

# A Clinical Service Framework for Optimising Cancer Care in NSW

Executive

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## Introduction

Cancer is the second most common cause of disease burden in males and females after cardiovascular diseases, accounting for just under one-fifth of years of healthy life lost due to premature death, disease and injury.

In NSW services for the management of cancer are delivered by public, private and community organisations functioning in a range of settings including hospitals, doctors' rooms, general practices, community health centres and the home environment. Within the current system, there is often insufficient linkage between these service providers, which compromises coordination, continuity, convenience and cost-effectiveness of patient care. It is acknowledged that service provision for people with cancer needs to be improved to ensure that a consistent and high standard of cancer care and evidence-based best practice is available to all NSW residents regardless of geographical, socio-economic or cultural considerations.

The Optimising Cancer Management (OCM) Initiative in NSW provided a starting point for a recommendation of the Cancer Expert Advisory Group in 1995: *To provide optimal cancer management for all patients requiring care.* Significant progress has been made in meeting many of the goals set by the OCM Initiative.

## NSW Chronic Care Program

The global increase in prevalence of chronic and complex diseases such as cancer, heart disease, chronic obstructive pulmonary disease and asthma, present a major challenge in terms of reconfiguring the way health services are currently delivered in favour of a more integrated and coordinated approach across the continuum of care.

The Chronic and Complex Care Implementation and Coordination Group (CCCICG) was established under the NSW Government's Action Plan for Health to address the challenges presented by the increasing prevalence of chronic and complex diseases. The NSW Chronic Care Program overseen by the CCCICG has three broad aims: to improve the quality of life of people with chronic and complex conditions; to improve the quality of life of their carers and families; and to reduce the number of crisis situations and avoidable admissions to Emergency Departments and hospital.

Evidence-based best practice strategies and recommendations have been identified by the CCCICG, in conjunction with the Clinical Expert Reference Groups, as the interventions that will best contribute to the prevention of chronic disease and the way in which care is provided for people with chronic illness. These include statewide clinical service frameworks, a personal health record known as *My Health Record*, and 24-hour points of contact for all patients.

## A Clinical Service Framework for Optimising Cancer Care

A *Clinical Service Framework for Optimising Cancer Care in NSW* sits between the Optimising Cancer Management Initiative and the NSW Chronic and Complex Care Program, and draws together evidence and clinical expertise to describe a framework for the practical management of patients with cancer.

The framework’s goal is to assist Area Health Services and clinicians in optimising cancer care by:

- setting standards of care, both clinical and organisational, for managing patients with cancer
- describing the optimal structure of a cancer service that will ensure equitable access to best practice care for all
- establishing initial milestones, goals and performance indicators against which progress within agreed timeframes can be measured
- identifying practical tools to support implementation and monitor progress.

The standards for cancer care in this framework have been developed following extensive consultation, to facilitate consistency and best practice in the management of people with cancer. These standards are based on a generic cancer services approach rather than dealing with aspects of the clinical management of site-specific cancers.

The seven areas in which standards have been developed are:

1. Implementation, monitoring and review of standards of cancer care in NSW
2. An Area-wide approach to optimising cancer care
3. Patient-centred care
4. Access to appropriate clinical services
5. Multi-disciplinary care
6. Communication between primary, secondary and tertiary services
7. Education, training and continuing professional development

The key objectives of this framework include:

- the establishment of formal and effective management groups for cancer services in each Area Health Service, with clear leadership, membership and scope of activities (Standard 2)

- the establishment of specific initiatives that promote patient-centred care, including provision of information packs and personal health records, development of a consent form, and use of care coordinators for appropriate patients (Standard 3)
- the establishment of a multi-disciplinary care approach and development of Area-wide site-specific clinical groups and multi-disciplinary teams (Standards 4 and 5)
- the establishment of waiting time limits and regular waiting time monitoring (Standard 4)
- the encouragement and facilitation of involvement of general practitioners at all relevant stages of care (Standard 6)
- the promotion of continuing professional development for all clinical and non-clinical members of the cancer workforce (Standard 7).

## Rural issues

It is recognised that rural Areas face specific challenges as a result of geography and resources, with issues such as transport, patient support, workforce planning, training and networks being of particular concern. It is intended that the framework should allow for some variation in the strategies employed by Areas in achieving the standards set depending on their different circumstances and requirements, while at the same time ensuring that standards of care are improved across NSW. The framework also allows for variation in the configuration and operation of organisational and clinical management groups for cancer services for rural Areas.

The following table provides a summary of the framework’s seven standards, and the requirements and timeframes for demonstration of compliance with these standards. The term ‘Area Cancer Service’ in the table refers to a formally constituted organisational structure, established by the Area Health Service, comprising the services that are provided specifically for cancer across the cancer continuum from population health to palliation within the Area Health Service, organised and managed on an Area-wide basis, under the directorship of the Area Director or Coordinator of Cancer Services with the assistance of the Area Cancer Service Management Group. Definitions of other key terms in the table are included in a glossary in the main framework document.

## Summary of the framework’s seven standards

Std	Demonstration of compliance	Responsibility
<b>1. Implementation, monitoring and review of standards for cancer care in NSW</b>		
1.1	Publication of Standards (by Jun 2003).	NSW Health/CCERG
1.2	Establishment of mechanisms for support of the standards, monitoring of compliance, and review (from Jun 2003).	NSW Health/CCERG
1.3	Participation in ongoing formal assessment of progress with implementation (from Jun 2003 at regular intervals).	NSW Health/AHS
1.4	Demonstration of compliance with framework’s standards at regular intervals (by Jun 2005 and at regular intervals prior to that).	AHS
<b>2. An Area-wide approach to optimising cancer care</b>		
2.1	Nomination or appointment of an Area director or coordinator of cancer services (by Dec 2003).	AHS
2.2	Membership of Area Cancer Service management group determined (by Jun 2004); clear specification of the scope of services offered by the Area Cancer Service, activities undertaken at specific facilities, arrangements for onwards referral for appropriate cases, and monthly monitoring of staffing profile (by Jun 2004).	AHS
2.3	Documentation of Area Cancer Service management structure, including clearly defined authorities (by Dec 2003).	AHS
2.4	Demonstrated use of Area’s cancer profile in Area cancer prevention and treatment activities (by Jun 2004).	ACS
2.5	Policies and mechanisms developed to ensure quality management strategies, minimum data set collection, research and education are planned and, where appropriate, are undertaken on an Area-wide basis (by Dec 2004).	ACS
2.6	Formalised structures in place for operation of Area-wide site-specific clinical groups ( <i>recognising that rural Areas may need to develop different structures and modes of operation for such groups to reflect particular geographic, staffing or other factors</i> ) and development of an Area Cancer Directory (by Jun 2004).	ACS
2.7	Appointment of lead clinicians responsible for co-ordinating each Area-wide site-specific clinical group (by Jun 2004).	AHS
<b>3. Patient-centred care</b>		
3.1	Information pack offered to all new cancer patients at diagnosis or before definitive treatment begins; and access to resource facilities in a variety of formats for patients, relatives and GPs (by Dec 2003); development of a checklist of information provided, to be signed by the patient and filed in the patient’s medical record.	ACS/AHS
3.2	Local protocols/guidelines in place which define degree of co-ordination support required for individual individual patients (by Jun 2004); an appropriate number of care coordinators are available for those cancer patients treated in the Area with specialised coordination needs, and protocols are in place for those needing specialised coordination of care who are primarily treated in another Area (by Dec 2004).	AHS
3.3	Development of facility-specific strategies to deal with logistical problems for patients in attending for treatment (by Jun 2004).	AHS
3.4	Establishment of mechanisms for the routine assessment of patients’ psychosocial well-being (by Dec 2004).	AHS
<b>4. Access to appropriate clinical services</b>		
4.1	Development of formal inter- and intra-Area linkages and collaborations with appropriate facilities and providers to ensure access to the full range of cancer services required (by Jun 2004).	AHS
4.2	Arrangements in place for after-hours support and points of contact (by Dec 2003).	ACS
4.3	Monthly monitoring of specified waiting times (by Jun 2004).	ACS
4.4	Development of priority categories within waiting time parameters to identify and manage more urgent cases appropriately (by Jun 2004).	ACS
4.5	Where services do not comply with the waiting time limits specified, written protocols are in place to ensure patients can gain access to services that meet Standards (by Dec 2004).	ACS
4.6	Protocols and strategies are in place to ensure access to appropriate rehabilitation services (by Dec 2004).	AHS
4.7	Protocols and strategies in place to ensure access to specialist palliative care services for patients with advanced cancer (by Jun 2004).	ACS
4.8	Documentation of patient participation in and accrual to trials approved by <i>Cancer Trials NSW</i> and to other clinical trials (by Jun 2005).	ACS

## Summary of the framework’s seven standards (continued)

Std	Demonstration of compliance	Responsibility
<b>5. Multi-disciplinary care</b>		
5.1	Documented procedures for development and operation of a multi-disciplinary approach for cancer (by Dec 2004).	ACS
5.2	Systems are in place across the Area to ensure all patients have access to multi-disciplinary care (by Dec 2004).	AHS
5.3	Records kept of number of patients discussed at Multi-Disciplinary Team (MDT) meetings, number of patients discussed at MDT meetings as a proportion of patients treated for that condition in the Area (by Jun 2004), and proportion of patients managed according to agreed protocols and guidelines (by Dec 2004).	MDTs/ AWCG
5.4	Establishment of appropriate referral guidelines or other formal linkages for common cancer sites where MDTs have not been established (by Dec 2004).	AHS
<b>6. Communication between primary, secondary and tertiary services</b>		
6.1	Personal health records offered to all cancer patients whose co-ordination support requirements are deemed to be complex (by Dec 2003 and ongoing); development and distribution of an Area Directory of Cancer Services (by Jun 2004); development of local protocols/guidelines defining what degree of coordination support is required for individual patients; one care coordinator position available for every 100 cancer patients needing specialised coordination of care (by Dec 2004).	ACS/ AHS
6.2	General practitioners contacted within 24 hours of admission and discharge for every cancer inpatient, and discharge summary given to patient (by Dec 2003); implementation of mechanisms to facilitate ongoing involvement of GPs while patients are in hospital (by Dec 2004)	ACS/Local Divisions of GP
<b>7. Education, training and continuing professional development</b>		
7.1/ 7.2	Monitoring of cancer workforce participation in training and continuing professional development (by Jun 2005)	ACS

**Legend** CCERG – Cancer Clinical Expert Reference Group; ACS – Area Cancer Services; AHS – Area Health Services; MDT – Multi-Disciplinary Team; AWCG – Area-wide Clinical Group

## Implementation and evaluation

The framework establishes foundation standards for a sound cancer service. These foundation standards are judged to be sufficiently important to recommend overall compliance by June 2005. It is intended that the development of standards that build upon these foundation standards beyond June 2005 will be undertaken by the NSW Health Clinical Expert Reference Group with the Area Directors of Cancer Services.

Regular evaluation of progress with implementation will occur using a standardised reporting proforma. Successful implementation of the framework is dependent on the active involvement and commitment of all parties including NSW Health, Area Health Services, clinicians and other health care professionals, patients and carers.

At a local level, key steps in effective implementation include:

- identifying key stakeholders
- establishing a local implementation team with explicit accountability arrangements
- maintaining effective clinical governance through the Area Quality Council
- developing agreed protocols and implementation strategies
- professional up-skilling and education programs designed to support change
- developing effective communication across the acute care, primary care and community health sectors
- effective ongoing collaboration with the Divisions of General Practice
- reporting strategies focusing on reviewing local performance data and identifying local priorities
- a scientific approach to continuous improvement.

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