health policy for non-DHB members.

Declarations of conflict of interest

Advisory Group members must declare if they believe they have a conflict of interest on a subject, which will prevent them from reaching an impartial decision or undertaking an activity consistent with the Advisory Group's functions. At this point the member should withdraw themselves from the discussion and/or activity.

Appendix 5 Regional Cancer Networks Service Specification

NB: This document has been amended to reflect generic service specifications for the regional cancer networks.

1. Background

- 1.1 In 2006/07, four regional cancer networks (“Networks”) were established in New Zealand.
- 1.2 Networks have a leadership, facilitation and co-ordination role in implementing the Cancer Control Strategy, improving cancer outcomes and reducing inequalities. Networks work across organisational boundaries and promote a collaborative approach to service planning and delivery.
- 1.3 The structures, scopes and functions of Networks continue to evolve. There will continue to be regional differences due to variations in the configuration of cancer control service providers, and different regional priorities for cancer control activities.
- 1.4 A lead DHB, receives the funding for the relevant regional cancer network infrastructure and operations on behalf of the populations of the designated DHBs and their cancer control stakeholders (including DHB funders and providers, Non Government Organisations, Māori, professionals and consumers).

2. Service Description

- 2.1 The lead DHB, during the term of this Schedule A25, will provide the following services (“the Services”):
 - 2.1.1 Fund the Network to:
 - (i) Maintain the Network’s core infrastructure and operations, in accordance with clause 4.1.1 to 4.1.4 of this Schedule;
 - (ii) Investigate and address systemic causes of cancer inequalities, especially for Māori, but also for Pacific, rural, lower socio-economic, other minor ethnicity, or other groups with poor cancer outcomes, in accordance with clauses 4.1.5 to 4.1.7 of this Schedule; and
 - (iii) Obtain cancer data analysis capacity to support the Network’s operations, in collaboration with the other Networks, in accordance with clause 4.1.8 of this Schedule.
 - (iv) Submit to the Ministry and regional stakeholders, for their approval, a final Regional Strategic Cancer Control Plan, based on the draft Regional Strategic Plan described in Schedule AP of the (Eighth) May 2007 Omnibus Variation to the 2004/05 CFA.
 - 2.1.2 Report to the Ministry, in accordance with clause 5.1 of this Schedule.

3. Term

- 3.1 This Schedule A25 commences on the date when this Schedule is duly executed by the Parties and, unless terminated earlier in accordance with the Principal Agreement, will expire on 30 June 2011.

4. Service Requirements

4.1 In performing the Services, the DHB must ensure the Network:

Maintains the Network's core infrastructure and operations

4.1.1 Brings together all constituent organisations, professionals and interest groups involved with cancer, and provides a formal governance structure that:

- (i) Involves patients, their families/whānau, and the public;
- (ii) Ensures input of all DHB and NGO cancer service providers across the region, including Primary Health Organisations (“PHOs”);
- (iii) Includes identified Māori leadership and a framework to support participation of Māori;
- (iv) Links to DHB funding and planning;
- (v) Links to national groups, in particular the Cancer Treatment Advisory Group, the joint Ministry of Health/DHB steering group and the other Networks; and
- (vii) Is accountable to constituent DHBs.

4.1.2 Maintains an effective management team with strong clinical and managerial leadership, which:

- (i) Develops region-wide, tumour-specific and service improvement multidisciplinary groups and workstreams, not constrained by organizational or professional boundaries;
- (ii) Develops patient pathways, promoting a focus on the patient journey and improving the experience of care;
- (iii) Provides specific cancer control expertise to support service planning, promoting the efficient and effective use of finite resources to improve cancer outcomes and reduce inequalities;
- (iv) Identifies existing gaps in cancer services, including workforce gaps, and supports providers to reduce duplication in the delivery of cancer services;
- (v) Identifies barriers to performance across provider organisations;
- (vi) Supports a range of quality improvement initiatives across the continuum and promotes the use of quality improvement tools such as clinical guidelines, protocols, patient information process mapping, and capacity or demand analysis;
- (vii) Promotes and facilitates information dissemination and knowledge sharing; and
- (viii) Supports clinical research, audit and outcomes reporting.

4.1.3 Undertakes, sponsors, or facilitates work programmes to improve the multidisciplinary management of specific tumours, the improvement of cancer services, and the development of the cancer workforce.

4.1.4 In collaboration with the Ministry and the other Networks, leads an annual national cancer control forum to report back and share knowledge and learnings with the wider cancer community.

Investigates and addresses systemic causes of cancer inequalities

4.1.5 Includes resources in the network management team with a specific focus on inequalities.

4.1.6 Raises awareness of inequalities among cancer service providers and other cancer stakeholders.

- 4.1.7 Works to better identify the causes of cancer inequalities and address those inequalities, by:
- (i) Promoting the consistent collection of ethnicity data by providers and the inclusion of ethnicity data in routine data reporting;
 - (ii) Undertaking, sponsoring or facilitating appreciative enquiry to better understand the inequalities in access apparent through data;
 - (iii) Sponsoring or facilitating innovative pilot or demonstration projects to reduce inequalities in service access and/or improve service effectiveness and acceptability for different populations groups. The network may allocate funding to small-scale, one-off projects or initiatives, but is not expected to sustainably support service delivery;
 - (iv) Ensuring that information on successful initiatives is widely disseminated and that other providers or stakeholders have the opportunity to learn and benefit from these successful initiatives;
 - (v) Promoting system-level changes that can reduce access barriers for population groups, including changes that may be required beyond dedicated cancer services;
 - (vi) Providing advice to funders and planners of both DHB and non-DHB services on strategies for reducing inequalities and the highest priorities from an inequalities perspective; and
 - (vii) Consulting with and ensuring the participation of Māori and other population groups in service delivery planning as well as at governance levels.

Obtains cancer data analysis capacity to support the Network's operations

- 4.1.8 Collaborates with other Networks to provide, contract for, or otherwise obtain, data analysis capacity that interrogates existing sources of clinical, service delivery, epidemiological, demographic, workforce, and financial data, thereby allowing the Network to:
- (i) Improve understanding of the local and regional cancer burden and inequalities, including at an individual DHB level;
 - (ii) Provide evidence-based advice to funders and planners on prioritisation;
 - (iii) Target priority areas for service improvement; and
 - (iv) Establish baselines for performance indicators and outcome measures.

5. Reporting

5.1 In addition to the reports required under the Principal Agreement, the DHB, will provide the following written report(s) to the Ministry:

Report Contents	Date Report Due
Report on progress to stakeholders within the Network.	Quarterly from 20 July 2008
Report on progress to the Ministry.	Six-monthly from 20 July 2008
Report on progress and prioritised annual work programme to the Ministry and stakeholders within the Network.	Annually from 20 July 2008

Regional Strategic Cancer Control Plan developed and endorsed by regional stakeholders and the Ministry.	30 June 2009
Quantitative and qualitative indicators that measure progress in reducing the impact and incidence of cancer and reducing cancer inequalities, as agreed with the Ministry and regional cancer stakeholders, and set out in annual and strategic plans.	Dates to be determined in discussion with the Ministry. High-level framework for indicators to be included in the Regional Strategic Plan.

7. Variation

- 7.1 Any proposed variation in the Services to be provided by the DHB under this Schedule A25 must be discussed and agreed in writing by the Ministry and the DHB.