



## A way forward for regional cancer centres – independent expert recommendations

How the Australian Government's \$560 million budget commitment could best reduce geographical inequities in cancer outcomes



Report of a national workshop convened by Australia's peak non-government clinical and community-based cancer organisations

August 2009

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### Acknowledgements

The Clinical Oncological Society of Australia (COSA) and Cancer Council Australia commend the Australian Government for committing to the \$560 million capital works program, for which these unsolicited recommendations have been independently developed.

COSA and Cancer Council Australia acknowledge and thank all presenters and attendees at the workshop, all of whom gave their valuable time voluntarily to contribute to these recommendations.

We also acknowledge and appreciate the voluntary work of a number of COSA members and supporters who have, over many years, contributed to the evidence base on regional cancer disparity and strategies to address it – particularly former regional oncology chairs Professor David Goldstein and Dr Craig Underhill, and current chair Dr Adam Boyce.

### Contact

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## Foreword

By international standards, cancer outcomes in Australia are good. But Australians in rural and remote areas do not share equitably in the nation's success in cancer survival, with the gap in treatment outcomes increasing in step with distance from a metropolitan area.

So, after years of campaigning for the Australian Government to invest in improving cancer outcomes in regional Australia, Cancer Council Australia and the Clinical Oncological Society of Australia (COSA) welcomed the announcement in the 2009-10 federal budget of \$560 million in capital grants for up to 10 regional cancer centres.

As peak bodies representing the non-government cancer sector nationally, COSA and Cancer Council Australia convened a workshop in Canberra on 4 August to develop an independent position on the ideal generic criteria for the capital grants, inviting many of the key players in regional cancer with both a government and non-government perspective.

Permeating the workshop were recommendations that the capital grants be allocated on the basis of demonstrated need, quality assurance, sustainability, networkability and flexibility. This report details the specific recommendations under these broad headings and summarises the presentations and discussion that helped to inform them.

The quality of the discussion showed the great potential for the government and non-government sectors to work together towards a common goal of reducing the disadvantages faced by Australians in rural and remote regions who are diagnosed with cancer.

We commend the Government for committing to this substantial capital investment and thank the workshop speakers and delegates for their participation, particularly the Department of Health and Ageing officers who provided important background.

We hope the recommendations in this report will provide a guide to the Government as it works through the consultation component of developing the grants assessment criteria and funding approval process.

Ultimately, capital funding is only part of what is required. We look forward to further opportunities to engage with government towards ensuring the regional cancer centres are also appropriately staffed and supported to deliver optimal patient care.



Professor Bruce Mann  
President  
Clinical Oncological Society of Australia



Professor Ian Olver  
Chief Executive Officer  
Cancer Council Australia



## Executive summary

Following the 2009-10 federal budget announcement of \$560 million in capital grants for up to 10 regional cancer centres, the Clinical Oncological Society of Australia (COSA) and Cancer Council Australia convened a national workshop in Canberra on 4 August to develop an independent cancer sector position on generic criteria for the grants allocation process.

Just under 50 delegates attended, covering a range of sectors and disciplines, including clinical specialists with hands-on experience in regional cancer service delivery, Commonwealth Department of Health and Ageing staff, state/territory health department representatives and consumers. (A full list of attendees begins on page 19.)

Overarching themes throughout the workshop discussion and recommendations included the need to ensure:

- successful grant applicants guarantee recurrent funding to support the capital investment – minimum staffing and appropriate professional mix will be critical;
- long-term sustainability is assured;
- systemic workforce issues are resolved;
- genuine multidisciplinary care underpins the service;
- current and future (projected) population needs will be met;
- cross-border issues are resolved; and
- linkages with both metropolitan cancer centres and ‘feeder’ hospitals are in place or developed.

The presentations were followed by a group discussion to develop a consensus view of the core generic principles that COSA, Cancer Council Australia and the jurisdictional and consumer stakeholders at the workshop considered integral to the funding approval process. The discussion took the form of five syndicate groups exploring:

- ideal models for regional cancer equity and access in a high-population state;
- ideal models for regional cancer equity and access in a low-population state;
- core principles to guide the location of the 10 centres;
- ideal models for aligning the centres with existing services (including primary care) and to engage with the jurisdictions; and
- how far the definition of ‘capital works’, as outlined in the existing grants criteria, could extend to build multidisciplinary cancer care capacity in the regions.

The workshop identified a unique opportunity to build on past and future policy efforts, by ensuring the grants criteria for the regional cancer centres initiative are based on both the principles of the National Service Improvement Framework for Cancer (2005) and the Government’s response to its National Health and Hospitals Reform Commission’s recommendations. On this basis, the following proposed core criteria were supported.

## Recommendations – generic criteria

### Principles

#### Needs-based

- Locations should be based on population/demographic profiling, planning, tumour-specific cancer incidence data and projections etc. (see Criteria for locating the centres, page 8)
- Population needs analyses should include ratio of current and projected patient caseload to specific service – e.g. radiotherapy, specialist surgery etc.
- Selected locations should reduce overlaps across and close gaps between population catchment areas
- Proposed centre locations should align with jurisdictional cancer plans
- If private provider grant applications are successful, plans will be required to ensure patients in the catchment area from disadvantaged communities and backgrounds have supported access to services.

### **Sustainable**

- Successful grant applicants must be able to meet recurrent costs to ensure capital investment delivers optimal returns in terms of patient outcomes
- Successful grant applicants must be part of a wider workforce strategy demonstrating that recruitment, training, placement and ongoing professional development plans are in place to ensure staffing meets local needs and supports capital investment
- Centres must be located where supportive general health services are available
- Centre location must be aligned where possible to jurisdictional cancer plans and strategies for enhancing overall health and medical services in catchment region
- Criteria should be consistent with Australian Government's response to National Health and Hospitals Reform Commission recommendations
- Cost-benefit analyses essential to planning.

### **Integrated/comprehensive**

- Centres must be able to provide genuine multidisciplinary care – i.e. coordinated, patient-centred care involving services from clinical specialists integrated with psychosocial support, allied health etc. (See Recommended key enablers, page 7)
- Centres must be networked with metropolitan tertiary services
- Centres must be linked with other services required to support an integrated cancer service such as radiology, pathology palliative care etc
- Where current and projected population needs meet required threshold, centres should be built around pre-existing radiotherapy services
- Centres must have strong links with primary care services
- Centres must have capacity for patient accommodation
- Capacity must be increased in smaller, networked outreach services for remote populations
- Facilities such as telemedicine must be available to support outer remote services and to allow linkage to metropolitan centres

- Efficient data-sharing capacity must be built into the networking of centres, to improve referral pathways and ensure capacity to manage single electronic health identifier (as government E-health agenda progresses)
- Capacity for workforce development and support, with formal links to educational resources in metropolitan teaching hospitals etc., should be a core requirement of a centre
- Centres should be able to provide access to cancer clinical trials.

### **Flexible**

- A broad interpretation of the Health and Hospitals Fund's capital works definition would allow grants to fund a wide range of infrastructure items (for full list, see Definitions of 'capital works', page 8)
- Options to make optimal use of public/private partnerships should be considered
- Equity between public and private patients must be assured
- Diverse/tailored approaches essential; one-size-fits-all will not work
- Needs of remote Indigenous communities should be built into centres as required
- 'Up to 10 centres' should allow scope for jurisdictions without adequate population density outside capital cities to benefit from the funding
- Consortia applications could be encouraged in catchment areas with special needs (e.g. highly dispersed populations, cross-border catchment areas, regions with significant Indigenous populations etc.)
- Grants criteria must recognise existence of cross-border relationships (e.g. northern NSW patients who go to Brisbane, Alice Springs links with Adelaide etc.); some centres may have to service more than one jurisdiction and/or link to a metropolitan centre in a different jurisdiction from their catchment area
- Generic criteria must ensure highest-denominator approach and that equity between jurisdictions is assured where possible
- Individual components of a service/centre could be at different locations, provided effective linkages are in place.

This report explores these recommendations in detail and summarises the discussion and presentations that informed them.

COSA and Cancer Council Australia will seek ongoing Government support for the incorporation of these recommendations into the funding approval process.

## Recommendations – key enablers

### Staffing and service mix for a regional cancer centre

The workshop discussed the requirements and recommended makeup of a regional cancer centre, in terms of staffing, the mix of services and other essential components to ensure sustainability and optimal effectiveness.

On the basis that flexibility was essential and a one-size-fits-all approach was unworkable (a theme throughout the discussion), it was agreed that core requirements, depending on the identified needs of a catchment population, should be as follows.

#### Staffing

Grant applicants should demonstrate capacity to support the staffing mix required to make a centre viable and able to meet its potential to improve cancer outcomes. To meet this requirement, the workshop proposed a number of essential/ideal staffing enablers:

- Radiation oncologists (minimum of two, numbers adjusted to need)
- Medical oncologists (minimum of two, except in outreach services; haematology or equivalent service provision)
- Surgeons with subspecialty oncological training and interest, depending on caseload
- Identified care coordination role
- At least one resident medical professional trained in palliative care
- At least one resident professional trained in psycho-social care
- Oncology pharmacy in larger facilities; networked to outreach services
- Resident or efficiently networked pathology
- Optimal nursing numbers; access to specialist nurse educators, chemotherapy support
- Access (via residency or networked external/visiting professional) to the full suite of allied health services, including nutritionists, physiotherapists, occupational therapists etc., depending on caseload, including the availability of fulltime professionals
- Resident staff with data management expertise
- Resident staff with clinical trials expertise.

#### Services/infrastructure

For the ideal staffing mix to function effectively and for the centre to meet current and future needs, a range of services and infrastructure would need to be in place, including:

- Core mix of radiotherapy, chemotherapy, surgical oncology, haematology allied health etc., as above
- Efficient referral pathways (e.g. to ensure patients with complex cancers requiring highly specialised care are promptly referred to, and monitored through, larger centres)

- Transport and accommodation facilities
- Strengthened links with primary care in the region; and with tertiary care in large centres
- Platform for technological advancements (e.g. radiotherapy)
- Telemedicine capability (either as hub, or as client if a remote outreach facility)
- Data management, linkages with cancer registries etc. – sophisticated IT platform, capacity to accommodate advent of eHealth
- Resident or networked access to high-quality imaging, nuclear medicine (MRI etc.). A centre with sufficient catchment population density to justify radiotherapy could also qualify for PET
- Blood banking facilities
- Access to clinical trials, tissue banking.

### **Criteria for locating the centres**

The keys to locating a regional cancer centre are capacity to meet population needs and achieve long-term sustainability:

- Must be sustainable – sufficient population density, successful grants applicants must demonstrate capacity to meet long-term operational costs etc.
- Alignment with jurisdictional plans – including private sector applicants
- Demonstrably needs-based – applications based on detailed needs analyses, including current and projected need, tumour-specific incidence and prevalence data, demographic trends etc.
- Directly match the capital outlay to need – e.g. close a gap in access to specific services such as radiotherapy, chemotherapy, accommodation etc.
- Maximum return on investment – e.g. build on existing radiotherapy investment if other core criteria are met
- Build the proposal around wider infrastructure environment – e.g. transport routes, town/regional planning, developments in the local economy etc.
- Capacity for expansion
- Must be able to accommodate cross-border patient base where required.

### **Definitions of ‘capital works’**

The underlying principle of the Government’s health and hospitals capital works program is that grants will only be allocated for infrastructure projects – no recurrent or operational costs will be funded, but must be met by grant recipients (see Rosemary Huxtable presentation). Priority should be given to grant applications able to systematically show how coordination of a range of infrastructure investments will optimise centre viability and patient outcomes.

On this basis, the workshop explored the extent to which the needs of a regional cancer centre could be defined as capital works, recommending for consideration.

- 'Bricks and mortar'
  - Treatment centres
  - Bunkers for radiation oncology
  - Chemotherapy centres
  - Ambulatory care centres
  - Endoscopy and day procedures
  - Inpatient facilities
  - Operating theatres
  - Clinical trials unit
  - Accommodation centres
- Health and information technology
  - Imaging, including radiotherapy, CT, MRI, PET etc.
  - Nuclear medicine
  - Pathology facilities
  - Pharmacy facilities
  - Clinic spaces including allied health
  - Vacuum tube system
  - Blood banking, tissue banking facilities
  - Data management equipment (eHealth)
  - Educational and communication facilities, including lecture and tutorial rooms, telemedicine, treatment simulation centres etc.
  - Software licences
- Patient support
  - Accommodation facilities
  - Parking, transport links/hub
  - Information centre
  - Meeting rooms
  - Wig library
  - 'Time-out' space (e.g. café)
  - Complementary therapy space
- Office management
  - Admin support for visiting professionals
  - Video and teleconferencing equipment
  - New/upgraded office management infrastructure
  - Facilities for improving referral pathways, patient monitoring and follow-up.



An overarching recommendation was that where these diverse services could not be co-located, they had to be effectively networked and integrated.

## Research

(\*Complete presentations in PowerPoint format are available at [www.\\_\\_\\_\\_\\_](http://www._____.) )

### **Presentation 1 - Cancer demographics and regional cancer centres: a collaboration between COSA, the Association of Australian Cancer Registries and the Australian Institute of Health and Welfare**

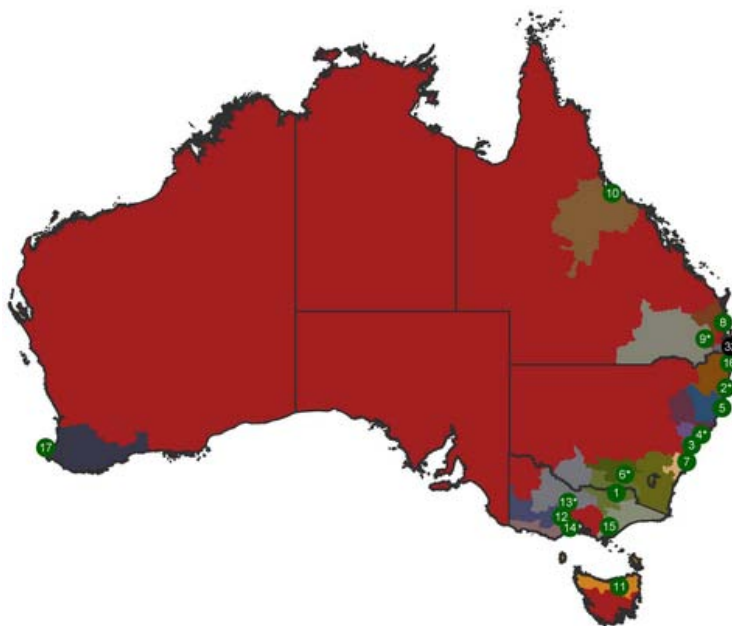
#### **Professor Graham Giles**

Professor Giles presented a preliminary snapshot of a study that he and colleague Emily Karahalios are undertaking on behalf of COSA, analysing regional demographic and infrastructure capacity to provide a geographic guide to assist prioritising regional cancer centres. The analysis was done on the basis of:

- Current and projected population need
- Harmonisation of statistical local area (SLA) boundaries
- Computation of average annual cancer incidence rates for each SLA
- Location of existing and planned regional and rural centres, on the basis of available radiotherapy and outreach
- Overlay of transportation routes.

In summarising, Professor Giles report that his study suggested:

- Demographic projections (ageing, domestic migration patterns etc.) will be critical – the clinical workload will change as the population profile changes
- Analyses of local/regional needs will require a high level of detail – e.g. incidence data alone will not be a sufficient guide, as cancer prevalence (particularly acute cases) will have a significant impact on workload
- Current and projected referral patterns, which could be tracked by cancer registries, should also be factored into service planning.



A graphic from Professor Giles's presentation, showing Australia's main regional cancer patient catchment areas on the basis of all-cancer diagnoses.

## Commonwealth overview

### **Presentation 2 – The Australian Government's regional cancer centre initiative Ms Rosemary Huxtable, A/g Deputy Secretary, Department of Health and Ageing**

As A/g Deputy Secretary of the Department with overarching carriage of the capital works initiative, Ms Huxtable provided a summary of the grants allocation process.

Key points included:

- The \$560 million will be allocated over five years to build a network of around 10 best practice new or enhanced regional cancer centres
- Locations are yet to be determined – except for a pre-announced commitment to develop a centre in the ACT, which would serve the local and south eastern NSW regions
- Criteria for the grants are currently being developed, based on the pre-existing capital works criteria applied by the Government's Health and Hospitals Fund (HHF)
- The HHF would assess the grant applications according to an agreed set of four principles:
  - projects should address national infrastructure priorities
  - projects should demonstrate high benefits and effective use of resources
  - projects should efficiently address infrastructure needs
  - projects should demonstrate that they achieve established standards in implementation and management
- Health Minister the Hon Nicola Roxon has appointed an expert group to advise the HHF on criteria for assessing applications, chaired by Australian Chief Medical Officer and cancer clinician Professor Jim Bishop and comprising representation from the HHF, the Department of Health and Ageing and Cancer Australia, with non-government input from Professor Ian Olver (Cancer Council) and consumer John Stubbs (Cancer Voices Australia)
- The Minister will be approving all documentation used in the process, including the grants application assessment criteria
- The draft criteria is expected to be finalised and subject to an open consultation process within a month
- There may be some flexibility around the plan to develop or establish “up to 10 centres”. This could be guided by the number and quality of applications in the context of the final grants criteria.

## Jurisdictional perspectives

Grant applicants' capacity to meet operational costs will be critical to ensuring the new or enhanced regional cancer centres are sustainable. So, although private interests are welcome to apply for grants, it will be essential for jurisdictional health departments to be involved at some level in the regional cancer centres initiative.

It was therefore useful to gain an insight into the cancer plans and challenges in each state and territory (the Northern Territory was unable to send a representative) – in a few cases from senior jurisdictional cancer care administrators who are also COSA members.

Key points follow.

### **Presentation 3 – Western Australia**

#### **Professor Ian Hammond, Director WA Cancer & Palliative Care Network**

- Populations outside Perth are low-density and dispersed
- Ideal patient to treatment ratios indicate WA needs 19 radiotherapy machines – it currently has 11 in Perth, another two in Perth to start up in 2014, and one in Bunbury
- Need to expand existing outreach services (e.g. chemotherapy) in four remote population centres and establish new services in three centres
- State government supportive, but faces significant funding constraints.

### **Presentation 4 – South Australia**

#### **Sinead O'Brien, Deputy Executive Director, Statewide Service Strategy**

- Insufficient population density to sustain a resident centre outside Adelaide
- Have developed outposted multidisciplinary team service at Mt Gambier
- Mapping population needs and developing clusters on the basis of transport routes
- Involvement of primary care – which is located within sparse or remote communities – is the key
- Introduction of CanNET program (see Cancer Australia/Professor Currow presentation following) of great assistance.

### **Presentation 5 – Victoria**

#### **Elise Davies, Manager, Cancer and Palliative Care, Department of Human Services**

- State cancer plan, includes 'Priority 1 – Improve cancer service capacity across Victoria; build linkages and referrals between metropolitan and regional centres; invest in new and redeveloped cancer centres in metropolitan and regional areas'
- Cancer plan aims to ensure regional service sustainability by 'building local capacity, embedding local capacity and extending local capacity'  
Population growth and ageing in regional Victoria exceeding previous projections
- Key issues are addressing workforce shortages, underpinning service quality, enhancing referral pathways and access (patient travel and accommodation)

- Some networks already in place (e.g. state-wide paediatric oncology network); further networks should be developed before capital works commence, to ensure sustainability and service-readiness
- Single machine unit radiotherapy trial showed some benefits, although it revealed high volume of unmet need and generated long waiting lists.

### **Presentation 6 – Tasmania**

#### **Dr Craig White, Chief Health Officer**

- Nation's highest cancer mortality rates
- Small, dispersed population; sustainability issues
- System not integrated
- Strategic direction for system-wide reform
- Government vision for improved coordination (patient management frameworks for all cancer streams, transition to MDC as standard, improved data collection etc.)
- Significant private sector role in Hobart and Launceston.

### **Presentation 7 – ACT**

#### **Kristen Connell, Director of Service Development, ACT Health**

- ACT earmarked to receive capital grant under the regional cancer centres initiative – \$27.9 million to upgrade existing medical oncology unit, combining research and coordinated care with general practice
- Goal to complete upgrade of centre by 2012
- Expanded centre will need to service NSW south coast region – developing local networks as capital upgrade rolls out
- ACT cancer plan also in development – draft document available online.

### **Presentation 8 – NSW**

#### **Cathryn Cox, Manager Statewide Services, NSW Health**

- NSW has a number of plans to guide service development including a Rural Health Plan and the NSW Cancer Plan
- Undertaken planning and developed a state business plan for new and expanded radiotherapy services. NSW has a strategy of establishing dual machine services related to population catchments and demand
- High proportion of ageing population in non-metropolitan NSW
- Has been developing regional referral hospitals which provide higher levels of services and which provide the necessary clinical support infrastructure for integrated and comprehensive cancer services in rural areas
- Current centres in development include Lismore and Orange. Both of which will commence clinical services with one machine but have capacity to expand
- Other geographic areas of priority which have been identified include Illawarra/Shoalhaven, New England and Central Coast.

## **Presentation 9 – Queensland**

### **Professor Euan Walpole, Medical Director, Cancer Services**

- State cancer plan 2008-2017, restricted in scope to cancer treatment, published in 2008
- Cancer incidence and prevalence, population projections, hospitals activity data etc. used to inform plan
- Also looked at drainage and flow, transport corridors, workforce issues, current capacity and infrastructure, and new policy directions (e.g. care coordination)
- Developed service framework recommendations for Queensland's heavily regionalised population base
- Developed range of objectives for service delivery across three strategic planning regions (Northern, Central and Southern areas).
- State cancer plan now used to guide funding of new and expanded services.

A common theme for the jurisdictional representatives was that recognition of the cross-border issues would be important to where and how regional cancer centres were expanded or established.

## **Consumer perspective**

### **Presentation 10 – Marianne Warren**

Ms Warren, a cancer consumer and senior healthcare administrator, added a vital consumer perspective to the discussion with a brief presentation focusing on:

- The importance of ensuring that access to multidisciplinary care for regional cancer consumers underpinned the regional cancer centre initiative, including...
- Access to the full suite of coordinated services – clinical, allied health, supportive care etc.
- Practical aids – assistance with travel, accommodation, maps to ensure important practical necessities that can be overlooked in service planning were built into the system
- The potential benefits of telemedicine – particularly when it can prevent unnecessary travel over substantial distances
- The applicability of the breast care nurse model across the cancer spectrum.

Ms Warren emphasised that her consumer colleagues were particularly concerned about problems with patient travel and accommodation schemes – which would need to be resolved if the regional cancer centres initiative were to realise its potential to reduce geographical disadvantage.

Enhanced care coordination, linkages with general practice (particularly for remote patients) and the need for real-time patterns of referral were also high priorities for cancer consumers.

## Regional oncologist perspective

### Presentation 11 – Lessons learned: COSA mapping report; Border Collaboration Dr Craig Underhill

Dr Underhill, an Albury-Wodonga based medical oncologist, presented the key findings of a COSA mapping report of regional oncology services published in 2006, when he was chair of COSA's regional oncology group. He also discussed the lessons learned from an intergovernmental pilot program, the Border Cancer Collaboration, which showed the significant benefits of an inter-jurisdictional model of providing patient support services and care coordination.

- The COSA mapping report clearly showed that oncology service provision became increasingly patchy in step with geographic isolation, strongly suggesting a link between restricted service access and the well-documented declines in cancer survival as populations became more remote. Core recommendations included the need for a network of regional cancer centres, supported by policy improvements in areas such as patient travel and accommodation, data collection and the use of technology such as telemedicine.
- Dr Underhill said the Government's regional cancer centres initiative provided an unprecedented opportunity to put the recommendations of the COSA mapping report into practice, by establishing or expanding centres in appropriate sites and working with the jurisdictions to develop a comprehensive plan for the services' sustainability.
- The Border Cancer Collaboration also provided an extraordinary insight into the potential for an appropriately resourced regional cancer centre to significantly improve patient outcomes.
- Facing the challenges of a diverse population mix and spread, cross-border issues (60/40 caseload split between Victoria and NSW) and a fragmented system, the Border Medical Oncology Unit extended its capacity and, through an intergovernmental pilot program, developed better patient support services, care coordination and monitored its impact on local cancer outcomes.
- The results were overwhelmingly positive, with evidence of improved patient outcomes and experience, the establishment of care coordination, the successful trialing of non-nursing care coordinators and participation in clinical trials.
- Dr Underhill suggested the success of the Border Cancer Collaboration could serve as a prototype for a model of support services, and care coordination, and platform for research and clinical service development for the regional cancer centres to now be funded by the Commonwealth.



## Regional oncologist perspective

### Presentation 12 – ‘Regional cancer centres of excellence’

Dr Adam Boyce

The current chair of COSA’s regional oncology group and a Lismore-based medical oncologist, Dr Boyce presented on the recommendations of how a regional cancer ‘centre of excellence’ would be structured, based on the expert input of COSA’s multidisciplinary membership. Key points include:

- Location should be determined by existing infrastructure and an analysis of population density and future need
- Radiation services are the most capital-intensive component of a cancer centre; their existence should be factored into the prioritisation
- A cost-effectiveness model needs to be developed to determine the minimum caseload to ensure the feasibility and sustainability of a regional cancer centre of excellence
- 12 non-metropolitan areas already have radiotherapy units:
  - Coffs Harbour, Port Macquarie, Wagga, Albury-Wodonga, Ballarat, Bendigo, Geelong, Latrobe Valley, Townsville, Nambour, Toowoomba and Wollongong
- Lismore, Orange, Darwin and Bunbury are under construction or pending
- A pilot site(s) from this list could be used
- Optimal staffing/service provision for a centre should include:
  - Two radiation oncologists
  - Two or more medical oncologists (or one medical oncologist and one haematologist)
  - Radiation therapists, physicists, nursing staff
  - Specialist surgical services and coordination of services to ensure patients with complex cases are referred in a timely manner to centres with higher caseloads
  - Specialist pharmacy services
  - Palliative care (medical and nursing)
  - Psycho-social support, allied health, blood banking etc.
  - Access to clinical trials, links to primary care etc. should also be embedded into the centre

Dr Boyce concluded that ‘Capital expenditure is the first step to providing such a service, but it must be complemented with adequate human resources, across all disciplines, to make these truly centres of excellence rather than just excellent centres’.

## Linkages

### **Presentations 13-15 – linking regional cancer centres to large cities and primary care**

**Professor David Currow, CEO, Cancer Australia**

**Professor Chris Milross, radiation oncologist, Sydney Cancer Centre**

**Professor Robert Thomas, Director, Surgical Oncology, Peter Mac Cancer Centre**

The final three presentations were delivered under the broad heading of ‘improving linkages’, beginning with Professor Currow, who outlined the objectives of Cancer Australia’s CanNET networking initiative and their relevance to the regional cancer centres initiative:

- CanNETs support the jurisdictions in developing knowledge, information and resources on consumer engagement in cancer service delivery and planning
- Under the program seven state or territory-wide pathways and 19 network-wide pathways were developed for a range of different tumour streams, together with key performance indicators and timeliness benchmarks to assist monitoring and evaluation
- Clinical leadership and governance were identified as key success factors for the most successful CanNET projects
- Effective networking had led to measurable improvements in access to radiotherapy and chemotherapy
- further work was required to define minimum caseloads by specific tumour type, if regional multidisciplinary teams were to be established and networked according to need.

Professor Milross expressed similar views about the principles of effective networking across metropolitan, regional and outer regional settings, and opportunities for the regional cancer centres initiative to address longstanding systemic problems:

- The connotation that ‘hub and spoke’ reflects an inferior distant service should be avoided; shared ownership of the service and responsibility for its outcomes, irrespective of locations, were the keys, and these needed to be embedded into the system
- The availability of genuine multidisciplinary care should underpin the development of centres and networks
- Historically, once radiotherapy had been introduced, patients assumed the full suite of services and care would also be available. The expansion of regional cancer centres where radiotherapy is already in place could help meet those expectations
- The tradition of random fly-in/fly-out specialist service visits can now be replaced by a better coordinated, systematic approach built around service expansion and improved networking – both of which could be supported through capital grants
- The centres will only meet their potential if the other part of the equation – patient travel and accommodation assistance – is markedly improved.

Professor Thomas provided an overview of how the Victorian cancer system, in working to reduce geographical disparities in treatment outcomes, faced a number of challenges and had reached a number of conclusions including:

- Integrated cancer services can be effective in delivering on the cancer reform agenda
- Clinical leadership is essential and not easy to engage
- The federal/state integration of services is important
- Recognition and support of the existing regional cancer centres is important
- There are potential difficulties with stand-alone 'professional empires'
- That a Service capability framework is important
- That networking is a better process than 'hub and spoke'.

Consistent with Professor Milross's presentation, Professor Thomas concluded that the notion of 'hub-and-spoke' should be replaced with a model that assigns equal responsibility for patient outcomes to both the metropolitan cancer centre and its networked regional service.

## Discussion

### Key issues explored

After the background was provided and the scene set by the structured presentations, Cancer Council Australia CEO, Professor Olver, facilitated a question-and-answer and group discussion. Workshop attendees were organised into five groups encompassing a diversity of skills and experience and asked to explore:

- ideal models for regional cancer equity and access in a high-population state;
- ideal models for regional cancer equity and access in a low-population state;
- core principles to guide the location of the 10 centres;
- ideal models for aligning the centres with existing services (including primary care) and to engage with the jurisdictions; and
- how far the definition of capital works could apply to the complex needs of a regional cancer centre

A high level of interaction characterised the ensuing discussion, which generated the recommended core principles and key enablers listed on pages 4-7 of this report.

The meeting then closed with informal presentations from consumer advocates Dr Ian Roos and John Stubbs, helping to ensure that the perspective of the patient resonated as proceedings were finalised.

## Ways forward

COSA and Cancer Council Australia will continue to promote these independent recommendations as the consultation process for development of the Government's regional cancer centre funding criteria and subsequent grants assessment process roll out.

The organisations will further promote their capacity to provide independent advice on the development of regional cancer centres and to use their national networks where appropriate to support the implementation of the initiative. COSA and Cancer Council Australia will also liaise with state/territory governments and jurisdictional allies to contribute where appropriate to the development of optimal operational capacity; appropriate staffing will be critical.

COSA will seek broader formal representation of its membership on any government and inter-sectoral bodies involved in the grants approvals and allocations process and will engage further with government to this effect, to help ensure that the independent clinician views articulated in this report are built into the regional cancer centres initiative.

<b>ATTENDANCE LIST</b>	
<b>Ms Sharon Appleyard</b>	Assistant Secretary, Rural Health Services & Policy Branch
<b>Dr Adam Boyce</b>	Medical Oncologist, Oncology North Coast, Lismore
<b>Ms Rhonda Coleman</b>	Project Director Cancer Redevelopment WA Health
<b>Ms Kristen Connell</b>	Director of Service Development, ACT Health
<b>Ms Cathryn Cox</b>	Manager Statewide Services, NSW Health
<b>Mr Raoul Craemer</b>	Senior Consultant , ACIL Tasman
<b>Prof David Curren</b>	CEO Cancer Australia
<b>Ms Elise Davies</b>	Manager, Cancer Coordination Unit, DHS, Vic
<b>Prof Graham Giles</b>	Cancer Control Research Institute , CCVic
<b>Prof David Goldstein</b>	Oncology Department, Prince of Wales Hospital,NSW
<b>Mr Paul Grogan</b>	Director Advocacy, CCA
<b>Prof Ian Hammond</b>	Director, WA Cancer & Pall. Care Network, WA
<b>Ms Georgie Harman</b>	A/g Secretary, Mental Health & Chronic Disease Div. DoHA.
<b>Dr Henry Hicks</b>	Oncology Surgeon, Wagga Wagga
<b>Ms Rosemary Huxtable</b>	First Assistant Secretary, Department of Health & Aging
<b>Ms Victoria Jones</b>	Project Coordinator, Queanbeyan, NSW
<b>Ms Emily Karahalios</b>	Cancer Control Research Institute , Cancer Council Vic
<b>Dr Liz Kenny</b>	Director Radiation Oncology ,Royal Brisbane Hospital
<b>Ms Rosemary Knight</b>	Assistant Secretary, Population Health, DoHA
<b>Prof Bogda Koczwara</b>	Director Medical Oncologist , Adelaide Cancer Centre
<b>Prof Ray Lowenthal</b>	Director Medical Oncology, Tasmania
<b>Mr Abel MacDonald</b>	Director Radiation Oncology, DoHA.
<b>Dr Bill Mackie</b>	Surgeon, Orange, NSW
<b>Prof Bruce Mann</b>	COSA President
<b>Prof Chris Milross</b>	Medical Oncologist, Sydney Cancer Centre, RPAH

<b>ATTENDANCE LIST</b>	
<b>Dr Tony Noun</b>	Group Managing Director, Cancer Care Assoc. Riverina
<b>Ms Sinead O'Brien</b>	Deputy Executive Director, Statewide Service Strategy, SA
<b>Ms Maureen O'Connor</b>	Principle Project Officer, Cancer Control Team, Qld
<b>Prof Ian Olver</b>	Chief Executive Officer CCA
<b>Ms Gabrielle Prest</b>	Director of Professional Services, President CNSA
<b>Dr Ian Roos</b>	Consumer Advocate, VIC
<b>Prof Christobel Saunders</b>	Director of Service Development, WA
<b>Dr Tom Shakespeare</b>	Radiation Oncologist, Coffs Harbour, NSW
<b>Ms Sue Sinclair</b>	Director Cancer Services and Education, CI, NSW
<b>Ms Helen Snodgrass</b>	Support Officer ,Leukaemia Foundation, Orange
<b>Prof Robin Stuart-Harris</b>	Director, Capital Regional Cancer Services ACT
<b>Mr John Stubbs</b>	Executive Officer, Cancer Voices
<b>Ms Meredith Taylor</b>	Department of Health & Ageing, DoHA
<b>Prof Robert Thomas</b>	Director of Surgical Oncology , Peter Mac Centre, VIC
<b>Mr Owen Torpy</b>	Policy Advisor, Office of Nicola Roxon, DoHA
<b>Dr Craig Underhill</b>	Medical Oncologist, Border Oncology, Wodonga
<b>Prof Euan Walpole</b>	Medical Director - Cancer Services, Princess Alexandra Hospital/Southern Area Health Service, Qld
<b>Ms Marianne Warren</b>	Consumer Advocate, Wodonga, VIC
<b>Dr Craig White</b>	Chief Health Officer, DOH Tasmania
<b>Prof Patsy Yates</b>	Director of Research, School of Nursing QUT, Qld