



Northland Cancer Control Strategic Action Plan 2006-2011

Adopted by the Board December 2006

*Includes action 1.1 amended March 2007, by GM Service
Development and Funding, pursuant to Board meeting Dec 2006*

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1 Executive Summary

This strategic action plan is based on the findings of a stock-take and gap analysis of services available for people with cancer who live in Northland. The purpose of the plan is to provide a simple and clear framework and series of actions that will reduce the incidence and impact of cancer in Northland, and to reduce inequalities that exist.

The approach taken was to adopt the New Zealand Cancer Control Strategy and Action Plan as a framework. The New Zealand strategy acknowledges that there is a cancer control continuum that includes the following phases of cancer care: prevention, early detection and screening, diagnosis and treatment, support and rehabilitation, and for some people, palliative care. A Northland Cancer Control Steering Group was established with members representing the continuum of cancer services to provide expert advice and guidance to the Northland DHB.

The stock-take found that Northland has a higher rate of cancer prevalence, incidence and mortality than the New Zealand average. It also found that Maori are disproportionately affected in terms of outcomes. Cancers that have the highest mortality rate in Northland are: lung cancer, colorectal cancer, breast cancer and cancer of the prostate. Lung cancer causes the most deaths, and is the cancer with the highest disparity when comparing Northland with New Zealand.

There are few cancer specific services in Northland. Services that do have a sole focus on cancer are the Cancer Society, and the Oncology services that are only provided on an outpatient basis at the Whangarei hospital. Northlanders have to travel to Auckland to access complex chemotherapy, radiotherapy and a range of other specialist cancer services.

Northland does not compare well, compared with the NZ average, when considering tobacco cessation services, the current waiting list for breast screening, the cervical screening coverage rate, and the utilisation of chemotherapy and radiotherapy services.

There is anecdotal evidence that cancer outcomes are adversely affected by the need to travel to Auckland to access services, including radiotherapy.

There are significant gaps in the availability of support services including information, transport and accommodation, and Ministry of Health funded support services for people aged under 65 years who have cancer and who require long term support.

Priorities for phase 1 implementation

There are many phase 1 priorities in this plan. To summarise, the main priorities are focused on reducing the inequalities that currently exist in cancer outcomes for Maori and for Northlanders when accessing cancer services (compared with the rest of New Zealand). The priority areas are:

- 1 Reducing tobacco use.
- 2 Increasing breast and cervical screening coverage rates, particularly for Maori women, through improved coordination between GPs, health providers and screening services.

- 3 Improving the referral system for tests and investigations, including developing guidelines for referrers.
- 4 Increasing the capability and capacity of oncology services provided within Northland, including the range of chemotherapy provided in Northland.
- 5 Improving the cancer journey for people who have a suspected or proven cancer through the development of a care coordination service, that includes a Kaupapa Maori approach; and incorporates case management and patient navigation functions to link primary, secondary and tertiary care, and support services.
- 6 Improving access to palliative care services at the time of diagnosis and treatment.
- 7 Improving the quality of information, particularly with regard to service utilisation, and the recording of ethnicity.
- 8 Workforce development.

The cancer priorities in this plan are lung cancer, colorectal cancer and breast cancer.

2 Introduction

2.1 Aim and Purpose

The aim of the Northland Cancer Control Strategic Action Plan is to reduce the impact and incidence of cancer through consolidating and building on existing cancer services, coordinating and improving access to cancer services and reducing inequalities.

Its purpose is to provide an overarching framework to guide existing and future NDHB activities with a view to:

- preventing cancer so that as many of the population as possible enjoy cancer free lives
- detecting cancer and providing treatment as early as possible
- ensuring that once a diagnosis is made those affected have prompt access to high-quality care throughout their experience of cancer
- assisting people, and their families/whanau, experiencing cancer to fully participate in all decision-making related to their treatment and care
- reducing barriers to cancer services for socially disadvantaged groups, such as Maori and Pacific peoples.

2.2 How This Plan Has Been Developed

This Plan was initiated by a joint application by the Northland District Health Board, Cancer Society and Manaia Health PHO.

This partnership approach has been further developed with the establishment of a Northland Cancer Control Steering Group comprising of representatives from Te Tai Tokerau MAPO, Cancer Society, PHOs, and palliative care services and the NDHB provider (both management and clinical) and funder. The Steering Group was set up under the auspices of the NDHB's planning and funding responsibilities reporting, via the Service Development and Funding Team to the General Manager Service Development and Funding.

The Northland Cancer Control Strategic Action Plan contains the goals, Northland priorities, and actions that have developed as a result of a stock-take and gap analysis. For a copy of the stock-take and gap analysis report please contact Health Planner, Northland District Health Board by phoning 09-470-0000.

Feedback from stakeholders was an important part of developing the stocktake, gap analysis and strategic action plan. The methods used to develop this stocktake included getting feedback from all Northland General Practices (through a questionnaire and some face to face interviews), Maori Health providers, key providers within the Northland District Health Board including clinical staff, managers, and the Service for Older People (including NASC).

Palliative Care strategic planning focus groups were held in four areas in Northland involving a wide range of services that provide generalist palliative care.

Consumer feedback was particularly sought and was obtained through interviews with consumers, as well as meeting a consumer support group in the Far North and carrying out a consumer focus group in Whangarei. Issues relating to Maori were obtained through meeting and talking with nurses employed by Maori health providers.

Quantitative data including service utilisation information was gathered (where available). Existing studies including analysis of service utilisation and access was also reviewed. A significant challenge posed by the timeframe was to obtain and interpret cancer services' utilisation data. Some of this task is still to be completed.

The Steering Group identified and prioritised objectives based on the information provided in the stock-take report and agreed the following criteria, which are as follows:

- health benefit
- equity
- effectiveness (evidence based)
- capacity and capability
- value for money
- ease of implementation
- sustainability.

When proposals for new initiatives are developed as a result of this strategic action plan, (including specific business cases), other evaluation criteria and tools, including the Health Equity Assessment Tool, will be applied by the Northland DHB.

2.3 Why do we need cancer control?

Cancer is a catch-all term which encompasses a whole range of different diseases which vary widely in how they affect the body, the ages at which they are most common, the likelihood of survival and the type of treatment required. The complex and varied nature of cancer means that there are a wide range of services and providers involved in cancer care.

Cancer is the second largest cause of mortality in Northland (behind circulatory diseases such as cardiovascular disease). The most current information shows that almost one third of all deaths (32%) in 2001 were due to cancer¹. This rate is higher than the New Zealand average (29%)².

Overall, Maori are 18% more likely to be diagnosed with cancer than non-Maori, but nearly twice as likely to non-Maori to die from cancer³. The Northland population has a higher proportion of Maori people (at 30%) than the New Zealand average, and also a high degree of social and economic deprivation amongst its population. This has contributed to the high rate of cancer registration and cancer related deaths in Northland.

Nationally it has been recognised that the cancer death rate has been increasing considerably faster than in comparable countries including Australia, Canada, the USA and United Kingdom.

The number of people developing cancer is expected to increase in the future due to population growth and ageing, along with other population changes such as the increase in obesity, increasing physical inactivity and insufficient intake of fruit and vegetables.

¹ Northland District Health Board, 2005. *District Strategic Plan*, pp 13.

² Ministry of Health, 2005. *The New Zealand Cancer Control Strategy: Action Plan 2005-2010*, pp4.

³ Wellington School of Medicine, 2005. *Access to Cancer Services for Maori* pp ii,

However while cancer is a leading cause of death, many people with cancer do survive and a great number of early cancer deaths can be prevented.⁴ Based on what is known about potential cancer risks and risk reduction interventions, it is estimated that it is possible to prevent one-third of all cancers. Better outcomes are achievable for a further third through early detection and treatment.⁵

2.4 What Is Cancer Control?

Cancer Control is an organised approach to the reduction of cancer incidence, morbidity and mortality. It provides a systematic approach based on the continuum of services. The approach aligns with the World Health Organisation's recommendation that the development and implementation of a national cancer control strategy is the most effective way to reduce the incidence and impact of cancer. Other countries, including Australia and Britain, have taken a similar approach.

Prevention is concerned with preventing the occurrence of cancer through the reduction of risk factors and the encouragement of protective factors. Services involved in the prevention of cancer include the Cancer Society, Public Health Unit, primary health practitioners, nurses, and Maori providers.

Early detection and cancer screening aim to detect cancer at as early a stage of development as possible, when options for treatment are greatest. National screening programmes exist for breast and cervical cancer. Guidelines have also been produced for the screening of individuals with a high risk of colorectal cancer.

Cancer diagnosis is the first step to cancer management, and is important in determining appropriate care pathways for patients. There are a number of services involved in the diagnosis of cancer, such as pathology and radiology. Some of these can be accessed through primary care, while others involve a referral to secondary care.

Cancer treatments can include surgery, radiation, chemotherapy or hormonal therapy, or a combination of these. The aim of treatment is to cure, or to prolong and improve the quality of life of those with cancer.

For Northlanders, most cancer diagnostic and treatment services are based in Whangarei and Auckland.

Support and rehabilitation services relate to helping those directly affected by cancer (e.g. patients and their families/whanau) to cope with the impact of the disease and its treatment. It includes cancer specific services, such as the support services provided by the Cancer Society of New Zealand (and delivered in Northland through its Northland branch). It also can include non-cancer specific services, such as rehabilitation services that may be necessary after surgery or treatment, or financial assistance for home help or carer relief.

Palliative care is

⁴ Acknowledgement is made to the NZ Cancer Control Trust for some of the information in this section. (www.cancercontrol.org.nz).

⁵ Director-General of Health. *The Annual Report 2004/05 including the Health and Independence Report*, pp78

“an approach that improves the quality of life of patients and their families facing the problems of a life threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems physical, psychosocial and spiritual. It can involve a range of providers including hospices, hospitals, general practitioners and community health services.” (WHO 2002).

Cancer control also includes improving the delivery of services across the continuum of cancer control through effective planning, coordination and integration of resource and activity, monitoring and evaluation. Cancer control activities and services are undertaken by a wide range of government and non government agencies and involve both a paid and volunteer workforce.^{6, 7}

2.5 Mana Tangata Model

The Mana Tangata Cancer Control Continuum of Services Model depicts the cancer continuum of services as being client centred, and the services as being inter-related. For example, treatment and support services are not sequential, and access to palliative care services can occur at an earlier stage of the continuum. Most services are based in the community. A priority of the cancer control strategy is to ensure that all people access the services they need, and experience a smooth ‘journey through services’. This requires excellent linkages between services, to manage the transitions. There is evidence that Maori have the least equitable access to services, and therefore are a priority group for cancer control activities. The Mana Tangata model is shown on the following page.

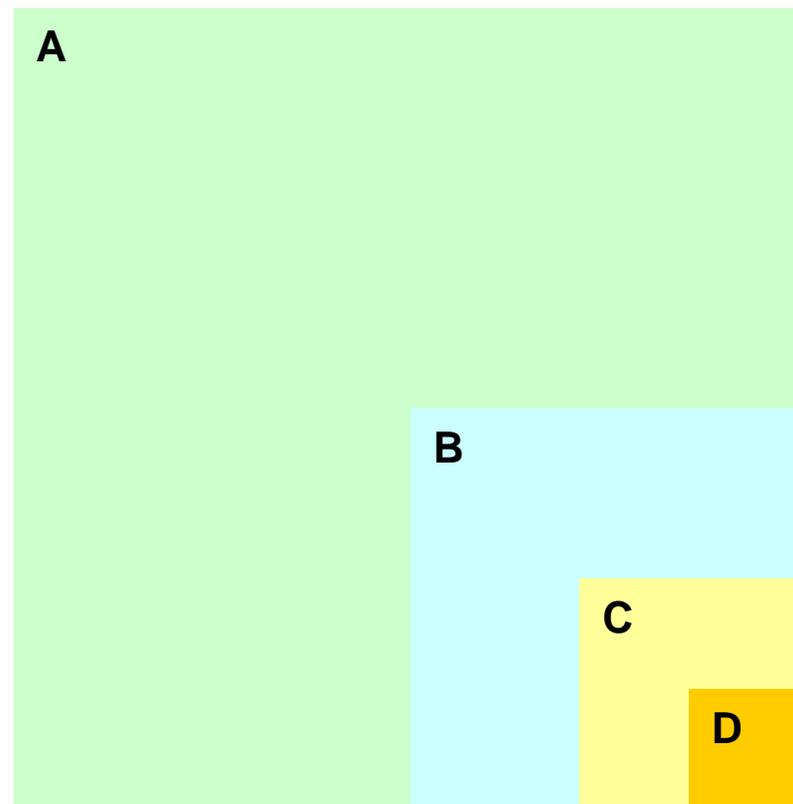
This section relating to cancer control is drawn from:

⁶ Wellington School of Medicine and Health Services, 2005. *Access to cancer services for Maori*, pp6-7.

⁷ Minister of Health, 2003. *The New Zealand Cancer Control Strategy*, 15-17

Figure People affected by cancer and their relationship with the Continuum of Cancer Services

Code	Population group	Services
A	Total Northland population. In 2001 the total population was 140,301 people.	Public health wellness services – health promotion, and disease prevention activities. Cancer screening services.- these are targeted to potentially ‘at risk’ populations. Primary health care providers.
B	People who have suspected symptoms of cancer, or have a cancer and are unaware of it. We do not know how many people are in this group.	Primary health care providers. Diagnostic services - NDHB
C	People who have a confirmed cancer. Between 8 and 11% of people over 15 years have ever been told they have cancer (8,400 – 11,500 people). On average, each year, 855 new cases in Northland are registered on the NZ Cancer Register.	Treatment services – NDHB and Auckland Regional Cancer Service. Can include surgical, medical oncology (chemotherapy), and radiotherapy. Support services, including Cancer Society, transport and accommodation assistance, home support, and palliative care services. Primary health care providers
D	People whose death is due to cancer. In 2003, 401 Northlanders died of cancer.	Support services Palliative care services – symptom management. Primary health care providers



(Areas of boxes are not to scale)

3 Key Findings of the Stock-take and Gap Analysis

3.1 Population

Northland's population is characterised as having a high proportion of Maori (at approximately 30% of the population), as well as a significantly higher proportion of older people and a higher level of socio-economic deprivation than the national average. Maori have a poorer health status compared to non Maori, and cancer mortality is an important contributor to this gap in health status. Ageing, socioeconomic status, and where people live also have an impact on health status.

The projected growth in the Maori population, the poorer health status of Maori, as well as the ageing of the population will mean that the demand for cancer services will continue to increase in the future, and that there is a risk that disparities will continue. This needs to be planned for.

3.2 The Burden of Cancer in Northland

3.2.1 Prevalence

The NZ Health Survey found that 7.8% of Northlanders had ever been told by a doctor that they had had cancer, higher than the national average of 5.8%. Dr Shane Reti's 2002/03 survey reported 11% of Northlanders saying they had ever had cancer.⁸

The five leading cancer site registrations for Maori in Northland between 1995 and 2003 were, in order, lung, breast, prostate, stomach and colorectal. For Northland Europeans, the most commonly registered cancers were lung, colorectal, prostate, breast, and skin.

3.2.2 Cancer Mortality Disparities

32% of Northland deaths were due to cancer in 2001, making it the second most common cause of death behind circulatory diseases. This is a higher rate than the New Zealand average (29% of deaths were due to cancer causes).

401 Northland people died of cancer in 2003. The five most common types of cancer causing death in Northland in 2003 were cancers of the lung, colorectal, prostate, breast and skin. Altogether these accounted for over half of all cancer deaths (225 people, 56% of total deaths due to cancer). Lung cancer is by far the leading type of cancer related death, at 23% of total cancer deaths in 2003. The proportion of deaths due to lung cancer increased from 16% in 2002.

The mortality rate in Northland, when compared with the NZ mortality rate is disparately high for:

- lung cancer (the highest rate in NZ)
- colorectal cancer
- non hodgkins lymphoma

⁸ This is self-reported cancers, and may include pre-cancerous conditions (ie. cancers that are not entered onto the NZ Cancer Register.

- stomach cancer
- liver cancer.

There are significant disparities in cancer incidence and outcomes between Maori and non-Maori that require urgent attention. The incidence of cancer for all cancers combined is higher in Maori males and females, than in non Maori males and females within New Zealand.⁹

Between 1996-2001, lung cancer was the leading cause of cancer death among Maori males and females. Maori are at a substantially higher risk of developing lung cancer, more likely to be diagnosed at a later stage, and have significantly lower survival chances after diagnosis than non-Maori. Maori are also more likely to die of cancer at a younger age than non Maori.

Survival Rates

Within New Zealand the cancer sites with the lowest five year survival ratio for all people between 1994 and 2003 were: pancreas; trachea, bronchus and lung; liver and intrahepatic bile ducts; oesophagus; brain; and stomach.¹⁰

Cancers of the lung, liver and stomach are also the three cancers which Northland people, particularly Maori, have a disproportionately high level of incidence and mortality, compared with NZ rates.

Projections

The projected rise of tobacco related cancer incidence and mortality is of great concern, and addressing tobacco consumption is an area that needs attention.

There is also a forecasted rise in the incidence on non-tobacco related cancer. This factor emphasises the importance of a heightened focus on nutrition, physical activity and obesity in relation to cancer prevention.

Breast cancer is “projected to continue to dominate the spectrum of cancer among young and middle aged females” (and is the second most common cancer amongst Maori).

Some cancers are relatively easily preventable via a vaccine for example Liver Cancer (caused by Hepatitis B) and Cervical Cancer. Although these cancers are relatively small in incidence, as they can be prevented, the control of these cancers is also a priority.

While Skin Cancer has a low level of mortality within Northland, it accounts for 9% of all cancers registered, and is the main cancer type serviced by Northland DHB inpatient (including day stay) diagnostic and treatment procedures. There is merit in examining the reasons for this, including whether the skin cancer pathway should be re-designed (e.g. by making more efficient use of primary health care services).

The incidence of cancer is forecast to increase in New Zealand and in Northland over the next decade, and the Auckland-Northland region is expected to have the highest projected

⁹ Robson B, Purdie G, Comack D, 2006. *Unequal Impact: Maori and Non-Maori Cancer sites 1996-2001*. Wellington: Ministry of Health, pp19.

¹⁰ Ministry of Health, 2006. NZHIS Cancer Patient Survival.

incidence of cancer within New Zealand.¹¹ Because of its relationship and dependence on Auckland oncology services, this projected increase in cancer incidence will have an impact on Northlanders needing to access tertiary oncology services. The current contractual arrangements between Northland and the regional cancer service require reviewing to ensure Northland's needs are met.

3.3 Configuration of cancer control services in Northland

The stock-take report was based on the continuum of services as outlined in the NZ Cancer Control Strategy. The stock-take found that whilst there is a range of generalist services providing services for people with cancer, there are few dedicated services.

Dedicated services for people with cancer are largely based in Whangarei or are funded and provided through the Auckland Regional Cancer Service. Being a satellite of the Auckland DHB cancer service has a significant influence on what specialist services are provided for Northlanders and where these services are located.

In the 2005/06 financial year, approximately 10,500 Northland outpatient visits were made at the Auckland Oncology Services outpatient services. Of these visits:

- 6,600 visits were for the Radiation Oncology Service,
- 3,000 visits were for Medical Oncology service, and
- 900 visits were for the Haematology service.

Of the people who made the visits, 71% were European, 20% were Maori, 4% were 'other' and 6% were 'unknown'.

3.4 Access to Services

Access to cancer services is complex and multidimensional; it includes health system factors, health care process factors, and patient-level factors including transportation. Northland's population characteristics and needs, and the way in which cancer services have been developed and delivered have resulted in a situation where improving access to services by addressing barriers is particularly important in order to reduce inequalities.

3.5 Gaps and Issues

From the stock-take and consultation process the gaps and issues that were identified could be classified into one or more of the following categories:

- **An actual gap in service** – in fact, there were relatively few services where there was a complete gap in service, if measured against the general 'menu' of cancer control services. However there are gaps in what is available as they are predominantly based on the medical model and are therefore treatment related, they are predominantly mainstream services, and there is a lack of a client-centred model for service delivery. For example there is a lack of kaupapa Maori support services, and there is also a lack of service coordination/case managers within the system.

Support and rehabilitation services are the part of the continuum which is possibly the most undeveloped with regard to services for people with cancer. This includes an actual

¹¹ Dr John Childs, "Improving provision of non surgical oncology services to the Northland population."

gap in services for people aged under 65 years, as well as a gap in information about what is available. There is also a lack of a coordinated 'pathway' that encompasses treatment, support, rehabilitation and palliative care services.

- **A gap in the level of services available, which affects access to the service, including the timeliness of the service.** This was the more common issue and is usually due to resource constraints – e.g. due to workforce shortages, or financial constraints. The lack of benchmarking or standards with regard to what level of service should be available in each area of the cancer services continuum makes it impossible to determine what the correct level of service should be.
- **A gap in access to service** occurs due to the **centralisation of specialist services.** Many people have to travel large distances to access secondary and specialist services, but lack transport options, or do not qualify for transport assistance.
- **Receiving a good quality and client centred service.** Many of the concerns, or barriers raised by consumers and providers related to the quality of the service provided. This included services being culturally appropriate, receiving full information that is easy to understand, the manner of the staff, the timing and location of appointments to meet individual circumstances, how patient notes are managed and how well service providers link and work together (including discharge planning).

3.6 What Northland is Doing Well

There are many services within Northland that are working well, and should be acknowledged and celebrated, including:

- The new Healthy Eating Healthy Action programmes.
- The network of Maori health providers throughout Northland, which plays a significant role in delivering health education and providing support and information for Maori with cancer.
- The Cancer Society provides a wide range of information and support services. Of particularly high value is the free accommodation service (Domain Lodge) which is available for people attending cancer services in Auckland.
- The new Breast Screening Unit in Whangarei, which offers for the first time a Northland based service meaning women do not have to travel to Auckland for breast screening analyst services as they have had to do in the past.
- The Breast Clinic which is based on a one-stop-shop and multi-disciplinary approach (and in future this will be further linked with the new Breast Screening Unit).
- Other diagnostic and treatment services that have received particularly positive feedback are services for gynaecological cancers, childhood cancers, and prostate, kidney and testicular cancers.
- The nurses at the Oncology Department also receive positive feedback.
- Dr John Childs, Oncologist, and his commitment to Northland is acknowledged as a strength for Northland.
- The volunteer transportation service based in the Far North and available to assist people to attend specialist appointments in Auckland and Whangarei, at no cost to the user, due to community fund raising.
- Hospice services in Northland, particularly the Specialist in Palliative Care received very high feedback from all consumers and providers spoken to.

4 Implementing the Plan

4.1 Working in Partnership

Health status is affected or determined by many social and economic influences outside the direct control of health service providers. Working with other agencies enables the health sector to better address needs that affect and underlie health status. It can also be a way of reaching the most deprived populations, particularly as they form the client base for agencies such as MSD and Housing NZ.

To influence the determinants that reduce the incidence, impact and inequalities related to cancer, the health and disability sector should work collaboratively with housing, transport, welfare, and local government.

4.2 Northland Cancer Control Network

At the time of preparing this draft plan, no formal Northland Cancer Control Network exists. However, there is some scope to form a network as:

- A Northland Cancer Control Steering Group has been developed to contribute to the formation of this Strategic Action Plan. The members of this group represent the whole continuum of cancer control services, and include the Cancer Society, Northland Primary Health Organisations (PHOs), palliative care services, Te Tai Tokerau MAPO, Northland DHB clinicians, senior managers and planners, and the Public Health Unit.
- As part of preparing this plan, a series of palliative care strategic planning workshops were carried out in the Far North, Mid North, Kaipara and Whangarei areas of Northland. The meetings were widely attended and attendees included consumers, DHB and NGO palliative care generalist and specialist providers. The people who attended the palliative care workshops showed support for the sector wide approach to palliative care planning. There is potential for palliative care to become a sector within the Northland Cancer Control Network.

4.3 Northern Region Cancer Control Network

At the time of preparing this draft plan, some work is being undertaken to form a Northern Region network. The Terms of Reference are currently being developed. This strategic action plan is unable to predict or pre-empt the configuration, terms of reference, representation, and activities of the regional network.

As specialist cancer treatment services are delivered to Northlanders by the Auckland Regional Cancer Service (ie. the Auckland DHB), Northland is a stakeholder in the regional network. Once the network and its functions become more clear, some actions in this plan may need to be undertaken either by or jointly with, the regional network.

4.4 Overall Priorities and Timeframe for Implementation

This Plan covers a five-year time period from 2006 to 2011. Within this five-year period, two phases have been identified:

- Phase 1: Actions are to occur within the first one to two years, and

- Phase 2: Actions to occur within three to five years.

Priorities for phase 1 implementation

There are many phase 1 priorities in this plan. These priorities are based on reducing the inequalities that currently exist in cancer outcomes for Maori and for Northlanders when they are accessing cancer services (as compared with the rest of New Zealand). The priority areas are:

- 1 Reducing tobacco use.
- 2 Increasing breast and cervical screening coverage rates, particularly for Maori women, through improved coordination between GPs, health providers and screening services.
- 3 Improving the referral system for tests and investigations, including developing guidelines for referrers.
- 4 Increasing the capability and capacity of oncology services provided within Northland, including the range of chemotherapy provided in Northland.
- 5 Improving the cancer journey for people who have a suspected or proven cancer through the development of a care coordination service, that includes a Kaupapa Maori approach; and incorporates case management and patient navigation functions to link primary, secondary and tertiary care, and support services.
- 6 Improving access to palliative care services at the time of diagnosis and treatment.
- 7 Improving the quality of information, particularly with regard to service utilisation, and the recording of ethnicity.
- 8 Workforce development.

The cancer priorities in this plan are: lung cancer, colorectal cancer and breast cancer.

4.5 Evaluation, Monitoring and Review

Information is vital to identify needs, determine patterns across population groups and trends over time, monitor needs over time and assess how well health services are meeting them. Information is essential to reducing inequalities. Health services cannot meet all needs so we must focus on the highest priorities first. Without accurate and complete information we cannot prioritise, target intervention and monitor outcomes.

Currently we lack information on:

- projections of cancer incidence in Northland
- service utilisation and outcome data recorded by ethnicity
- accurate cancer mortality data
- primary care utilisation
- measures of lifestyle and wellness (smoking, physical activity, nutrition, weight, alcohol and drug use, etc). At the moment we often have to rely on one-off surveys and studies
- outpatient activity. This is particularly significant as most of the Northland and Auckland District Health Board cancer services are provided on an outpatient basis
- cancer diagnostic and treatment services provided to Northlanders outside of Northland
- quality assurance measures.

We also need to develop comprehensive and planned approach to the collection and analysis of the information collected that is tied to the measuring the goals of this strategic plan.

Information flow between health and disability service providers is frequently mentioned as a source of frustration because inadequate information handicaps the ability of providers to provide quality care.

5 Indicators/Measurements for the Strategic Action Plan

The indicators and measures listed below were taken from the Director-General of Health's Annual report 2004/05 including the Health and Independence Report. They will be used as a guideline for the monitoring the progress of the cancer disease outcomes.

Indicator	All New Zealand	Northland (2000-2002)	Northland 2011 (target)
Reducing the Impact of Cancer			At least as good as the NZ average.
All cancer registrations 2001-01, rate per 100,000	363.3	398.5	
All cancer mortality, 2001-02, rate per 100,000	140.4	169.7	
Female breast cancer registrations, 2000-01, rate per 100,000	98.9	105.1	
Female breast cancer mortality, 2001-02, rate per 100,000	22.2	24.6	
Cervical cancer registrations, 2000-01, rate per 100,000	9.0	11.1	
Prostate cancer registrations, 2000-01, rate per 100,000	128.6	145.3	
Prostate cancer mortality, 2001-02, rate per 100,000	22.8	29.2	
Colorectal cancer registrations, 2000-01, rate per 100,000	51.2	51.1	
Colorectal cancer mortality, 2001-02, rate per 100,000	20.5	22.2	
Melanoma registrations, 2000-01, rate per 100,000	38.9	42.5	
Melanoma mortality, 2001-02, rate per 100,000	4.5	6.0	

6 Guiding Principles of Strategic Action Plan

The plan will be delivered in accordance with the principles in the New Zealand Cancer Control Strategic Action Plan. These principles have also been endorsed by the Northland Cancer Control Steering Group.

All activities undertaken to meet the purposes of the cancer control strategic action plan should:

- work within the framework of the Treaty of Waitangi to address issues for Maori;
- reduce health inequalities among different population groups;
- ensure timely and equitable access for all Northlanders to a comprehensive range of health and disability services, regardless of ability to pay;
- be of high quality;
- be sustainable;
- use an evidence-based approach;
- reflect a person-centred approach;
- actively involve consumers and communities;
- recognise and respect cultural diversity; and
- be undertaken within the context of a planned, coordinated and integrated approach.

These principles are consistent with the approaches identified by the Northland DHB as being critical to the planning and delivery of its services. Further discussion of some of the Northland DHB's key approaches is provided below.

Treaty of Waitangi

The Treaty of Waitangi is considered the founding document of this nation and establishes the unique and special relationship between Maori and the Crown. Northland DHB participates in relationships with Maori that recognise and respect the Treaty of Waitangi principles of partnership, participation and active protection of Maori health interests, in order to improve health outcomes and reduce inequalities for Maori.

For Northland DHB, this means enabling Maori participation in funding, planning and decision making through active partnership with Maori at all levels of the health sector – in governance, operational management and workforce development, in supporting Maori health provider development, including Kaupapa Maori models of service delivery, and in acting to improve the health and wellbeing of Maori while safeguarding Maori cultural concepts and values.

Whanau Ora

To incorporate the four He Korowai Oranga (Maori Health Strategy) pathways¹² in to service planning and resource allocation decision-making, analysis of service proposals includes an assessment of their contribution to Whanau Ora. Therefore they must:

- reduce inequalities in health status for Maori;

¹²The 4 pathways are: development of whanau, hapu, iwi and Maori communities; Maori participation in the health and disability sector; effective health and disability services; and working across sectors.

- increase Maori participation in the delivery and utilisation of health and disability support services;
- improve the health status of Maori;
- improve independence for Maori with disabilities;
- improve opportunities for Maori to participate in wider society as well te ao Maori (the Maori world);
- consider Maori values (as well as value for money) and be culturally appropriate; and
- increase the level of Maori participation in service planning, implementation and delivery.

Reducing Inequalities

Reducing inequalities is one of the key strategic issues that permeate all NDHB's planning and funding processes and decisions. It is one of the main thrusts of our prioritisation policy to ensure that funding decisions are consistently driven by the need to reduce inequalities among population groups.

The most common inequalities relate to measures of health and health service usage by Maori. Pacific people also experience inequalities. Other inequalities that may be relevant to particular situations exist between rural and urban, deprived and wealthier populations, age groups, and male and female.

To ensure inequalities are being reduced NDHB uses the Health Equity Assessment Tool (HEAT). This incorporates within in the Reducing Inequalities Framework and the principles of the Treaty of Waitangi.

The goals of the Northland Cancer Control Strategic Action Plan

The Northland Cancer Control Steering Group has endorsed the goals of the New Zealand Cancer Control Strategy but within each goal, has developed objectives that are based on addressing Northland's particular issues and priorities. These goals are to:

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

7 Goals, objectives and actions

Format of the Northland Cancer Control Strategic Action Plan

The following plan contains five sections that are based on the first five goals of the New Zealand Cancer Control Strategy. (It is thought that goal 6 is not an area within which Northland has a direct function).

Each section includes a table showing the issues and priorities and why they are important to the District. This table has been developed based on the findings of the stock-take and gap analysis. This is followed by a table showing what we are going to do to; measures or milestones; whether the actions can be achieved using existing, increased or new resources; phase 1 or phase 2 start; and key stakeholders involved.

Goal 1: Reduce the incidence of cancer through primary prevention

The table below summarises the key cancer risk factors in Northland. Tobacco use is high in Northland, and there is evidence that in 2005, Northland ranked second-bottom in NZ for the number of quit cards dispensed per 1000 estimated smokers. Lung cancer causes the highest number of deaths in Northland.

Cancer risk factors	Incidence in Northland	Mortality in Northland	Inequalities in Northland
Tobacco use and second-hand smoke (cancers of the lung, stomach, cervix and liver)	Very high	Very high	High Maori Women Low socio-economic
Obesity and physical inactivity (cancers of the colon, rectum and breast)	Physical activity and nutrition same as the rest of NZ.	High	High Maori
Alcohol (cancers of the oral cavity, pharynx, oesophagus, larynx and liver) Linked to increasing the risk of cancers of the breast, colon and rectum)	A higher level of hazardous drinking than the rest of NZ.	High	High Maori
Excessive exposure to sunlight/UV radiation (skin cancer, especially melanoma)	High	Low	High European
Hepatitis (cancer of the liver)	Low	Low	High Maori
Lack of knowledge of healthy behaviours and cancer risk factors, and/or a lack of motivation and support to change risky behaviour.	High Anecdotal evidence	Insufficient evidence	High?

What we are going to do

The priority area for this goal is to **target tobacco use**, as this the most effective means of preventing lung cancer. Lung Cancer is the leading cause of cancer mortality in Northland, and has a low five year survival rate. The incidence of lung cancer is projected to increase. Therefore, programmes aimed at preventing tobacco use, and at smoking cessation are important tools in addressing the burden of cancer in Northland.

Other priorities for Phase 1 are to continue to roll out the HEHA initiatives and 'Fruit in Schools' programmes to all decile 1 schools to promote healthy nutrition and to prevent obesity.

Objectives	Actions	Measures/milestones	Resources required ¹³), Phasing	Key stakeholders
Target tobacco use				
1.1 To increase quitting rates especially among Maori and other high risk population groups.	Provide effective and culturally appropriate smoking cessation services, including enhanced services for Maori men and women.	To increase the number of Quit Cards issued (there are currently 7 providers) Reduction in adult smoking prevalence to 20% or less by the end of phase 2. Increase in the number and range of cessation support providers and services.	Increased. Phase 1	MoH Quit Group Aukati kaipaipa NDHB primary and public health service providers
	Investigate and implement effective smoking cessation programmes for low socioeconomic status communities; and continue to implement the Systems First approach in the secondary setting and investigate its introduction to primary care settings.	Reduction in tobacco products sold. Systems First approach implemented in secondary settings and investigation completed re primary, with recommendations implemented.	Increased/new Phase 1	MoH NDHB MAPO smoking cessation providers primary and public health service providers
1.2 To reduce the rate of young people taking up smoking, especially groups with higher rates of smoking.	Implement strategies to reduce smoking initiation among young people.	Strategies launched. Reduction in percentage of younger smokers, by sex, age and ethnicity.	New Phase 1	MoH NDHB MAPO public and primary health providers Cancer

¹³ Existing, increased or new.

Objectives	Actions	Measures/milestones	Resources required ¹³), Phasing	Key stakeholders
				Society.
1.3 To increase emphasis on tobacco control throughout the health and disability sector, as well as other sectors, including the MoE.	Primary health service providers to incorporate information on smoking and quitting smoking into their clinical practice and health promotion plans.	Information on smoking cessation including in health promotion plans.	Existing Phase 1	MoH NDHB PHOs and other primary care service providers
	Continue to implement the NDHB policy on smoking prevention.	Achievement of smoking outcomes as listed in the NDHB Smokefree/Auahi Kore policy.	Existing Phase 1	NDHB
1.4 To promote and normalise smoke free environments and communities.	Carry out a joint campaign with territorial local authorities and NGOs to promote the benefits of being smokefree (eg smokefree children's play grounds).	Joint initiative developed and initiated.	Existing	NDHB TAs NGOs
Reduce infectious-disease related cancers.				
1.5 Reduce the incidence of Hepatitis B, especially in Maori, and Pacific and Asian peoples, and health care workers.	Develop guidelines for extending the criteria for free Hepatitis B vaccinations.	Guidelines for extended criteria for free Hepatitis B vaccination.	Increased. Phase 1/2	NDHB
	Research the benefits of expanding the Hep B screening programme.	Results of research.		
1.6 Reduce the incidence of cervical and vaginal cancer.	Monitor and assess developments in HPV screening and potential vaccination, and implement as appropriate.	Long term reduced incidence in cervical and vaginal cancer.	New Phase 2	MoH NDHB PHOs Pharmac

Objectives	Actions	Measures/milestones	Resources required ¹⁴), Phasing	Key stakeholders
Target physical activity and nutrition				
1.7 Reduced levels of obesity in vulnerable populations, particularly Maori, Pacific peoples and low socioeconomic groups.	Support childhood obesity programmes.	Enrolment in childhood obesity programmes.	Increased Phase 1	NDHB PHOs NGOs
	Implement the Te Tai Tokerau Oranga Kai Capacity Building Project.	<p>Maori public health workforce building of capacity and capability with a focus on healthy eating.</p> <p>Number of public health events on Healthy Eating Healthy Action delivered by Maori health providers.</p> <p>Development of Maori health dietician service.</p> <p>Development of weight loss initiatives by Maori health providers.</p> <p>Research and piloting of affordable food initiatives for whanau and hapu.</p>	Existing Phase 1	Te Tai Tokerau Rural Health Training Consortium
1.8 Reduce the number of people developing physical inactivity and obesity-related cancers.	Develop and implement a district HEHA plan.	Plan developed and implemented by June 07.	Existing Phase 1	NDHB TAs Sport Northland LTNZ MoE PHOs
	Implement and monitor the enhanced Green Prescription Programme (HEHA) which includes physical activity and a nutrition component.	Number of green prescriptions issued by gender and ethnicity.	Existing Phase 1	HEHA providers (PHOs and Sport Northland)

¹⁴ Existing, increased or new.

Objectives	Actions	Measures/milestones	Resources required ¹⁴), Phasing	Key stakeholders
1.9 Increased consumption of fruit and vegetables	Roll out the Fruit in Schools Programme.	Increased fruit and vegetable consumption among school children within Decile 1 schools.	Existing Phase 1	MoH NDHB Schools Heart Fdn
	Facilitate the development of community garden programmes for low income communities.	Number of programmes initiated.	Increased Phase 1/2	PHOs NGOs NDHB
Reduce alcohol related cancers				
1.10 Encourage cessation/change in hazardous alcohol consumption.	Existing alcohol awareness programmes are reviewed as to their effectiveness.	Review of alcohol prevention, awareness programmes.	Resource for review. Phase 2	NDHB PHOs NDHB Public Health Unit
	Based on the review, target alcohol awareness campaigns to vulnerable groups, to raise awareness of risks associated with certain cancers.	Change in existing alcohol awareness programmes.	Service change. Phase 2	NDHB

Cancer control: health outcome and risk/protective factor indicators applicable to Goal 1¹⁵

Aim: that by 2011, Northland's performance against measurements will be no worse than the New Zealand average.

Indicator	All New Zealand (2002)	Northland (2002)	Northland 2011
Reduce smoking			
Tobacco smoking, 14-15 years, 2002, %	20.9	23.4	
Tobacco smoking, 15+ years, 2002/03 %	23.3	32.4	
Lung cancer registrations, 2000-01, rate per 100,000	30.5	38.8	
Lung cancer mortality, 2001-02, rate per 100,000	26.9	34.1	
Improve nutrition			
3+ servings of vegetables per day, 2002/03, %	67.3	66.7	
2+ servings of fruit per day, 2002/03 %	53.9	47.6	
Reduce obesity			
Overweight, 15+ years, 2002/03, %	34.0	34.9	
Obesity, 15+ years, 2002/03, %	20.1	25.5	
Increase the level of physical activity			
Physically active, 15+ years, 2002/03, %	74.0	73.4	
Regularly physically active, 15+ years, 2002/03 %	52.5	52.3	

¹⁵ Ministry of Health. 2005. *An Indication of New Zealanders' Health 2005*. Wellington: pp 27. These are the total lifestyle factors that relate to cancer risk/protective factors that are measured in the Director General's annual report.

Goal 2: To ensure effective screening and early detection to reduce cancer incidence and mortality

During the course of preparing this plan, a new enhanced Breast Screening service opened in Whangarei. This is a substantial initiative which will assist Northland women by addressing the current two year waiting list for mammograms, and also reduces the need for women to travel to Auckland for other breast screening services. The early detection of colorectal cancer is another priority in Northland.

Northland issues and priorities

Cancer service issues	Inequalities in Northland
Population based screening: breast	High – a two year backlog Maori Rural
Population based screening: cervical	High – in 2003 67% of Northland women included in cervical screening programme (third lowest rate in NZ) Maori
Opportunistic screening: colorectal	High Non Maori Kaipara
Lack of information resources about the importance of early detection of cancer amongst vulnerable population groups.	High Low socio economic Rural Maori

What we are going to do

There is evidence that Northland performs lower than the national average in the coverage of breast screening and cervical screening. There is also evidence that Maori present late to their primary care practitioner with a suspected cancer. Early detection, and increasing the coverage rates of organised screening programmes are the priorities under this goal. This links in with the NDHB's and PHOs' approach to achieve health gain by reducing barriers to primary health care.

Objectives	Actions	Measures/milestones	Resources required ¹⁶), Phasing	Key stakeholders
Breast screening				
2.1 Reduction in breast cancer mortality among Maori and other at risk women.	Address the two year backlog for women waiting for mammograms.	Breast Screening Unit measures.	Existing Phase 1	Breast Screening Unit
	Develop joint initiatives with Maori health providers to encourage and/or enable Maori women to attend mobile screening unit, or the new Breast Screening Unit at Whangarei.	Joint Initiatives in place between the Breast Screening Unit and Maori health providers.	New Phase 1	NDHB MAPO Maori health providers Breast Screening Unit PHOs
Cervical cancer screening				
2.2 Reduction in cervical and vaginal cancer.	To increase the coverage of cervical screening to those women who are 'hard to reach'. More primary care nurses, particularly in rural areas, become trained as smear takers.	The cervical screening coverage rate matches the national coverage target (would require an increase from the current rate of 67% coverage to 75%).	Increased Phase 2	NDHB PHOs NGOs
Opportunistic screening				
2.3 Reduction of colorectal cancer mortality.	GPs inform population at risk of colorectal cancer of the effectiveness of early detection, and use of colorectal screening guidelines.	Increase in the number of 'early' referrals for investigations due to suspected colorectal cancer increases	Existing Phase 1	GPs PHOs
Early detection of cancer				

¹⁶ Existing, increased or new.

2.4 Encourage the early detection of cancer to reduce cancer mortality, particularly for Maori, Pacific peoples and low socio-economic groups.	Research the reasons for delays in the early detection of cancer, with a particular focus on barriers and inequalities in accessing services by Maori and other vulnerable groups.	Results of research.	New Phase 1	NDHB MAPO PHOs
	Develop and support programmes and information resources, including Kaupapa Maori programmes, that encourage Maori to present early to their primary health practitioner.	Information resources and programmes aimed at encouraging Maori to present early to their primary health practitioner.	New Phase 1	NDHB MAPO NGOs PHOs
	Develop and support mainstream programmes and information resources that encourage people to present early to their primary health practitioner.	Number of health promotion initiatives, including men's health evenings. Resources to raise health awareness amongst men – eg 'warrant of fitness' check.	Existing Phase 1	NDHB PHOs NGOs
	Investigate the viability of subsidised wellness clinics/visits that provide familial screening and health information and education.	Scoping report and feasibility study.	New Phase 2	NDHB MAPO PHOs
	Implement the findings of the feasibility study.	Number of wellness clinics.	New Phase 2	NDHB MAPO PHOs GPs and other primary health practitioners

Goal 3: Ensure effective diagnosis and treatment of cancer to reduce morbidity and mortality

This goal raised the most issues and priorities during the stock-take and gap analysis. This is not to say it is necessarily more important than the other goals, but rather reflects the complexity and detail involved.

Northland Issues and Priorities

Cancer service issues	Inequalities in Northland
Lack of standardised timeframes within which those with a suspected cancer should be able to access diagnostic procedures, see a specialist, and receive treatment.	Insufficient evidence
GP referrals are not prioritised accurately, leading to delays in treatment.	Insufficient evidence
Lack of contact person to acknowledge and track referrals.	Insufficient evidence
Transportation barriers to diagnostic and treatment services.	High Low socio-economic People with long distances to travel. People unable to drive (e.g. unwell, elderly and people living alone)
Patients do not understand information about their disease and treatment options.	High People with low education, low socio-economic. People for whom English is a second language.
Insufficient capacity of imaging services, resulting in long waits (CT and MRI)	
Lack of benchmarking information and timeframe standards for diagnostic and treatment services	
Lack of a one-stop approach for multiple tests, consultations, FUs – especially for lung cancer diagnosis.	Yes Maori
Lack of information avail for GPs and patients about actual waiting times.	Yes
Lack of clarity about cancer pathways.	High
People ‘fall through gaps’ along diagnostic and treatment pathway.	High as Northlanders need to access a wide range of providers in a number of organisations locally, in Whangarei and in Auckland. Particularly high for people with co-morbidities, high and complex needs.
Lack of a multi disciplinary and coordinated	High

Cancer service issues	Inequalities in Northland
approach to care within Northland	
A high proportion of skin cancer cases dealt with by NDHB services	Insufficient evidence
Oncology services based in Northland are limited and restricted by being managed under a regional service contract.	High Oncology services in Northland available on an outpatient basis only. No Northland based Oncologist. Auckland based specialists impacted by pressures on services in Auckland.
A very high number of Northland treatment services are provided via ADHB outpatients.	High Impacts on people as they have to be able to travel to Auckland, have family support, has an economic impact. Distance can be a deterrent to people accepting treatment.
Chemotherapy intervention rate for Northlanders is low.	High (as above)
Radiotherapy intervention rate for Northlanders is low.	High
A shortage of Physician with Respiratory Interest capacity to diagnose lung cancer.	High Maori
Auckland based gynaecological surgical and non surgical services lack the capacity to meet demand	Yes
Delays in the length of time taken from referral, diagnosis to starting treatment for childhood cancer.	Insufficient evidence

What we are going to do

This goal involves two main priorities:

- improving access to diagnostic and treatment services, and
- creating a person-centred, multi-disciplinary and coordinated approach to diagnosis and treatment, which includes a Kaupapa Maori approach.

Underlying these priorities is the need to address the inequalities that currently exist regarding cancer outcomes – between Northland and the rest of New Zealand, and between Maori and non Maori.

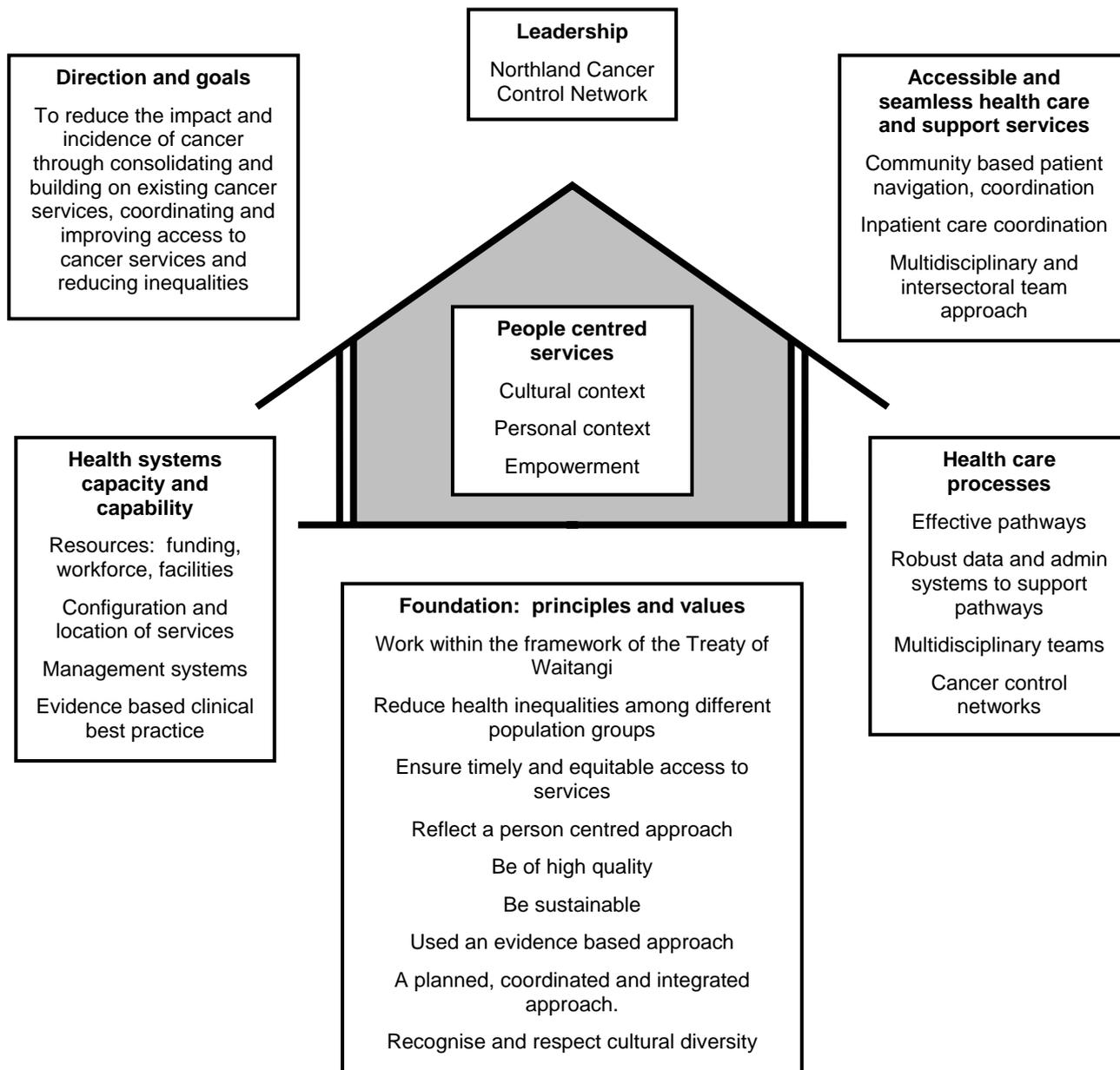
The cancer disease priorities, based on the number of patients affected and cancer epidemiology and disparities in Northland, are lung cancer, breast cancer, and colorectal (bowel) cancer.

Due to the outstanding disparities that exist with regard to cancer outcomes, any approach to improving diagnostic and treatment services for Maori and other people who are vulnerable to adverse outcomes, requires a strong patient focus. This means including a Kaupapa Maori approach to cancer control; ensuring there is a good link between hospital based services and with primary health and community services; and smoothing the transition points between cancer services for patients. Specific priority actions for the next two years are:

- Improving access to diagnostic services (as once a person is diagnosed, they are placed on the cancer treatment pathway). Improving access to colonoscopy and barium enema procedures is a priority, along with developing guidelines for referrers (GPs) to facilitate more accurate prioritisation of referrals and speedier processing;
- Expanding Northland based oncology services, including extending the range of chemotherapy services provided in Northland. This would reduce the number of people who have to travel to Auckland for oncology services, and
- Developing a coordinated pathway of care for cancer treatment – in particular to improve the coordination between Auckland and Northland based oncology services. This involves putting in place management systems and resources (including a redesign of some staff roles in primary and secondary care to have a coordination focus, along with the development of information and communication systems) to support coordination and is discussed further in Goal 5.

The model on the following page illustrates the elements for achieving cancer control in Northland. It will be governed by leadership which spans the cancer control continuum. At its heart is the service user/patient. Direction and goals align with the NZ Cancer Control Strategy. A key priority of the Northland Cancer Control Strategic Plan is accessible and seamless health care and support. This will require building on the capacity and capability of health systems and health care processes in Northland. The foundation for cancer control is the principles and values of the service.

Elements for managing cancer control in Northland



Goal 3: What we are going to do

Objectives	Actions	Measures/milestones	Resources required ¹⁷), Phasing	Key stakeholders	
Improve access to services					
3.1 To ensure appropriate referral and timely access to diagnosis and treatment for those with recognised disadvantages such as Maori, who have lower cancer survival.	Review the procedures and checks for receiving and acknowledging referrals, prioritising referrals and providing timely appointments for Maori.	National benchmarks and timeframes established.	N/a	NDHB cancer diagnostic and treatment providers and professional groups	
		Accurate recording of ethnicity, and monitoring of progress of Maori.	Existing; add to quality assurance data collection. Phase 1		
	Establish appropriate timeframes within which those with suspected cancer should be able to see a specialist for diagnosis, or for treatment.	Evidence that waiting times for appointment are being monitored. Appropriate and transparent prioritisation procedures.	Existing Phase 1		
	Provide a single point of contact for the management of referrals, including communicating timeframes to primary practitioners and consumers.	Redesign of referral and prioritisation process.	Increased Phase 2		
	Prioritise initiatives aimed at reducing cancer related inequalities for Maori.	Allocation of resources for Maori initiatives.	New Phase 1		NDHB MAPO
	Develop resources and processes to assist providers to communicate effectively with Maori about cancer care.	Communication strategies or approaches for Maori are developed and implemented with Maori stakeholders.	New Phase 1		NDHB MAPO Maori providers

¹⁷ Existing, increased or new.

Objectives	Actions	Measures/milestones	Resources required ¹⁷), Phasing	Key stakeholders
	Diagnostic and treatment providers monitor access to their services and the cultural acceptability.	Develop cultural acceptability criteria and carry out an internal cultural audit. Customer feedback survey. Results of monitoring of outcomes. Maori service utilisation rates. Cancer mortality rates.	Existing Phase 1	NDHB treatment providers
	Carry out analysis of need to increase access to colonoscopies, barium enema, and other investigations required to diagnose colorectal cancer. Based on results of analysis, identify options (including methods and resources) that will improve access to these diagnostic investigations, and the flow-on effects this may generate on other diagnostic and treatment services.	Completion of review.	Increased Phase 1	NDHB
3.2 Improve referral processes for timely access to diagnostic and treatment service.	Create referral guidelines and template for primary health practitioners to use when referring people with a suspected cancer for diagnosis or treatment, prioritising lung, breast and colorectal cancers.	Referral guidelines and template in use.	Existing Phase 1	NDHB PHOs
	Investigate the viability of using an IT system such as Health Point to keep referrers and patients informed on waiting times etc.	Research into the suitability of the Health Point IT package.	New Phase 2	

Objectives	Actions	Measures/milestones	Resources required ¹⁷), Phasing	Key stakeholders
3.3 Improve access for people who have to travel to Auckland for cancer services by addressing the barriers (in particular transport, accommodation, financial and childcare support).	Produce an easy to read summary of services for people who need to access services in Auckland, and ensure all providers and consumers receive copies of this information.	Summary of support services required and available for people who need to access cancer support services.	New Phase 1	NDHB NGOs PHOs
	Investigate and scope a care coordination service that includes a Kaupapa Maori approach, and incorporates case management and patient navigation functions to link primary, secondary and tertiary care, and support (also refer to objectives 3.6, 4.2, and 5.1)	Scoping report on the coordination of services for people with cancer.	New Phase 1	
	Implement the scoping report's recommendations	Implementation of the care coordination report recommendations.	New Phase 2	
3.4 Provide accessible information to patients so that they are empowered to make informed choices on treatment options.	Ensure information, including provider-patient communication informs patients of their possible choices in an easy to understand manner.	Information made available.	Existing Phase 1	NDHB PHOs NGOs
	As a standard practice, encourage all patients to bring along support people to assist them in to understand what they are being told, to feel comfortable, and to make informed choices.	Develop a protocol for providers to use, to encourage information and support for people with cancer.		

Objectives	Actions	Measures/milestones	Resources required ¹⁷), Phasing	Key stakeholders
3.5 To increase the capacity of oncology services, including consideration of the appointment of a Northland-based Oncologist and increasing allied health resources (eg social workers, counselling, dietician) and support services within Northland to facilitate timely access by Northlanders to cancer treatment services.	Re-negotiate the oncology services contract with the Auckland Regional Cancer Service to gain more Northland based services.	Contract negotiations. Increase in the level of oncology services based in Northland, including a Northland based Oncologist, allied health professionals, and nurse specialists. Increased Auckland specialist outpatient visits to Northland – including follow-ups and streamlining of appointments where possible.	Existing Phase 1	NDHB ADHB (Auckland Regional Cancer Service)
	Increase the range of chemotherapy treatment available within Northland.	Nurses trained, facilities increased, commencement of expanded chemotherapy service.	Increased Phase 2	NDHB ADHB (Auckland Regional Cancer Service)
	Monitor waiting times for all cancer treatments.	NDHB and ADHB report waiting times on a monthly basis.	Existing Phase 1	NDHB ADHB (Auckland Regional Cancer Service)
Person-centred, multidisciplinary and coordinated approach to cancer diagnosis and treatment				
3.6 Develop a person-centred, multi-disciplinary and coordinated approach to cancer diagnosis and treatment that targets Maori, and other people at risk of poor outcomes.	Review and redesign specific cancer pathways and outcomes of treatment, in order of priority, and put in place measures to improve access and outcomes.	Review of specific cancer pathways. Pathway re-design.	Increased and new. Phase 1 and 2.	NDHB
	Develop cancer multi disciplinary teams, including protocols and standards.	MDTs for priority cancer areas developed.	Existing Phase 1	

Objectives	Actions	Measures/milestones	Resources required ¹⁷), Phasing	Key stakeholders
	Investigate and scope a model of care coordination, that includes a Kaupapa Maori approach, incorporates case management and patient navigation functions and links primary, secondary, tertiary care along with support services. (also refer to objectives 3.3, 4.2 and 5.1)	Scoping of care coordination and case management / patient navigator models.	New Phase 1	
	Implement the scoping report's recommendations	Implementation of the care coordination recommendations.	New Phase 2	
	Develop a Northland Cancer Network to coordinate and improve communication.	Northland Cancer Control Network established. Electronic records shared.	New. Phase 1	All cancer services
	Have input to the Northern Regional Cancer Network to ensure Northlanders' access to Auckland based services is maximised.	Appropriate level of participation in the Northern Regional Cancer Network.	New. Phase 1	NDHB MAPO All cancer services
	Review the pathway for people with skin cancer (including malignant neoplasms and melanoma) and if appropriate, re-design to make most effective use of primary and secondary health services.	Completion of review of skin cancer pathway.	Existing Phase 2	NDHB

Goal 4: Improve quality of life for those with cancer, their family and whanau through support, rehabilitation and palliative care

Supportive care and rehabilitation encompasses the ‘essential services to meet the physical, emotional, nutritional, informational, psychological, sexual, spiritual and practical needs throughout a person’s experience with cancer’. (Minister of Health, 2003). Access to, and the availability of, support is particularly important for Northlanders with a suspected or proven cancer due to the:

- high level of socio-economic deprivation within the population,
- absence of Ministry of Health funded disability support services for people with cancer up to the age of 65 years,
- distances people have to travel to access diagnostic and treatment services in Auckland,
- need for accommodation for people receiving diagnostic and treatment services in Auckland,
- gaps in free accommodation for people who have high needs and no personal carers
- fragmentation of existing services, and an
- absence of a needs assessment and coordination process to link people who have cancer with available support services.

Whilst there are quality palliative care services run by NGOs in Northland, there is a lack of a palliative care liaison team based at the hospital to provide education and liaison for hospital providers. As there can be a high staff turnover at hospitals, including a large number of people from outside of New Zealand who are not familiar with our palliative care approach in NZ, the availability of information and training for these providers is important.

Northland Issues and Priorities

Cancer service issues	Comment
No formal link or pathway between treatment, support services and palliative care services.	People do not receive services because of a lack of a coordinated pathway.
Lack of information on available support services.	People who do not get referred to the Cancer Society have a lower level of information.
Gaps in support services for people with cancer, particularly for people aged under 65 years.	High level of inequality for people aged under 65 years needing support.
Home support providers are risk-averse concerning workforce issues, barriers for putting in place services in the home for people with a terminal illness.	Palliative care patients and people living in remote or rural areas can suffer inequalities.
Information about palliative care services is often not provided to clients until late in the pathway ‘as a last resort’	
Variation in knowledge and attitude amongst hospital staff about palliative care and its potential benefits for clients	A significant number of providers (in primary, secondary and tertiary health services) from outside of NZ who have a limited knowledge of palliative care and available services in Northland.

Cancer service issues	Comment
Need for clarity on definition of palliative care, and how generalist and specialist palliative care is provided and funded.	
Need to ensure consistent quality and capability of palliative services outside of Whangarei	
A large number of people are involved in the care of people with terminal illness – need to ensure good communication, and coordination amongst all involved.	
Maori are not accessing palliative care services at the same level as non Maori.	

What we are going to do

Priorities to be addressed under this goal are:

- making available support services for people under 65 years. This includes the availability of home help, personal cares, carer support and respite services;
- accommodation services in Auckland – particularly for people who are frail and have high support needs, or who have a terminal illness, and thus do not meet the criteria to access the Domain Lodge, run by the Cancer Society;
- establishing hospital based palliative care liaison teams to provide an education role within the hospital, and to ensure there is a link between hospital and NGO palliative care services.

Objectives	Actions	Measures/milestones	Resources required ¹⁸), Phasing	Key stakeholders
Improve quality and availability of information				
4.1 Ensure that all people with cancer are aware of what support services are available to enable informed choices, and to promote access the services.	Refer to objective 3.2. Develop quality information resources.	New information resources developed.	New Phase 1	Cancer Society DHB Iwi providers GPs PHOs
Coordinate support and treatment services				
4.2 Develop and implement a coordination model which formalises the link between treatment and support services (including palliative care)	Investigate and scope a model that facilitates the coordination of services for people with cancer, which includes a kaupapa Maori approach. (Also refer to objectives, 3.3, 3.6, and 5.1).	Scoping report on the coordination of services for people with cancer.	New Phase 1	NDHB MAPO
	Implement the scoping report's recommendations	Implementation of a care coordination recommendations	New Phase 2	
4.3 Develop systematic assessment and appropriate multidisciplinary intervention approach to meet people's support and vocational needs.	Await the national policy on support services for people with 'personal health' needs, and then carry out the necessary actions.	Implementation of the national policy on support services for people with 'personal health' needs.	New Phase 2	MoH NDHB

¹⁸ Existing, increased or new.

Objectives	Actions	Measures/milestones	Resources required ¹⁸), Phasing	Key stakeholders
4.4 To ensure use of support services is maximised by facilitating access them.	Develop a shared data base on the available support services for Northlanders who have cancer (refer to objective 3.2).	Database in place.	New Phase 1	NDHB
	Develop referral protocol linking people needing support and rehabilitation services with the available services.	Referral protocols and templates are place.		
Build capacity				
4.5 To reduce the gap in the provision of community based support services for people with cancer who have longer term support needs	Implement the National Policy Guidelines (pending), for the provision of community support services for those with personal health needs.	Home based/community support services are accessible to those who are eligible for longer term support.	New Phase 1	MoH DSD NASC NDHB Home support providers
	Align policy with NASC service eligibility criteria.		New Phase 1	
	Establish a HBSS advanced nursing contract to cover all regions.	There is a HBSS/advanced nursing contract in place.	Increased Phase 1	
	Establish respite care service options.	Respite care services are provided in a range of settings	Increased Phase 2	
Improve access to palliative care services, particularly for Maori				
4.6 To increase access to palliative care for Maori with cancer and deliver services in a culturally appropriate manner.	Carry out research to identify barriers to Maori to access palliative care services and methods that improve access.	Completion of research. Implementation of recommendations. Increased utilisation of palliative care services by Maori.	New Phase 1	NDHB MAPO NGOs

Objectives	Actions	Measures/milestones	Resources required ¹⁸), Phasing	Key stakeholders
4.7 To provide improved access to palliative care services at the time of diagnosis and treatment.	Establish specialist care coordination roles/ palliative care liaison team for all regional hospitals.	Early referral, assessment and intervention by specialist palliative care team within agreed response times.	New Phase 1	NDHB Palliative Care Specialist and providers NDHB diagnostic and treatment services
	Establish systems for early referral, and clinical pathways between treatment services, community support services and palliative care.	Documented policies and clinical pathways.	New Phase 1	PHOs GPs
	Implement specialist/generalist palliative care training across the continuum of cancer care. (Refer also to objective 5.2).	Provision of formal and informal training.	New Phase 1	NDHB
	Research and develop integrated patient information systems.	Integration of patient information and reporting systems.	Existing Phase 1	NDHB
4.8 To ensure that local palliative care services are responsive to local needs, and that there is consistency in the range and quality of palliative care services throughout Northland.	Develop a Northland Palliative Care Strategy.	Strategy completed.	Existing Phase 1	NDHB NGOs PHOs
	Define and monitor service levels.	Data definition. Service specifications in contracts.	Existing/ increased Phase 1	NDHB
4.9 To reduce barriers for people with terminal illness accessing palliative treatment in Auckland.	Scope transport and accommodation solutions to enable people with terminal illness to attend treatment in Auckland.	Scoping report on transport and accommodation solutions for people with terminal illness receiving services in Auckland. An increase in the range of transport and accommodation support services for people with a terminal illness.	Increased/new Phase 1	NDHB NGOs

Goal 5: Improve the delivery of services across the continuum of cancer control, through effective planning, coordination and integration of resources and activity, monitoring and evaluation

The coordination of services to ensure a patient has a smooth journey across the continuum of cancer control services has been identified as an issue throughout this plan. Other issues identified are the availability of quality information to enable effective planning, and workforce development.

Northland Issues and Priorities

Cancer service issues	Comment
<p>Delivery across the continuum</p> <p>Information gaps on service delivery, esp. outpatient service utilisation, diagnostic and treatment service intervention rates, what services are being delivered to Northlanders in Auckland.</p> <p>A lack of monitoring and evaluation of the effectiveness of cancer services.</p> <p>Lack of focus on ensuring cancer control services are accessible to Maori.</p> <p>Need to ensure a consumer focus in cancer services.</p>	<p>There are examples of networks occurring elsewhere in New Zealand; not yet established in the north.</p>
<p>Workforce</p> <p>Need for a workforce development strategy to ensure adequate capacity and capability of workforce based in Northland and Auckland to meet projected demand for cancer services.</p> <p>Need for balanced cultural representation in workforce. Maori are under-represented in the workforce.</p> <p>Workforce recruitment and retention issues, particularly for diagnostic and clinical personnel.</p> <p>Workforce shortages and barriers in home based support services affected ability to meet increasing demand for home support.</p> <p>Volunteers and carers are ageing, and will be facing increasing pressure.</p>	
<p>Information</p> <p>A lack of information on cancer service</p>	<p>Difficult to prioritise, target interventions and</p>

Cancer service issues	Comment
<p>utilisation – particularly with regard to outpatient activity, and for services provided outside of Northland.</p> <p>Refer to other information issues on page 17.</p>	<p>monitor outcomes without quality information.</p>

What we are going to do

A priority of this strategic action plan is to scope and develop a cancer care coordination service which targets addressing disparities between Maori and non Maori regarding access to services. The scoping report would therefore include a description of a Kaupapa Maori service and recommendations relating to such a service. The scoping process will include:

- consulting with stakeholders
- reaching agreement on a process and terms of reference
- a review of what is happening elsewhere and lessons learnt (targeting initiatives aimed at Maori and other indigenous peoples)
- development of an implementation plan
- preparing a funding proposal for approval by the end of phase 1.

Other priorities addressed in this section are the availability of quality information to enable effective planning; and workforce development.

Workforce priorities include addressing shortages within diagnostic services, and the enhancement of the existing oncology service based in Whangarei so that a wider range of chemotherapy is provided within Northland.

Many of the information gathering and monitoring activities will also require national and regional input. Some work is currently occurring at the national level on the collection of information relating to cancer control. The NZ Cancer Collection Framework Project report is available on the Ministry of Health's website. Accurate information gathering and analysis may also be a priority of the Northern Cancer Control Network once it is formed.

Objectives	Actions	Measures/milestones	Resources required ¹⁹), Phasing	Key Stakeholders
Improving coordination across the cancer control continuum of services				
5.1 To achieve improved coordination of cancer care and support services, and reduce disparities between Maori and non Maori relating to access to cancer services. (refer also to objectives 3.3 3.6 and 4.2).	Investigate and scope a model that facilitates the coordination of services for people with cancer, which includes a Kaupapa Maori approach.(also refer to objectives 3.3, 3.6 and 4.2).	Scoping report on the coordination of services for people with cancer.	New Phase 1	NDHB MAPO PHOs NGOs including Maori health providers and Cancer Society
	Implement the scoping report's recommendations	Implementation of a care coordination report recommendations	New Phase 2	
	Develop a Northland Cancer Control Network to facilitate communication and coordination of services for people with cancer.	Development of the Northland Cancer Control Network.	New Phase 1	All services involved in cancer control continuum Consumers Maori.
	Develop an information system to support care coordination.	That information systems are developed to support care coordination (e.g. web based patient management database)	New Phase 2	NDHB
Build and improve the capacity and capability of services for Maori with cancer.				
5.2 To ensure appropriate programmes and services are accessible to Maori across the cancer control continuum.	Ensure Maori are actively involved in identifying Maori priorities across the cancer control continuum.	Involvement of Maori in cancer control priorities exercises. Use of HEAT tool to prioritise programmes.	Existing Phase 1	NDHB MAPO Maori health providers
	Evaluate the extent to which Maori inequalities are being addressed in the implementation of the Cancer Control Strategic Action plan.	Monitoring of key indicators, by ethnicity.	Existing Phase 1 and 2	

¹⁹ Existing, increased or new.

Objectives	Actions	Measures/milestones	Resources required ¹⁹), Phasing	Key Stakeholders
	Ensure appropriate resourcing and support for improving Maori capacity and involvement in the implementation of the Strategic Action Plan.	Evidence of resource allocation and involvement.	Increased Phase 1 and 2	
	Planners and funders of cancer services consider the needs of Maori when piloting initiatives aimed at reducing cancer-related inequalities, such as Kaupapa Maori initiatives.	Identification of priority areas for Maori. Development of service plans.	New Phase 1	
5.3 To improved information for, and communication with, Maori communities.	Ensure effective communication with, and development of resources for, Maori communities to keep them informed of cancer, and cancer service options, and to engage Maori in new developments.	Communication strategies or approaches for Maori are developed and implemented with Maori stakeholders.	New Phase 1	NDHB MAPO Maori health providers PHOs
Carry out workforce development				
5.4 To improve the capacity of Northland based oncology services through gaining additional oncology staff based in Northland.	Negotiate with the ADHB for additional funding to employ Northland based personnel, including a Northland based oncologist, nurse coordinators, and social workers.	Results of negotiations with the ADHB.	New Phase 1	NDHB
5.5 To provide access to specialist palliative care education to increase the range of accessible palliative care services. (refer also to objective 27).	Contract a Specialist Palliative Care Educator.	Education delivered.	New Phase 1	NDHB NGOs

Objectives	Actions	Measures/milestones	Resources required¹⁹), Phasing	Key Stakeholders
5.6 To improve the capacity and capability of the cancer nursing workforce.	Train the nurses in the oncology department to carry out more complex chemotherapy services.	Provision of more complex chemotherapy services in Northland.	Increased Phase 1 and 2	NDHB ADHB Regional Cancer Service
5.7 To have increased involvement of Maori professionals in cancer control.	Carry out and support initiatives that encourage Maori to become health professionals.	Number of initiatives. Number of Maori within the professional workforce.	New Phase 1 and 2	NDHB MAPO
5.8 To have a full complement of diagnostic personnel employed at Northland DHB.	Develop strategies to attract and retain hospital radiologists and radiographers.	Levels of diagnostic services.	Existing Phase 1 and 2	NDHB
5.9 To develop a sustainable workforce to meet the rehabilitation and support service needs of cancer patients and their family/whanau.	Carry out a pilot project that scopes a model of service delivery for sustainable home based support and community services and addresses workforce capacity issues.	Results of pilot project	Increased/New Phase 1 and 2	NDHB
Improve information systems				
5.10 To ensure quality information to identify existing service delivery patterns, gaps, and to facilitate planning processes.	Develop systems for the collection and analysis of outpatient service data for people with cancer. Develop systems for the collection and analysis of data on Auckland based services utilised by Northlanders. Develop systems for the collection and analysis of data on chemotherapy and radiotherapy intervention rates for Northlanders.	Cancer control information strategy and system in place. Data collection, storage, retrieval systems are put in place to support MDTs.	Increased/ new Phase 1	NDHB ADHB Other Auckland based treatment providers PHOs

Objectives	Actions	Measures/milestones	Resources required¹⁹), Phasing	Key Stakeholders
5.11 To develop and implement a patient management system that supports a care coordination approach.	Develop information systems to support care coordination (eg web-based patient management database)	Patient management system in place	Increased/New Phase 2	NDHB
Monitor and evaluate services				
5.12 To establish a cancer service monitoring and evaluation system that provides ongoing information about access to cancer services, and cancer-related inequalities, particularly for Maori.	Institute a system to routinely report on equity of access to cancer services by Maori across the cancer control continuum.	Monitoring and data collection processes are developed to report on Maori access to cancer control services and activities and cancer related inequalities.	Increased Phases 1 and 2	MoH NDHB ADHB Cancer control service providers and networks
	Review NDHB data collection activities to ensure that the data collected is in alignment with service evaluation criteria. Northland Cancer Service Network to receive results and monitor results.	Monitoring and data collection processes are developed to report on access to cancer control services and activities and cancer related activities, targeting inequalities for Maori.	Increased. Phases 1 and 2	MoH NDHB ADHB Cancer control service providers and networks
	Expand and standardise the collection of ethnicity data.	That all ethnicity data is collected.	Existing Phase 1	MoH NDHB ADHB Cancer control service providers and networks
	Establish evaluation criteria and process to enable the monitoring of the effectiveness of cancer diagnostic and treatment services.	Evaluation criteria and process is in place and used.	Increased Phases 1 and 2	Cancer control service providers and networks

8 Glossary of terms

Term	Explanation
acute	Used to describe an illness or injury, either mild or severe, which lasts for a short time.
age-standardised, age-standardising	Some features occur at different rates at different ages; heart disease, for example, is more common in older age groups. Thus if 2 population groups have different age structures (as Maori and European do), their rates cannot be compared directly. Age-standardising is a statistical process which converts data from different populations as if it came from the same (standardised) population. The resulting rates are not 'real', but they are comparable.
barium enema	A procedure involving the introduction via the anus of a liquid which shows up as high contrast on xray, thus providing a clear picture of the structure of the lower intestine.
benchmarking	The process of comparing one organisation's service data with another, typically for DHBs with national data or other DHBs.
cancer registration	A system run by the Ministry of Health which contains a record of every cancer diagnosed in NZ. Once laboratories have diagnosed a cancer, they must under a special act, report it to MoH.
cardiovascular disease (CVD)	Related to the heart (cardio) and circulatory (vascular) system. The term includes both <i>coronary heart disease</i> and <i>stroke</i> .
chemotherapy	The treatment of cancer with chemicals that have a specific toxin effect upon the disease-producing microorganisms or that selectively destroy cancerous tissue.
daypatient	See <i>hospitalisation</i> .
DC	District council.
deprivation, deprived	Describing those with high, often multiple, needs (often used loosely to mean 'poor', though income is only one of the factors considered). The most widely quoted source of data on deprivation is the NZ Deprivation (NZDep) scale which analyses 5-yearly Census data to describe deprived populations. Once 'deprivation index' scores are calculated across the whole of New Zealand, the data is divided into deciles, 10 population groups of equal number. (These deciles are calculated differently, and use a different scale to the school deciles used by the education system.)
DHB	District Health Board.
discharge planning	The process of actively planning for someone's discharge to ensure the process happens smoothly, they have adequate support at home and the likelihood of complications developing is minimised.
District Annual Plan (DAP)	Northland DHB's statement of its intentions for the coming year. (See also <i>District Strategic Plan</i> .)
District Strategic Plan (DSP)	Northland DHB's statement of its intentions, based on the needs identified in the <i>HNA</i> , over the coming 5 or 10 years. Prepared once every 3 years. (See also <i>District Annual Plan</i> .)
epidemiology	A population science concerned with the distribution and determinants of health- and disease-related states in human populations.

Term	Explanation
ethnicity	A measure of cultural affiliation defined by Statistics New Zealand as a social group whose members share a common origin, claim a common sense of distinctive history and destiny, possess one or more dimensions of collective individuality and feel a sense of unique collective solidarity.
Fruit in Schools	A Ministry of Health-driven programme to promote health and wellbeing in high need primary schools. It involves a <i>Health Promoting Schools</i> / whole-school-community approach to promoting 4 priority areas (healthy eating, physical activity, sun protection and smokefree), as well as the provision of fresh fruit for children in eligible primary schools in high-need areas.
Green Prescription (GRx)	Written advice about physical activity from a health professional (typically a GP), given to a person as part of managing their health.
haematology	The study of the structure and composition of blood and blood-forming tissues.
HBSS	Home-based support services. The services which assist people to remain at home, either because they have disability support needs (often older people) or shorter term health needs (often after discharge from hospital).
Healthy Eating, Healthy Action (HEHA)	A Ministry of Health-driven strategy which aims to identify, promote, and coordinate programmes for healthy nutrition and appropriate physical activity at national, regional, community and iwi levels.
He Korowai Oranga (HKO)	The national Maori health strategy published by the Ministry of Health (see also <i>Whakatataka</i>).
Hospitalisation	The process of attending hospital as a patient. There are 3 main types: <i>inpatient</i> (a patient who stays at least one night in hospital), <i>outpatient</i> (a person who is seen in a non-inpatient setting, or 'clinic', by a <i>specialist</i> after referral from a GP) and <i>daypatient</i> (a patient who undergoes an operation or other procedure in hospital and able to return home without staying overnight). The term 'hospitalisation' is often used loosely to mean one or any combination of the 3 types.
incidence	The number of new instances of a disease or illness in a defined group of people over a particular period of time (compare with <i>prevalence</i>).
inpatient	See <i>hospitalisation</i> .
intersectoral	Used to describe relationships between health and other sectors, often other government organisations, <i>TAs</i> (compare with <i>intrasectoral</i>)
Maori provider	A provider of health services which is run by Maori for Maori (as distinct from a 'mainstream' provider who deals with Maori clients or patients).
MAPO	A Maori co-funder organisation, Northland DHB's funding and planning partner (the name persists from the days when they were called 'Maori purchasing organisations'). NDHB deals with 2: Te Tai Tokerau MAPO (whose responsibilities for Maori correspond with the DHB's responsibilities for the population bounded by the Whangarei and Far North territorial local authority areas) and Tihi Ora MAPO (whose responsibilities for Maori coincide with the DHB's responsibilities for the Kaipara district).
MoE	Ministry of Education.

Term	Explanation
MoH	Ministry of Health.
MSD	Ministry of Social Development.
NASC	A NASC is an organisation contracted by the Ministry of Health to: determine a person's eligibility and need for publicly funded disability support services (needs assessment) allocate services which are then delivered by third party providers(service coordination)
NDHB	Northland District Health Board, which has 2 parts, <i>NDHB Funder</i> and <i>NDHB Provider</i> . The NDHB Funder is that part of NDHB that has been legislated to carry out the funding function for health services in Northland. The funder assesses needs, sets priorities for services, allocates funds, lets contracts to providers, and monitors performance. The NDHB Provider is that part of NDHB that provides health services (as distinct from the <i>NDHB Funder</i>). The majority of the Provider Service's funding goes on <i>Secondary care services</i> . In the strategy documents, 'NDHB' refers to the whole organisation with involvement as relevant in each case from the funder or from the provider arm.
Northland Cancer Control Network	A group, yet to be set up, which could oversee future planning for cancer in Northland. The idea has arisen as a result of the involvement of many people and organisations involved in the preparation of this strategy.
obese, overweight	Degrees of excess weight, as defined by the <i>Body Mass Index (BMI)</i> . Overweight = BMI 25-29 for Europeans, 26-31 for Maori and Pacific. Obese = BMI 30+ for Europeans, 32+ for Maori and Pacific. (Acceptable figures differ across ethnic groups because of variations in bodily composition and how this relates to risk of developing health problems such as heart disease and diabetes).
oncologist	A doctor who specialises in the diagnosis, treatment and rehabilitation of people with cancer.
opportunistic screening	Taking advantage of opportunities as they arise, such as during a GP visit, to assess individuals for health problems (as distinct from a formal population-based programme of screening, such as the Cervical Screening Programme). People may not realise that they have signs or symptoms already developing, so this is an important way of catching problems (especially chronic diseases) early, when they are more likely to be preventable or are easier to treat.
outcome	The result of an action. As distinct from an output, which is a measure of an activity rather than the result it has. An operation to mend a broken leg is an output, while the return to full function of the leg is the outcome. In a bigger picture sense, a focus on outcomes aims to analyse how effectively health services are provided and how well they work together.
outpatient	See <i>hospitalisation</i> .
palliative care	"an approach that improves the quality of life of patients and their families facing the problems of a life threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems physical, psychosocial and spiritual'. It can involve a range of providers including hospices, hospitals, general practitioners and community health services." (WHO 2002).

Term	Explanation
pathology	The study of disease, its diagnosis and effects on the body. Pathology services are provided by pathologists who work within laboratory services.
patient management system	A system for managing data about all the people to whom an organisation provides services.
primary health care	Health services provided in the community which people can access themselves. The most well known are those provided by general practitioners, though they also include pharmacy services, private physiotherapists and, increasingly, nurse practitioners. (See also <i>secondary services</i> , <i>tertiary services</i>).
Primary Health Organisation (PHO)	A group of providers of <i>primary health care</i> services whose responsibility is to look after the people who enrol with them (those who are ‘on the register’). PHOs include GPs as well as a whole range of primary health care providers and practitioners (Maori and community health service providers, nurses, pharmacists, dietitians, community workers, and many others). As well as providing traditional primary health care services, PHOs must improve access to services for those with higher needs (such as Maori or those with chronic health conditions), have a focus on preventing ill health (rather than waiting till they are visited by sick people) and improve the way services work together.
prevalence	The total number of instances of a disease or illness in a defined group of people at any one time (compare with <i>incidence</i>).
Public Health Unit	Part of the Community, Dental and Public Health Services of Northland DHB which provides health promotion and health protection services.
Quit Cards	A credit-card-sized card given to people who want to give up smoking by health workers. It contains summarised information about techniques and the 0800 of the quit-smoking phone line.
radiology	Disease diagnosis and treatment through the study of images derived from xrays, <i>barium enemas</i> , CT scans, MRIs and the like (originally applied to just xrays, but usually used now to cover imaging processes generally).
radiotherapy	The treatment of disease with radiation.
reducing inequalities	Inequalities in the health status of populations exist by <i>socioeconomic status</i> , <i>ethnicity</i> , gender, age and geographical areas. The reducing inequalities approach is about recognising these and proactively planning, funding and delivering services to reduce these differentials.
registration	See <i>cancer registration</i> .
risk factor	A factor, which may be biological (such as a genetic predisposition) or associated with behaviour (such as smoking), that increases the likelihood of a disease developing.
secondary services, secondary care	Hospital services which people can access only through a referral from a primary health care worker. (See also <i>primary health care</i> , <i>tertiary services</i>).
socioeconomic status (SES)	Social position along a scale (which runs, in everyday terms, from ‘rich to ‘poor’), as measured by criteria such as income level, occupational class or educational attainment.

Term	Explanation
specialist	A physician or surgeon, usually based in a hospital, who has undertaken extra training on top of the normal medical degree to specialise in a particular type of service or disease. Also called a consultant.
tertiary services	Hospital services that are more specialised than secondary, serve smaller numbers of people and higher in cost. Most of these are provided in only a few larger centres (for Northlanders, mainly in Auckland). (See also <i>primary health care, secondary services</i>).
waiting time	The time it takes to receive treatment, usually in <i>secondary services</i> . There are 2 main waiting times: (a) <i>first specialist assessment (FSA)</i> , the time from referral by GP to being seen by a hospital <i>specialist</i> ; (b) waiting time till treatment, the time that elapses from FSA till when treatment is received.
Whanau Ora	A Ministry of Health-driven process aimed at supporting healthy Maori families which emanates from He Korowai Oranga. It aims to identify and extend whanau strengths and build them into initiatives throughout the health sector.

Appendix 1 Members of the Northland Cancer Control Steering Group

Name	Organisation/Service Represented
Margaret Curry	Cancer Society
Leonie Gallagher	Manaia Health PHO, representative for the Northland Primary Health Organisations
Dr Warrick Jones	Northland Palliative Care Medical Specialist, North Haven. Representative for palliative care Services
Jenni Moore	Te Tai Tokerau MAPO
Louise Kuraia	Te Tai Tokerau MAPO
Dr Loek Henneveld	Medical Officer of Health, Public Health Unit
Dr Alan Davis	NDHB – Department of Medicine - Clinical Director
Dr M Sanders	NDHB – General Surgeon
Jane Holden	NDHB - General Manager, Surgery and Critical Care
Dr Nick Chamberlain	NDHB – Clinical Advisor/GP Liaison
Cayti Whitton	NDHB – Population Health Strategist
Susanne Scanlen	NDHB Cancer Control Project Manager

Data analyst and support services to the project was Lisa Melissa, NDHB Health Planner.