Mapping Progress II:

PHASE 1 OF THE CANCER CONTROL STRATEGY ACTION PLAN 2005–2010
The Cancer Control Council of New Zealand would like to thank the many individuals and organisations who have contributed to this report by providing information to the Council. In particular we acknowledge the work of the Council’s Evaluation and Monitoring Working Group (Professor Tony Blakely, Chair, Ms Helen Glasgow, Dr John Childs, Dr Garry Forgeson, Dr Beverley Lawton) and the staff of the Cancer Control Council (Craig Tamblyn, Mary Clare Tracey, Scott Trainor, Caroline Fyfe, Natalie McCarthy, Tina Nixon and Inga O’Brien) for making this report a reality.
This report of the Cancer Control Council of New Zealand is a follow-up to the report that was released by the Council in August 2007. That report, *Mapping Progress: The first two years of the Cancer Control Strategy Action Plan 2005–2010*, examined progress that had been made in implementing the Cancer Control Strategy Action Plan at the end of Phase one (2005–2007). In that report the Council noted that while some of the milestones contained in the Ministry Action Plan were achieved, there were a number that were in progress or delayed.

The Council deemed that many of the milestones that were not achieved in Phase one were essential ‘building blocks’ for progress to occur in Phase two of the Action Plan. This report revisits Phase 1 of the Action Plan to examine whether there has been any further progress over the past year.

For this report the Council has adopted a focus on the outcomes contained in the Action Plan rather than on the individual milestones.

The Council has identified several areas where the cancer control community has made progress towards specific outcomes contained in the Action Plan in ways other than those described by the milestones. Measuring progress toward achieving the outcomes, in addition to just progress against milestones, allows this progress to be captured and recognised.

This report provides a big picture view of progress that has been made in implementing the Cancer Control Strategy over the past year. This will be useful in helping organisations see how their work contributes to the overall achievement of the goals of the Cancer Control Strategy.

It is useful, as we continue to implement Phase two of the Action Plan, to take stock of the progress that has been made in the field of cancer control in recent years. Indeed, there has been much progress. It is also useful to take some time to think about the challenges that we must confront in order to achieve the best possible outcomes in cancer control. This report does both of those things.

The Council would like to thank the many organisations and individuals who have contributed to this report by responding to our request for information and meeting with us to discuss different areas of cancer control. The Council welcomes any feedback on this report so that we can continue to improve in our monitoring and evaluation role.

The Council looks forward to continuing to monitor progress as Phase two of the Action Plan is implemented.

Dame Catherine Tizard
Chair, Cancer Control Council

Professor Tony Blakely
Chair, Monitoring and Evaluation Working Group
Cancer Control Council
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The Cancer Control Council is responsible for ensuring New Zealand’s Cancer Control Strategy is turned into action. The Council is an independent advisory body appointed by the Minister of Health. The Council gives strategic advice directly to the Minister as well as to the wider cancer control community.

The Council works with all the bodies involved in cancer control. Together we are entrusted with reducing both the incidence and impact of cancer in New Zealand and the inequalities that surround it.

The Council’s key tasks are to:

- monitor and review implementation of the Cancer Control Strategy
- provide independent strategic advice to the Minister of Health, the Director-General of Health, district health boards and non-government organisations on matters related to cancer control
- foster collaboration and co-operation between bodies involved in cancer control
- foster and support best practice in, and an evidence-based approach to, improvements in the effectiveness of cancer control
- set up links with overseas cancer control agencies.

**Purpose of this report**

The purpose of this report is twofold:

1. to update progress on Phase 1 cancer control activities in New Zealand, which were due to be completed in the 2005–2007 period
2. to provide a strategic-level evaluation of how the multiple activities in the cancer control field contribute to achievement of the overall outcomes of the Cancer Control Strategy Action Plan

While Phase 1 applies to the first two years of the five year Action plan, not all Phase 1 actions were completed in this timeframe hence their further evaluation in this report.

**Goals of the Cancer Control Strategy**

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 of cancer 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.
Goal 1

Objective 1: Tobacco
Over the past year published results have shown favourable trends in the reduction of smoking prevalence. The New Zealand Health Survey shows a significant decrease in the rate of smoking prevalence in New Zealand, including for Māori and Pacific peoples. However, there has been no significant decrease in the amount of tobacco consumed. The Action on Smoking and Health Year 10 survey reports that there are fewer young people taking up smoking than ever before, in fact 57 percent of students surveyed had never smoked, not even a puff. There has also been progress in helping smokers to quit smoking with an increase in funding for, and widening of access to, nicotine replacement therapy.

Objectives 2 and 3: Nutrition and physical activity
The New Zealand Health Survey has shown mixed results on healthy eating habits of New Zealanders, although there has been a slowing in the rate of increase in obesity, and for Māori there has been no increase in the rate of obesity since 1997. Programmes that promote healthy eating, such as the fruit in schools, and feeding our futures, have been expanded across the country and a particular focus has been developed on meeting the needs of the most vulnerable groups.

Objective 4: Ultraviolet radiation
There has been action addressing this objective, however the outcomes specified in the Action Plan have not yet been achieved. Sector discussions have been initiated to develop appropriate messages in relation to Vitamin D, and Ultra Violet Radiation exposure in different parts of the country. There has been a focus on sun safety for schools and outdoor workers over the past year. Progress has been slow due to a lack of agreement between some stakeholders and the Department of Labour for updating of the Guidance Notes for Protection of Workers from Solar Ultraviolet Radiation. The Clinical Practice Guidelines for the Management of Cutaneous Melanoma is currently being updated and it is anticipated that this process will be completed by the end of 2008.

Objective 5: Infectious disease
The main development relating to infectious diseases and cancer over the past year has been the government decision to implement a programme to vaccinate all girls born on or after 1 January 1990 against Human Papilloma Virus. The vaccine will be provided free of charge and it has been estimated that, in time, the vaccination programme has the potential to save over 30 lives per year.

Objective 6: Alcohol
The links between alcohol consumption and cancer have not previously received a lot of attention, especially compared to the other risks associated with alcohol use. However, over the past year there have been several developments that have raised awareness of the link between alcohol and cancer. Most of this increased awareness has been among the research community, however the National Drug Policy now also mentions the alcohol related risk of developing cancer.

Objective 7: Occupational
Awareness of occupational related cancers is increasing; however cancers that may arise from occupational exposure to carcinogens still remain under reported to the Department of Labour. The Accident Compensation Corporation is aiming to improve information and support for workers who are eligible to receive compensation for cancer arising from occupational exposure. Collection of data that enables a clear understanding of occupational cancer is poor, and this is an area where the Council expresses concern.
Goal 2

Objective 1: Screening

Rates of coverage in the two cancer screening programmes that operate in New Zealand, BreastScreen Aotearoa and the National Cervical Screening Programme, continue to improve. Despite an overall improvement in the coverage of breast screening there are still significant ethnic and geographical disparities in screening coverage. There are also ethnic disparities in coverage for cervical screening. Maintaining and improving cervical screening coverage by dissemination of information remains an important component for controlling cervical cancer and it is important that this is taken into account by the implementers of the Human Papilloma Virus (HPV) vaccination campaign. The Council notes and commends the announcement of a colorectal cancer screening programme, and will monitor its implementation.

Objective 2: Early detection

The Council has not received any further reports on progress toward the outcomes within this objective, except to note that the joint Australasian Melanoma Guidelines, currently under development and due to be released by the end of 2008, may contribute to reducing deaths from melanoma in the future.

Goal 3

Objectives 1 and 2: Diagnosis and treatment

The Council considers that there has been real progress toward achieving outcomes under these objectives over the past year. Guidelines for radiation oncology referral have been developed and provide a model that will assist in the development of guidelines for other areas of diagnosis and treatment of cancer. A number of other guidelines are in development, including for Prostate Specific Antigen testing, early breast cancer diagnosis, melanoma diagnosis and treatment, sharing of web-based protocols and primary care and access referral. The regional cancer networks have continued to evolve over the past year and have been developing a multi-disciplinary team framework that will assist DHBs in implementing multi-disciplinary team approaches to patient management.

Objective 3: Patient-centred care

Over the past year three pilot programmes have been initiated that aim to improve the cancer journey for patients. These pilots have a strong inequalities focus, with two focussing on Māori communities and the other on a rural community. The pilot programmes that focus on Māori communities are the being run in Rotorua and Tamaki Primary Health Organisation and both aim to increase uptake of cancer services by Māori through community based support. West Coast Primary Health Organisation is running a pilot programme that aims to remove barriers, such as geographic distance and isolation, experienced by patients in a rural setting. This pilot programme has been nominated as a finalist in the 2008 Health Innovation Awards for “Alternative Pathways for New Patients”. The Council awaits the evaluation of these pilots to see if they are successful in improving the cancer journey for patients and reducing inequalities in cancer.

Goal 4

Objectives 1, 2 and 5: Supportive care and rehabilitation and appropriate levels of resourcing for supportive care

The Action Plan suggested establishment of a number of groups to address support and rehabilitation issues. A national advisory group has been established to produce national supportive care guidance, and three pilot studies have been established to assess models of supportive care for Māori and geographically isolated populations. Regional cancer networks and DHBs have also commenced various projects. Progress has been made toward outcomes under this objective through actions that have since superseded those specified in the Action Plan. The Council will assess these outcomes in the review of the Action Plan.

Objective 3: Support and rehabilitation for paediatric and adolescent cancer survivors

The Late Effects Assessment Programme is up and running throughout the country. It is designed to assess whether young survivors of cancer experience any long term side effects from the treatment of their cancer. A secure computer network has been developed to keep track of
young patients’ treatments and provide ongoing monitoring of these patients. The Council would encourage the integration of this information, in a useful way, into the national cancer datasets, as practicable in the future.

**Objective 4: Access to information**

There has been some progress toward achieving the outcomes under this objective. The Supportive Care Guidance, informed by the Cancer Society of New Zealand’s 2006 stocktake of cancer information resources, will include nationally consistent standards for the development and provision of cancer information.

**Objectives 6 and 7: Palliative care**

This is an area that the Council feels has been slow to make progress since the release of the Action Plan, however, over the past year there have been several developments that are likely to lead to real progress in the future. The New Zealand Palliative Care Working Group is developing Palliative Care Service Specifications, due to be released by the end of 2008. The palliative care nursing competency framework that has been developed includes options for professional development for the palliative care nursing workforce, the national specialist palliative care medical education proposal and a gap analysis of the palliative care nursing workforce. Palliative care networks are being established at regional levels, however this is not always in conjunction with regional cancer networks. While the Council recognises that palliative care is required for conditions other than just cancer, there may be room for improvement in palliative care services for cancer patients if palliative care networks and regional cancer networks are able to work together in a more collaborative manner.

**Goal 5**

**Objective 1: Workforce**

The Council notes that progress toward this objective has been slow, due to several factors. A clear and robust definition of ‘workforce need’ is not available; we simply do not know how many workers, across the range of cancer related occupations, are needed to provide optimal outcomes for cancer control. Further, many areas of the current workforce are highly specialized and therefore fragile, meaning that deficiencies can quickly arise from the loss of a relatively small number of workers. While these problems are not unique to New Zealand, the Council considers that these are an impediment to the implementation of the Cancer Control Strategy. There have been some developments made over the past year to address these problems. This has included the completion of a stocktake and needs assessment of the cancer control workforce by the Ministry of Health, the establishment of the Medical Training Board, the development of the Health Workforce Careers Framework, the development of national specialist competency frameworks for palliative care and cancer nursing and the development of a new curriculum for radiation therapy students to increase capacity in the radiation therapy workforce. The Council views the work of these bodies and programmes as a high priority, and will continue to monitor the resulting work and recommendations to determine if they lead to progress in addressing workforce issues.

**Objective 2: Services accessible to Māori**

The Council notes that there has been much activity under this objective, but is hesitant to designate particular actions or outcomes as “achieved”. Consultation and cooperation with Māori to ensure accessibility and participation are not something that can be achieved, but rather need to be ongoing. There have been a number of initiatives that have contributed to improved accessibility and participation for Māori over the past year. These include the funding of regional cancer networks to address systemic causes of inequalities, the two Māori-specific pilot programmes running in Rotorua and Tamaki Primary Health Organisation which provide a case management approach and therefore ensure that services are appropriate to the needs of Māori cancer patients, the specific inclusion, from the outset, of Māori and Pacific people’s representation in regional networks and on the development teams for guidelines being developed by the New Zealand Guidelines Group and the updating of ethnicity data collection protocols and standards. The Māori Health Joint Venture between the Ministry of Health and the Health Research Council is a partnership programme that will promote health outcomes for Māori.

**Objective 3: Consumer representation**

Health and disability consumer summits have been held over the past year with the aim of establishing a Consumers’ Collaboration of Aotearoa. A working group has been established to advance this initiative and the Consumers’ Collaboration of Aotearoa is due to hold its first Annual General Meeting on May 26 2009.
The Cancer Voices cancer consumer representative training programme has been established over the past year. This has included the Māori Health Joint Venture, and other more specific research into cancer control.

Objective 2: Information and data collection
The rate of progress in implementing the outcomes that are specified in Goal 6 Objective 2 of the Action Plan has been slow, and these have not yet been achieved. However there has been considerable activity towards developing a national data system over the past year. Such activity has largely focussed on “laying the groundwork” for a data system to be established, and much of this work, while necessary, was not foreseen at the time the Action Plan was written. This work has included ensuring that any cancer data that is to be collected is compatible with the national systems development programme and this has slowed progress. The collection, and subsequent use, of data and information is critical to understanding cancer trends and patterns in any population. The current absence of a comprehensive and up to date national dataset is hindering the implementation of other sections of the Action Plan.

Reducing inequalities
One of the two overall purposes of the Cancer Control Strategy is to reduce inequalities with respect to cancer. While specific goals and objectives of the Action Plan include a focus on inequality, a focus on reducing inequalities needs be incorporated — from the outset — into all aspects of work that contribute to implementing the goals of the Action Plan. The Council challenges the cancer control community to ensure that an inequalities focus is maintained in all work that is undertaken. There is a risk that projects or programmes that are implemented to reduce the incidence and impact of cancer may, in fact, increase inequalities. The Council urges the cancer control community to mitigate this risk by including an inequalities focus into all projects and programmes from their inception.

The recently announced colorectal cancer screening pilot programme is a good example of how a project designed to reduce the incidence and impact of cancer may increase inequalities if a concerted effort to design the project in such a way as to reduce inequalities is not adopted. For example, we know that for colorectal cancer the mortality among Māori is similar to that of European New Zealanders, despite Māori having a lower incidence of colorectal cancer; we also know that Māori are less likely to undergo screening than are European New Zealanders. If this disparity in screening coverage rates arises in the colorectal screening programme then the screening programme may decrease the rate of mortality from colorectal cancer for European New Zealanders at a greater rate than for Māori, thus increasing inequalities.
Data collection

The Council has serious concerns over the slow rate of progress in developing a comprehensive and integrated national cancer data system. While there has been an increase in activity toward laying the groundwork for such a data system over the past year, in terms of the actions specified in the Action Plan there has been little progress. The activity that has been occurring over the past year largely relates to the completion of tasks that were not envisaged at the time that the Action Plan was written, but that need to be completed before further progress can be made. The Council reaffirms that accurate, comprehensive, meaningful and timely cancer data is absolutely vital and underpins all research, reporting and decision making that needs to be undertaken in the cancer control arena and strongly recommends that a high priority is assigned to progressing the cancer information programme.

Workforce

The Council expresses concern at the current fragility and vulnerability of the cancer workforce. While there has been some activity over the past year that is relevant to this objective, it has not yet led to comprehensive progress in terms of the actions and outcomes specified in the Action Plan. The workforce section of this report discusses the need for a clear definition of ‘workforce need’ and the need for a process to ensure a coordinated national approach to addressing workforce issues, both now and into the future. Such a process will require professional leadership from members of the cancer control workforce and meaningful engagement and buy-in from workforce managers. Whilst a challenging area to address, it is one that the Council sees as a priority.
This Cancer Control Council 2008 report presents information on and the evaluation of progress of “Phase 1” and conjoint “Phase 1 and 2” actions from the Cancer Control Action Plan 2005–2010. The report focuses on the outcomes of the six goals of the Cancer Control Strategy.

Background

The Cancer Control Strategy (the Strategy) was launched in 2003. It is a high-level framework with two overall purposes, which are to:

1. reduce incidence and impact of cancer
2. reduce inequalities with respect to cancer

The Cancer Control Action Plan was launched in 2005. It outlines in detail how the Strategy’s goals and objectives can be achieved, through the combined efforts of the cancer control community. As noted in the Council’s 2007 report Mapping Progress: the first two years of the Cancer Control Strategy Action Plan 2005–2010 (Mapping Progress), this community includes consumers, non-government organisations, professional groups, public health services, district health boards, the Ministry of Health and organisations involved in standards, audit, research, workforce development, education and training.

The Cancer Control Council was established in 2005 to provide an independent, sustainable focus for cancer control.

Its key tasks are to:

- monitor and review implementation of the Strategy
- provide independent strategic advice to the Minister of Health, the Director-General of Health, district health boards and non-government organisations on matters relating to cancer control
- foster collaboration and cooperation between bodies involved in cancer control
- foster and support best practice in, and an evidence-based approach to, improvements in the effectiveness of cancer control
- establish and maintain linkages with overseas cancer control agencies
The Council’s first evaluation and monitoring report *Mapping Progress* focused on a point-by-point examination of all individual milestones designated as Phase 1 (i.e. to be achieved in 2005–2007).

**Process for this report**

Following the publication of the 2007 report, *Mapping Progress*, the Council consulted with the cancer control community on the process undertaken in obtaining relevant information, the style of presentation of the report and the usefulness of the findings and commentary. Implications of this commentary are described further in the Methods section.

**Purpose of this report**

The purposes of this report are:

1. to gather and evaluate progress and/or completion of Phase 1 — designated activities, projects and programmes, as these activities were originally intended to be completed by the end of 2007

2. to promote understanding of the independent role of the Council by undertaking an evaluation and monitoring role within cancer control in New Zealand

3. to provide the Council with an understanding of areas of the Action Plan where specified actions or milestones are no longer aligned with the direction being taken by the community to determine, three years into the implementation of the Action Plan, how well the Action Plan is providing relevant direction to the community, and what if any changes of focus or structure may be required when considering the next Action Plan (to cover the years 2011–2015).

**Feedback on this report**

This report is the second evaluation and monitoring report of the Cancer Control Council. While the Council’s emphasis has remained on providing an independent overview of progress of Phase 1 actions, the methodology used was improved and enhanced, within the Council’s available resources and the timeframe.

Feedback is invited on all aspects of this report, from the process employed to the ongoing usefulness of the findings and commentary. Suggestions for improvement or alteration would be appreciated.

**The Evaluation and Monitoring Working Group of the Cancer Control Council**

This report was planned and overseen by the Evaluation and Monitoring Working Group of the Cancer Control Council: Professor Tony Blakely (Chair), Professor John Gavin, Dr Garry Forgeson, Dr Beverley Lawton, Ms Helen Glasgow and Dr John Childs. The Council staff collected and analysed the information and drafted the report.
Methods

The following section describes the methods used to collate the information used in this report and the approach taken to analyse the information.

Stakeholder Forum

On the 26th October 2007 the Council held a stakeholder feedback and planning forum to achieve four specific purposes:

1. To obtain feedback from the cancer control community on
   a. the process used in obtaining information for the 2007 “Mapping Progress” evaluation and monitoring report
   b. the usefulness of the 2007 Mapping Progress evaluation and monitoring report
2. To discuss options for obtaining quality monitoring information from stakeholders
3. To establish a process for whichever option is decided
4. To present an overview of Phase 2 of the Action Plan and seek stakeholder input into priority areas.

The findings from this forum relevant to evaluation and monitoring were:

- That the Council move monitoring of the implementation of the New Zealand Cancer Control Strategy and Action Plan to a more strategic level by identifying key performance indicators (KPIs). These KPIs need to reflect the breadth of work across the cancer control continuum.
- That the Council continues to monitor progress of the specific actions in Phase 1 of the Cancer Control Strategy Action Plan to ensure that infrastructure exists to ensure success of Phase 2.

The findings of the forum led the Council to the following decisions:

- focus evaluation and monitoring on the national, strategic-level outcomes of the Action Plan
- make greater use of published information, thereby reducing the reporting onus on stakeholders
- take note of the establishment of action-level monitoring by the Ministry of Health’s Cancer Control Implementation Working Group.

Sources of information for this report

Information for this report was primarily sourced from interviews with key cancer control stakeholders and from published reports provided by these stakeholders. Interviewees were chosen to ensure that at least two (but preferably three) viewpoints were represented with regard to each particular objective of the Action Plan being evaluated.

A final contact list of 27 stakeholders was produced (see Appendix 1). These contacts included Ministry of Health directorates, a district health board group, a cancer charity, special interest committees and other non-governmental agencies.

For each objective in the Action Plan, the Council’s Monitoring and Evaluation Working Group (the working group) identified the
key organisations with interests in the progress of this objective. Comprehensive searches of these organisations’ websites were conducted to obtain relevant policy, programme, project, news, and evaluation documents. This search had the additional purpose of ensuring a thorough understanding of the organisation’s goals, interconnectedness within the cancer control community and key activities, both current and historical.

An interview template was created, which focused on the strategic-level outcomes as laid out in the Action Plan. The template included questions on progress of both Phase 1 and Phase 2 actions. Two examples of these templates are included in Appendix 2. Where appropriate, questions were also asked about specific milestones (particularly where the Council had assessed these milestones as being “Delayed” in 2007). Please note that for the purposes of clarity and timeliness this document is focussed on reporting progress on Phase 1 actions.

Response rates
Of the 27 chosen organisations or groups, 26 responded to the request for an interview. For the regional cancer networks, one in-depth interview was held, a member of the Council also attended a joint regional cancer networks meeting to consult with the remaining three networks. One governmental organisation provided a short written report in response to emailed questions.

Analysis of information
Almost all numbered outcomes in the Action Plan contain milestones designated as “Phase 1”, “Phase 1 and 2” or “Phase 2”. This report provides an overview of progress towards the achievement of “Phase 1” and “Phase 1 and 2” milestones in the Action Plan. The decision to include those milestones termed “Phase 1 and 2” in this report is a pragmatic one — independently evaluating progress on either Phase 1 or Phase 2 activity in these conjoint milestones proved unfeasible.

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<td>Phase 2</td>
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Figure 1 depicts the different phases for the Action Plan and the dates they are evaluated.

Feedback on this report
The methodology for this 2008 evaluation and monitoring report was developed with two aims:

1. To achieve the Council’s stated purpose of providing independent monitoring and evaluation of progress against the Action Plan and provide independent strategic advice to the Minister and the cancer control community

2. To foster collaboration and cooperation within the cancer control community by carefully considering all feedback on the 2007 report and discussing the approach for 2008 (a national level, strategic overview rather than a specific “tick-the-box” milestone-focused approach) with key stakeholders.

The Council thanks the cancer control community for all commentary and suggestions. The Council would be pleased to receive feedback on the processes and methods used for this 2008 report, as well as the overall utility of the report.
Goal 1:

Reduce the incidence of cancer through primary prevention

Within this widely varied goal, there are seven objectives, covering the use of tobacco and alcohol, improved nutrition and exercise, reducing exposure to UV radiation and decreasing infectious disease-related and occupational-related cancers.

There are a number of long established primary health care strategies, such as the New Zealand Health Strategy, Clearing the Smoke, the National Drug Policy 2007–2012 and Healthy Eating — Healthy Action. Oranga Kai — Oranga Pumau: A Strategic Framework. Many of the actions within Goal 1 of the Cancer Control Strategy Action Plan were included so as to work in cooperation and collaboration with these pre-existing strategies, not to present a competing set of objectives. This approach has provided a multifaceted, comprehensive approach to addressing the incidence and impact of cancer through primary prevention.

1  The New Zealand Health Strategy. MOH
2  Clearing the Smoke: A five-year plan for tobacco control in New Zealand (2004–2009) MOH
3  National Drug Policy 2007–2012 MOH
4  Healthy Eating — Healthy Action. Oranga Kai — Oranga Pumau: A Strategic Framework MOH
Objective 1:

Reduce the number of people who develop cancers due to tobacco use and second-hand smoke

The combination of tougher restrictions on indoor smoking, cross-sectoral activity and advocacy and increased Ministry of Health focus on cessation support including heavily subsidised nicotine replacement therapy, over the past nine years has taken time to impact on the rate of smoking prevalence. However, the recently released New Zealand Health Survey (NZHS)\(^5\) shows a significant reduction in smoking prevalence. Other contributing factors include social marketing campaigns focusing on second-hand smoking, promoting smoking cessation, and more recently a youth campaign — “Smoking — Not Our future”.

Social marketing campaigns have had a particular emphasis on Māori and Pacific smokers, and there are specific programmes such as Aukati Kai Paipa for Māori women, and Auahi Kore which develops partnerships with the community through the support of important Māori events in sport, arts and culture.

Progress towards Action Plan Phase 1 outcomes 1–9

1. Reduction in the exposure to second-hand smoke for all New Zealanders

The Health Sponsorship Council (HSC) evaluates the success of second-hand smoking campaigns through the Smokefree Monitor. The HSC is currently awaiting the next set of results, due to be published in early 2009.

The wider tobacco control sector has met several times over the last year or so to discuss and elaborate on a vision of an “end game” for tobacco — in other words, a smoke-free/tobacco-free New Zealand. Many organisations are actively looking to see how they can contribute to achieving this sector-wide vision. Suggestions for achieving the vision include having tobacco declared a “controlled substance”, having retailers required to be licensed to sell tobacco and increasing the number of smoke-free environments (e.g. doorways, children’s parks, cars, stadium etc).

The Cancer Society of New Zealand (CSNZ) and the HSC have worked with local promoters to promote the adoption of smoke-free educational policies by local councils with considerable success.

In some regions local smoke-free coordinators have worked with local Councils to develop smoke-free policies for parks and playgrounds. Regions that have developed such policies include Upper Hutt, Ashburton, Queenstown, New Plymouth, Optiki and Rotorua. The policies have received strong community support. This indicates a change in public attitudes towards second hand smoke.

2. Reduction in levels of tobacco consumption and smoking prevalence\(^6\)

Statistics New Zealand reports\(^7\) that the number of cigarettes available for consumption in New Zealand in 2007 was “virtually unchanged for the third consecutive year at 2.4 billion”, while the volume of loose tobacco available for consumption has “increased 2.8 percent to a new high of 904 tonnes in 2007”. It is likely that this increase in loose tobacco is due to the lesser tax burden that loose tobacco attracts (compared to manufactured cigarettes) when rolled into thin cigarettes.

The New Zealand Health Survey shows that smoking prevalence has decreased from 22.9 percent in 2003 to 19.9 percent in 2007. This 3 percent reduction is significant, and smoking prevalence in New Zealand is now at the lowest ever recorded level. While some of this reduction may be a function of random variability in successive surveys, it seems likely that there has been a decrease in smoking prevalence.

However, there is still a strong correlation between smoking prevalence and neighbourhood deprivation (NZDep2006) — those who are most deprived are approximately three times more likely to smoke than those who are least deprived.

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6\(^\text{It is important to note the difference between tobacco consumption and smoking prevalence. Tobacco consumption refers to the amount of tobacco consumed in New Zealand in a given timeframe. Smoking prevalence refers to the number of people who consume tobacco.}\)

Evidence\(^8\) shows that tobacco tax increases, above the rate of inflation are one of the most effective means of reducing tobacco consumption. The Ministry of Health has provided advice to the Minister of Health about an on-going tobacco tax policy in November 2007, with a government decision yet to be made.

Overall, the Council notes the implementation of actions to achieve this outcome are in progress. While there has been a decrease in smoking prevalence, there has been no decrease in tobacco consumption. This is an outcome toward which activity should be ongoing and can only be considered “achieved” when tobacco consumption is eliminated.

The Council recommends that the tax rate on loose tobacco be increased to equalise it with that of manufactured cigarettes and that a programme of regular tax increases, above the rate of inflation, be implemented to further reduce tobacco consumption and smoking prevalence. Given the fiscal impact of price rises on poor smokers and their family/whānau, it is important that such tax increases are accompanied by extra support for cessation.

3 Increased quitting rates especially among the most at risk groups

The number of people who engage the services of the Quit Group continues to rise. In 2007 there were 37,568 registrations with the Quit Group, of whom 75 percent identified as European, 23 percent identified as Māori, and five percent identified as Pacific. Overall, this was a 15.4 percent increase in registrants compared to the 32,555 in 2006. More women than men used Quit Group cessation services in 2007 (54 percent identified as women and 44 percent identified as men). From mid 2006 the Quit Group has used a different classification for collection of ethnicity data; this has meant that comparisons for registrants between 2006 and 2007 are not available by ethnicity. These will, however, be available for future reports.

The Ministry of Health has made a significant investment into improving quitting rates. A document was released in September 2007 entitled “Reducing Smoking — A Target for the Whole Health Sector”. This document signals a renewed focus on encouraging and supporting smokers to make a quit attempt. The focus is on “more smokers making more quit attempts and using NRT (nicotine replacement therapy) more often”.

As of February 2008, all prescribing practitioners (medical practitioners, midwives, dentists, optometrists, nurse prescribers etc) were provided with Quit Cards in an effort to widen access to nicotine replacement therapy. Quit cards allow practitioners to prescribe subsidised NRT to smokers. Previously these practitioners would have been required to attend a series of training sessions before being allowed to issue Quit cards, and this had limited the number of practitioners eligible to provide the Quit Cards.

The ABC (Ask, Brief advice, Cessation support) training module has recently been developed and provides a model for use by all health practitioners (doctors, nurses, physiotherapists, dentists etc) to promote smoking cessation, as per the recently updated New Zealand Smoking Cessation Guidelines\(^10\).

The CSNZ has been working with social welfare agencies, including the Federation of Family Budgeting Services, to promote links with smoking cessation services outside the health sector.

There is considerable activity in this area with potential to achieve an outcome over time. Ongoing monitoring will be required.


4 Reduction in the rate of young people taking up smoking, especially groups with higher rates of smoking

The Action on Smoking and Health (ASH) Year 10 Survey is conducted annually and reports smoking trends among 14–15 year olds. The 2007 survey\(^\text{11}\) shows that much progress has been made in achieving this outcome.

The report found that:

- Daily smoking prevalence amongst 14–15 year olds in 2007 was 7% compared to 12% in 2003 and 16% in 1999. Students are significantly less likely to be a smoker in 2007 compared to 2003 and 1999.
- The percentage of 14–15 years olds who smoked regularly decreased by almost half; from 21% in 2003 to 13% in 2007.
- The proportion of students who've never smoked in 2007 has continued to increase. 57% of 14–15 year olds have never smoked, not even a puff.
- Smoking by Māori girls and boys continues to decrease.
- Decreases in smoking rates, from 2003–2007, have been larger for girls of all ethnicities compared to boys.
- Prevalence of regular smoking among Pasifika girls and boys has also decreased but by about one third compared to a decrease of almost half for NZ European/Other and Māori.

The Framework for Reducing Smoking Initiation continues to guide ongoing thinking, but the Action Plan developed over the past year has not had the expected impact. This is now under consideration by the Ministry of Health and other stakeholders.

5 Reduction in Māori smoking rates

The NZHS reports that among Māori, there was a significant decrease in current daily smoking from 47.2% (95% confidence interval 43.8–50.6%) in 2002/03 to 37.6% (35.5–39.7%) in 2006/07. This decline was evident in both Māori men and women.

The NZHS reports that the rate of current daily smoking for Pacific Peoples has decreased from 34.6% (30.0–39.1%) in 2002/03 to 25.4% (21.9–29.0%) in 2006/07. There has been a larger decrease in smoking prevalence among Pacific women than among Pacific men.

After adjusting for age, Māori women were more than twice as likely to be current smokers than women in the total population. Māori men and Pacific men were 1.5 times more likely to be current smokers than men in the total population.

Overall, the activity that has occurred in this area appears to have led to a reduction in both Māori and Pacific smoking prevalence. The Council commends this progress and anticipates that further reductions will be achieved in the future if the current levels of activity in this area are maintained.

6 Reduction in Pacific smoking rates

The NZHS reports that the rate of current daily smoking for Pacific Peoples has decreased from 34.6% (30.0–39.1%) in 2002/03 to 25.4% (21.9–29.0%) in 2006/07. There has been a larger decrease in smoking prevalence among Pacific women than among Pacific men.

After adjusting for age, Māori women were more than twice as likely to be current smokers than women in the total population. Māori men and Pacific men were 1.5 times more likely to be current smokers than men in the total population.

Overall, the activity that has occurred in this area appears to have led to a reduction in both Māori and Pacific smoking prevalence. The Council commends this progress and anticipates that further reductions will be achieved in the future if the current levels of activity in this area are maintained.

7 Increased emphasis on tobacco control throughout the health and disability sector

8 Improved leadership and co-ordination of the tobacco control programme at national and regional levels

From 2008 DHBs have been required to include a tobacco control focus in their District Annual Plans. These plans have a focus on cessation and primary care, and are aimed at implementing the newly updated cessation guidelines. Tobacco control networks are being established in most DHBs, often in conjunction with the regional cancer networks.

A Tobacco Control Research Strategy Steering Group has recently been appointed to oversee the revision of a national strategy for tobacco control
research. It is anticipated that this revision will be nearing completion by the end of 2008.

The National Smoke-free Working Group is a collective of organisations working in the tobacco control sector, and continues to act as a forum for national discussion and strategic thinking on smoke-free initiatives. The group also acts as an organizing and planning body for national multi-stakeholder projects.

9 A workforce that is trained in tobacco control and meets the needs of the population

A framework and training competencies are being developed to address this outcome, as a first step in establishing a workforce development plan.

Overall, the Council considers the implementation of this outcome to be in progress, and looks forward to receiving reports on the outcome of the workforce development plan.

Additional initiatives

Tobacco Packaging

In accord with New Zealand’s obligations under the International Framework Convention on Tobacco Control, pictorial warnings are now required on all tobacco packaging. The 14 graphic warnings are being rolled out over a two-year period, with seven warnings appearing in the first year, and the remaining seven appearing in the second year. The warnings will be rotated in each subsequent year. The rotation system will optimise consumer learning and awareness of the health effects of smoking. The warnings appear with text in both English and Te Reo Māori.

Tobacco Retail Displays

The Ministry of Health is reviewing the display of tobacco products in retail settings, such as dairies, convenience stores, supermarkets and service stations.

In 2007 a consultation document was prepared and feedback requested on three broad options:

- Current requirements with enhanced education and enforcement
- Further restrictions
- Ban on display

The results of the consultation showed a high level of support (over 80%) favoured a complete ban on all retail displays of tobacco products. Less than 5% favoured keeping the current regulations, and those that did were largely retailers and tobacco companies.

The Cancer Control Council has advised the Minister of Health that a complete ban on tobacco retail displays is the best option to reduce the incidence, impact and inequalities with respect to cancer.

The recently-released New Zealand Health Survey has shown a significant decrease in the rate of smoking prevalence, with the overall population rate decreasing from 22.9% to 19.9% over the past four years. The rate of reduction is greater for Māori and Pacific Peoples. It is likely that this reduction can be attributed to a multifaceted approach to tobacco control, including social marketing campaigns (such as second-hand smoke, smoke-free homes and cars, promoting smoke-free lifestyles to young people, cessation campaigns and health warnings), smoke-free environments and comprehensive smoking cessation support.

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Objective 2:
Reduce the number of people developing physical inactivity and obesity-related cancers

Objective 3:
Reduce the number of people developing nutrition-related cancers

There is a whole-of-government approach to Healthy Eating — Healthy Action (HEHA) implementation, based on the long-standing HEHA strategy. A Sector Steering Group has been established at a national level with membership made up of government agencies, DHBs, NGOs, Māori and Pacific peoples, academia and industry.

All 21 DHBs have established HEHA Project Manager positions (see highlight box page 22). There has been an increase in the numbers of Green Prescriptions issued (which provide advice on physical activity), and a key result from the recently released NZHS has shown that the rate of increase in obesity appears to be slowing, with no statistically significant increase between 2002/03 and 2006/07 for both men and women. The NZHS also shows an increase in the amount of fruit being eaten, but a small decrease in the consumption of vegetables. An Evaluation Fund ($1.6 million) has been established by the Ministry of Health to fund the evaluation of nutrition and physical activity initiatives. Reports on these evaluations will be reviewed by the Council as they are made available.

Key initiatives over the past year have been the adaptation of programmes to ensure that they reach Māori, Pacific peoples and low socioeconomic groups, increased levels of investment in nutrition and healthy-weight programmes, and the development and implementation of strategies for increased consumption of fruit and vegetables.

The Council looks forward to the evaluation reports on these programmes.

Progress towards Action Plan Phase 1 outcomes 11–14

11 Increase in physical activity among vulnerable populations

The Green Prescription (GRx) programme is being expanded as part of Mission-On, with a target referral number for 2010 of 50,000 per year. For the 2007/2008 year, there were approximately 25,000 referrals. An expansion programme for GRx has been focused so as to better meet the needs of Māori and Pacific peoples, with ethnicity data (July – December 2007) showing that 23% of GRx were issued to Māori, and 11% to Pacific peoples.

A 2007 survey of general practitioners showed that 3% of GRx were issued for cancer (down from 4% in 2006), as compared to the key categories of overweight/obesity (94% of GRx), diabetes (69% of GRx) and high blood pressure/stroke (51% of GRx). Each GRx contract holder (Regional Sports Trusts and Primary Health Organisations) provides monthly reports to SPARC on their number of GRx referrals, promotions and contact with health professionals.

SPARC has co-funded a seminar with the HSC and Cancer Society of New Zealand (CSNZ) to promote the World Health Organisation expert report Food, Nutrition, Physical Activity and the Prevention of Cancer, and has also funded the CSNZ to develop a leaflet called “Being Active When You Have Cancer”. Many GRx support programmes have a nutrition component funded by a DHB or PHO, with a survey showing that in 2007, 59% of patients had changed their diet as a result of participating in the Green Prescriptions programme.

An evaluation of a Counties Manukau DHB project is comparing the effectiveness and cost effectiveness of GRx phone support with group support — reporting on this is due in 2008.

15 GRx ethnicity data, 1 July 2007–31 December 2007. SPARC
16 Green Prescriptions in General Practice. 2007. SPARC Ihi Aotearoa
17 NOTE: It is assumed that the number of GRx prescribed equates to more than 100% because GRxs may be prescribed for co-morbid conditions.
18 Food, Nutrition, Physical Activity and the Prevention of Cancer WHO 2007
Overall, there has been much activity in this area of the Action Plan, it appears that the Green Prescriptions programme (in particular) has led to increased physical activity among vulnerable populations.

12 Reduced levels of obesity in vulnerable populations, particularly Māori, Pacific peoples and low socioeconomic groups

The NZHS reports that obesity among the general population has increased from 1997 to 2002/03 but that there has been no significant increase in the rate of obesity for all New Zealanders from 2002/03 to 2006/07.

For Māori there has been no statistically significant increase in obesity since 1997. These results indicate that progress has been made in reducing the rate of increase in obesity over time; it is probable that the many initiatives taken under the HEHA strategy have assisted this slow down. However, when compared to the general population, Pacific peoples were approximately 2.5 times more likely to be obese and Māori were approximately 1.5 times more likely to be obese.

The development of guidelines for the management of overweight and obesity is now well underway. These guidelines will include a consideration of the effectiveness of the management of overweight and obesity in light of the needs of those groups over-represented in overweight and obesity statistics in New Zealand. These groups include Māori, Pacific, south Asian and those living in more deprived neighbourhoods, as well as those on certain medications. Approximately $3.5 million of the 2007 HEHA budget package has been allocated to community-based projects that focus on reducing obesity, improving nutrition and increasing physical activity for Māori. As part of this project, each of the DHBs is being funded to 1) consult with Māori communities and 2) fund Māori communities to carry out these community-based projects. There are also 7 DHBs that are funded to consult with and implement these types of community based projects for Pacific peoples. Action plans for these projects are due to be submitted to the Ministry of Health in April 2008.

The Food and Beverage classification support programme was distributed to schools in August 2007. This programme includes a freephone line providing help and information for school personnel, a food and beverage product registration scheme and database (active from mid-2008), a quarterly newsletter to schools and support from the DHB HEHA coordinators to assist schools to access the Nutrition Fund and implement the classification system.

The Mission-On programme continues, with the launch of a child-focused website in February 2008 (www.missionon.co.nz).

Overall, there has been much activity in implementing actions aimed at achieving this outcome, this has led to some progress, but the Action Plan outcome remains unachieved. The rate of increase in obesity has begun to slow, but there has not been a decrease in overall rates of obesity. The obesity epidemic is going to take a long period of time to combat, and in this sense this Action Plan outcome needs to be considered ongoing. While “reduced levels of obesity in vulnerable populations” have not been achieved yet, the slowing of the increase in obesity rates indicates that real progress is likely to be made in the future if current progress is maintained.

13 Increased consumption of fruit and vegetables

The NZHS has shown an increase in the consumption of fruit over the past three years, but a decrease in the consumption of vegetables.

The Feeding our Futures campaign was launched in May 2007, with the express goal of helping parents and caregivers achieve healthy diets for kids. A tracking survey is currently underway, with results expected by the end of 2008.

The Fruit in Schools programme has undergone a process evaluation, with very positive anecdotal feedback from schools and parents, such as improved educational outcomes for the children in the programme. The recent Inquiry into Obesity and Type 2 Diabetes in New Zealand recommended that Fruit in Schools be expanded to all decile schools. However, the Ministry of Health’s response was that this programme was designed with a strong inequalities focus and needed to stay in low decile schools at this stage. The whole programme currently costs approximately

20 Health Select Committee. (August 2007) Inquiry into Obesity and Type 2 Diabetes in New Zealand New Zealand House of Representatives.
$10 million per year. The programme has been expanded to include decile 2 schools, with 450 schools in total to be included by April 2009.

Overall, there has been mixed progress toward the achievement of this outcome, with an increase in the amount of fruit being consumed, but a decrease in the amount of vegetables being consumed.

14 Increased awareness and knowledge of healthy nutritious foods

The HSC has undertaken a large qualitative research project (with a focus on Māori and Pacific parents) to better understand behaviours around eating. This will help inform future social marketing strategies.

While this outcome has not been achieved, the Council awaits the reporting on this research project, due in 2008, and believes that increased understanding of behaviours around eating will lead to the progress toward achieving this outcome.

Additional initiatives

The Food Industry Group (FIG) has recently met with the Ministry of Health, and reported that it has seven projects and associated goals to address obesity in New Zealand, based on the HEHA Implementation Plan. They have a four-step programme for the food industry to ensure that they are finding solutions to the obesity problem. These steps are

1. ensure that all members are aware of the obesity issue
2. ensure all members are making progress in terms of making changes to their products
3. gain measurements of these changes
4. ensure that the food industry set targets for further change.

The Council welcomes such initiatives, and agrees they are necessary steps in the implementation of HEHA. However, the Council is also eager to assess what actual improvements in promoting and protecting the public health result within the next year or so. The obesity epidemic is an important problem to address in cancer prevention, and concerted societal change is required in addition to individual responsibility. Therefore, the Council notes with interest the forthcoming Public Health Bill that includes non-communicable diseases within its scope, and provides the Minister of Health, Director General and Director of Public Health with powers to promulgate industry codes of practice. The Council also notes and approves of the intended ability to develop and implement regulation if voluntary codes of practice are deemed unsatisfactory after two years.

Leadership and co-ordination of the HEHA strategy at DHB level has included the establishment of 21 DHB HEHA Project Manager positions. Project Managers have been in place since February 2007 and have been focused on co-ordinating the development of a Ministry-approved district HEHA plan. This has included co-ordinating partnerships that include regional sports trusts, the Ministry of Education (through School Support Services) and other relevant sectors at both a regional and district level. DHBs completed their first Ministry-approved plans (MAP) in June 2007 and are now working on their second MAP, which has a focus on developing action plans for breastfeeding promotion and support and community action plans in Māori communities in 21 DHBs and in Pacific communities in seven DHBs. These action plans are designed to support DHBs’ progress on the breastfeeding and fruit and vegetable consumption health target indicators. These plans will be implemented from 2008/2009 and beyond.
Objective 4:

Reduce the number of people developing skin cancer due to UV radiation exposure

The Council has received many reports of activity in this area of cancer control over the past year. However, as with other areas of the Cancer Control Strategy, it seems that much of this activity has occurred in areas that are not specified by the Action Plan, but that nonetheless contributes to progress and improved outcomes in cancer control.

This type of activity has occurred in two main areas: Vitamin D and the Ultra Violet Radiation Index. These are areas that are not mentioned in the Action Plan, but are important and in the case of Vitamin D an ever increasing source of academic and policy concern (i.e. the hypothesis that Vitamin D is protective for cancers yet (usually) requires sufficient sunlight exposure that might be contrary to sun smart messages). However, where in other areas of the Action Plan actions have been superseded by new initiatives that still contribute to the outcomes listed in the Action Plan, these actions can be considered complementary to the actions that are listed in the Action Plan. In other words, the original actions contained in the Action Plan are still relevant to the outcomes listed for this objective, but additional ones have been identified by stakeholders, and have formed part of their work.

While the Action Plan calls for the involvement of a number of organisations, the Cancer Society and the Health Sponsorship Council appear to be the main bodies actively involved in this area of cancer control.

This report will examine the actions that have contributed to progress in implementing those actions designated as phase 1 in the Action Plan. Areas of progress that contribute to implementation of phase 2 actions, such as work on solaria guidelines, will be reported on when the Council monitors implementation of phase 2 actions.

The progress that has been made in areas such as Vitamin D and the Ultra Violet Radiation Index are discussed in the “additional initiatives” part of this section. Such areas of activity will need to be considered for inclusion during the developmental stages of the next Cancer Control Action Plan.

Progress towards Action Plan Phase 1 outcomes 18–22

18 Reduce exposure to UVR among children (12 years and under)

As at 1st May 2008, 265 (11.3%) primary and intermediate schools were enrolled in the Cancer Society’s SunSmart Schools Accreditation programme. 155 of these schools had achieved accreditation with the remaining schools working towards meeting the criteria. Over the previous 12 months, there have been 159 new applications and 94 schools gaining accreditation. Of these applications 35% were from decile 1–3 schools, indicating that this programme includes an inequalities focus.

The accreditation programme is fully funded and run by CSNZ. Health promoters throughout the country promote the programme to schools and assist them to develop policies or bring their policies up to accreditation standard. A lack of funding at a national level, and of human resources at a regional level, has limited expansion of this programme.

While the Ministry of Education is supportive of the programme, there is no requirement for schools to be involved in the accreditation process, and the decision to join the programme is left up to each school.

Schools involved in the Fruit in Schools (FIS) programme run by the Ministry of Health are required to make a commitment to SunSmart but, at this stage, are not required to join the accreditation programme. (FIS was introduced as a separate and unanticipated development around the time when the CSNZ’s SunSmart Schools programme was launched). While FIS has increased interest in the programme from low-decile schools, this has highlighted the lack of capacity in CSNZ regional divisions to cope with demands of the SunSmart programme, which includes professional development for teachers. (Research shows that low decile schools have less comprehensive policies and therefore will frequently require more support to reach accreditation).

The Council recommends that the Ministry of Education and Ministry of Health work collaboratively to examine methods of increasing schools’ participation in the SunSmart Schools programme.
19 Increase sun protection policies and practices in secondary schools

There is currently a large gap with respect to advancing sun protection awareness and behaviour among adolescents. For instance, the triennial survey of New Zealanders’ sun protection awareness and behaviour (commissioned by the Cancer Society and HSC) has consistently found that adolescent respondents are significantly more likely to have been sun burnt on the previous summer weekend, than older respondents.

The CSNZ reports that it has commissioned research\(^1\) into policies and practices for sun protection in secondary schools in 2004, however it currently lacks the funding and capacity to implement any programmes in secondary schools.

The HSC has considered a social marketing campaign, but notes that it only has a small budget ($780,000) overall for SunSmart activities and this has prohibited the development of such a campaign.

The Council recommends that the Ministry of Education and Ministry of Health work collaboratively to examine ways to implement sun protection policies and practices in secondary schools.

20 Reduce the number of outdoor workers who develop skin cancer

From reports received by the Council, the CSNZ appears to be the most active body in this area of cancer control.

The CSNZ has met with the Department of Labour’s Occupational Safety and Health (OSH) division to discuss developing an updated occupational Ultraviolet Radiation (UVR) exposure standard. The OSH website lists Guidance Notes for the Protection of Workers from Solar Ultraviolet Radiation, published in 1994 as the current standard. The CSNZ reports that OSH does not view the updating of these guidelines as a priority.

The National Occupational Health and Safety Advisory Committee (NOHSAC) recommended in 2006 that occupational exposure to UVR should be addressed as a priority area, with collection of baseline data through regular workforce surveys. NOHSAC is not aware of any progress towards implementing this recommendation over the past year.

The CSNZ has been working with a range of industry bodies, including the New Zealand Council of Trade Unions and Site Safe, to develop resources for employers and outdoor workers, and to assist industry bodies in developing sun safety policies. The Council will follow these developments to assess their impact in reducing outdoor workers to UVR.

The Council recommends that the Department of Labour work collaboratively with the CSNZ to increase the focus on sun safety in the workplace. Particularly, to update the Guidance Notes for the Protection of Workers from Solar Ultraviolet Radiation and to collect baseline data on sun safety practices in workplaces through regular workforce surveys.

21 Improve understanding of at-risk audiences’ sun related attitudes and behaviours

The HSC has funded a PhD to analyse the results of the triennial National Sun Safety Surveys. This study is now complete, with a report due to the HSC in April 2008. The HSC is also undertaking a qualitative research programme into parents’ understanding of UVI, with a report due in July 2008.

22 Increase shade provision in public settings/environments

The HSC reported that they continue to promote the software tool WebShade — a programme to assist organisations implement sun-safe, comfortable, outdoor environments, including schools, childcare centres and local government. However, schools have reported some concerns over the usability of this software and the level of support provided.

The HSC has recommended that the Department of Education provide assistance to ease the use of this software in schools, but this recommendation has not been implemented. The CSNZ reports that it does not have capacity to promote the increase of shade provision to territorial local authorities, and suggested that this might not be the best use of their funding towards this outcome.

\(^{1}\) Jopson, J. and Reeder, A. Sun Protection in New Zealand Secondary Schools. Obstacles and Opportunities. Social and Behavioural Research in Cancer Group, Otago University, June 2004

Quality Improvement Assessment for the Sun Safety Programme

In December 2007 the HSC released the Summary of Findings and Recommendations of the Quality Improvement Assessment for the Sun Safety Programme. This assessment sought to identify ways in which the HSC’s Sun Safety Programme could be improved. Key findings of the assessment include:

- That sound progress has been made against the Sun Safety Programme objectives, but that significant improvement in the adoption of sun safety behaviours is required to reduce skin cancer rates in New Zealand.
- There is potential for wider engagement with other organisations around sun safety policy development and programme implementation.
- That wider involvement with other sectors, particularly the Ministry of Education, Occupational Safety and Health, the Accident Compensation Corporation and Sports and Recreation New Zealand, should be pursued.

Additional Initiatives

Vitamin D

Over the past year, there has been considerable interest in the beneficial aspects of sun exposure, mainly in relation to human synthesis of Vitamin D, which requires exposure of skin to sunlight.

In July 2007, the CSNZ convened the Vitamin D, Ultraviolet Radiation, and Health Roundtable.

This forum affirmed the Cancer Society’s leadership role on this complex issue and acknowledged the need to develop and refine a balanced sun exposure message which addresses both the beneficial and adverse effects of sun exposure at different times of the year. The Position Statement is in the process of expert review.

As part of the focus on the benefits of Vitamin D, the CSNZ commissioned a review of vitamin D, UVR and Cancer (available on the CSNZ website), and has developed the winter Hats off campaign.

The Skin Institute has commissioned a study (The Skin Cancer Commissioned Survey) looking at Kiwis’ sun protection habits during the warmer weather. This study found that nearly 1 in 4 people reported changing their summer behaviour towards more unprotected skin exposure, following media coverage of the Vitamin D issue.

“A Climatology of UVI in New Zealand”

The CSNZ has been actively working to refine messages for healthy sun exposure in the New Zealand context. In 2007 this included the preparation of a report on the Ultraviolet Index (UVI) to clarify the Society’s advice on sun protection and commissioning NIWA to prepare a report on the UVI (The Climatology of UVI in New Zealand). This report is available on the CSNZ website (http://www.cancernz.org.nz/Uploads/NIWA). The report highlights UVR levels in different centers and at different times throughout New Zealand. There is ongoing discussion between CSNZ, the National Institute of Weather and Atmospherics (NIWA), HSC, Social and Behavioural Research in Cancer Unit at Otago University and the Cancer Council Victoria to refine healthy sun exposure messages in relation to UVI.
Objective 5:

Reduce the number of people developing infectious disease-related cancers

The Council is pleased to note the announcement in May 2008 concerning the introduction of the HPV vaccination programme. Over time, this will make a significant impact on the incidence and impact of cervical cancer in the New Zealand population, and may also provide additional impact on labial and oropharyngeal cancers.

The inclusion of Chronic Hepatitis B as a notifiable disease will allow better tracking of infected persons and will also allow information about the elevated cancer risk from Hepatitis B to be more accurately targeted.

Ongoing assessment of the gaps for Māori in access to sexual health services is vital to ensure that public health initiatives reduce inequalities. The Council is pleased to note the pilot study to be funded by the Ministry of Health in this regard.

Progress towards Action Plan Phase 1 outcomes 24–28

24 A raised awareness in the population, especially in high-risk groups, of the cancer risks associated with some infectious diseases

There has been significant interest in the relationship between the human papilloma virus (HPV) and its link with cervical cancer, culminating in the announcement (May 2008) of the introduction of an HPV vaccination programme.

The raised awareness of this particular link may lead to raised public awareness of the links between other infectious agents and cancers, such as that between Helicobacter pylori and stomach cancer or Hepatitis B and liver cancer.

The roll-out of the HPV vaccination programme will be supported by enhanced health promotion activities, with a particular emphasis on providing evidence-based coverage of the pros and cons regarding this vaccine to the New Zealand public. A stock-stake of health promotion programs relating to infectious diseases (as specified in the Action Plan) would therefore be best undertaken after the HPV program and new sexual health programs have become established and, in fact, would coincide well with the planned evaluations of these new initiatives26.

Core publicly funded health promotion messages have not changed since they were last evaluated by the Council for the Mapping Progress report in 2007. These include publicly-funded hepatitis B and C (as related to liver cancer) management programmes and the work of the New Zealand AIDS Foundation (e.g. skin cancers such as Kaposi’s sarcoma).

Overall, the Council feels that there has been a raised awareness of the cancer link associated with some infectious diseases, especially HPV.

27 A raised awareness of the risks associated with intravenous drug use

A programme to test and immunise all people in the corrections system was introduced in 2007. This programme aims to reduce the risk factors for Hepatitis B and C that are associated with intravenous drug use through educating at risk groups. This is to be achieved through health promotion and the provision of information. Contracts for needle exchange programs are in place, both at local and national levels

28 Ensure that emerging links between infectious agents and cancer are assessed

Health and Disability Intelligence (formerly Public Health Intelligence) provides an overview of the links between infectious agents and cancer. No new or emerging links have been recently identified.

26 Health and Disability National Services Directorate report to the Cancer Control Council. May 2008
Introduction of HPV vaccine and education programme
The Government has allocated $177 million over five years for an HPV vaccination and education programme. The vaccine will be available free to all 12–13 year old girls, with a catch-up programme being offered for girls born on or after 1 January 1990. It has been estimated that over 30 lives will be saved per year. According to Cancer: New Registrations and Deaths 200427 cervical cancer mortality is almost three times greater among Māori females (5.5 per 100,000) than among non-Māori females (2 per 100,000)28. This programme therefore has potential to reduce ethnic inequalities in the impact of cancer.

Additional initiatives
Recently the Ministry of Health has undertaken a review of notifiable diseases. For the first time Chronic Hepatitis B and HIV are to be included as notifiable diseases, with information anonymised. Certain other sexually transmitted infections are also to be included. This information will be linked to the National Health Index.

The Māori Health Policy Team and the Communicable Diseases Team within the Ministry of Health have collaborated on a request for proposal and evaluation tool for A Pilot Study to Identify Gaps in Young Māori Access for Sexual Health Services. Two DHBs (Bay of Plenty DHB and Taranaki DHB) have been chosen as potential pilot sites for this study29. Results of this study should assist in reducing inequalities between Māori and non-Māori in terms of access to services and education regarding the links between sexually-transmitted infectious diseases and cancer.

Objective 6:
Reduce the number of people developing alcohol-related cancers
In the greater context of the harm that alcohol causes (through drink-driving and to personal safety, for example) the alcohol-related risk of cancer has not been widely promoted, if at all. The Council is pleased to note that the link between alcohol consumption and cancer is now being acknowledged in the updates of national policy and strategy documents, and would support work being undertaken into the impact of alcohol on cancer-related mortality and morbidity.

Evidence suggests that the total amount of alcohol consumed over time, and the interactions of alcohol (and its by-products) with compounds found in tobacco smoke, are the major alcohol-related risk factors for cancer. While there are significant differences in rates of binge drinking by ethnicity, binge drinking is not necessarily a significant risk factor for cancer in and of itself. The ethnic differences for total consumption of alcohol are not hugely significant.

Progress towards Action Plan Phase 1 outcomes 29–31
29 More New Zealanders are aware that alcohol consumption increases the risk of certain cancers
No actions directly linked to this outcome were reported to the Council, with the primary focus of strategies in the NGO sector appearing to be alcohol supply control, demand reduction and problem limitation. However, ALAC reports that it is planning work for the 2008/09 financial year on identifying alcohol-attributable fractions towards cancer deaths — in other words, how much does each factor (alcohol, occupational exposure, tobacco etc) contribute towards the mortality and morbidity of cancer.

No social marketing campaigns are currently focusing on the alcohol-related risks of cancers, but recent international research (April 2008) has added further weight to the contention that for women, consumption of alcoholic drinks may increase the risk of oestrogen-positive breast
Research has also shown that alcohol is implicated in the development of mouth, oropharyngeal, oesophageal, laryngeal and liver cancers, especially among smokers. In a report from the Ministry of Health’s Non-communicable Diseases Policy team “There is no alcohol intervention that is specific to cancer. In the same way that reduction of tobacco use contributes to lessening the risk factors for a number of diseases — so general approaches to reducing risky drinking are expected to impact on a range of harms including the risk from cancer.”

A National Alcohol Action Plan is being developed to support the National Alcohol Strategy, with the timeframe for implementing this yet to be agreed. While the current Strategy includes known alcohol-related risks, the Action Plan needs to include strategies to minimise these risks, including an emphasis on “safe” drinking levels.

Overall, while there seems to be a raised awareness that alcohol consumption raises the risk of developing certain cancers among the research community, there does not seem to be the same raised awareness among New Zealand society. The Council is encouraged by the research that has been done into alcohol and cancer, and recommends that the findings of this research be disseminated through effective communication to the public.

**Objective 7:**

**Reduce the number of people developing occupational-related cancers**

The Council is pleased to note ongoing research into occupational-related cancers and contaminants. However, with coding of occupation not being included in national datasets, there is a strong risk that future research in this area will be compromised. The Council strongly recommends that the Department of Labour and Ministry of Health work together to resolve these issues to improve both the evidence-base for occupational-related cancers and reporting on occupational-related cancers.

**Progress towards Action Plan Phase 1 outcomes 33–34**

33 **Improve the evidence base for occupational exposure-related cancers and contaminants**

Work-related cancers appear to affect between 700 to 1000 people per year and kill about 400, yet fewer than 40 cases are reported to the Department of Labour.

The National Occupational Health and Safety Advisory Committee (NOHSAC) reports that the Centre for Public Health Research at Massey University is continuing research into several aspects of occupational cancer, including workplace exposure to carcinogens, occupational cancers, and other occupational-related diseases. Recent publications include an examination of high risk occupations for Non-Hodgkin’s Lymphoma and bladder cancer in New Zealand.

The National Drug Policy has been updated (2007), with the alcohol-related risk of cancer now being explicitly recognised.

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11 Ministry of Health Non-communicable Diseases Team report to the Cancer Control Council. May 2008
This research could have implications for ACC, which has signalled its intention to ensure that workers are well informed as to their entitlements if they develop an occupational-related cancer.

34 Improved reporting of occupational cancers

In 2006, NOHSAC recommended to the Minister of Labour that a comprehensive system for surveillance of occupational disease be established. This would primarily be based on routinely available data sets on mortality, cancer, and hospital admissions. It would not rely on the Notifiable Occupational Disease System (NODS), which relies on voluntary notifications and therefore seriously underestimates the true extent of occupational-related cancer. **No progress has been reported to the Council regarding this recommendation.** NOHSAC has reported that they are willing to act as an expert advisory committee to the Ministry of Health's Health and Disability Intelligence unit (HDI) (formerly Public Health Intelligence) which would undertake the work, but a mandate and funding is required before this can occur.

Furthermore, occupational information is frequently collected in the datasets for deaths, hospital admissions and the Cancer Registry, but these datasets are not coded for occupation. NZHIS has suggested that the Department of Labour should pay for coding of these datasets by occupation, but the Department of Labour is unwilling to do this, arguing that no charge is made to other governmental agencies for coding of ethnicity, gender etc.

Overall, the implementation of actions to achieve this outcome has not been achieved, largely due to disagreement between the NZHIS and the Department of Labour around coding of data by occupation. The Council feels that this has impaired the reporting of occupational cancers.

**The Council recommends that these demographic factors should be routinely collected and coded for all cancer and mortality data held by the Ministry of Health.** Collection and coding of health information by key demographic factors should not be the responsibility of other government agencies.
Goal 2:

To ensure effective screening and early detection to reduce cancer incidence and mortality

Screening has received a considerable amount of public interest over the past year, with cervical, colorectal and prostate screening often being reported in the media for a variety of reasons. Longstanding cancer-related programmes, such as BreastScreen Aotearoa (BSA) and the National Cervical Screening Programme (NCSP), continue to be universally available to women within the eligible age range.

Early detection is an effective way of reducing the impact of cancer. While good progress was made in some areas of early detection during the first two years of the Action Plan (2005–2007), the National Screening Unit has reported that many of the specific milestones in the Action Plan have been superseded by progress that has been made in other ways. The Council will review the actions and milestones in Goal 2 to assess whether they are still relevant given that progress is now occurring in this area in other ways.
Objective 1:
At a national level, provide a strategic approach to cancer screening and the assessment and surveillance of those with familial risk to ensure quality, acceptability and effectiveness.

It may be too early at this stage to accurately assess the impact of the Cancer Control Action Plan 2005–2010, or of activities within this field, on reducing the impact and incidence of cancer, considering that cancer registrations and deaths are not yet officially available for the years 2005 onwards. The Council will continue to monitor this information, and will report on it as it becomes available. The Council notes the ongoing increased coverage rates of breast and cervical screening, the developments of new or potential screening programmes and the increased collaborative working between the National Screening Unit (NSU), DHBs, regional cancer networks and the wider cancer control community.

The emphasis placed by the NSU on achieving equity in screening programmes provides a model for other areas of the cancer control continuum where the “Inverse Care Law” often applies (i.e. where those most in need of a service are less likely to receive it). However, there are still significantly lower rates of screening for Māori and Pacific peoples and a need for further improvement exists. The NSU has incorporated a reducing-inequalities focus into programmes, policies, and relationships with key stakeholders.

The NSU has also developed a framework for improving the quality of screening services in New Zealand. This framework is based on the Ministry of Health’s Improving Quality Approach, and has been applied to both cancer screening programs that currently operate in New Zealand (BreastScreen Aotearoa and the National Cervical Cancer Screening program). The application of this framework to screening programs is intended to “generate the information needed to confirm whether or not a programme is safe, effective and being delivered at a reasonable cost.” The application of this framework to cancer screening programmes is one example of progress that has occurred in this area, but that is not laid out in the action plan as a milestone or action.

Whilst encouraged, the Council also awaits evidence that this framework will improve quality, and assist in reducing inequalities.

Progress towards Action Plan outcomes 36–39

36 High-level oversight of existing and potential cancer screening, and of the assessment and surveillance of those with familial risk.

The milestones within this outcome were both achieved within Phase 1. Over the past year, the National Screening Advisory Committee has focused on issues of opportunistic screening, antenatal screening, social and ethical issues and informed consent.

37 Reduction in breast cancer mortality for Māori women aged 55–74 years

38 Reduction in breast cancer mortality for Pacific women aged 55–74 years

39 Reduction in breast cancer mortality for women in the North Island aged 55–74 years

The most recent report on breast screening coverage reports on the 24 months up to June 2007. Against a stated total coverage target rate of 70%, an average of 61.2% (95% CI 61.0–61.3) of the eligible population was screened in the past 24 months. Average reported coverage for Māori women is 43.5% (43.0–44.0), Pacific women 43.8% (43.0–44.6) and women in the North Island of 56% (42.9–63.8). These percentages have all increased from those reported in Mapping Progress (which were 40.9% for Māori women and 40.8% for Pacific women, with the coverage rate among the eligible population across the North Island DHBs ranging from 37%–63%). This may reflect increased capacity following the BSA age extension and initiatives to reduce inequalities and achieve equity, including regional campaigns using local Māori and Pacific celebrities. Nevertheless, coverage is still considerably less than needed.


The most recent published statistics on cancer registrations and deaths are from the year 2004\(^39\). For the New Zealand non-Māori female population, the rate of new registrations of breast cancer (per 100,000 of population) was 81.6 with the mortality rate at 20.2. Māori women showed a similar registration rate (81.5) but a higher mortality rate (32.7). When more up-to-date information is made available, it will be possible to assess whether there has been a reduction in breast cancer mortality since the implementation of the Cancer Control Action Plan.

Additional initiatives

Reducing inequalities

In 2007 the NSU reported that it had developed a Reducing Inequalities Business Plan, which would be the main focus of its work in the 2007/2008 year. Over this year, the NSU has focused on integrating an inequalities focus into the overall screening pathway including relationships with key stakeholders such as DHBs, screening providers and primary care to increase recruitment into screening programmes for Māori and Pacific women. Activities have included prioritising inequalities at the policy development and programme design phase, developing contracting mechanisms which aim to reduce the barriers to participation in screening, developing performance management indicators that create incentives for providers to reduce inequalities, and establishing greater relationships within and across the Ministry of Health to help achieve equity for Māori and Pacific peoples. The Council applauds this initiative, and will be interested to see what ongoing impact on reducing inequalities in screening rates will eventuate.

Workforce

There is a well-developed workforce plan for both the cancer screening programs currently operating in New Zealand. In conjunction with the NCSP a successful cytology training school has been established. In BSA, workforce initiatives have included the appointment of an international recruitment agency to assist BSA providers with the recruitment of Medical Radiation Technologists and Radiologists from abroad and the introduction of a radiology fellowship scheme aimed at attracting registrars.

Cervical cancer screening

Work is in progress with Ministry of Health teams to ensure that the importance of continued screening for cervical cancer is included in the education programme about HPV vaccination. The NSU is also leading a study to estimate the prevalence and distribution of HPV genotypes in women in the New Zealand population.

The NCSP is independently monitored on a regular basis, with data fed back to DHBs (including comparative performance) every six months. Reports on coverage for Māori and Pacific are provided monthly to the Ministry of Health. As at December 2007, the national coverage rate was 71.8% for the overall population (with a stated coverage rate target of 75%). By ethnicity, the average coverage for Māori was 48.0%, for Pacific 50.7% and for other ethnicities 77.9%\(^40\), again highlighting the large inequalities in cancer screening that must be addressed.

The Independent Monitoring Group expressed concern at the evidence of ethnic disparities in the follow-up of women with high grade cytology reports. A higher proportion of Māori women (40.0%) had no subsequent smear recorded on the NCSP register after their high grade cytology report compared to non-Māori, non-Pacific (20.3%) and Pacific women (26.1%)\(^41\).

Colorectal and Prostate Screening Initiatives

These are reported on in the Council’s update on Phase 2 activities, to be published in 2009. However, the Council notes that the Minister of Health has decided to ‘fast-track’ a feasibility study/pilot programme for a national bowel cancer screening programme. This will be reported on at a later stage.

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\(^40\) NSU NCSP 2008. Report to the Cancer Control Council.

Objective 2:

Establish a process to assess the value of early detection of cancer other than that obtained through organised screening

The Council has not received any further information on developments within this objective, other than to note that the Australasian Melanoma Guidelines are at the peer review stage and are due to be launched in November 2008.

Progress towards Action Plan outcomes 40–43

40 Identification of those cancers for which early diagnosis is both feasible and is likely to lead to an improved outcome

The milestone associated with this outcome (preparation of a literature review) was achieved within Phase 1 (2005–2007) of the Action Plan.

41 Assessment of the extent to which delays in early detection and diagnosis are contributing to New Zealand’s high cancer mortality rates, particularly among Māori and Pacific peoples.

The Council has not received any further information on a strategic, national approach to this outcome. However, as noted in Mapping Progress, patient navigator or care coordinator roles have been identified as one appropriate way to improve services across the cancer control continuum. These roles have now been implemented by DHBs across the country, and are reported on to the Ministry of Health as part of the regular quarterly reports.

Overall, there seems to have been little activity toward achieving this outcome. Patient navigator and care coordinator positions may address this outcome as part of other work they are doing, but no actions to specifically address this outcome appear to have occurred over the past year.

42 Identification of interventions with the potential to improve survival and quality of life. Identification of interventions with the potential to reduce inequalities in cancer mortality and morbidity in New Zealand.

The Council has not received any further information on a strategic, national approach to this outcome.

43 Reduce deaths from melanoma in New Zealand

According to the most recently published statistics on cancer registrations and deaths\(^2\), in 2004 the rate of melanoma registration (per 100,000 of population) was 34.5 (male) and 32.4 (female), with the mortality rate being 5.2 (male) and 2.6 (female). Age-standardised mortality rates have remained stable over the decade from 1995–2004. Age-standardised rates for melanoma among Māori were not considered a useful comparative tool, as there were too few cases to provide reliable rates. The Council will continue to monitor registration and mortality data as it becomes available, to assess whether actions in the Cancer Control Action Plan are contributing to a reduction in deaths from melanoma in New Zealand.

The joint Australasian Melanoma Guidelines are currently undergoing peer review, and are due to be launched in November 2008.

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Goal 3:

Effective diagnosis and treatment of cancer to reduce morbidity and mortality

Cancer diagnosis, treatment and care involve patients following a multitude of pathways between a wide range of providers. To ensure effective diagnosis and treatment of cancer, it is vital to reduce delays between initial presentation and definitive diagnosis, to ensure continuity between treatment providers, to maintain consistent capture of patient information and always maintain a focus on the patient and their needs.

Goal 3 presents a model to achieve these aims, emphasising the need for national consistency of diagnosis and treatment to agreed standards, maintaining an inequalities focus and ensuring that at all times, treatment is focused on the patient, their family and whānau.
Objective 1:
Provide optimal treatment for those with cancer

Objective 2:
Develop defined standards for diagnosis, treatment and care for those with cancer

Considerable activity has occurred over the past year in regards to ‘laying the groundwork’ towards improvements under these objectives, including the development of a number of guidelines, establishment of Māori and Pacific consultation structures, further development of the regional cancer networks and the establishment of a cancer-specific health target in the Ministry of Health’s ten national Health Targets. The Council considers that the reported activity in this area is leading to real progress in implementing the Cancer Control Strategy. This progress, along with effective monitoring, will help to reduce the incidence and impact of, as well as inequalities with respect to, cancer in New Zealand. The Council will overview the findings of monitoring in this area and include this in future reports.

There has been a specific focus throughout these two objectives of actively incorporating consultation and cooperation with Māori and Pacific peoples, to ensure that there is a constant focus to reduce inequalities with respect to cancer.

Progress towards Action Plan Phase 1 outcomes 44–54

44 Prompt presentation and timely diagnosis and treatment for all patients with suspected cancer. Reduction in delays in patients presenting with symptoms suggestive of possible cancer. Appropriate referral and timely access for diagnosis and treatment for all those suspected of having cancer.

45 Improve access to diagnosis and treatment for those with recognised disadvantage, such as Māori and Pacific people, who have lower cancer survivals.

46 Cancer diagnosis and treatment are provided to defined standards and quality.

Progress towards achieving outcomes 44, 45, and 46 over the past year has predominantly focused on the production of guidelines for diagnosis, referral and treatment.

The Primary Care Access and Referral Guidelines are being developed to provide nationally consistent, evidence-based guidance to general practice on the timely diagnosis and referral of patients with cancer or suspected cancer. The guidelines cover the twelve most common cancer sites: lung, upper gastrointestinal tract, lower gastrointestinal tract, breast, urinary, haematologic, bone, brain, skin, paediatric, gynaecologic and head and neck.

Māori and Pacific peoples subcommittees have been established (through the New Zealand Guidelines Group) to ensure that an inequalities focus is incorporated into the development of cancer guidelines. These guidelines are due to be finalised in February 2009 and the Ministry of Health is currently working with the New Zealand Guidelines Group (NZGG) to develop an implementation plan for these guidelines. The implementation plan will be finalised in consultation with regional cancer networks and representatives from the primary care sector. Having an implementation plan will allow for easier monitoring of the implementation of these guidelines, and this will be reported on by the Council in future reports.

Other guidelines in development include:

- Prostate cancer — guidance on PSA testing (due June 2008)
- Early breast cancer (due February 2009)
- Melanoma detection and treatment (to be launched in November 2008)

The Ministry of Health is also working with the NZGG to develop and provide a web-based portal for treatment protocols. This portal will be shared and accessed by hospital based clinicians around the country.
DHBs are monitored against set Indicators of DHB Performance (IDP), agreed with the Minister of Health as part of the District Annual Plan process. The Māori Health Directorate within the Ministry of Health monitors the IDPs relating to Māori health. These include indicators derived from He Korowai Oranga (HKO), the Māori Health Strategy:

- HKO-01 (Local iwi/Māori are engaged and participate in DHB decision-making and the development of strategies and plans for Māori health gain),
- HKO-02 (Māori health workforce and Māori health providers),
- HKO-03 (Improving mainstream effectiveness) and
- HKO-04 (DHBs will set targets to increase funding for Māori health and disability initiatives).

In addition, targets by ethnicity were set for the ten key health target indicators, where data quality allowed. This has allowed for progress updates on reducing ambulatory sensitive hospital admissions and improving diabetes services, but has not yet been implemented for the cancer-related target of “reducing cancer waiting times”. However, from 1 July 2008 DHBs are required to provide ethnicity data against the stated target for cancer.

Overall, there seems to be good progress toward achieving this outcome.

47 Patients have appropriate access to a multidisciplinary team approach throughout their continuum of care.

Evidence indicates that a multidisciplinary approach is most effective in ensuring best outcomes from modern cancer treatments. DHBs will need to address the underlying resourcing and staffing issues that threaten the full implementation of this important objective.

The Council is aware that DHBs and regional networks have been addressing this issue over the past year, and report on the development of such teams through the Ministry of Health’s quarterly reporting system.

In implementing multidisciplinary approaches, the Council urges DHBs and regional networks to mitigate the risk that time spent by clinicians attending multidisciplinary team meetings could negatively impact on time available to be spent with patients. A judicious balance needs to be struck in the best interests of the patient and the overall management of cancer services.

The regional cancer networks have been developing a multi-disciplinary team framework over the past year, and this framework might help to mitigate this risk.

There has been good progress in developing multidisciplinary approaches to patient care. The Council commends the activity that has occurred in this area over the past year, and will continue to monitor the improvement of multidisciplinary approaches across the cancer control continuum.

48 There is regional and national consistency of cancer diagnosis and treatment.

One of the national health targets set by the Ministry of Health is Reducing cancer waiting times — defined as “All patients in category A, B and C wait less than eight weeks between first specialist assessment and the start of radiation oncology treatment (excludes category D patients)”. Most recent results against this target show a national trend towards the majority of patients starting treatment within 4 weeks, although there is some regional variation.

In December 2007, 96 percent of radiation oncology patients were treated within eight weeks of their first specialist assessment. From 1 July 2008, the health target for receiving radiation oncology treatment has changed to “patients in categories A, B, and C wait less than six weeks between first specialist assessment and the start of radiation oncology treatment.”

The Council notes that, while the Action Plan calls for consistency to be developed across all aspects of patient diagnosis and treatment, radiation oncology treatment waiting times have been identified as an area where consistency (through the use of a health target) can first be achieved. This is because radiation oncology treatment waiting times are an area where the most comprehensive data is available, and is therefore easy to monitor. Radiation Therapy waiting times capture only a part of the cancer diagnosis and treatment pathway, and as DHBs and regional networks are able, development of more extensive pathway timeframe monitoring is needed.
Overall, the Council feels that this is an area that has been slow to make real progress. While national and regional consistency has been developed for radiation oncology, this is only one part of cancer diagnosis and treatment. The Action Plan calls for consistency to be developed across all areas of diagnosis and treatment, and this has not occurred.

The Council considers that the lessons learnt in developing consistency in radiation oncology treatment waiting times should inform the process for developing consistency in other areas of cancer diagnosis and treatment.

There is ongoing advice on, and future planning of, cancer treatment services.

The New Zealand Cancer Treatment Working Party continues to provide advice in this regard, and a number of sub-groups provide advice in their area of treatment. The radiation oncology and medical oncology groups are examples of such sub-groups.

The Service Planning and New Health Intervention Assessment (SPNIA) framework covers regional and national collaborative decision-making in two related areas:

- new health interventions (including a new method of delivering an existing treatment)
- service reconfiguration (including the introduction of a new service, cessation of a service, service expansion, quality change or change of providers).

The SPNIA process is used when a new treatment or technology is proposed but it reacts to, rather than leads, the field in this regard.

The Ministry of Health, through its Cancer Team, has initiated a horizon scanning function to inform the front end of the cancer prioritisation process. Advice is being sought from the Cancer Treatment Working Party on how best to respond to anticipated new technologies or treatments.

In addition, the Ministry of Health Cancer Team has also completed a Capacity and Capability study which seeks to define the baseline trends in cancer services. This study will be used to support the planning of services and inform the decision making process.

The Council encourages further work in developing a comprehensive prioritisation process, and has promoted this through sponsoring the recent national workshop on prioritisation.

54 Define public entitlement for cancer treatment so there is certainty of treatments available.

Once the various guidelines currently in preparation are released, it may be possible to initiate a round of public/stakeholder consultation to ascertain public expectations of, and entitlement to, cancer treatments in the public health service (as specified in the Action Plan).

The West Coast District Health Board has been nominated as a finalist in the 2008 Health Innovation Awards, for its “Alternative Pathways for New Patients” project. This project has significantly reduced the time between referral and procedure in colonoscopy through the development of a criteria-based referral tool. Previously patients would go to their GP and be referred for a consultation with a specialist, who would then place them on the waiting list for surgery. Because the West Coast is geographically remote, some specialists aren’t based there and do not visit frequently so patients often wait some time to be seen. Under the new scheme, for patients who require a colonoscopy, the GP completes a form based on the patient’s symptoms and test results which are then sent straight through to the surgical waiting list.

The direct access referral tool has proven to be an efficient and safe method of assessing patients using the virtual FSA (first specialist assessment) concept. The West Coast District Health Board is implementing the tool on an ongoing basis and work is already underway to further develop the tool to encompass all priorities of scope including gastroscopy, and expansion of the concept to other procedures or diagnostics such as DHB-funded mammograms.
Development of regional cancer networks

The four regional cancer networks have continued to develop and evolve over 2007–2008. The three North Island-based networks have progressed well from an early stage. Although the Southern network has been slower to develop, the Council notes recent progress, including the appointment of a network manager, project manager, two part-time clinical directors, the initiation of several pieces of work and the first meeting of DHB cancer portfolio managers.

The networks are currently in the process of developing their strategic plans. The networks plan to collaborate to develop a consistent operating framework which will allow them to achieve their goals. This framework will include a number of common components for each network including communications plans, engagement principles, models of care, Key Performance Indicators, etc. This high level framework will be flexible enough so each region will be able to adapt it to meet their local requirements. The development of this framework will facilitate the development of the networks’ strategic plans.

The service mapping by tumour streams is an important area of work being undertaken by most regional cancer networks, based on the adoption of the Victorian Cancer Tumour Stream Frameworks. Initial tasks may include a stocktake of current policies and practices, service and patient mapping, project and workplan development based on the results of the stocktake.

From January 1 2008, each of the four regional cancer networks received an additional $250,000 per annum to increase their capacity to focus on addressing systemic causes of inequalities for population groups with respect to cancer. The regional networks worked together to develop a joint project scope for undertaking this initiative, this has included a mechanism that enables each of the networks to identify and focus on priorities for reducing inequalities at a regional level as well as a national level.

An ongoing challenge for regional cancer networks, and other stakeholders, is defining the role of networks with respect to DHBs, and determining what is planned and implemented at a nationally versus at network (or DHB) level.

Objective 3:
Ensure patient-centred and integrated care for those with cancer, their family and whānau.

Prior to the establishment of the regional cancer networks, DHBs cancer plans acted as the mechanism to ensure a focus was maintained on patient navigators and community based care being available to those undergoing cancer treatments. Regional networks have now taken over this function. The Council considers this to be a positive step towards ensuring co-ordinated and seamless cancer journeys. Assessment of these programmes will assist in determining their effectiveness for individuals and communities.

Three pilot programmes, currently underway (see below), have all focused on rural and/or Māori communities in the first instance. Evaluation of these programmes will allow for an initial assessment of the potential for reductions in inequalities with respect to cancer.

Progress towards Action Plan Phase 1 outcomes 55–57

55 A co-ordinated and seamless cancer journey for the patient.

57 Improved care in the community setting.

Following the success of several pilot projects (see below) examining the patient journey, most DHBs have reported interest in establishing patient navigator or care coordinator positions. These are primarily community-based and are usually filled by a nurse coordinator. The Ministry of Health reports that 12 DHBs now have these positions filled within, at least part of, their DHB.

In order for these outcomes to continue to be achieved, further coordination within support and rehabilitation services, as well as effective data collection and coordination with general practice information systems will be necessary.

There are three pilot programmes in place to evaluate the effectiveness of pilot navigators in rural and Māori environments. These are being undertaken through West Coast PHO and Tamaki PHO.
1. West Coast PHO is piloting a community-level cancer support service aimed at reducing inequalities, with respect to cancer, faced by the rural community on the West Coast. The objective of this pilot is to explore whether this kind of service can be effective in overcoming barriers within the cancer journey faced by people challenged by geographic distance and isolation. This service is well underway with the appointment of a coordinator and three navigators (one specifically for Māori). A number of referrals have already been made to the service and it already appears to be showing benefits for cancer patients.

2. Tamaki PHO is piloting a community-level cancer support service aimed at reducing inequalities faced by Māori with respect to cancer in South Auckland. The pilot project focuses on providing information, facilitating contacts with treatment services and social support agencies, and providing a support person to attend appointments. The objective of the pilot is to evaluate whether community-level support services for Māori cancer patients and their whānau can be effective in increasing uptake of cancer treatment services by this group (and therefore, ultimately reduce inequalities in cancer outcomes). Tamaki PHO has appointed a coordinator for this service and is currently recruiting for the navigator positions. The additional challenge of a large urban environment has meant that this pilot project has been more difficult to establish than the West Coast PHO pilot.

3. The Hunga Manaaki cancer care service in Rotorua. This hospital-based cancer support service is aimed at reducing inequalities faced by Māori cancer patients in Rotorua. This pilot programme also aims to evaluate whether community-level support services for Māori cancer patients and their whānau can be effective in increasing uptake of cancer treatment services by Māori.

The Council is encouraged by the establishment of these pilot programmes, and awaits the results of process evaluations of all three, which are currently underway.

While the activity reported under these objectives is promising, the Council notes that the Action Plan calls for this type of activity to be occurring across the entire country — presumably conceptualised at a regional cancer network level, rather than at a DHB level.

Overall, the pilot programmes that have been implemented signal some progress has been made toward achieving these outcomes. The process evaluations of these pilot programmes will provide guidance and will inform the development of programmes to ensure patient centred and integrated care at a national level.

Objective 4:

Improve the quality of care delivered to adolescents with cancer and their family and whānau

Progress towards Action Plan Phase 1 outcome 58

58 Development of designated regional adolescent oncology services to provide co-ordinated care for adolescents with cancer, ensuring that standards of medical and psychological care are met.

The Adolescent and Young Adult (AYA) Working Group have been established and have overseen the development of the AYA service specifications and the setup of the Late Effects Assessment Programme (LEAP).

The AYA service specifications have been incorporated into the national framework and AYA coordinators have been appointed in each of the six cancer centres, with some clinical leaders still to be appointed.

The AYA Working Group is also considering the involvement of adolescents and young adults in clinical trials and will examine a multidisciplinary team approach for ensuring that adolescents and young adults do not get “lost in the gaps” between paediatric and adult oncology.

The Council recommends that the regional cancer networks consider assisting with AYA coordination and networking between the regional cancer centres.
Goal 4:

Improve the quality of life for those with cancer, their family and whānau through support, rehabilitation and palliative care

Supportive care and rehabilitation are aspects of cancer control that need to be effectively integrated with all other areas of the cancer control continuum, from prevention through to palliative care. Appropriate, timely and useful cancer information is vital for patients, their family and whānau throughout their interaction with cancer services. The cancer journey can be markedly improved when patients, their family and whanau have access to consistent advice, reassurance of best practice and a comprehensive understanding of all services available. National consistency and availability of support and rehabilitation services will work towards reducing inequalities, whether occasioned through ethnicity, socio-economics or rurality.

Palliative care should provide a comprehensive service, tailored to individual need, that encompasses symptom control, emotional, spiritual, cultural and social aspects and that interacts with support services for both the patient and their family.
Objective 1:
Establish integrated programmes of supportive care and rehabilitation with defined leadership

Objective 5:
Ensure optimal independence and function for those with cancer through systematic assessment and appropriate multidisciplinary intervention for their social and vocational needs

The Action Plan suggested that no less than six groups be formed to address specific outcomes or actions within this goal. However, since the Action Plan was developed, other structures and processes have been established, providing alternative mechanisms to achieve these outcomes. In August 2007, advice was provided to the Ministry of Health’s Cancer Control Implementation Steering Group on Future Direction for Supportive Care Workstream\(^43\) recommending several changes to the way that supportive care and rehabilitation are addressed, both at national and regional levels. This advice included:

- postponing implementation of particular actions in the Action Plan
- replacing other actions with national and regional programmes
- supporting the development of the regional cancer networks in this area
- acknowledging and supporting work which contributes to this goal but is not specified in the Action Plan

Groups that are key to the achievement of Goal 4 objectives include:
- The Cancer Control Implementation Steering Group
- The Supportive Care Guidance Expert Advisory Group (EAG)
- The regional cancer networks
- The cancer-related NGO forum (CANGO)

The EAG was established in July 2007, with the express objective to “oversee the development of an evidence-based, New Zealand specific, source of advice and guidance on planning and delivering supportive care and rehabilitation for adults with cancer”\(^44\). This guidance will inform strategic and resourcing priorities for provision of supportive care for adults with cancer at all levels, by providing best practice service models, research priorities and recommendations for both government and non-government organisations. The guidance will thus provide, in one document and without the development of multiple new groups, the direction required at national and regional levels. The guidance is due to be completed towards the end of 2008.

Explanatory note
In the Council’s 2007 Mapping Progress report, individual specific milestones as laid out in the Action Plan were assessed for progress, in line with the methodology used for the other goals and milestones of the Action Plan. However, given the evolutionary nature of this goal and the change in thinking in the cancer control community regarding the best approach to support and rehabilitation since then, the Council considers that many of the milestones in Goal 4, objectives 1–5 should be reassessed, rephrased or deleted (while still noting the significant progress being made towards achieving the overall outcomes for this goal). For this 2007–2008 report, recommendations from the Implementation Steering Group and the Council will be noted under each outcome. Progress has been made toward achieving specific outcomes in this Goal by actions not specified in the Action Plan. Outcomes where this has occurred will be noted as “to be reviewed by the Council”.

Progress towards Action Plan Phase 1 outcomes 59–61

59 There is ongoing national leadership of supportive care and rehabilitation. There is supportive care and rehabilitation recognised at a strategic level as having an integral role in cancer care. There is improved implementation of the objectives and actions relating to supportive care and rehabilitation. The establishment of the EAG, and the development of supportive care

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\(^{43}\) Ministry of Health memo. August 2007. Future Direction for Supportive Care Workstream

and rehabilitation guidance, will provide the key foundation for the achievement of this objective. The establishment of a “national care committee” (as per the milestone) should be postponed until such time as the guidelines are in place and national organisations have begun to implement them.

60 Supportive care and rehabilitation are an integral component of cancer care. Existing services are maximised, and there is consistency in availability of, and access to, services. Effective service models and standards developed to assess the range of services provided. Ability to identify workforce requirements, workforce development needs and priorities.

This set of outcomes directly refers to the establishment of a working group to develop guidelines for supportive care and rehabilitation. All aspects of this outcome have been included in the development of the Supportive Care Guidance, including:

- the needs of adults with cancer, cancer survivors, family and whānau, and caregivers
- access to services
- information and communication
- support (including psychosocial, spiritual and physical)
- workforce

61 Supportive care and rehabilitation are an integral component of cancer care and management for children and for adolescents with cancer, their families and whānau. Existing services are maximised, and there is consistency in availability of, and access to, services. Effective service models and standards developed to assess the range of services. Ability to identify workforce requirements, workforce development needs and research priorities.

Supportive care and rehabilitation for children and adolescents was specifically excluded in the development of the guidance detailed above. However, the Paediatric Oncology Steering Group and the Adolescent and Young Adult Advisory Group have provided oversight and direction towards this outcome.

The job descriptions of the adolescent and young adult coordinators in the regional cancer centres include provision for supportive care and rehabilitation services, and have been detailed in the CFA variations which are due to be implemented in July 2008.

The Council will continue to monitor supportive care and rehabilitation services for adolescents and young adults.
Objective 2:

Ensure people with cancer and their families and whānau are able to access the appropriate resources for support and rehabilitation that they need.

As with Goal 4 Objectives 1 and 5, the Council considers that progress toward this objective has occurred in different ways from what is specified in the Action Plan and the actions need to be reassessed. Please see the explanatory note in the introductory section to Goal 4, Objectives 1 and 5 for an overview.

The Action Plan suggests a number of actions intended to improve consistency in availability of, and access to, services and resources for supportive care. These actions, if considered as a work programme, would naturally build on the Supportive Care Guidance by acting on gaps between current policy and practice and the best practice models recommended by the guidance. However, instead of driving the work programme entirely at the national level, the Implementation Steering Group has suggested a dual approach, with work at both the national and regional levels.

This approach would ensure:

- that a distinction is made between national level and regional level needs
- sufficient flexibility for regions to address their own gaps and issues
- cancer-specific work benefits from work already underway to improve supportive care resourcing generally.

Progress towards Action Plan Phase 1 outcomes 62–69

For this report, the Council will not be assessing actions within this objective, except to note that the actions will be considered in the Council’s upcoming review of the current Action Plan. The Ministry of Health’s Cancer Control Implementation Steering Group has suggested that all of the actions within this objective be replaced by work to improve the policy, practice and funding of supportive care (based on the supportive care guidance) and take place at both the national and regional levels. The Council recommends this approach, and suggests that it should be supported by the regional cancer networks having access to a database of resources available in each network for patients, families and professional staff.

Objective 3:

Ensure all survivors of childhood and adolescent cancer receive timely and ongoing support and rehabilitation, including the early identification of, and early intervention in late effects.

As reported in Mapping Progress, the Late Effects Assessment Programme is in place throughout the country. It is a clinical initiative designed to assess whether young cancer survivors have suffered any long term physical or psychological effects from their treatment.

Progress towards Action Plan Phase 1 outcome 70

70 Early identification and remedial action of problems in children and adolescents treated for cancer, through a high-quality and long-term surveillance.

The Paediatric Oncology Steering Group (POSG) was established in 2000 and has been very successful in establishing a tight and cohesive approach to paediatric oncology throughout New Zealand. Objectives 1, 2, 4 and 5 in Goal 4 of the Action Plan were included to bring adult supportive care and rehabilitation up to the same level as paediatric care. A supportive care workstream has now been established within the Paediatric Oncology Steering Group.

The cut-off age for deeming a patient as adolescent or young adult is currently being reconsidered. The current cut-off of age 14 for adolescents is considered somewhat anachronistic. All paediatric services are now providing for up to 16–17 year olds, unless the disease in question is of a particularly “adult-type”. There are also issues around young adults who have particularly “child-type” cancers, but who are not suited to being treated in a paediatric environment. These are issues currently being considered by the POSG.

The LEAP programme is well established and is used to follow up those who have been treated within paediatric oncology centres. It is supported by the National Paediatric Oncology Database New Zealand Child Cancer 45 Paediatric Oncology Steering Group report to the Cancer Control Council, May 2008.
Registry. This database has been developed separately from other oncology databases, because the number of child cancer cases are so low that it was feared that data may be swamped if included with adult data. In the future, such paediatric data may feasibly sit within national data sets.

Overall, there has been good progress in implementing this outcome. However, this is an outcome towards which can be considered ongoing and activity must continue if we are to see continued progress.

LEAP-IT, a national online clinical tool was designed to support the development of the Late Effects Assessment Programme. All clinical data is entered into a secure online tool, hosted on a dedicated server. This tool took three years to develop, was implemented in December 2006, and won the “Excellence in the Use of ICT in Health” category at the 2007 Computerworld Excellence Awards in July 2007. The aim of such a clinical software tool is to ensure that all survivors are monitored, regardless of where they live, with the ultimate goal of having each survivor being given their own “health passport”, a summary of all treatment they have undergone over the years.

The LEAP-IT tool could be expanded and made available as a follow up tool to monitor late effects for all survivors of cancer, including those adolescents and young adults who have received their cancer treatment through the six adult oncology centres.

Objective 4:

Ensure that those with cancer and their family and whānau have access to high-quality information on treatment and care, including complementary and alternative medicine

In the development of the Supportive Care Guidance (SCG), the Expert Advisory Group (EAG) has considered closely the set of principles produced by the CSNZ to guide those producing and reviewing cancer information resources. The EAG has also used the NICE guidance on “Improving Supportive and Palliative Care for Adults with Cancer”. The scope of the information section within the Supportive Care Guidance will cover the spectrum of cancer control, from prevention through to survivorship.

Maintaining strong and consistent representation of Māori and Pacific peoples on the EAG will ensure that there is success in developing accessible and appropriate approaches to providing information on treatment and care for these groups at a national level.

Progress towards Action Plan Phase 1 outcomes 71–73

71 Establishment of a national standard for the development, dissemination and review of consumer information across the cancer control continuum.

This is a task which falls within the terms of reference of the Supportive Care and Guidance EAG. The set of principles developed by the CSNZ during their stocktake and review of cancer literature has been used in the EAG’s development of recommendations to:

- develop nationally consistent standards/principles for development and provision of information
- evaluate resources
- ensure consumer involvement in developing resources

• ensure information can be communicated to people affected by cancer, irrespective of language
• establish an information repository
• ensure a range of resources is developed appropriate to the target audience

The NICE guidance has also been adapted and incorporated into this section of the Supportive Care Guidance. The Guidance will include a section on communication, based on the NICE guidance, which will cover communications between health professionals and patients, between health professionals themselves, and will ensure that patients and carers have appropriate contact information for cancer-related services.

72 Stocktake, recording and assessment of cancer information resources available and in use in New Zealand.

The CSNZ has maintained a full register of all cancer information resources included in its review. They are now proceeding with an update of this stocktake, working with Cancer Society regional divisions and using this exercise as a marketing and information tool. The CSNZ also provides informal advice on the development of literature to other NGO’s, but this is not considered a formal endorsement. Endorsement to a national standard ought to be included in the Supportive Care Guidance.

73 Consumers have access to quality cancer-related information that meets the national standard.

One objective of the EAG is that “all people affected by cancer have access to high quality information materials when they need them, in a format and at a level of complexity appropriate to need”.

This has not yet been achieved, but it is anticipated that provisions included in the supportive Care Guidance will be sufficient to achieve this outcome.

The Council recommends that a database of information be made available within each regional cancer network, to be disseminated to health professionals, support services and consumers. The regional cancer networks will need to be supported at a national level through the Supportive Care Guidance to achieve this aim.

Objective 6:

Continue to improve access to essential palliative care services that provide appropriate symptom relief and emotional, spiritual, cultural and social support for those with cancer and their family and whānau

Objective 7:

Ensure an integrated and comprehensive service is provided to all those with cancer who require palliative care and their family and whānau

In order to reduce the impact of cancer at the end of life, it is vital that palliative care services are comprehensive, well integrated with other areas of the cancer control continuum (from primary care through to treatment and supportive care) and provided in a manner that is appropriate to all recipients. This is an area that the Council feels has been slow to gain momentum over the first three years of the Cancer Control Action Plan. However, the Council is pleased to note the development of the Palliative Care Service Specifications and looks forward to monitoring reports on the implementation of these.

Further, it is anticipated that provision of, and access to, palliative care services will be enhanced by the development of the palliative care Nursing Competency Framework. This framework includes: options to support professional development; the national specialist palliative care medical education proposal; and a gap analysis (which addresses funding the new specifications).

The lack of a national palliative care leadership body is still cause for concern, both to the Council and to other national palliative care organisations. Solving this problem will be an integral part of successfully implementing the actions under these objectives. The Council has been working with key palliative care stakeholders to try and move this issue forward, see highlight box over.
Progress towards Action Plan Phase 1 outcomes 76–83

76 The New Zealand Palliative Care Strategy will be implemented.

DHBs have developed palliative care plans within their district annual plans with progress monitored in Quarterly reports provided to the Ministry of Health. Delays in establishing a clear national leadership body have led to frustration in the palliative care community; however this should now be addressed by the proposal to establish a palliative care council. The Palliative Care Service Specifications, once implemented, should, over time, provide more national consistency of service delivery.

77 Access to palliative care for people with cancer from specific underserved populations will increase and will be delivered in an appropriate manner.

The actions in this outcome are addressed in the palliative care service specifications, currently undergoing a formal ratification process. In addition, a subgroup of the palliative care working group will support development of national palliative care data definitions and code sets for eventual inclusion in national cancer data.

78 Access to and need for palliative care services will be appropriately monitored.

Requirements for monitoring of palliative care services have been included in the palliative care service specifications and address this outcome.

79 A system and structure for national leadership in palliative care will be developed for the Cancer Control Strategy.

The proposal to establish a national peak body to address this outcome (as reported in Mapping Progress 2007) has still not been officially accepted or implemented.

The Council continues to express concern at the lack of progress in this regard, and considers that the implementation of the Palliative Care Strategy at both national and regional levels has been less than optimal as a direct result.

The Council is currently working with key stakeholders from the palliative care sector to examine options on how to progress a national peak body that will monitor and provide guidance on palliative care in New Zealand.

The New Zealand Palliative Care Working Group has developed several work streams that relate to palliative care, including:

- Palliative Care Service Specification development
- Developing an agreed national approach to specialist palliative physician training
- Developing a national competency framework for nursing and a plan to support professional development in accord with this
- A medications group addressing issues in relation to palliative medication provision
- A new data workgroup that will develop a Palliative care minimum data set.

80 National standards for service provision will be developed and implemented at local and network levels.

The national palliative care service specifications are expected to be published in late 2008. Referral and discharge guidelines for specialist palliative care have been issued and implemented at local levels. National specialist competency frameworks for palliative care and cancer nursing are in development. These will be informed by the results of a recently completed nursing workforce study.

Overall, the Council notes that actions toward achieving this outcome are in progress. The development of palliative care service specifications is nearing completion and the Council looks forward to receiving reports on the implementation of these.

81 Palliative care services will be appropriately resourced and delivered.

Activities towards this outcome include the development of the palliative care service specifications and the nursing workforce study\(^\text{48}\). In addition, $2 million of additional sustainable funding was made available from the 2007/2008 Budget to assist with implementation of the new components of the specialist palliative care specifications.

Overall, the Council notes that there has been good progress toward achieving this outcome. However, this outcome should be considered ongoing and continued activity will be needed to ensure that it is achieved into the future.

82. Improved communication, integration and co-ordination of cancer services between patients, family/whānau and services.

This outcome has been hindered by the lack of a national peak body to guide the development of the regional palliative care networks.

Palliative care networks are being established at regional levels, but this is not always in conjunction with the regional cancer networks. The Council has found that this has occasioned some tension across the country, with a lack of clarity and direction as to what groups should be involved and what should be expected from such a network. The palliative care CFA variation to the DHBs (December 2007) states that the DHBs must “engage and continue to engage with regional cancer networks and district palliative care networks to obtain advice about implementation of the new components [of the service specifications] and to ensure that the new components are available across the region”. The DHBs are also obliged to provide reports of progress made with implementing the new components, including engagement with other regional DHBs and palliative care stakeholders.

Overall, the Council notes that progress has been made in implementing actions toward achieving this outcome, and that it would be possible to make further progress if a national peak body for palliative care existed.

83. Support care will be easily accessed, no matter where a person lives, or their age.

The Supportive Care Guidance described in Goal 4 Objectives 1–5 does not specifically incorporate supportive care for patients undergoing palliation. As reported in Mapping Progress 2007, a national leadership group for palliative care would contribute significantly to the planning and implementation of such services.

Overall, the Council notes that this is another area in which progress has been hindered due to the lack of a national peak leadership body for 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

Underlying all provision of cancer-related services throughout the cancer control continuum should be smooth, effective and above all consistent methodologies for the delivery of services. This includes every aspect of service delivery, from the initial planning of any service or project, through ensuring a sufficient and trained workforce, to the development of good communication and integration strategies.

In conjunction with such methodologies, should be an understanding of the vital role of monitoring and evaluation of all aspects of any programme. The planning, development, implementation and working stages of any programme or service all require ongoing monitoring and evaluation to ensure that they are achieving the desired outcomes. Methods and strategies for undertaking this ongoing monitoring and evaluation should be incorporated from the very start of each activity.

This goal of the Cancer Control Strategy was developed in order to address all of these issues, in a logical and ordered manner. The Council notes that progress under this goal has been somewhat patchy. There is good progress in implementing the actions outlined under Objectives 2 (accessibility of services to Māori) and 3 (consumer representation). The Council feels that there has been insufficient progress under Objective 1 (workforce). This Objective presents many challenges, which are constantly changing and solutions are not obvious. In the textbox below the Council proposes the notion of a ‘process’ to plan and manage workforce issues, as opposed to a fixed plan which risks becoming rapidly out of date. Nevertheless, the Cancer Control Action Plan 2005–2010 does propose a number of specific actions and milestones that we also consider.

The Council is pleased to note the development of a prioritisation process for new interventions and service delivery by the Ministry of Health. This process is to be informed by horizon scanning, advice from a range of advisory groups, the Cancer Control Action Plan, the Capacity and Capability study, and additional detailed analysis, as necessary. While the application of this process is in its infancy, and will require further consideration and development, it is anticipated that it will lead to improved delivery of cancer services.
Objective 1:

Develop a co-ordinated national cancer workforce strategy

A discussion of the issues around workforce:

The issue of workforce in cancer control is a complex and difficult one to address. Jurisdictions world-wide are experiencing similar challenges to those encountered in New Zealand. These challenges include:

- the cancer workforce is fragile and gaps can arise quickly and frequently. Because some areas of the workforce are highly specialized, supply remains marginal and these areas readily become deficient when there are unplanned or unexpected losses of workers.

- while supply of workers is increasing, demand for workers is increasing at a faster rate resulting in ongoing, or even increasing, workforce deficits.

To sufficiently and effectively address these shortages into the future it will be necessary, not just to react to shortages, but to have a clear vision of what is needed to minimize this fragility of the workforce and insulate it against factors beyond the control of workforce planners and implementers.

As outlined in the table below (under outcomes 87–90), there have been increases in both the number of positions funded and in the number of workers employed in key cancer control occupations over the past several years. However due to fast growing demand the deficit between the number of people employed in cancer control and the number of funded positions that are filled remains, and in some cases has expanded.

In addition, the deficiencies are not uniform across the country, hence individual units may be severely disadvantaged; by way of example, two unfilled paediatric oncologist positions might not be perceived as a major shortage across the entire country, but if those unfilled positions both arise in the same cancer centre then they could have the effect of dramatically reducing the capacity of that cancer centre — or even tipping it into non-viability.

A further problem is that a clear definition of ‘workforce need’ (rather than just the number of funded but unfilled positions) that can address workforce issues on a national and regional basis is lacking. That is, an independent and robust analysis and definition of the number of workers regionally required now, and projected into the future, across the range of different cancer-related occupations to provide optimal outcomes for cancer control is not available.

That said, the Council notes the recent progress that has been made towards addressing the issue of workforce. In particular the development of the DHBNZ Future Workforce Group aims to provide a strategic response to DHB’s collective priorities for the health and disability workforce over the next five to ten years; the development of the Health Workforce Careers Framework aims to help inform health and disability workforce planning and help organisations and individuals develop careers and career pathways; and the Medical Training Board has been established to provide leadership in the education and training of the medical workforce.

The Council views the work of these advisory groups as a high priority and will continue to monitor their recommendations and programmes to see if progress is made in developing a strategic response to the overall issue of shortages in the cancer workforce. The Council will review progress in developing a strategic response to shortages in the cancer workforce again in 2009. If, at that time, the Council deems sufficient progress not to have been made, it is likely that the Council will recommend the establishment of a specific taskforce to develop a strategic approach to address this issue.

The Council considers that workforce may be an area where a formal, printed strategy will not be “the answer”, and a strategic process may be required to provide regular advice, overview and direction for the development and maintenance of the cancer control workforce. It may be that a coordinated approach by the three groups stated above, with other key stakeholders such as the Ministry of Health, will fulfill the need for such a process.
A strategic process for ensuring that the cancer control workforce is sufficiently maintained will need to take into account the ever-changing landscape of cancer control, both nationally and internationally, the development of new governance, advice and implementation structures (such as the Cancer Control Implementation Steering Group, the Cancer Control Council and the regional cancer networks), and the inevitably changing nature of the health workforce as different health careers are promoted and health professionals seek to find the best possible working conditions, perhaps offshore.

Such a strategic process will need to be proactive in nature and this will require professional leadership as well as engagement and buy in from management.

Progress towards Action Plan Phase 1 outcomes 84–93

84 Appropriate levels of recruitment, training, professional development, and retention of the paid and voluntary workforce required for effective cancer control.

The Ministry of Health’s stocktake of the cancer control workforce49(as called for under this outcome in the Action Plan) provided an overview, including a review of training recruitment and retention rates of the cancer control workforce. While this stocktake did address the workforce in terms of the cancer control continuum, some areas were covered in more depth than others, and no information was sought or provided on the workforce specific to child cancer. This is largely the result of more information being provided to the Ministry of Health in some areas than in others.

“Appropriate levels” for recruitment, training and professional development are difficult to determine in the absence of a robust analysis of how many workers are needed to provide optimal outcomes.

85 A comprehensive workforce development plan to direct future training and recruitment needs for cancer control.

There has been some progress towards this outcome over the past year through addressing workforce issues, both specific to cancer control and in the wider health sector generally. Initiatives to address workforce issues include:

- The DHBNZ Future Workforce group. Future Workforce is the DHB/DHBNZ strategic plan to progress the goal of sector wide development of the health and disability workforce. It focuses on DHB’s collective priorities and actions for the health and disability workforce over the next 5–10 years.

- The development of the Health Workforce Careers Framework. The Career Framework describes the structure of, and progression within, the health and disability workforce with the aim of:
  i. supporting individuals and organisations to develop careers and career pathways

ii. informing and improving health and disability workforce planning,

- The Medical Training Board has been established to provide leadership in the education and training of the medical workforce. The Board’s work programme to June 2008 includes a range of activities that address training for the current and future medical workforce. The board is due to report to the Ministers of Health and Tertiary Education by August 2008, including a plan for its 2008/09 work programme.

Other cancer-specific workforce initiatives include the national specialist palliative care medical education proposal, the development of national specialist competency frameworks for palliative care and cancer nursing, and a proposal to improve endoscopy capacity by increasing available training in the procedure.

The Cancer Control Implementation Steering Group has agreed to include measures to address areas of concern identified in the Ministry of Health’s stocktake of the cancer control workforce into the Ministry of Health’s 2008/09 cancer control work programme.

The New Zealand Cancer Treatment Working Party also provides advice to the Ministry of Health on a range of cancer issues as required. This advice includes workforce issues.

There are targeted areas of activity for training and recruitment in the cancer control workforce. This outcome remains in progress and the Council will continue to monitor progress to see if these and future actions contribute to reducing shortages in the cancer workforce. Such plans could form part of the strategic approach that is discussed above.

86 Increased involvement of Māori and Pacific health professionals in cancer control

The Māori Health Directorate of the Ministry of Health monitors Māori health workforce and Māori health providers through the Indicator of DHB Performance HKO-02.

The Māori Provider Development Scheme (MPDS) allocates funding for key national Māori health workforce organisations such as Māori doctors, medical students, nurses, midwives, dental and community health workers. The Hauora Māori scholarships for 2008 were recently enhanced through the addition of the Te Apa Mareikura scholarships. Essential criteria for these include involvement with and effective networking within the community, and leadership, competence and achievement in community health.

While the actions described here are not specific to cancer control, each of them could be incorporated into a workforce development plan for cancer control, if and when this is initiated.

There is not evidence yet (be that due to lack of data to determine progress, or simply lack of progress itself) of an increase in the Māori and Pacific cancer control workforce by the 10 percent targeted in the Action Plan.

87 Oncology pharmacists are appointed to DHBs with cancer treatment centres to improve the management and safety of chemotherapy.

88 Increased training and retention of hospital physicists to meet the growing needs for cancer diagnosis.

89 Increased training and retention of anatomic pathologists to meet the growing needs for cancer diagnosis.

90 Increased training and retention of radiation therapists to meet the growing needs for cancer diagnosis.

These four outcomes were written into the Action Plan at a time when these cancer-related occupations were most in deficit in terms of Full Time Equivalent positions (FTEs). (This is not to say that there were not other deficits at that time, but that these were the occupations which provided information to the Action Plan Taskforce.)

Workforce issues change rapidly over time and a more flexible strategy to address current and emerging challenges should be developed (see text box above), rather than having fixed numbers reflected in a printed document.

As at June 2008, there were the following FTEs in these cancer treatment related occupations (Note: FTEs refers to the number of full time equivalent workers actually employed in that occupation, while vacant refers to the
number of positions that are **funded but remain unfilled**. The total number of positions funded is equivalent to the number of FTEs plus the number of vacant positions:

<table>
<thead>
<tr>
<th>Workforce area</th>
<th>% of total funded positions that are vacant</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>June 06</td>
</tr>
<tr>
<td>Radiation Oncologists</td>
<td>0%</td>
</tr>
<tr>
<td>Medical Physicists</td>
<td>11%</td>
</tr>
<tr>
<td>Radiation Therapists</td>
<td>2%</td>
</tr>
<tr>
<td>Senior Radiation Therapists</td>
<td>0%</td>
</tr>
<tr>
<td>Medical Oncologists</td>
<td>6%</td>
</tr>
<tr>
<td>Palliative Medicine Specialists</td>
<td>14%</td>
</tr>
</tbody>
</table>

The table below gives the percentages of all funded FTEs that were vacant for the four time periods in the table above. Noting the reservations about using such a measure as a marker of workforce shortages in the absence of a ‘proper’ assessment of workforce need, shortfalls are increasing over time in some workforce areas, and decreasing in others.

The Council notes that in each workforce area, the number of positions filled was less than the number of positions funded in the most recent period (June 2008), ranging from a 3% to 17% shortfall. However, the Council also notes that in all workforce areas there have actually been increases in the number of positions filled over the past five years. This highlights the fact that demand in the cancer treatment workforce is increasing as fast as, if not faster than, supply in the cancer workforce. Information is more difficult to collate for the workforce requirements across the rest of the cancer continuum; however, the Council believes similar situations apply.

While it has been possible to identify the number of workers required to fill all funded positions in each occupation, it has not been possible to determine whether the number of funded positions is the best mix to provide optimal outcomes in cancer control. It will not be possible to determine this until a robust analysis of need and/or demand is available.

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1 “Radiation therapists” includes assistant radiation therapists. Include an examination of high risk occupations for Non-Hodgkin’s Lymphoma.

A new radiation therapy graduate programme has been developed and in 2008 there are a current total of 66 radiation therapy students\(^5\). This number is equivalent to the number training in 2001. In the intervening years there was a steady increase in radiation therapy trainees, until 2004, when the numbers began to decrease. A new curriculum has been developed by the University of Otago, starting in 2009.

Overall, progress toward achieving these outcomes has been slow. This is due to the fact that medical workforce training takes a long time to complete and the areas of greatest need are constantly changing.

91 **Improved capacity and capability of the cancer nursing workforce.**

A national specialist competency framework for cancer nursing is being developed through the Ministry of Health’s Cancer team and has recently entered a national consultation process. A nursing workforce study commissioned by the Ministry of Health from Auckland University has recently been completed.

Together with the Cancer Control Workforce Stocktake\(^5\), these will address the specific actions of this outcome, i.e.: “agree on appropriate establishments for oncology/haematology nurses for cancer centres and for ambulatory care” and “define the scope of a senior oncology nurse”.

Overall, there is progress toward achieving this outcome, however considerable work is still required to ensure that this outcome is achieved.

92 **The cancer control research workforce is expanded to provide skills and expertise across the continuum of cancer control including behavioural, social and psychological research.**

The Health Research Council (HRC) reported\(^5\) to the Council that it currently has six programmes and sixteen individual projects which directly relate to areas of the cancer control continuum. They have also developed “The Primary Prevention of Cancer and other Chronic Diseases”, a joint venture with the Ministry of Health. It is anticipated that this programme will provide the evidence base required to improve the effectiveness of cancer control in New Zealand through research and surveillance. In addition, the HRC has developed a Māori Health Joint Venture and a Pacific Health Research Programme. While these two latter programmes are not cancer-specific, they do both aim to attract Māori and Pacific health researchers into fields of interest, including placing young researchers into established research institutes.

The HRC is not currently funding research into cancer-related behavioural, social and psychological issues, but these would fall within their cancer criteria, if any such proposal were received.

93 **Increased recruitment and retention of palliative care workers to provide an integrated and comprehensive service throughout New Zealand.**

A recent recommendation from the New Zealand Palliative Care Working Group to the DHBNZ Workforce Group (regarding a palliative medical training funding proposal) proposes nine palliative medicine specialist training positions across the country (producing up to three new graduates per year) — based on the estimated need for palliative medicine physicians and national capacity to train them. The Ministry of Health has supported this recommendation and is working with DHBs to implement it.

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\(^5\) Health Research Council report to the Cancer Control Council. March 2008
Objective 2:

Ensure programmes and services are accessible to Māori across the cancer control continuum

As per the Council’s 2007 Mapping Progress report, all milestones for this objective are still “in progress” over the past year. The Council commends this as acceptable progress, considering that these milestones should really be considered as “ongoing”, with no specified endpoint. Consultation and cooperation, accessibility and participation do not fall within “timeframes”, and the Council is pleased to see the establishment of numerous initiatives, such as the funding of the regional cancer networks to investigate inequalities, which will contribute to the effective achievement of this objective.

Progress towards Action Plan Phase 1 outcomes 95–102

95 Appropriate and effective governance models are developed to address Māori inequalities in access and outcomes.

96 Services across the cancer control continuum are appropriately focused towards Māori priorities and reducing cancer-related inequalities.

DHBs continue to be monitored against targets and expectations relating to Māori health providers and Māori involvement in the sector. These are agreed with the Minister of Health as part of the DAP process. Quarterly reports to the Ministry of Health include information on how DHBs have engaged with Māori communities, how cancer-related inequalities are being addressed for Māori, how priority areas for Māori have been identified, incorporated into strategic plans and had resources allocated.

In October 2007, a further $1 million was allocated to the regional cancer networks ($250,000 per network). A Crown Funding Agreement variation was prepared which specified the services the regional cancer networks were required to provide (through the DHBs). The networks are now required to:

- raise awareness of inequalities among cancer service providers and other cancer stakeholders
- work to better identify the causes of cancer inequalities and address those inequalities.

This approach will be beneficial to each region if disseminated widely throughout the community and recommendations are acted on by DHBs and NGOs. It will be necessary to undertake a national analysis of results and compile nationally-focused recommendations to ensure consistency of approaches to addressing inequalities in Māori priorities, access and outcomes.

Crown Māori Relationship Instruments (CMRI) has been developed to formalise governance relationships between some DHBs and local iwi and Māori communities. While some iwi have decided that they will not seek a formal agreement, other iwi have chosen to follow this pathway. To date, two CMRIs have been signed and there are negotiations in place with three further iwi.

The Council notes that both of these Action Plan outcomes (#95 and #96) are specified to run for the full duration of the Action Plan (2005–2010) and commends the research and actions that are currently underway. The Council looks forward to continuing to see improved reporting and initiatives in this area.

97 A case management approach is in place for Māori patients from commencement of treatment.

“Case management” tends to refer to a coordinated team of clinical professionals working together to ensure the best possible journey for the patient, which focused on the clinical components of care. This is sometimes seen as being independent of the “patient navigator” role, often undertaken by a health professional from the primary care end of the cancer control continuum.

The Council has considered two areas of the continuum where patients may experience a “gap” in services, these being between primary care (or referral) and entry into treatment, and at discharge to supportive care/rehabilitation and/or palliative care. The Council looks forward to the
evaluation reports of the three pilot programmes regarding cancer care in the community, particularly in regard to recommendations regarding strengthening the ties between the extreme ends of the cancer control continuum.

In 2007, the DHB cancer plans examined for the Council’s Mapping Progress report showed that the majority of DHBs were committed to implementing a case management approach for all cancer patients. The regional cancer networks have now been required (through the DHB CFA variation) to develop region-wide, tumour-specific and service improvement multidisciplinary groups and workstreams, and to develop patient pathways, promoting a focus on the patient journey and improving the experience of care. The Council commends this approach, given the cross-regional nature of the networks and the wide community consultation and representation available to the networks.

98 Decisions about policy and funding address inequalities and Māori priorities in cancer control.

The planned regional cancer network investigations into regional inequalities will help to inform decisions about policy and funding issues, and the Council looks forward to evaluating reports in this regard. The Minister of Health’s 2007/2008 Letter of Expectations to DHB Chairs restated all priority areas, which included reducing disparities, especially for Māori and Pacific populations. In addition, DHBs were advised that the Minister will expect an increased emphasis from boards on programmes that will more rapidly reduce the levels of disparity that exist between Māori, Pacific peoples and other groups.

99 The development of national standards and guidelines reflect priorities for Māori

The New Zealand Guidelines Group has a process in place to ensure that guidelines in development address cancer-related inequalities for Māori and Pacific people. This process includes ensuring representation on each guidelines development team of at least two Māori members and one Pacific member, and also includes a comprehensive review of any New Zealand-focused literature relevant to the guideline area.

However, in a report from the Ministry of Health’s Māori Health Directorate to the Council54, concern and surprise was expressed that the directorate was not consulted in regard to the recent development of many cancer-related guidelines.

The Council has reviewed a number of cancer control policies and related strategies (e.g., the Primary Health Care Strategy, the Palliative Care Strategy) and would like to see a far stronger and better-defined focus on both aspects of cancer control (i.e., reducing the incidence and impact of cancer and reducing inequalities with respect to cancer.)

The Council recommends the integration of an inequalities focus into all projects that aim to develop policies, guidelines and standards, from the outset, rather than developing this focus “along the way” or through later ad hoc consultation with minority groups.

The Council recommends that in any future development of standards, guidelines, strategies or policies, the ongoing requirements for evaluation, monitoring and reporting be considered at an early stage of development, and be explicitly incorporated into the final documents in a manner that is clear, concise and achievable.

100 Improved information for, and communication with, Māori communities.

The structure of the regional cancer networks has explicitly included the requirement to engage with Māori groups within their region. Initial reports from the networks are encouraging, including details of Māori representation on governance structures, communication strategies and wide consultation on network workplans and strategic plans.

In 2007, the Council noted a few DHBs with specific initiatives towards this outcome (Action Plan #100). Quarterly reporting to the Ministry of Health does include a report on how local iwi/Māori are engaged and participate in DHB decision-making and the development of strategies and plans for Māori health gain. However, the Council finds that specific reporting against this outcome is patchy and perhaps does not reflect the complex interactions within communities at the DHB level.

Ongoing monitoring and evaluation that provides ongoing information about Māori access to cancer services and cancer-related inequalities for Māori will be undertaken.

The Council has received a report from NZHIS regarding the collection of ethnicity data (see also Goal 6, Objective 2, Outcome #112). The report states that “NZHIS is leading a consultation process to align the Health and Disability Ethnicity Data Protocols with the Statistics New Zealand Ethnicity Data Standard 2005. The Health and Disability Ethnicity Data Protocols currently align with the previous Statistics New Zealand Standard. Once agreement has been reached in terms of alignment, the Protocols will be updated and re-issued. This will be supported by training and other materials.”

In addition, the NZHIS provides training materials to the health and disability sector and promotes the Ethnicity Data Protocols as the basis for collecting quality ethnicity information.

Until these processes are fully established, the Council continues to hold concerns regarding regional collection of ethnicity data, with inconsistent implementation and reporting across the country hindering the ability to provide meaningful comparisons between regions.

Any changes to the official ethnicity classification will also have a serious impact on ethnicity data collection and health statistics. For example including ‘New Zealander’ as an official ethnicity into the next census, will disrupt time series analyses, thereby making it more difficult to monitor the trends over time, which is an important component in measuring and monitoring Māori health and ethnic inequalities. This change will also compromise objectives aimed at reducing inequalities in various strategies, including the Cancer Control Strategy and Action Plan.

In New Zealand, the census ethnicity question is often used as a denominator in calculating health statistics and rates, changes to the classification that impact on the denominator also impact on the comparability of datasets.

Research will inform the planning, development and delivery of cancer services for Māori across the cancer control continuum.

The Council has recently established a Research Advisory Group (RAG), which has provided recommendations to the Council on the development of a five-year rolling research plan for cancer control. Key recommendations from the RAG, which may act directly to ensure that this outcome (Action Plan #102) is achieved, are:

- encourage researchers to direct their efforts towards those aspects of research which are likely to have the greatest benefit to New Zealanders affected by cancer
- identifying, giving priority to, and supporting the case for more resources for those fields of research that are at present under-resourced
- be specific enough to stimulate research effort in priority areas
- include reference to the translation of research into improved outcomes for those affected by cancer and at the population level.

Recently, the Māori Health Directorate has issued an invitation to Māori Research Units to align their work with the Māori Health Directorate’s interests. The directorate will be funding a fellowship to provide FTEs to work on these research projects. Research has also been undertaken into the provision of Māori services, with a Cancer Chartbook on rurality and deprivation due to be published in August 2008.

The Māori Health Joint Venture between the Ministry of Health and the Health Research Council is a partnership to jointly fund research which will promote health outcomes for Māori.

The venture will invest in a project of up to 12 months in duration that identifies Māori health research priorities in cancer that will contribute to the achievement of whanāu ora, more effective service delivery for Māori and improved health outcomes for Māori.

The Māori Health Joint Venture has recently released a request for proposals.
The recent publication (November 2007) of Hauora: Māori Standards of Health IV has brought together key statistics over a range of health issues, covering the years 2000–2005. The Māori Health Directorate sponsored funding for this project. Chapter 6 of this publication relates specifically to cancer.

The health statistics for Māori in this document are located within the broader context, including the theoretical, demographic and socioeconomic contexts.

Objective 3:

Ensure active involvement of consumer representatives across the spectrum of cancer control

The Council has been pleased to receive updates on the first courses in consumer training, held by Cancer Voices. The Council has approved a decision to provide funding for evaluation of these courses. This is a first step towards achieving many of the outcome milestones within this objective.

Recognition of the importance of the consumer viewpoint at all levels of the cancer control continuum has been increasing over the past year, and the Council looks forward to seeing the inclusion of trained consumer representatives on all committees, boards and community organisations.

Progress towards Action Plan Phase 1 outcomes 103–107

103 Increased consumer participation and opportunities for consumer representatives to be actively involved in cancer control activities at local, regional and national levels.

105 All groups involved with cancer control and related work are committed to working with consumers and are able to demonstrate this in practice. They will also have Māori and Pacific expertise that is appropriately supported.

106 All consumer representatives involved with cancer control groups and related activities have the appropriate experience and/or training so they are well prepared to be effective and knowledgeable representatives.

Over the past year, Cancer Voices, in collaboration with the CSNZ, have developed a consumer representative training course. Two courses have been completed. The CSNZ has developed, and will undertake, evaluation of the success of these two courses, with funding from the Council. Recommendations from these evaluations will then be incorporated into the course before it is run again. A wide cross-section of consumers (e.g. by ethnicity, rurality, socio-economics, experience with cancer) is being targeted for these courses.
Cancer Voices have developed Guidelines for Consumer Representation on a Committee or Working Party\textsuperscript{55} which clearly defines what a consumer representative is:

A Cancer Consumer Representative (CCR) is a committee member who voices the consumer perspective and takes part in the decision-making process on behalf of consumers. The CCR should perform as an integral member of the committee with additional specific expertise to contribute.

In terms of the ongoing expectations of the CCR, the CCR would be expected to:

- contribute in the same manner as any other committee member
- represent the spectrum of cancer consumers, with a focus not limited to just one type of cancer
- respect negotiated confidentiality of matters discussed in meetings
- report all significant committee advice and/or recommendations affecting consumers for dissemination to the consumer community

The CSNZ is working to promote the use of trained consumer representatives to all organisations within the cancer control community. This promotion may include raising awareness of the need for policies or terms of reference that include the active involvement of consumer representatives. Links to regional cancer networks are considered extremely important. The Council recommends that the networks be considered the prime repositories of information on potential consumer representatives, community organisations, consumer groups and Māori and Pacific Island groups in each region in order to co-ordinate and facilitate the smooth integration of a consumer perspective into all aspects of cancer control.

Goal 6:

To improve the effectiveness of cancer control in New Zealand through research and surveillance.

Research and surveillance in cancer control underpins all activities across the cancer control continuum, whether issues of access to primary care services, analysis of waiting times for key clinical procedures, easing of the cancer journey or assessment of requirements for palliative care. Research identifies and evaluates ways to reduce morbidity and mortality, and to improve the quality of life of cancer patients. Surveillance assesses progress on key indicators, and may also point to emergent problems and etiologies. Research and surveillance, and the effective use of the resulting information, is therefore vital to maintaining and developing the best possible cancer control programme for all New Zealanders.

Research and surveillance often depends on data collected elsewhere, for example registries of patient information, DHB population statistics and clinical outcomes. For efficient and reliable interpretation of this information, the underlying databases must be optimally designed, populated and maintained, with access to them being available in a timely, interconnected yet protected fashion.

Over the three years since the release of the Cancer Control Strategy Action Plan 2005–2010 and the establishment of the Council, there has been concern (both from the Council and from the cancer control sector) at the slow progress to improve cancer data collection and develop better information systems that support clinical care. Some of this lack of progress is due to necessary extra steps that were not foreseen (and are now being implemented), information requirements and systems of the whole health sector, and other issues external to the Cancer Control Strategy. It is the Council’s view that better progress in the short to medium term is essential to the advancement of cancer control in New Zealand.
Objective 1:

Extend and enhance research across the continuum of cancer control

There has been an expansion of activity which directly addresses this Action Plan objective. This includes the establishment of a Research Advisory Group to provide advice on the structure and content of a five-year rolling research plan for cancer in New Zealand, the development of the HRC’s Primary Prevention of Cancer and other Chronic Diseases Research Strategy, Māori Health Joint Venture and Pacific Placement Programme, Te Kete Hauora’s initiatives around the Māori Health Review and their interaction with Māori health research units and the overall focus of the sector on issues raised within the Cancer Control Action Plan.

Developing and maintaining research capacity across all areas of the cancer control continuum will form a solid foundation on which to base essential decision-making on accessibility and ease of the patient journey, diagnosis and treatment, supportive and palliative care for all New Zealanders. In turn, this should facilitate a reduction in the impact of cancer, and inequalities with respect to cancer.

Progress towards Action Plan Phase 1 outcomes

108 A strategic and regular process for facilitating research relevant to cancer control in New Zealand.

During the 2007/2008 year, the Council set up a research advisory group (RAG). Membership of the group has been drawn from governmental, non-governmental, academic research, funding and consumer bodies to advise the Council on:

- the process by which a five-year rolling strategic plan should be developed so that it will be influential and respected by the cancer control community, particularly researchers and research funding agencies
- the form of the plan so that it will be easily interpreted and have a clear rationale

- how the cancer control community, particularly researchers and research funding agencies, should be involved in the development of the strategic plan
- how the effectiveness of the plan will be monitored

The Council has been pleased to receive recommendations from the RAG. Further details of these recommendations are available through the Council’s website: www.cancercontrolcouncil.govt.nz.

Methodology for the development of the content of the research plan is currently under discussion by the Council and the RAG.

109 The development and maintenance of Māori research capacity.

Several key initiatives have been developed or undertaken over the 2007/2008 year.

Through the Māori Health Joint Venture, the HRC and the Ministry of Health have sought to establish a flagship portfolio of collaborative research that will contribute to the development of Māori research capacity. Several projects have been funded to date through this partnership, including:

- a project focused on the need for trained Māori professionals, managers, community and voluntary workers to strengthen the health and disability sector to deliver effective and appropriate services to whānau where they are located
- a research project examining Māori health and disability workforce recruitment and retention issues to identify what attracts and discourages young Māori from entering into the health science professions (information from the HRC website: www.hrc.govt.nz/root/pages_policy/Māori_Health_Joint_Venture.html)
- A current RFP for the Māori Health Joint Venture seeks to establish a project that will develop a research agenda for Māori in regards to the cancer control continuum and focus on the prioritisation of cancer research for Māori with cancer and their whānau and communities.\(^\text{56}\)

The *Māori Health Review*, an online journal that highlights research relevant to Māori health, is produced bi-monthly and is available at www.māorihealthreview.co.nz. This journal has been developed as a vehicle for informing Māori communities, Māori researchers and government agencies on Māori health research.

Invitations have been extended to Māori health research groups in universities to engage in discussions on:

- building strategic Māori health policy and research relationships with Māori health researchers
- facilitating Māori health researcher’s understandings of key Māori health policy initiatives, workforce development and research needs and priorities within the Ministry in order to build an ongoing policy of dialogue
- building Te Kete Hauora’s understanding of Māori health, research programmes, researcher skill base and specialities, and new findings and innovations

The Council notes that while these initiatives have all contributed to the development of the Māori health research capacity in general, there seems to be a lack of development of cancer-specific Māori research workforce. It will need to be considered whether it is appropriate to develop a Māori health research capacity in every aspect of health research.

110 Development of research capacity in the behavioural, social, cultural and psychosocial aspects of cancer control.

In its recommendations to the Council, the RAG specifically mentions directing the planning process towards “identifying, giving priority to, and supporting the case for more resources for those fields of research that are, at present, under-resourced.” The HRC reports that while it does not specifically request proposals for research in these areas in the absence of partnership funding (see below), it does have a prioritisation process which supports research in all areas of the Cancer Control Strategy, including the behavioural, social, cultural and psychosocial aspects of cancer control.

When the Cancer Control Strategy was launched the HRC and Ministry of Health developed a Joint Venture in the Primary Prevention of Cancer and Other Chronic Diseases, this was supported by $5.4 million over three years. The broad objective of this initiative is to generate a targeted programme of research that will provide the evidence base required to reduce the incidence of cancer and other chronic diseases through primary prevention. The first three years of this programme have focused on tobacco control and nutrition, physical activity and obesity. Three projects are currently underway, these are:

1. Enhancing food security and physical activity for Māori, Pacific and low income whanau/families
2. Developing strategies to reduce smoking uptake and second hand smoke exposure of children in New Zealand.

The Council awaits findings of these projects.

The Joint Venture Steering Committee has finalized two more Requests for Proposals. These requests have both been called for and the Steering committee will be considering applications of interest in August 2008. The RFPs are:

- Improving the effectiveness of the ‘HEHA workforce’, and,
- Motivations for quitting smoking and staying quit in Māori, Pacific and low income New Zealanders.

**Additional initiatives**

The Pacific Health Research Programme has been developed by the HRC and the Ministry of Health. A current initiative within the Programme has provided an opportunity for an established research organisation to host emerging Pacific researchers for approximately two years. This programme supports Pacific researchers to undertake research projects focusing on the Pacific health and disability workforce. The most recent research addressed issues relating to the Pacific Non-Regulated Workforce. This project aims
to identify the composition, characteristics and constitution of the Pacific non-regulated workforce. The research will also examine developmental pathways, impacts, barriers and enablers and workforce models relative to the Pacific non-regulated workforce and provide detailed information on how the effectiveness of the Pacific non-regulated workforce can be improved to meet the health needs of the Pacific population in New Zealand.

The Pacific Health Research Placement Programme (PPP) is a capacity building initiative designed to place Pacific students within ‘world-class’ research teams in the health research sector. The role of the HRC is to identify entry points and training opportunities within leading research teams and to match these with the research interests identified by eligible Pacific students. To date, one Pacific PhD student has been funded to undertake research into dendritic cell-based vaccines for treatment of cancer, and there are an additional three Pacific placements currently funded.

Objective 2:

Improve the use, efficiency and scope of national data collection and reporting

The Council has received reports of activity against this Objective over the past year. The Council is concerned about the lack of progress in developing an improved and expanded national cancer data collection, although acknowledges that activities reported in 2008 indicate an increased momentum and include the completion of tasks that are necessary but were not anticipated at the time when the Action Plan was formulated. Integration of the information-related actions contained in the Cancer Control Action Plan with the National Systems Development Programme (NSDP) (a health sector wide initiative led by the Ministry of Health) is essential to provide a sustainable solution to current issues around gathering and use of information; however this wider integration has slowed progress on the cancer specific actions. The development of a national health information strategy and its implications for cancer information systems was not foreseen when the Action Plan was being developed.

The Council reaffirms that accurate, meaningful and timely cancer data is absolutely vital and underpins all research, reporting and decision-making that needs to be undertaken in the cancer control arena and strongly recommends that a high priority is assigned to progressing the cancer information programme.

Progress towards Action Plan Phase 1 outcomes 111–112

111 A national cancer information set that provides up to date and meaningful information for monitoring the effective implementation of the Cancer Control Strategy.

To achieve this objective requires implementation of better systems for the collection of data and sharing of information for cancer and palliative care patient management. Although key work was completed by the Cancer Treatment Working Party (scoping of a National Cancer Management Data Base Project) and NZHIS (Cancer Collections Framework59), the

need to ensure consistency with developments of the National Systems Development Programme (NZ Health Information Strategy) has slowed progress over the last 2 years.

The earlier work by the NZCTWP to develop a core dataset, the recent Northern Region project to develop an RFP for a regional non-surgical cancer patient management system, work progressing the primary health care information and the systematic improvement of the NSDP have established the foundations to now progress towards “a national cancer information set that provides up to date and meaningful information...” (i.e. what was initially envisaged as Outcome 111 of the Action Plan. This has recently been advanced as the Cancer and Palliative Care Information Systems Project, led by the Cancer Control Implementation Steering Group and advice from a stakeholder advisory group (see below under Action 3). The project will contribute to:

1. Improved sharing of information for patient cancer care and collection of the data to form a national core cancer and palliative care data set

2. Completing work on the core data set and establishing a process for expanding the core set. This will involve affirming agreed code and data sets working with the NZ Health Information Standards Organisation (HISO)

Regarding the first objective, the emphasis is at the national level to complement the Northern region’s procurement of a patient management system. Regarding the second objective, defining data variables that must be collected nationally is an essential building block regardless of the future shape of a national information system. It is envisaged that by mid 2009, these two objectives will converge to provide a “roadmap” for an integrated national information system for cancer control. The Council will closely monitor, and champion where appropriate, the achievement of this outcome. The Council regards this as a high priority.

Considering the Action Plan, there are four specific actions which contribute to this outcome:

1. Refine the role of the cancer registry

2. Continue work to develop a core cancer data set

3. Consult with other specialist providers to expand the core data set

4. Ensure that the refined Cancer Registry links with the appropriate clinical, pathology and palliative care databases

**Action 1**: The Action Plan calls for a refinement of the role of the Cancer Registry to identify the essential links it needs to collect the information most effective for cancer control. In a report to the Council, the NZHIS states that “the Cancer Registry system will have completed redevelopment by December 2008. A key benefit of this project will be the enhancement of the quality, timeliness and accessibility of coded data from the New Zealand Cancer Registry and the related Datamart. This will enable earlier availability of more accurate provisional cancer data to support cancer control activities, including research and surveillance.”

**Action 2**: Development of national core cancer and palliative data and code sets requires nationally agreed definitions that are endorsed by the New Zealand Health Information Standards Organisation (HISO), this will be another important prerequisite for achieving Outcome 111. The work that was undertaken for the National Cancer Management Database (NCMD) scoping project will form the basis on which the palliative care and cancer information workgroups will progress this development. A subgroup of the Ministry of Health’s palliative care working group will support development of national palliative care data definitions and code sets.

**Action 3**: A cancer information systems advisory group has been formed to guide the Cancer and Palliative Care Information Systems Project. Membership has been drawn from interested parties and will help to expand and refine the core data set to incorporate other requirements, and provide advice on a national-level complement to the proposed Northern Region patient management system. The advisory group is chaired by a member of the Cancer Control Council.

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60 NZHIS report to the Cancer Control Council. May 2008

61 A data mart is a repository of data gathered from operational data and other sources that is designed to serve a particular community of knowledge workers. The emphasis of a data mart is on meeting the specific demands of a particular group of knowledge users in terms of analysis, content, presentation, and ease-of-use. Users of a data mart can expect to have data presented in terms that are familiar.
Workshops have been held with key stakeholders, as part of the initial NCMD project, to understand the requirements needed to ensure adequate information is collected to support improved clinical decision making and improved patient outcomes.

**Action 4**: Linkages between the Cancer Datamart and clinical and other databases will be via the National Health Index (NHI). In addition, essential links required to collect all necessary information have been identified, including those with laboratories and the Coroner. (in the short-to-medium term, expanding such linkages seems to be the most obvious way to allow access to and analyses of, national cancer information in a manner consistent with the original intent of Outcome 111.)

**112 Improved and consistent collection of ethnicity data.**

NZHIS is currently leading a consultation process to align the Health and Disability Ethnicity Data Protocols with the Statistics New Zealand Ethnicity Data Standard 2005. The Ethnicity Protocols currently align with the previous Statistics New Zealand Standard. Once agreement has been achieved in terms of alignment, the Protocols will be updated and re-issued. This will be supported by training and other materials.

NZHIS provides training materials to the health and disability sector and promotes the Ethnicity Data Protocols as the basis for collecting quality ethnicity information.

**Additional initiatives**

From 1 January 2008, the joint DHB/Ministry of Health Cancer Control Implementation Steering Group agreed to fund an amount of $200,000 ($50,000 each) to the regional cancer networks to allow them to obtain dedicated data analysis support. The accompanying CFA variation states that the DHBs must ensure that the networks “collaborate 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”.

The Council considers that national collaboration by all the regional cancer networks will be a useful strategic action for data collection and analysis, and that this will contribute to reducing the incidence, impact and inequalities with respect to cancer.
Appendices

Appendix 1: List of cancer control agencies that received a request for interview

Adolescent Oncology Working Group (subgroup of the NZCTWP)
Alcohol Advisory Council of New Zealand
Cancer Control Trust
Cancer Society of New Zealand — Consumer issues
Cancer Society of New Zealand — Tobacco Control
Cancer Society of New Zealand — UV
Central Cancer Network
DHBNZ Service Improvement Group
Health Research Council
Health Sponsorship Council
Midland Cancer Network
Ministry of Health: Cancer Control Implementation Working Group (Sector Capability & Innovation Directorate)
Ministry of Health: Healthy Eating, Healthy Action (Sector Capability & Innovation Directorate)
Ministry of Health: Population Health Protection Group (Population Health Directorate)
Ministry of Health: Māori Health Directorate
Ministry of Health: Supportive Care and Rehabilitation (Sector Capability & Innovation Directorate)
Ministry of Health: Tobacco Control (Sector Capability & Innovation Directorate)
National Occupational Health and Safety Advisory Committee
National Screening Unit
New Zealand Cancer Treatment Working Party (NZCTWP)
New Zealand Guidelines Group
New Zealand Health Information Service
Northern Cancer Network
Paediatric Oncology Steering Group (subgroup of the NZCTWP)
Palliative Care Advisory Committee
Southern Cancer Network
Sport and Recreation New Zealand (SPARC)
Appendix 2: Templates used for stakeholder interviews

**Template 1: 2008 Cancer Control Action Plan evaluation of progress**

**Interviewee:** SPARC — (Individuals)

**{Date}**

**General overview of progress in:**

Green Prescription

Mission-On

He Oranga Poutama

**Physical inactivity and obesity-related cancers**

**Phase 1 progress:**

- **#11: Increased PA among vulnerable populations**
  
  - **Action:** Raise awareness of link between cancer risk and inadequate PA
  - **Milestone:** Increased awareness via SPARC/CSNZ survey

  Have there been any further initiatives developed as a result of this survey?

  - **Action:** The inclusion of a nutrition component in GRx.
  - **Milestone:** Programme adapted and available if appropriate.

  Has there been any progress (outcomes/outputs) in the GRx models SPARC has funded in Northland, Waikato, Counties Manakau and Waitakare?

  Are there results from the two studies about the effectiveness of face-to-face support of GRx in the Waikato?

  Are you able to track the percentage of GPs giving nutrition advice and/or support when prescribing a GRx?

- **Action:** Further adapt the GRx programme to ensure it reaches Māori, PI and low SE groups. **Milestone:** Programme adapted and available.

  What is the progress of Mission-On? How are you ensuring it reaches the target populations?

- **Action:** Maintain and expand the GRx programme. **Milestone:** Number of GRx prescriptions issued by gender and ethnicity.

  What are the numbers of GRx prescribed by gender and ethnicity for the last year?

  What progress has there been in developing the new information infrastructure for GRx under the Mission-On strategy? Is this leading to more accurate ethnicity data collection?

- **#12: Reduced levels of obesity in vulnerable populations.**

  - **Action:** Encourage increased investment in community-based initiatives to improve nutrition and promote healthy weight for Māori. **Milestone:** Increased levels of investment and participation in Māori-led programmes.

  What progress has there been in the He Oranga Poutama programme? Budget increase, programme increase?

  - **Action:** Explore opportunities to include traditional and contemporary PA into programmes for Māori. **Milestone:** Increased use of traditional Māori activities in PA programmes.

  SPARC Facts 2001 collected baseline data. What is the progress of the NZ Sport and PA survey — due to show comparative information mid 2008?
Template 2: 2008 Cancer Control Action Plan evaluation of progress

Interviewee: HSC

(Date)

Nutrition and Physical Inactivity-related cancers

Phase 1 progress:

#14: Increased awareness and knowledge of healthy nutritious foods

- **Action:** Develop a social marketing campaign. **Milestone:** Survey to monitor reach, knowledge and awareness, uptake of messages and change in behaviour

The mass media campaign was launched in May 2007, have there been any further initiatives developed as a result of this campaign? e.g. You reported that community based activities, consumer research and a behaviour change indicator survey were to be implemented or developed in later in 2007.

UV-related cancers

#18: Reduce exposure to UVR among children (12 years and under)

- **Action:** Enhance social marketing strategies aimed at raising awareness, improving knowledge and developing sun protective attitudes and behaviours. **Milestone:** Increased investment by national orgs.

Did HSC run the annual campaign aimed at 5–12 year olds this summer? Has any progress been made on refining the strategy for the next 3 years to include adolescents/youth? Any other progress??

#21: Improve understanding of at-risk audiences sun related attitudes and behaviours

- **Action:** Undertake research to better understand behaviour and attitudes to sun safety among caregivers, schools and outdoor workers.

**Milestone:** Stage qualitative research programme developed and acted on.

What research has HSC undertaken in these areas over the last year?

#22: Increase shade provisions in public settings/environments

- **Actions:** Increased natural and built shade in public places and policies, Standards and guidelines, Strengthen legal frameworks to include shade provision, ensure local government long-term community plans include a focus on increasing shade **Milestones:** Shade provisions in place

What progress has been made in increasing shade provision??

#43: Reduce deaths from melanoma in NZ — early detection other than organised screening

- **Actions:** Develop a strategic approach, including a literature review and workshop. **Milestones:** Background document including literature review developed. Workshop of key stakeholders to develop policy and identify priorities for action held.

Has the revised strategic framework for skin cancer been developed? What progress has been made in the NZ component of the Australasian Melanoma Guidelines Group? You reported that its work was due to be completed in 2008, is this still so?
**Tobacco-related cancers**

# 3: Increased quitting rates especially among the most at risk groups.

- **Action:** Enhance social marketing campaigns to reduce second-hand smoke in non-regulated environments. **Milestone:** Exposure to second-hand smoke reduced.

  Does the second-hand smoke mass communications campaign continue? Has it been re-evaluated in the last year?

# 4: Reduction in the number of young people taking up smoking, especially groups with higher rates of smoking

- **Action:** Undertake research into young peoples initiation **Milestone:** Initial research programme completed

  What progress has been made on the RSI implementation guide?

**Phase 2 progress:**

#18: Reduce exposure to UVR among children (12 years and under)

- **Action:** Enhance social marketing strategies aimed at raising awareness, improving knowledge and developing sun protective attitudes and behaviours. **Milestone:** Sun safety included in all DHB public health plans

- **Action:** Ensure local government long-term community plans include a focus on increasing shade **Milestone:** Territorial local authorities plans include focus on increasing shade
Appendix 3: Cancer Control Council email of notification of upcoming Action Plan progress report

25 February 2008

Dear [stakeholder]

New Zealand Cancer Control Strategy: Assessing Progress

It is now a year since the Cancer Control Council undertook its first annual monitoring and evaluation of progress against the New Zealand Cancer Control Action Plan. The Council was established by the Minister to provide independent advice on this and other matters relating to cancer control.

In 2007, the Council contacted all cancer control community stakeholders directly for detailed feedback on progress made by their organisation in meeting the milestones of the Action Plan. While this approach provided us with much valuable information, we were asked by stakeholders to look at the process we used, specifically in relation to our timing (too near reporting deadlines), quantity of information required and perceived replication of information already provided in published reports.

This year we are applying a more strategic-level, evaluative approach, in which we will be assessing overall outcomes and performance towards the objectives of the Action Plan. We will be assessing further progress towards Phase 1 objectives (specified for years 2005–2007) as well as noting progress in Phase 2 (years 2008–2010).

Shortly, we will directly contact key personnel within your organisation to arrange a meeting to discuss these issues. Wherever possible, we will draw on existing data/published reports to ensure we avoid duplication and minimise additional work for your organisation.

The important final step will be to make sure everyone involved in cancer control can learn from the evaluation. The Council will present its evaluation report to the Minister of Health in July and will then ensure its wider distribution to the cancer control community.

We look forward to working with the many groups and organisations involved in cancer control to reduce the incidence and impact of cancer and reduce inequalities in New Zealand.

Yours sincerely

Dame Catherine Tizard
Chair
Appendix 4: Cancer Control Council email request for an interview to discuss progress towards Action Plan Phase 1 and Phase 2 outcomes

27 February 2008

Dear [stakeholder]

The Cancer Control Council is currently undertaking its second annual evaluation of progress of the New Zealand Cancer Control Strategy Action Plan (“the Action Plan”). In 2007, the Council contacted all cancer control community stakeholders directly for detailed feedback on progress made by their organisation in meeting the milestones of the Action Plan. While this approach provided us with much valuable information, we were asked by stakeholders to look at the process we used, specifically in relation to our timing (too near reporting deadlines), quantity of information required and perceived replication of information already provided in published reports.

This year we are applying a more strategic-level, evaluative approach, in which we will be assessing overall outcomes and performance towards the objectives of the Action Plan. We will be assessing further progress towards Phase 1 objectives (specified for years 2005–2007) as well as noting progress in Phase 2 (years 2008–2010).

I would appreciate the opportunity to meet with you to discuss progress in the Action Plan Goal [x] area of [specified area].

Could you please let me know when it would suit you to meet, over the next four weeks? If a meeting will not be possible, then we can arrange a time to talk on the phone. I will send you an overview of the questions I have prepared, once we have a time arranged.

I look forward to hearing from you

Regards

Mary Clare Tracey
Senior Analyst, Monitoring and Review
Cancer Control Council of New Zealand
Appendix 5: List of Abbreviations

CANGO Cancer Non-Governmental Organisations Forum
CCR cancer consumer representative
CMRI Crown Māori Relationship Instrument
CSNZ Cancer Society of New Zealand
EAG expert advisory group
FTE full time equivalent
HISO NZ Health Information Standards Organisation
HRC Health Research Council
HWAC Health Workforce Advisory Committee
IDP Indicator of DHB Performance
MPDS Māori Provider Development Scheme
NCMD National Cancer Management Dataview
NHI National Health Identifier
NIWA National Institute of Water and Atmospherics
NODS Notifiable Occupational Disease System
NRT nicotine replacement therapy
NZCTWP New Zealand Cancer Treatment Working Party
NZHIS New Zealand Health Information Service
RAG research advisory group
RFP request for proposal
SPNIA Service Planning and New Health Intervention Assessment
UVI Ultra Violet Index