



"Better Health and Independence"

***Whanganui District Health Board
Local Cancer Control Action Plan***

2007 - 2012

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Overview

The purpose for developing this Local Cancer Control Action Plan is to guide planning, funding and development of cancer services for the Whanganui District Health Board over the next three years. The Local Cancer Control Action Plan will also support Whanganui District Health Board to effectively participate in the development and implementation of regional cancer networks and the implementation of the Central Region Cancer Control Plan 2006.

The New Zealand Cancer Control Strategy requires that all district health boards develop methods locally to achieve the objective of 'reducing the incidence and impact of cancer'.

How we developed this plan

The development of the Whanganui District Health Board's Local Cancer Control Action Plan has been project lead by Whakauae Research Services in consultation with an advisory group made up of key stakeholders and additional information and opinion sort from a wide range of local and regional service providers, clinical people, Iwi health providers and Non Government Organisations. A discussion document / report was developed and provided to the District Health Board Community and Public Health Advisory Committee for discussion. This report was used as a basis for the development of this action plan.

The District Health Board acknowledges the contribution of Whakauae Research Services, the advisory group and key stakeholders to the report and to the successful development of this action plan.

Interviews with stakeholders and discussions with the advisory group identified a number of key issues outlined as follows:

- the recruitment and retention of a skilled workforce is difficult;
- access across the continuum needs improving, particularly as the most vulnerable tend to have the poorest access;
- increasing investment in public health and health promotion, priority areas include tobacco control, nutrition and activity is required;
- communication both between service providers and to the patient needs to be improved;
- travel policies and cost of travel is a barrier to access;
- effective partnerships need to be built up;
- there is a lack of cancer leadership in the Whanganui area.

The issues, key strategies and recommendations identified by the stakeholder group and the wider consultation have been integral to informing the development of the objectives and work streams of this plan.

Service providers

A stock take of service providers was undertaken as part of the development of this plan and included in the discussion document/report. The stock take indicated that there are a variety of service providers and community groups providing cancer services. These services include primary prevention and health promotion; screening and early detection, diagnosis and treatment, support and rehabilitation, palliative care and research.

The Cancer Burden and Demographic Profile

Generally, Whanganui has comparable cancer registration rates to the rest of the country. Whanganui, like most areas in New Zealand, shows an increase in cancer mortalities with an increase in deprivation. Māori experience higher cancer mortality rates per 10,000 people than non-Māori, indicating an inequality between Māori and non-Māori populations. Proportionally, more people die from cancer in Whanganui than in the rest of New Zealand.

Colorectal cancer is the top cause of cancer mortality in the district. This differs from the national figures, where colorectal cancer is ranked as the third highest cause of cancer mortality. Whanganui has higher than national mortality rates for lung and breast cancer for Māori.

Across district health boards in New Zealand, Whanganui has the sixth largest Māori population. Whanganui has a high proportion of people living at deprivation decile ten, creating a higher risk of cancer registrations and mortality, as well as inequalities in health outcomes across the district. Whanganui has a higher percentage of older people (65+) than other areas in New Zealand, and this group is more likely to be affected by cancer.

Further information related to the cancer burden and demographic profile of the Whanganui district is included in information section one and two respectively.

Approach to the implementation of the plan

The approach taken in this cancer control action plan is: realistic, achievable, measurable, patient/whānau-centered and has consumer involvement. If implemented effectively it has the ability to address similar issues across disease states and across a range of other health services.

The work streams identified in the plan will be identified as actions in each District Annual Plan over the next three year period, and progress related to the implementation of the plan reported to the board committees and Hauora a iwi regularly.

The plan has taken cognition of the Ministry of Health's Cancer Control Action Plan 2003, and Cancer Control Action Plan 2005-2010, Palliative Care Strategy 2001, the Central Region's Cancer Control Plan 2006 and the Whanganui District Health Board's own District Strategic Plan for the region, which sets a new path and direction for the Board, particularly in relation to increasing its focus on population health and the outcomes of services it funds and provides.

The measurement of success will be based on the following imperatives:

- The achievement of the Cancer Control Action Plan 2006
- The achievement of the District Strategic Plan 2005-2010
- The achievement of the Central Region Cancer Control Action Plan.

1.0 Vision, Objectives and Work streams of the Local Cancer Control Action Plan

VISION

The vision of the Local Cancer Control Action Plan is that cancer services will be delivered through:

'A Patient Focused Continuum of Care and Effective Networks and Relationships' – inter-sectoral, inter-regional, inter-disciplinary, across organisations and within levels of organisations related to cancer control

Objective One : Provide leadership to improve and develop local services

Leadership has emerged as an area of development. There is a gap in clinical leadership to guide further development of cancer control in the Whanganui district. To improve this situation we need to support, guide and encourage those identified as having leadership potential. A system to support the champions across the continuum will need to be explored further. It is important to foster the leadership, which is different to fostering management. Leadership to guide services currently available in Whanganui will help those services to operate efficiently and effectively. Clinical leadership should include both medical and Nursing specialist and generalist representation.

With a small population and limited resources, the key priority for Whanganui will be to work in with the Central Region Cancer Network and the Regional Cancer Treatment Advisory Group.

The Regional Cancer Treatment Advisory Group is currently developing multi disciplinary teams to address specific cancer types. This will be an opportunity to share knowledge and also provides an excellent training and mentorship situation. Participation in regional networks will provide us with an opportunity to reduce the impact of cancer through the use of formal relationships and to foster our own local leadership.

The Central Region Cancer Network Plan 2006 provides clear and useful guidance on how district health boards may participate in the network.

As part of developing leadership and encouraging integration it is essential to share knowledge and information. Currently there is no formal local mechanism for shared decision-making or widely communicating decisions regarding cancer control and treatment at a local, regional and national level.

Work stream

- Demonstrate consistent participation and leadership in the areas of the Regional Cancer Treatment Advisory Group, Central Region Cancer Network and the Regional Cancer Network;
- The district health board will effectively participate in the regional network;
- Develop a feedback mechanism for conveying information across the district health board region including a mechanism for conveying shared decision making across sectors on behalf of the Whanganui cancer continuum.

Investment Pathway

The assumption is this plan will be implemented within current funding arrangements not withstanding additional funding from the government. Some initiatives do not require funding and can be progressed and particular focus will be on integrated approaches.

Objective Two : Strengthen the role of primary health care in cancer control

Primary health care has a significant role in cancer control, as with all other chronic disease state groups. It is primary health care that the patient continuously consults and seeks support from during their journey through the continuum. The potential of primary health care has been greatly under-

utilised to this point. As a result, primary clinicians are often ill prepared to communicate the complexities of cancer care to their diverse patient populations (Mandelblatt, Yabroff & Kerner, 2000).

There is a role for the general practice team in managing ongoing aspects of cancer and this role could be explored as part of the development of the cancer continuum described above. An enhanced role for primary health care also should include extending the palliative care approach to accommodate a more integrated approach including; hospices, primary health care services, whānau and communities, and Iwi /Māori health providers.

Single points of entry and improved information and communication systems and processes into local and regional specialised services will be critical to support primary health care development and foster relationships across the sector and continuum.

Access to early diagnosis is a key to reducing inequalities and improving health outcomes for the whole population.

Work stream

- Explore options for removing primary health care barriers to access to diagnostic procedures / screening;
- Implementation of medical and Nursing General Practice Team training and support that will identify a scope of practice for generic palliative care services that will interface with specialist palliative care services;
- Increase opportunities to reduce cost as a barrier to access to primary care services for cancer patients and their families, such as Care Plus programmes;
- Include the role of the primary general practice team in the development of the cancer continuum

Objective Three: Establishment of a Patient Focused Continuum of Care

A continuum of care and integration of services is about “providing the right treatment in the right place at the right time to support the patients’ journey”. For a paradigm shift to occur, service development must be centred around the needs of the patient and their whānau/family.

Other countries around the world have long recognised that cancer is a major cause of morbidity and mortality and have developed strategies to address aspects of cancer care across the cancer continuum. Recurring themes from the literature are:

- the utilisation of a multidisciplinary approach;
- infrastructure and workforce;
- patient focused;
- safe and high quality care;
- supportive/psychosocial care;
- care coordination.

Multidisciplinary care

The cornerstone of best practice in cancer care is multidisciplinary treatment planning and multidisciplinary care. An effective multidisciplinary approach can result in survival benefit, increased recruitment into clinical trials, detection of emotional needs of patients, reduction in service duplication and improved coordination of services.

Infrastructure and workforce

Improved communication between all providers and effective information systems that will support information sharing, analysis and evaluation of service outcomes, systems and processes. Workforce capacity and capability is essential to achieve the best outcomes for patients across the continuum.

Patient/whānau-centred care – informed and involved

Patients should be involved as active participants in care planning and decision making, and wherever appropriate so should their partners, families and carers. Ultimately, any treatment decision rests with

the patient or designated person. This requires information and discussion presented in a way that is easily understood, and sensitive to cultural needs.

There is a need to strengthen the response of vulnerable consumers to services – teaching and encouraging assertive response to getting treatments and having a strong focus on actively supporting self management approaches to care. This may require a culture change for some health professionals and will require strong leadership and drive to ensure that change occurs.

Safe and high quality care

Cancer care is complex, involving a range of clinicians with different expertise. To ensure safe and high quality cancer care, it is important that clinicians providing care across the continuum have the technical skills and experience to carry out those aspects of cancer care they undertake and that there is institutional capacity to support such care, such as equipment, staffing and skill mix including consistent clinical guidelines and practices.

Supportive care

People with cancer have psychological and social needs that are frequently undetected and unmet. This has the potential to result in long term distress. In the context of cancer, supportive care describes all services that may be required to support people with cancer and their carers to meet their physical, psychological, social, information and spiritual needs.

Care coordination

The cancer journey is complex and challenging, and it is not uncommon for patients to be seen by many health professionals within and across multiple health services and across different sectors. To ensure patients experience care that is coordinated and integrated over time and settings, services need to consider the range of strategies required to facilitate care coordination. Better co-ordination of services across the cancer continuum will result in a smoother ride for patients.

There are many similarities in the management of different cancers. Early detection and accurate diagnosis are crucial to the effective treatment of most cancers. Other priority areas for the cancer continuum are palliative care, psychosocial care and the need to increase the patient and their whānau/ families involvement in all stages of their journey.

A focus on the wider determinants of health will identify opportunities to incorporate non-health sectors such as local government, ministry of social development and education in health promotion and community awareness programmes and support services for patients who as a result of cancer treatment are unable to maintain their income.

Work streams

Identify the components of a continuum of care for cancer services and implement the continuum in line with the Chronic Disease Prevention and Management Framework:

- Map and analyse cancer patients' journeys and clinical pathways to inform the development of a cancer continuum;
- Development of leadership that will ensure that health professionals actively encourage self management strategies for consumers and their families through empowerment, education and support.
- Review options and service models to establish patient co-ordination activity to ensure a smoother pathway for patients/whānau and enhanced collaboration between cancer services including improved co-ordination and advocacy services at a secondary service level;
- Ensure models of care recognise the importance of whānau in recovery and the interface between culture and clinical practices;
- Review the current travel policy to reduce the financial cost of travel for patients as a barrier to accessing services;
- Work in collaboration with intersectoral agencies that can assist / support the delivery of cancer services including social services, community education and support, education and skill development options for patients and their whānau/families;

- Development of a primary care led, single point assessment and care coordination service that includes cancer and palliative care services;
- Work with the public health directorate to review and identify options for increasing investment in public health and health promotion, priority areas include tobacco control, nutrition and activity;
- Identify collaborative working relationships that will improve access for Māori whānau to palliative care support; and improved co-ordination between primary health care, iwi providers and hospice;
- When reviewing a co-ordination role for cancer services ensure that Māori cancer patients are assisted with access across the cancer continuum – explore effective models in other areas;
- Explore the opportunities to introduce a palliative care partnership between primary care and palliative care specialists to implement the Liverpool Care of the Dying Pathway to consider options to implement the Liverpool Care of the Dying Pathway, this pathway is based on international best practices and has been developed to transfer the hospice model of care into other care settings;
- Ensure that consumers are able to provide advice that will influence planning, purchasing and delivery of service;
- Identify workforce capacity and capability to provide services across the cancer continuum and introduce a planned approach to workforce development;
- Capacity planning begins by forecasting the demands and converting these requirements into capacity requirements. Such demands include: location of services, deciding how the services will be delivered; facilities required; growth in technology; and workforce required. A workstream as part of the development of the cancer continuum;
- Identify and ensure that Māori-led initiatives are highlighted and positioned as models of good practice and innovation;
- Monitor and evaluate services and service outcomes.

Objective Four : Cancer Services Responsive to Māori

There is considerable evidence of health inequalities amongst the diverse communities in New Zealand. Overall Māori are 18% more likely to be diagnosed with cancer than non-Māori, but nearly twice as likely as non-Māori to die from cancer (Ministry of Health, 2005).

The district health board's commitment to reducing inequalities requires us to focus on what can be done to improve the relative health status of those in target groups.

Models of practise must recognise the importance of whanau in recovery and the interface between culture and clinical practices. The district health board Huarahi Oranga , Māori Health Strategy 2007-2012 identifies whanau ora as the model of care for Kaupapa Māori services and concepts for mainstream services to improve health outcomes for Māori.

Active participation of Māori is critical. Without this Māori cancer outcomes may not be improved.

This plan recognises that Whanau, Iwi and Māori communities must be supported to achieve their own aims and aspirations for whanau ora in relation to all health including cancer.

Work streams

- Ensure Hauora a Iwi, and the Iwi provider forum have the capacity required to lead and participate in the development and support of cancer services for Māori;
- Strengthen the Whānau Ora service model and purchasing strategies to include coordination, advocacy and support for whanau diagnosed with cancer and their movement through the cancer continuum;
- Monitor and evaluate the effectiveness of different culturally-derived health care practices and the delivery of services to ensure improved health outcomes for Māori in relation to cancer;
- Support for Māori health workforce and provider development;

- Develop a model for 'holistic' needs assessment and service coordination that includes family/whanau;
- Note and address gaps in current service provision, improving access for Māori and those in high decile and rural areas, to address inequalities;
- Strengthen mainstream services to deliver services to Māori in line with whanau ora concepts.

Objective Five : Increase access to screening services for priority populations

Across the region, demand for screening is greater than provision resulting in access issues for many communities. Ensuring all reasonable screening and diagnostic resources are available in the right place supported by population numbers requires careful planning. Potential solutions are complex and need to be made within the context of the wider region. Increasing screening for priority populations will reduce inequality in access.

General themes identified in the region from the consultation process are that the inclusion of General Practice teams during the process of detection and screening is essential. This includes improving communication methods and timely transfer of information. The other key issue is the poor uptake of screening for particular population groups resulting in inequalities in access.

Continuing to monitor the effectiveness of services, particularly for priority populations will lead to solutions that will ensure timely and effective services for the whole population.

Work stream

- Explore options for low cost cervical screening including opportunity for primary health organisations to prioritise free cervical screening as a service to improve access initiative and other service options at no cost to the individual;
- Review service models that are achieving increased screening uptake with the view of introducing different approaches to achieve better results in the Whanganui area;
- Monitor timely, effective and coherent transfer from screening to treatment;
- Work to ensure improved data collection and sharing for cancer continuums.

Objective Six: Enhance the capacity of existing services

There is a wide disparity with existing providers in their capacity and capability to provide services now and in the future. The capacity and capability for organisations to contribute strategically and clinically will be monitored and supported to ensure there is sustainability and appropriateness of services.

Capacity planning begins by forecasting the demands and converting these requirements into capacity requirements. Such demands include: location of services, deciding how the services will be delivered; facilities required; growth in technology; and workforce required.

The first step in moving towards this framework is to build and maintain a regional stock take of organisations and services involved in delivering care or support across the continuum. This can be achieved by building on the current service stock take completed in the development of this plan.

Work Stream

- The Whanganui District Health Board is to effectively participate in the regional network;
- Introduce a palliative care partnership between primary care and palliative care specialists to implement the Liverpool Care of the Dying Pathway;
- Whanganui District Health Board is to review options for strengthening the Whānau Ora model of care.

2.0 Our Approach to developing the Local Cancer Action Plan

2.1 Purpose

The purpose for developing this Local Cancer Action Plan is to guide planning, funding and development of cancer services for the Whanganui District Health Board over the next three years. The Local Cancer Control Action Plan will also support Whanganui District Health Board to effectively participate in the development and implementation of regional cancer networks and the implementation of the Central Region Cancer Control Plan 2006.

The New Zealand Cancer Control Strategy requires that all district health boards develop methods locally to achieve the objective of 'reducing the incidence and impact of cancer'.

Cancer is one of the leading causes of death for middle aged and older people in New Zealand. Yet one third of cancer is preventable and another third is treatable. Māori and low socio-economic communities have disproportionate rates of cancer registrations and mortalities. Reducing the impact and incidence of cancer is an achievable goal that will improve the health of New Zealanders and eliminate inequalities currently extant in the health system.

Cancer Control is a priority area for the government as reflected in:

- The New Zealand Health Strategy 2000
- The New Zealand Disability Strategy 2001
- He Korowai Oranga , Māori Health Strategy 2002 and Whakatātaka Tuarua Māori Health Action plan 2006
- The New Zealand Cancer Control Strategy in 2003
- The New Zealand Cancer Control Strategy Action Plan 2005-2010
- The New Zealand Palliative Care Strategy 2001.

The vision in Whanganui District Health Board's District Strategic Plan 2005-2010 is for "better health and independence". The Health Needs Assessment, on which the strategic plan is based, identifies that the Whanganui region has higher than average levels of deprivation which directly impacts on the physical health and wellbeing of the population. Generally, Whanganui has comparable cancer registration rates to the rest of the country. Whanganui, like most areas in New Zealand, shows an increase in cancer mortalities with an increase in deprivation. Māori experience higher cancer mortality rates per 10,000 people than non-Māori, indicating an inequality between Māori and non-Māori populations.

Implementation of national cancer control strategies and actions fit within Whanganui District Health Board's strategic framework of:

- Improving Health;
- Reducing Inequalities; and
- Promoting Recovery, Wellbeing and Independence.

2.2 The New Zealand Health Strategy 2000

One of the 13 key population health objectives outlined by the Ministry of Health is "to reduce the incidence and impact of cancer" (New Zealand Health Strategy, 2000). In order to effect this the Ministry of Health released The New Zealand Cancer Control Strategy in 2003.

2.3 He Korowai Oranga, The Māori Health Strategy 2002 and Whakatātaka Tuarua Māori Health Action Plan 2006-2011

He Korowai Oranga, the Māori Health Strategy 2002 sets a new direction for Māori health development over ten years, and provides guidance at a strategic level on ways to achieve Māori health improvements and eliminate health inequalities. Following this Whakatātaka, the Māori Health Action Plan 2002-05 was developed to guide implementation of the strategy. In 2006 Whakatātaka Tuarua, the Māori Health Action Plan 2006-2011 was released to guide Māori health action for the

next five years. As part of Whakatātaka Tuarua, the Ministry of Health has identified the following areas for priority attention:

- Building quality data and monitoring Māori health;
- Developing whānau ora-based models;
- Ensuring Māori participation: workforce development and governance;
- Improving primary health care.

2.4 The New Zealand Cancer Control Strategy in 2003

The New Zealand Cancer Control Strategy 2003 provides a high level framework for reducing the incidence and impact of cancer in New Zealand for reducing inequalities with respect to cancer.

There are six key goals in the strategy:

- Reduce the incidence of cancer through primary prevention;
- Ensure effective screening and early detection to reduce cancer morbidity and mortality;
- Improve the quality of life for those with cancer, their family and whānau through support, rehabilitation and palliative care;
- Improve the delivery of services across the continuum of cancer control through effective planning, coordination and integration of resources and activity, monitoring and evaluation;
- Improve the effectiveness of cancer control in New Zealand through research and surveillance.

Cancer control continuum

The New Zealand Cancer Control Strategy describes the cancer control continuum as the basis for a planned, systematic and co-ordinated approach to the range of activities undertaken from reducing the risk of developing cancer, to the care of those who will intimately die from the disease.

The cancer continuum entails:

- Prevention;
- Early detection and cancer screening;
- Diagnosis and treatment;
- Support and rehabilitation;
- Palliative care;
- Research;
- Surveillance.

The district health board will develop its Chronic Disease Prevention and management framework in 2007 .The framework will support the development of a cancer continuum to meet the needs of the population utilising an integration of regional and local services across the cancer networks.

2.5 The New Zealand Cancer Control Strategy Action Plan 2005-2010

Following the development of the national strategy, The New Zealand Cancer Control Strategy Action Plan 2005-2010 was produced. The Action Plan provides a framework for reducing the cancer burden across the country and outlines in detail how the Strategy's objectives can be achieved.

The Action Plan aims to:

- Close existing gaps in services or reduce duplication;
- Ensure greater co-ordination of services being developed;
- Ensure that scarce and finite resources are used efficiently and effectively.

2.6 The New Zealand Palliative Care Strategy 2001

The vision for the provision of palliative care services is that:

- All people who are dying and their family/ whanau who could benefit from palliative care services have timely access to quality palliative care services that are culturally appropriate and are provided in a co-ordinated way.

2.7 Regional Plans and Networks

2.7.1 Central Region Cancer Control Plan 2006

The Central Region Cancer Control Plan was completed for the Ministry of Health in response to a successful request for proposal process to develop a plan for the areas serviced by the MidCentral District Health Board treatment service. This Plan was informed in its development by consultation with district health boards and key stakeholders in the region, the Cancer Society of New Zealand Central Districts Inc and through regional discussions over a number of prior years and planning, primarily via the Regional Cancer Treatment Advisory Group.

The main objective of the regional plan is to form a Central Regional Cancer Network. This network will enable the integration of cancer services across the six district health boards. Communication and planning across services will be improved through the network, reducing inefficiencies and making the patient journey smoother and more satisfactory. It is also envisioned that equity of access to services will be improved through the network.

2.7.2 The Regional Cancer Treatment Advisory Group

Although this group has a treatment focus, it is proposed that this group will be the conduit through which a paradigm shift will be supported to focus on regional collaboration that improves delivery of cancer services across the cancer continuum.

The group is well established and meets regularly disseminating information across the network via a regular newsletter and through meeting minutes.

2.7.3 Central Region Cancer Network

As district health boards are developing their regional plans the Ministry of Health has facilitated national discussions centred on the development of regional cancer networks as a key milestone to the implementation of The New Zealand Cancer Control Strategy Action Plan. This methodology is based on the model of cancer control networks introduced in the United Kingdom, which have resulted in patient journey improvements through regional and local service improvement plans.

The Central Regional Cancer Network proposes to facilitate the paradigm shift from independent district focus to strategic regional planning for services across the cancer continuum. Within the concept that it is not about district health boards or tertiary treatment centres but all organisations that encompass cancer control. It is expected that the network will be involved in strategic and relationship activity and will not have direct control of operational decisions or budget holding for services or assets. Nor will the actions be about expanding services or increasing costs, but about a network that will support service enhancement and maximising opportunities (Central Region Cancer Network Draft Plan, 2006).

2.8 Whanganui District Health Board District Strategic Plan

The Whanganui District Health Board has recently released its District Strategic Plan for 2005–2010. The plan sets a new path and direction for the Board, particularly in relation to increasing its focus on population health and the outcomes of services it funds and provides. The vision is “better health and independence”.

The populations goals contained in the Plan are as follows:

Population Goals

Improving Health

Objectives

- Focus on prevention strategies, health promotion and education.
- Ensure access to appropriate and timely/early intervention to improve health.
- Achieve seamless integrated service delivery and break down barriers, especially across primary and secondary services.

Population Goals

Reducing Inequalities

Promoting recovery, wellbeing & independence

Objectives

- Undertake activities with other agencies (local territorial authorities, community organisations and primary care providers etc) to help improve health.
- Achieve improved health status in target areas.
- Implement He Korowai Oranga through Whakatataka: Māori Health Action Plan.
- Improve Māori health status in target areas.
- Maintain access to services for rural people.
- Reduce avoidable hospital admissions for target groups:
 - older people
 - children
 - Māori and Pacific peoples.
- Reduce affordability/cost as a barrier to accessing services.
- Undertake activities with other agencies (local territorial authorities, community organisations and primary care providers etc) to help reduce inequalities.
- Ensure recovery models/approaches are central all health services and especially Mental Health Services.
- Ensure restoration and independence models/approaches are central to all services and especially disability support services.
- Undertake activities with other agencies (local territorial authorities, community organisations and primary care providers etc) to promote community wellbeing.
- Promote family, whanau, hapu and community wellbeing.

*Other agencies – includes local territorial authorities, community organisations and primary care providers etc.

The district health board Local Cancer Control Action Plan contributes to the achievement of the following key objectives and targets identified in the district health board Strategic Plan 2005-2010:

- Focus on prevention strategies, health promotion and education;
- Ensure access to appropriate and timely/early intervention to improve health;
- Achieve seamless integrated service delivery and break down barriers, especially across primary and secondary services;
- Undertake activities with other agencies (local territorial authorities, community organisations and primary health care providers etc) to help improve health;
- Achieve improved health status in target areas;
- Implement He Korowai Oranga through Whakatātaka: Māori Health Action Plan;
- Achieve improved Māori health status in target areas;
- Reduce affordability/cost as a barrier to accessing services.

Population Health Targets

Target	Description	Measure	Whanganui DHB rates	National rates	Short-term desired outcome/goals (1-4 years) (2006/07-2009/10)
1. Reduction in cancer rates	Youth smoking (Year 10, 15 years) smoking rates	More than monthly smoking	23.3% (2003) (There was a 6% drop between 1999 and 2003)		1% reduction per year
		Never smoked	37.0% (2003) (There was a 5% drop between 1999 and 2003)		1% increase per year
	Lung cancer	Registrations – Total (Standardised rate per 10,000)	3.3 per 10,000 (1997-2000) Average growth trend (1997-2000) = 5.1% per year	3.14 per 10,000 (1997-2000)	≥ 5.1% reduction per year
		Registrations – Maori (Standardised rate per 10,000)	10.8 per 10,000 (1997-2000) Average growth trend (1997-2000) = 3.7% per year	8.06 per 10,000 (1997-2000)	≤ 3.7% growth per year
	Colorectal cancer	Registrations – non-Maori (Standardised rate per 10,000)	6.3 per 10,000 (1997-2000) Average growth trend (1997-2000) = 1.9% per year	5.2 per 10,000 (1997-2000)	≤ 1.9% growth per year
	Melanoma	Mortality non-Maori (Standardised rate per 10,000)	0.81 per 10,000 (1998-2001) Average growth trend (1998-2001) = 3.1% per year	0.69 per 10,000 (1998-2001)	≤ 3.1% growth per year
	Cervical cancer	Screening of at risk and high risk groups (groups to be determined)	Unknown (TBA)	Unknown (TBA)	To be advised
		Mortality (Standardised rate per 10,000)	0.28 per 10,000 (1998-2001) Average growth trend (1998-2001) = 6% per year	0.27 per 10,000 (1998-2001)	≤ 6% growth per year
	Breast cancer	Screening rates (as per PHO performance monitoring indicator)	61.9% ('Coverage rate' at July 2005)		Increase in screening rates ≥ 80% (MoH target)
		Mortality – Maori (Standardised rate per 10,000)	5.9 per 10,000 (1998-2001) Average growth trend (1997-2001) = 10% per year	3.4 per 10,000 (1998-2001)	≤ 10% per year

<u>Target</u>	<u>Description</u>	<u>Measure</u>	<u>Whanganui DHB rates</u>	<u>National rates</u>	<u>Short-term desired outcome/goals (1-4 years) (2006/07-2009/10)</u>
		Screening rates as per PHO performance monitoring indicator (Women 50-64 years)	64% (24 months ending June 2005)	31.1% (24 months ending June 2005)	Increase in screening rates $\geq 70\%$ (MoH target)

2.9 Stakeholder Consultation

This planning document was developed by the Whanganui District Health Board. In order to produce the plan, an advisory group was established that consisted of a range of key stakeholders (refer to information section three).

The local cancer control action plan project leader, Whakauae Research Services, sought information not only from the advisory group but also from General Practitioners, Whanganui District Health Board Public Health Centre, Te Oranganui Iwi Health Authority, Whanganui Regional Primary Health Organisation, Taumata Hauora Trust Primary Health Organisation and the Māori provider network, Whanganui Cancer Society, MidCentral and Hawkes Bay District Health Boards, Arohanui and Whanganui Hospice, consumers, Whanganui District Health Board Planning and Funding staff and Whanganui Hospital and Health Services clinical staff.

Feedback from this process has been very valuable and provided the basis for the development of the vision and objectives of the plan.

The Local Cancer Control Action Plan 2006-2009 will be provided to the Ministry of Health as part of the annual planning process for the District Annual Plan 2007/08.

Information Section One:

The Cancer Burden

Cancer is a major cause of death for middle aged to older people. Overall, cancer mortality is decreasing among non-Māori. This is not the case for Māori, who have increasing rates of mortality from cancer. This discrepancy contributes greatly to the differences in life expectancy among Māori and non-Māori.

Discrepancies in cancer survival rates arise not so much from biological aspects of the disease as from the care the different ethnic groups receive. Māori are often diagnosed at a later stage, reducing chances of recovery, and have less access to protective factors and cancer services. The disparity between Māori and non-Māori cancer survival rates is outlined in depth in *Unequal Impact: Māori and Non-Māori Cancer Statistics*, produced by Te Rōpū Rangahau Hauora a Eru Pōmare, 2006.

The incidence of all adult cancers in New Zealand is expected to increase by 7% in males and 6% in females between 1996 and 2011. Over this same period cancer mortality rates are expected to decline by 20% in males and by 11% in females (MoH 2002).

Whanganui generally has comparable cancer rates to the rest of the country. The number of cancer registrations increased annually at around 6 additional cases per year over the period 1999-2003, but there has been no substantial increase in registrations in the last 3 years (only 1.3%). Māori in Whanganui have a 48% higher registration rate than Māori in the rest of New Zealand, although this is not statistically significant due to low numbers (Whanganui District Health Board, 2005). Whanganui, like most areas in New Zealand, shows an increase in cancer mortalities with an increase in deprivation (Whanganui District Health Board, 2005). Māori experience higher mortality rates per 10,000 people than non-Māori, indicating an inequality between Māori and non-Māori populations (Whanganui District Health Board, 2005). Non-Māori in Whanganui have a concerning rate of colorectal cancer: 21% higher than the national rate (Whanganui District Health Board, 2005).

Proportionally, more people die from cancer in Whanganui than in the rest of New Zealand (Whanganui District Health Board, 2005). Whanganui has higher than national mortality rates for lung and breast cancer for Māori. General trends noted over the last three years include an increase in female trachea, bronchus and lung registrations and continued low rates of prostate cancer in Māori. This may be attributable to low rates of detection rather than low prevalence. Data up to 2003 indicated a lower mortality rate for cervical cancer for Māori women than the national average. Colorectal cancer is the top cause of cancer mortality in the district. This differs from the national figures, where colorectal cancer is ranked as the third highest cause of cancer mortality.

Observations

- **There is a need to focus on actions to reduce inequalities between Māori and non-Māori.**
- **The role of service delivery (such as access issues) in producing and maintaining inequalities needs to be examined.**
- **The Whanganui District Health Board needs to focus on cancer types that disproportionately affect the region, such as colorectal cancer.**
- **We need to focus on earlier detection and access to treatment to rectify higher than national mortality rates for certain cancers.**

Information Section Two

Demographic Profile

The total population living within the Whanganui District Health Board region is 63,600. Within this, 22.2% are Māori, 2% are Pacific Island and 75.8% are non-Māori non-Pacific. This is the sixth largest Māori population of all DHBs in New Zealand. Around 18% of the total population (11805) live in rural areas. Overall, the population in the Whanganui district is projected to decline. By 2011 the population is expected to be around 62,000. Birth rate has also dropped: the number of births has decreased 25% since 1996.

The Whanganui District Health Board area has more older people and fewer younger people than other regions. In comparison with other district health boards Whanganui has the fourth highest number of people in the sixty-five and over age bracket. The proportion of older people in the Whanganui district is projected to increase from 14% in 2001 to 22% in 2021. This is a higher rate of increase than the rest of New Zealand, which is set to increase from 11.9% to 17.6%. Whanganui also has the fourth lowest number of people in the 25-44 year age bracket. An aging population also impacts on resources available in future, both through a drop in earnings and an increased demand for health services.

Life expectancy in Whanganui is low. Currently it is 1.2 years below the national average for both men and women. Māori women in Whanganui have a life expectancy of 10.4 years less than the national average of 80.5 years. It is little better for Māori men, who are expected to live for 9.9 years less than the national average of 75.2 years.

The proportion of population living in decile 10 in Whanganui District Health Board is twice the national average. This high proportion has implications for access to healthcare. Families with low incomes often experience difficulty in affording healthcare and may miss out on the early detection and prevention of cancer.

Observations

- **Whanganui has a high proportion of people living at deprivation decile 10 (twice the national average). This has implications for health access and outcomes.**
- **Whanganui has the sixth largest Māori population of DHBs in New Zealand, creating a higher risk of cancer registrations and mortality and inequalities in health outcomes across the district.**
- **Whanganui has a higher percentage of older people (65+) than other areas in New Zealand. Registrations will be higher for Whanganui as those in older age groups are more likely to be affected by cancer.**
- **Whanganui's aging population will impact on resources available in future.**

Information Section Three:

Stakeholders consulted in the development of the plan

Advisory Group

Rowena Kui	Whanganui District Health Board
Karen Veldhoen	Whanganui Regional Primary Health Organisation
Lauren Tamehana	Whanganui District Health Board
Lynley Cvitanovic	Whanganui District Health Board
Sue Stuart	Cancer Society
Pat Morrow	Cancer Society
Lovey Ratima	Te Oranganui Iwi Health Authority
Alan Millar	Whakauae Research Services
Tom Joll	Hospice Wanganui
Sharlene Tapa-Mosen	Te Oranganui Iwi Health Authority
Ali Hamlin	Manawatu Wanganui Cervical Screening Regional Programme

Stakeholders interviewed regarding the plan

Beryl Honeybone	Whanganui District Health Board
Carmel Hurdle	Whanganui District Health Board
Charis O'Neil	Whanganui District Health Board
Marg McDonnell	Whanganui District Health Board
Warren Jackson	Whanganui District Health Board
Peter Wood-Bodley	Whanganui District Health Board
Sue Capenhurst	Whanganui District Health Board
Ali Hamlin	Mid-Central Health
Ann Shaw	Mid-Central Health
Brad Grimmer	Mid-Central Health
Judy Boxhall	Mid-Central Health
Penny O'Leary	Mid-Central Health
Robert Bull	Hawkes Bay DHB
Karen Anderson	Whanganui Hospice
Barry Keane	Arohanui Hospice
Amiria Teki	Whakapai Hauora
Lovey Ratima	Te Oranganui Iwi Health Authority
Sharlene Tapa-Mosen	Te Oranganui Iwi Health Authority
Bonnie Sue	Ngāti Rangi Community Health Centre
Joe Huwyler	Te Runanga o Ngāti Apa
Moira Raukawa-Haskell	Otaihape Māori Kommittee
Pet McDonnell	Te Puke Karanga Hauora
Joanne Hayes	Taumata Hauora Trust
Cheryl Linge	Taumata Hauora Trust
Craig Maxwell	Child Cancer Foundation
Alistair Wilson	Whanganui Regional Primary Health Organisation
Fiona Corbin	Whanganui Regional Primary Health Organisation
Clinical Governance Group	Whanganui Regional Primary Health Organisation
Te Ahurewa o Te Ora	Rongoa Clinic
Te Kopere o Raehina Trust	Rongoa Clinic
Te Rapu Ora	Rongoa Clinic
Te Whare Ora	Rongoa Clinic
Ti Hauora o Te Aroha	Rongoa Clinic
Cancer Consumer Group	Cancer Society

Glossary

Early detection: detecting cancer prior to symptoms or as soon as is practicable after the development of signs or symptoms.

Health promotion: the process of enabling people to increase control over, and to improve their health. Health promotion involves community and individual measures to help people develop lifestyles that can maintain and enhance the state of well-being. The concept of health promotion underlies many of the approaches to reducing the risk of cancer among individuals and populations. Five action strategies for health promotion developed by the World Health Organization are:

- promoting healthy public policy
- creating supportive environments
- strengthening community action
- developing personal skills
- reorienting health services.¹

Primary prevention: preventing a particular problem from occurring. Primary prevention through reduction in risk factors, such as smoking and poor nutrition/lack of physical activity, offers great promise as an effective means of reducing the incidence of cancer.

Reducing incidence: influencing the reduction of the incidence of cancer in the population as a whole.

Reducing risk: identifying individuals at higher risk and advising them accordingly (e.g., health provider advice)².

Screening: a process whereby people who have no symptoms are invited (either directly or through publicity) to undergo a test or procedure, usually at regular intervals at certain times in a person's life.

Local Cancer Control Action Plan

Linked with the Key Objectives and Regional and National Strategies

Objectives from the Whanganui District Health Board Local Cancer Control Action Plan

Objective One: Provide leadership to improve and develop local services

- Demonstrate consistent participation and leadership in the areas of the Regional Cancer Treatment Advisory Group, Central Region Cancer Network and the Regional Cancer Network.
- The District Health Board will effectively participate in the regional network.
- Develop a feedback mechanism for conveying information across the District Health Board region including a mechanism for conveying shared decision making across sectors on behalf of the Whanganui cancer continuum.

Objective Two: Strengthen the role of primary health care in cancer control

- Explore options for removing primary health care barriers to access to diagnostic procedures/screening.
- Implementation of medical and Nursing General Practice Team training and support that will identify a scope of practice for generic palliative care services that will interface with specialist palliative care services.
- Increase opportunities to reduce cost as a barrier to access to primary care services for cancer patients and their families, such as Care Plus programmes.
- Include the role of the primary general practice team in the development of the cancer Continuum.

Workstream

National Cancer Control Action Plan Objectives

Goal 4: Objective 7 – Ensure an integrated and comprehensive service is provided to all those with cancer who require palliative care and their family and whanau.

Goal 3: Objective 1 – Provide optimal treatment for those with cancer

Goal 3: Objective 2 – Develop defined standards for diagnosis, treatment and care for those with cancer.

**Objective Three:
Establishment of a Patient
Focused Continuum of care**

Identify the components of a continuum of care for cancer services and implement the continuum in line with the Chronic Disease Prevention and Management Framework:

- Map and analyse cancer patients' journeys and clinical pathways to inform the development of a cancer continuum.
- Review options and service models to establish patient co-ordination activity to ensure a smoother pathway for patients/ whānau and enhanced collaboration between cancer services including improved co-ordination and advocacy services at a secondary service level
- Ensure models of care recognise the importance of whanau in recovery and the interface between culture and clinical practices.
- Review the current travel policy to reduce the financial cost of travel for patients as a barrier to accessing services.
- Work in collaboration with intersectoral agencies that can assist / support the delivery of cancer services including social services, community education and support, education and skill development options for patients and their whanau/families.
- Development of a primary care led, single point assessment and care coordination service that includes cancer and palliative care services.
- Work with the public health directorate to review and identify options for increasing investment in public health and health promotion, priority areas include tobacco control, nutrition and activity.
- Identify collaborative working relationships that will improve access for Māori whānau to palliative care support; and improved co-ordination between primary health care, iwi providers and hospice.
- When reviewing a co-ordination role for cancer services ensure that Māori cancer patients are assisted with access across the cancer continuum – explore effective models in other areas.
- Explore the opportunities to introduce a palliative care partnership between primary care and palliative care specialists to implement the Liverpool Care of the Dying Pathway to consider options to implement the Liverpool Care of the Dying Pathway, this pathway is based on international best practices and has been developed to transfer the hospice model of care into other care settings.

Goal 3: Objective 3 – Ensure patient-centred and integrated care for those with cancer, their family and whanau

Goal 3: Objective 1 – Provide optimal treatment for those with cancer

Goal 3: Objective 2 – Develop defined standards for diagnosis, treatment and care for those with cancer

Goal 1: Objective 1 – Reduce the number of people who develop cancers due to tobacco use and second hand smoke

Goal 5: Objective 1 – Develop a co-ordinated national cancer workforce strategy.

- Ensure that consumers are able to provide advice that will influence planning, purchasing and delivery of service.
- Identify workforce capacity and capability to provide services across the cancer continuum and introduce a planned approach to workforce development Capacity planning begins by forecasting the demands and converting these requirements into capacity requirements. Such demands include: location of services, deciding how the services will be delivered; facilities required; growth in technology; and workforce required. A workstream as part of the development of the cancer continuum.
- Identify and ensure that Māori-led initiatives are highlighted and positioned as models of good practice and innovation.
- **Monitor and evaluate services and service outcomes.**

Goal 5: Objective 3 – Ensure active involvement of consumer representatives across the spectrum of cancer control.

Objective Four : Cancer Services Responsive to Maori

- Ensure Hauora a Iwi, and the Iwi provider forum have the capacity required to lead and participate in the development and support of cancer services for Māori.
- Strengthen the Whānau Ora service model and purchasing strategies to include coordination, advocacy and support for whanau diagnosed with cancer and their movement through the cancer continuum.
- Monitor and evaluate the effectiveness of different culturally-derived health care practices and the delivery of services to ensure improved health outcomes for Māori in relation to cancer.
- Support for Maori health workforce and provider development.
- Develop a model for 'holistic' needs assessment and service coordination that includes family/whanau.
- Note and address gaps in current service provision, improving access for Maori and those in high decile and rural areas, to address inequalities.
- Strengthen mainstream services to deliver services to Maori in line with whanau ora concepts.

Goal 5: Objective 2 – Ensure programmes and services are accessible to Maori across the cancer control continuum.

Objective Five: Increase access to screening services for priority populations

- Explore options for low cost cervical screening including opportunity for primary health organisations to prioritise free cervical screening as a service to improve access initiative and other service options at no cost to the individual
- Review service models that are achieving increased screening uptake with the view of introducing different approaches to achieve better results in the Whanganui area.
- Monitor timely, effective and coherent transfer from screening to treatment
- Work to ensure improved data collection and sharing for cancer continuums

Goal 2: 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.

Objective Six: Enhance the capacity of existing services

- The Whanganui District Health Board is to effectively participate in the regional network
- Introduce a palliative care partnership between primary care and palliative care specialists to implement the Liverpool Care of the Dying Pathway
- Whanganui District Health Board is to review options for strengthening the Whanau Ora model of Care
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Goal 4: 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 whanau.