Te Aho o Te Kahu
Cancer Control Agency

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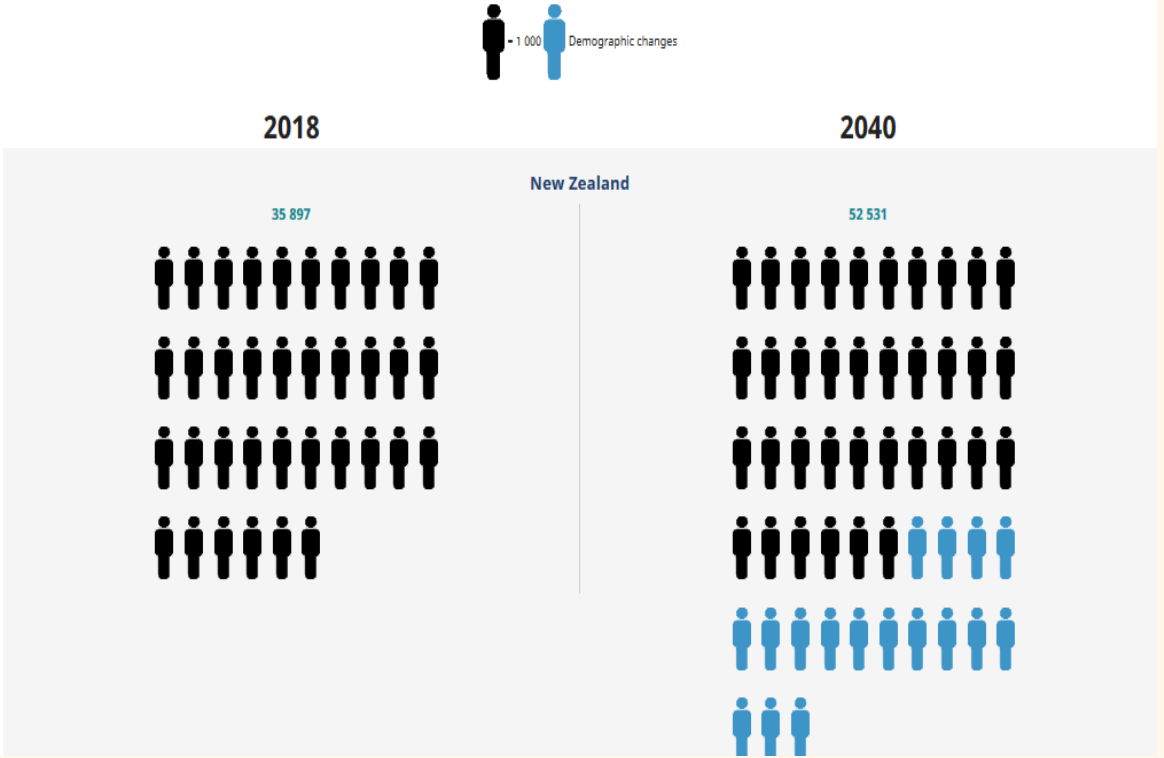
Tumutuarua Haumanu

Te Aho o Te Kahu

Where did we come from?

- Cancer leading cause of death
- Doubling of cases expected in next two decades
- Costs and complexity of cancer diagnosis and treatment increasing exponentially
- Longstanding and persistent inequities
- Survival improving but slower than comparable countries



TE AHO O TE KAHU CANCER CONTROL AGENCY

Te Mahere Mate Pukupuku o Aotearoa

Four Goals:

New Zealanders will:

1. have a system that delivers consistent and modern care
2. experience equitable cancer outcomes
3. have fewer cancers
4. have better cancer survival, supportive care and end of life care

Why do we need a Cancer Control Agency?

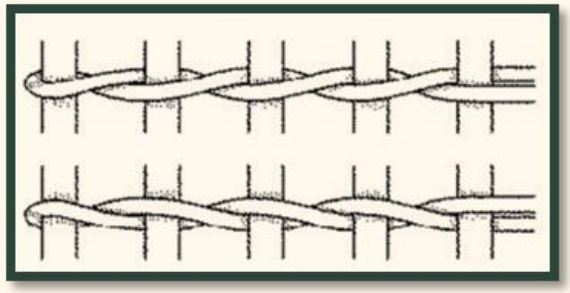
- To provide national leadership for, and oversight of cancer control.
- To provide sound policy advice to the Government on cancer control.
- To be accountable for ensuring transparency in progress towards the goals and outcomes in the Cancer Action Plan.

Cancer Control Agency established 9th December 2019

- Stand-alone Departmental Agency
- Chief Executive reporting to Minister of Health
- Te Aho o Te Kahu Council
- Leadership groups:
  - Clinical Assembly
  - He Ara Tangata, Consumer Reference Group
  - Hei Āhuru Mōwai, Māori Cancer Leadership
- Clinical advisory/ working groups
- Four regional hubs

Te Aho o Te Kahu

Name gifted by Hei Āhuru Mōwai 18th June 2020



Te Aho o Te Kahu means ‘the central thread of the cloak.’

This thread binds the many strands into one cloak which provides protection to people and their whānau.

Te Aho: the central thread symbolises the Agency and its role as a leader and connector across the cancer control continuum.

Te Kahu: the cloak symbolises all the services, organisations, people and communities that work with those affected by cancer.

Our Vision

Fewer cancers. Kia iti iho te mate pukupuku.

Better survival. Whakapai ake i te mōrehutanga.

Te Kaupapa

Equity for all. Kia taurite ngā huanga.

Our Purpose

To lead and unite efforts to deliver better cancer outcomes for Aotearoa New Zealand.

Our Values

Data Standards and Guidance

Nationally agreed and Health Information Standards (HISO) endorsed data standards support Te Aho o Te Kahu and the Ministry of Health's shared vision of a fully interoperable digital health and disability system.

And more...

- COVID response
- Response to Health and Disability Support Services Review
- Support to DHBs in relation to cancer services
- Response to public advocacy
- Other (e.g. PRRT service)

Cancer Services Planning – a Vision for cancer treatment in the reformed health system

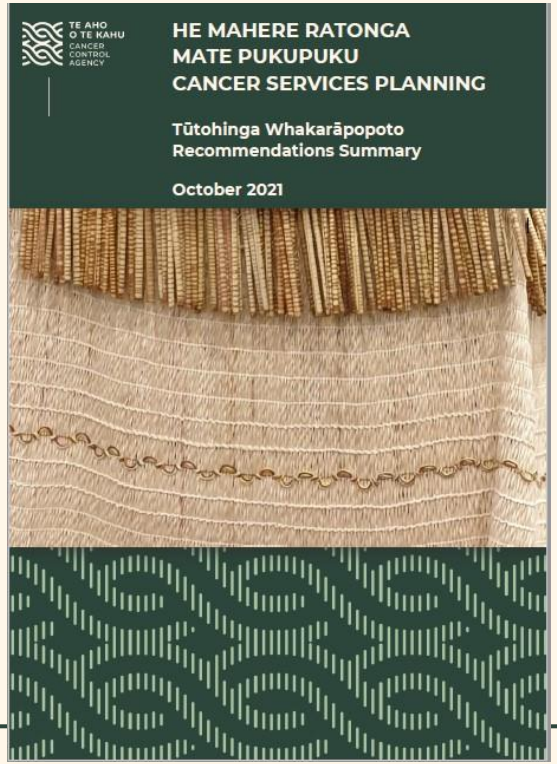
Stakeholder engagement was undertaken at project level and at workstream level.

Nearly 100 individual and group engagements took place (e.g. Cancer Society, RACS, surgeons).

Insights from 13 Māori cancer community hui held across Aotearoa – with around 2800 attendees

Hei Āhuru Mōwai and He Ara Tangata were actively involved in identifying concerns about the current state and developing the recommendations.

The HDSR Transition Unit was also engaged



What are the issues with the current cancer treatment system?

This work identified several comm… …fferent cancer treatment services. Th…

- Fragmented and i…
- Ad-hoc di…
- Cri…

…ng

…ad

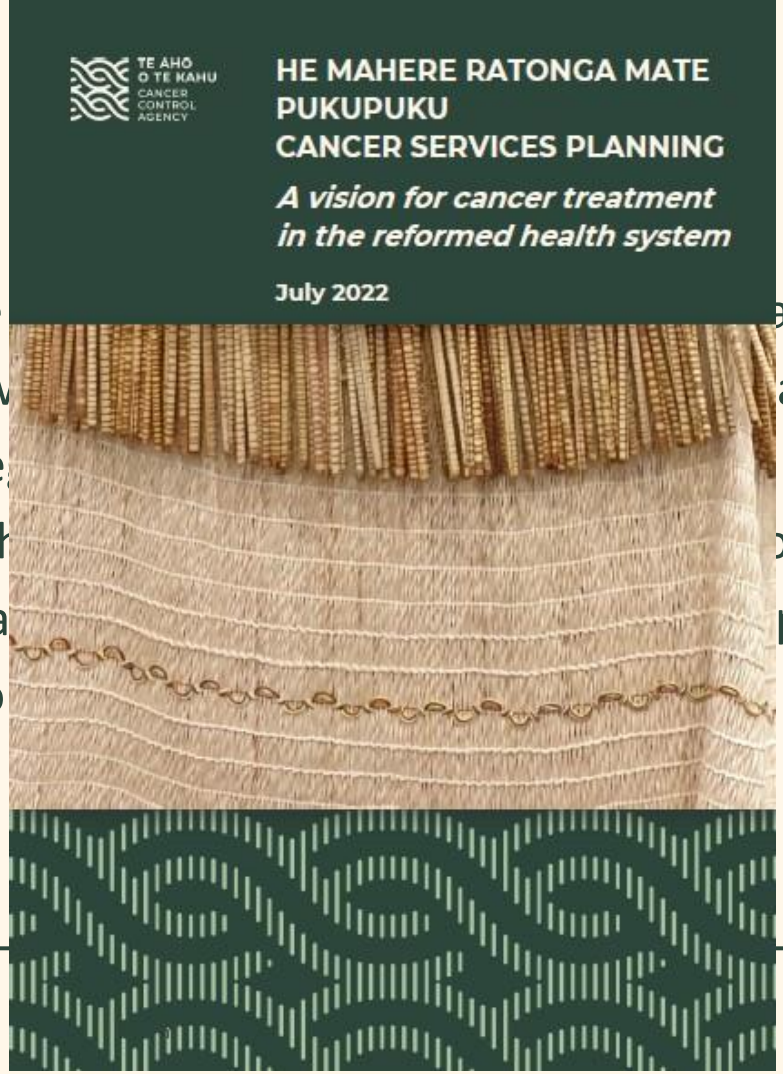
…e integration

…e services (including …support services)

…process for assessment and …ew technologies

…poor integration of research into practice and …cable access to clinical trials

- Analysis across all workstreams identified the following common high-level themes:
  - The need for a transformative approach to cancer treatment and care
  - National system leadership
  - Clinical service distribution
  - Workforce
  - Coordination and supportive care services



The a high-level vision for how are services can be inte a way that puts whānau at th omes, and locates trea possible to where peo

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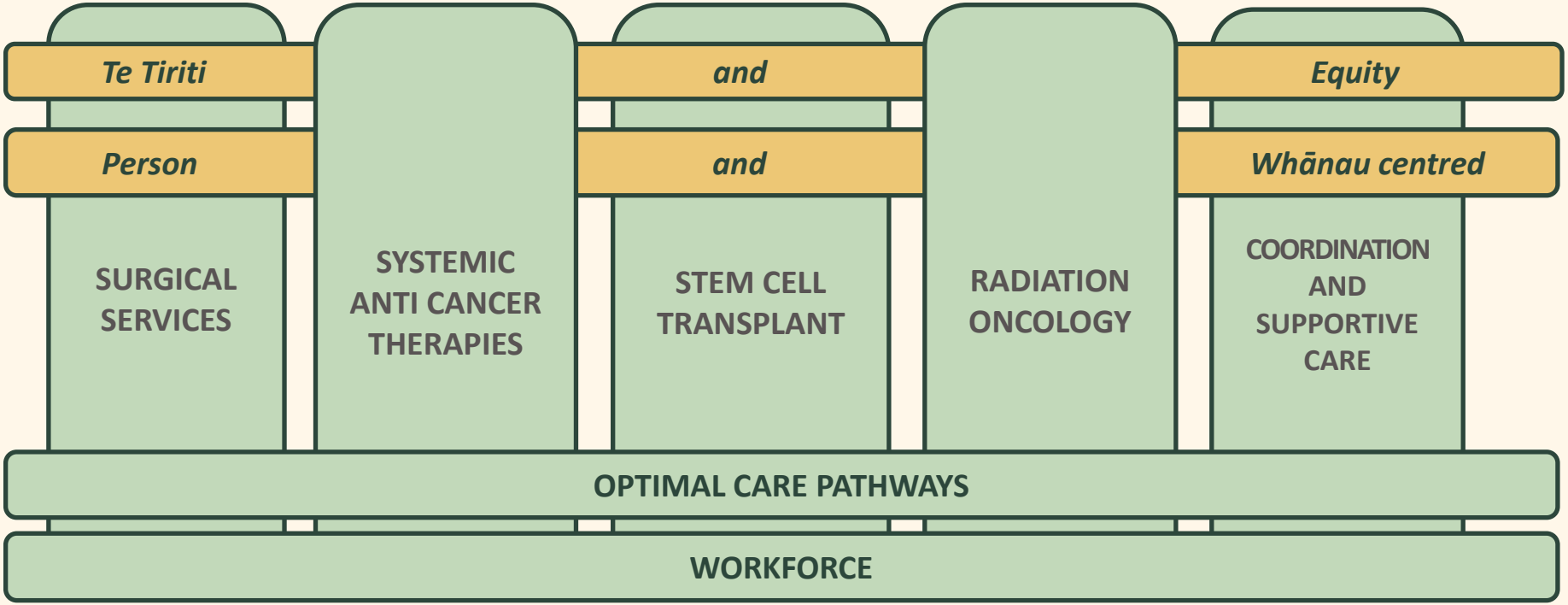
Phase 2 Design



Surgery

Case for Change

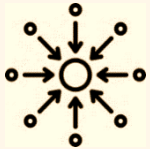
- Ad-hoc distribution of services and barriers to access
- Critical issues with workforce capacity, diversity and cultural safety
- Challenges with infrastructure capacity and suitability (including buildings and data/information systems)
- Variable acceptability of services for patients and whānau
- A lack of consistent referral pathways and service integration
- Lack of recognition and funding for some services (including allied health and coordination and support services)
- Lack of consistent national process for assessment and implementation of new technologies

Model and recommendations ?

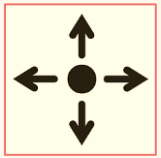
Distribution of surgical services – current models in use in NZ

Role delineation - determines what work can be done where, depending on the sophistication of the services – including clinical expertise, workforce, support and integration with other services. E.g. Northern Region Head and Neck RDM

Hub-and-spoke -arranges hospitals into a network consisting of an anchor 'hub' that offers a full array of services, including service leadership, and several 'spoke' hospitals that offer more limited services, referring patients to the 'hub' hospital for more complex treatment. E.g. Gynae cancer services have three hubs



In the **centralised** model, all cases are referred to the central hospital. E.g. child cancer services. This is different to the hub and spoke model, where the hub hospitals only get involved in treating cases when they are too complex for the spoke hospitals

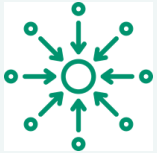


There are several examples of **reactive** provision of surgical services. E.g. surgeons setting up new services in their own hospital, bespoke solutions, national services set up on application.

Model	Advantages when applied to cancer surgical services	Disadvantages when applied to cancer surgical services
STATUS QUO 	No extra funding, no change to current levels of resourcing	Fragmented system
	No implementation complexities	Provision of services is often reactive and ad-hoc
	Tried and tested system that delivers acceptable health outcomes for most patients, most of the time	Inequities and access issues

Model	Advantages when applied to cancer surgical services	Disadvantages when applied to cancer surgical services
ROLE DELINEATED 	Relatively straightforward process to review hospitals and delineate based on what we already know	Continuation and/or further development of reactive, ad-hoc services
	Fewer surgeries would be performed in locations where peri-operative clinical services are insufficient – the 'failure to rescue' risk would be reduced	Continuation of inequitable distribution of services
		Continuation of surgeries with insufficient volumes for optimal outcomes

Model	Advantages when applied to cancer surgical services	Disadvantages when applied to cancer surgical services
HUB & SPOKE 	Model is supported by clear evidence that surgical volumes are important and result in improved outcomes	Probable de-skilling and disenfranchising of services in spoke settings (this is important as acute/ non-cancer work, which can be complex, will still need to be managed by these resources)
	Pulls together the right teams to manage patients efficiently	NZ geography makes it difficult to reach a distribution of surgical services where patient travel to services would be equal for all
	Opportunity for skill development in spoke settings – learning from the hub team	Several larger hospitals are currently located close together – which ones would be the hub hospitals?
	Keeps straightforward surgery local to the patient's home	NZ population isn't large enough to support this model in the way it was designed to run – with likelihood of inadequate volumes of high complexity surgeries being carried out

Model	Advantages	Disadvantages
4. CENTRALISED 	Model is supported by clear evidence that volumes are important and result in improved outcomes	Significant set-up costs to develop one or two centres with the capability to provide all cancer surgeries and associated services
	Pulls together the right teams to manage patients efficiently	Probable de-skilling and disenfranchising of services in local/regional settings (this is important as acute/ non-cancer surgeries, which can be complex, will still need to be managed by these resources)
	Appropriate peri-operative clinical services and clear liaison processes with local services – the 'failure to rescue' risk would be substantially reduced	Increased travel and accommodation requirements for most patients & whānau (cost & access issues, resulting in inequities)
	Higher degree of standardisation of treatment and care	Other highly complex treatments would also be managed out of the same hospitals, putting significant pressure on resources and infrastructure
		"Puts all eggs in one basket" - risk of being affected by adverse events e.g. earthquake, pandemic, cyber security breach

Model	Advantages	Disadvantages
Mixed Model 	More even distribution of patients/volumes to a spread of hospitals than other models	Some surgeries would need to cease in hospitals where volumes are insufficient or support services are inadequate- resulting in implications for workforce
	Combines optimal access with optimal outcomes for patients & whānau	Low-volume/ high-complexity surgeries would be provided further from home and therefore increased travel and accommodation requirements for these patients & whānau
	Maintains skill mix in local settings as much as possible (ensuring breadth of expertise and limiting single points of failure). Offers opportunity for skill development	Multi-layered system requiring careful management to ensure access and equity issues do not develop

What are we doing?

- Across the CSP programme, we are currently defining the outputs from each of the 7 projects. The outputs include:
  - New patterns of distribution for cancer treatment services
  - New models of care
  - Structures for system leadership & clinical governance
  - Optimal care pathways
  - Commissioning advice
  - Workforce capacity and capability planning
  - Outcomes monitoring and evaluation mechanisms

What are we doing? Surgery

- Developing a framework which can be used to determine how cancer surgical services could be distributed across the motu
  - Optimal case numbers / resection rates
  - Service sustainability and resilience
  - Level of services likely to be required
  - Geography
  - Population
  - Staff expertise
  - Referral pathways
  - Surveillance

Benefits

- Improved access through planned and co-ordinated distribution of resources
- Improved survival and reduced emergency presentations
- Skill development for clinical staff
- Improved patient / whānau experiences – efficient, effective and meets the needs of the people
- Development of inter-regional co-operation
- Development of committed national leadership

Caveats

- Can’t separate cancer from non-cancer surgery
- May not be a single optimal distribution
- Implications
- May introduce new inequalities
- Will require trade-offs

Who is involved? (currently)

- Manager Northern Hub Te Aho o Te Kahu
- Project Manager – equity
- Project manager
- Senior advisor (contract)
- Advisor - Whānau Centred Care
- Advisory group
  - 5 surgeons (2 regional/ 3urban/ 3NI/ 2SI)
  - 1 anaesthetist
  - 1 consumer rep
  - 1 colorectal nurse practitioner

He waka eke noa.

We are all in this together.

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