



Strategic Plan 2009-2014

Improved cancer control through increased regional collaboration

Mihi

Tēnā rā koutou, e te iwi nui tonu, me te
whaikorōria tonu i te Atua Kaha Rawa. Kia tau, tonu,
ōna manaakitanga maha ki runga i te Arikinui, a, Kiingi
Tūheitia, me te Whare Ariki nui tonu!

Kua tangihia, kēngia, ngā mate o te wā! No reira, rātou
ki a rātou! Tātou, kē, o te ao morehu, ki a tātou!

Ka kitea, i raro nei, he mahere rautaki ka pa ki tēnei
mea, te mate pukupuku me āna āhuatanga, pērā i te
karo tonu i a ia me te whakaheke iho i te taha ritekore.

Kua whakarāpopotonga ngā kōrero hei tirohanga ma
koutou, hei awhina koutou, ngā hoamahi o te hauora,
e mahi ana i roto i ngā ratonga mate pukupuku, mai i
Te Tairāwhiti, whiti atu ki Te Moana a Toi, tau atu ki Te
Arawa, peke atu ki aTaranaki, tae noa ki te rohe o te
waka o Tainui.

Tēnā koutou katoa, rau rangatira mā!



An explanation of the mihi

Paragraph 1 – Greets the reader and extends salutations to our creator, then to King Tūheitia and the royal family.

Paragraph 2 – Pays respects to those who have passed away and then returns the attention of the reader to the world of the living.

Paragraph 3 – Confirms that the document focuses on cancer and has a strategic focus.

Paragraph 4 – Confirms that this strategic plan has a Midland focus.

Paragraph 5 – Acknowledges those reading the document.

Acknowledgements

The Midland Cancer Network would like to acknowledge the collaborative input from stakeholders, other cancer networks within New Zealand and the Ministry of Health cancer team in the development of this plan.

Published by:

Midland Cancer Network
198 Pembroke Street
Hamilton
New Zealand
+64 7 859 9154
www.midlandcancernetwork.org.nz

Contents

Mihi	2
Contents	3
Executive Summary	4
Introduction	5
Midland Cancer Network Strategic Framework	
Strategic direction 1	10
Strategic direction 2	12
Strategic direction 3	16
Measuring success	18
Risk management	20
Appendix 1	Summary of cancer health needs assessment
Appendix 2	Key themes from engagement with stakeholders
Appendix 3	Measuring success - intermediate and process indicators
Bibliography	29



Executive Summary

Cancer touches most people and their family/whānau at some time in their lives, whether this is through diagnosis and treatment or caring for someone with cancer. Cancer control is complex and challenging. The Midland Cancer Network¹ has a leadership, facilitation and coordination role in bringing together and working with stakeholders across organisational and service boundaries to:

- reduce the incidence and impact of cancer;
- reduce inequalities with respect to cancer; and
- improve the experience and outcomes for people with cancer.

The cancer incidence and mortality rates for the Midland Cancer Network area, and in particular for Māori are higher than national rates. There is a need to reduce inequalities both in terms of reducing risk factors to prevent cancer and improving access to cancer services and treatment.



The Midland Cancer Network strategic directions are to:

1. share knowledge and information to enable informed decision making
2. facilitate regional service quality improvement leading to better, sooner, more convenient services
3. support innovation and infrastructure development to reduce inequalities and build capacity and capability.

Implementation of the plan will be adjusted according to national priorities set in the national cancer control work programme (2009, Ministry of Health) together with regional priorities, and will require the collaborative action of all cancer control stakeholders.

The strategic activities are supported with evidence based planning, implementation and a measuring success framework that includes audit, monitoring and evaluation.

Work has started on the development of a performance monitoring framework for the network that will measure success in the medium term. Proposed indicators include:

- wait times between the critical steps of the patient journey by ethnicity
- intervention rates by ethnicity
- national health targets that are related to cancer control
- feedback from patients and their family/whānau.

The underlying drive for the Midland Cancer Network strategic activity comes from the commitment to meet the purposes and goals of *The New Zealand Cancer Control Strategy Action Plan 2005-2010* published by the Ministry of Health in 2005.

¹ The Midland Cancer Network area includes the Bay of Plenty, Lakes and Waikato district health board regions with an open invitation to Tairāwhiti and Taranaki.

Introduction

Cancer control is an organised and systematic approach to the reduction of cancer incidence, morbidity and mortality. *The New Zealand Cancer Control Strategy* published by the Ministry of Health in 2003 provides a framework for reducing the incidence, impact and inequalities of cancer along the whole cancer continuum². This strategy is referred to throughout this document as the national strategy.

The Midland Cancer Network is one of four regional cancer networks, covering a population of 632,442 people in the Bay of Plenty, Lakes and Waikato district health board regions.

The purpose of this strategic plan is to describe the unique role that the Midland Cancer Network has in working with the cancer continuum stakeholders across organisational boundaries towards achieving the goals of the national strategy and the action plan in the next five years.

The national strategy and action plan present significant challenges and opportunities to all those involved in cancer control, setting out a programme of action that seeks to prevent cancer; improve the cancer experience and outcomes.

The network actively works on actions in some of the national strategy goals and undertakes to positively influence others as in the table below:

Network actively works on	Network positively influences
Goal 3: Effective diagnosis and treatment of cancer to reduce cancer morbidity and mortality	Goal 1: Reduce the incidence of cancer through primary prevention
Goal 4: Improve the quality of life for those with cancer, their family and whānau through support, rehabilitation and palliative care	Goal 2: Ensure effective screening and early detection to reduce cancer incidence and mortality
Goal 5: Improve the delivery of services across the continuum of cancer control, through effective planning, co-ordination and integration of resources and activity, monitoring and evaluation	Goal 6: Improve the effectiveness of cancer control in New Zealand through research and surveillance

The network recognises that Māori are a priority group for improved health outcomes because of unequal access to services that leads to poorer health outcomes. Other groups also experience poorer health outcomes and these include Pacific peoples, Asian people, refugees and new migrants, low socioeconomic groups, and rural people.

In the Midland Cancer Network area:

- Māori have higher rates of cancer than non-Māori
- there is a higher rate of cancer mortality for Māori in the network area than for Māori nationally
- Māori have the highest rates of cancer mortality compared to other ethnicities, especially in Māori aged 65 and over
- malignant cancer is the second highest cause of death for Māori and the third highest for Pacific people.

It is against these important drivers that the developed objectives set out the proposed strategic direction for the network to 2014.

² Continuum – prevention, screening and early detection, diagnosis and treatment, rehabilitation and supportive care, palliative and end of life care, research and surveillance.

Midland Cancer Network

Vision

The network's vision is improved cancer control through increased regional collaboration not constrained by organisational, service or professional boundaries.

The network is committed to the national strategy's purposes to:

- reduce the incidence and impact of cancer
- reduce inequalities with respect to cancer.

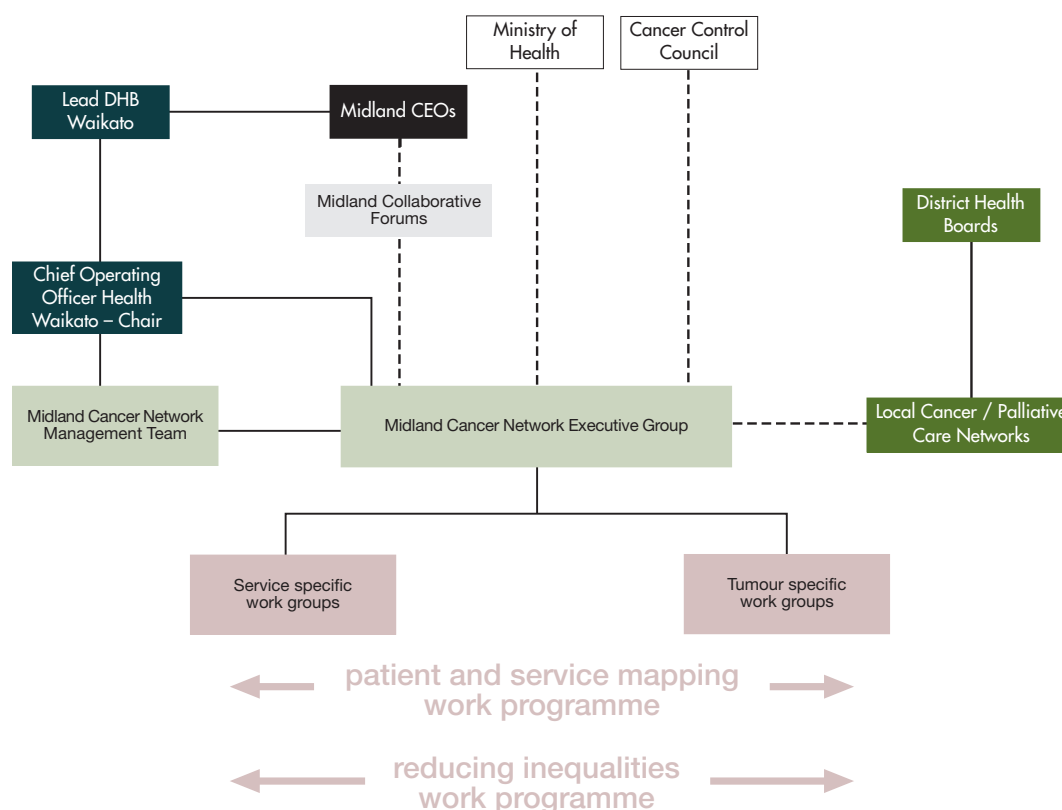
Principles

Core principles to guide the network's structure and function include:

- a person centred approach
- ensuring timely and equitable access to cancer control services
- recognising and respecting cultural diversity
- promoting a seamless patient pathway across the cancer control continuum
- services being of high quality
- being effective and evidenced based
- being sustainable
- ensuring a multidisciplinary team approach
- ensuring a continuous quality improvement approach
- taking a partnership approach with stakeholders, actively engaging health professionals, Māori, Pacific peoples, non-government organisations, consumers, carers and communities
- undertaking service improvement within the context of a planned, coordinated, collaborative and integrated approach.



Governance and structure



Midland Cancer Network Executive Group

The Midland Cancer Network Executive Group oversees the network. Membership includes both planning and funding and service representatives from the three district health boards; non-government organisations; Māori; Pacific peoples and consumers and carers.

The role of the Executive Group is to facilitate and coordinate the work of the stakeholders ensuring that the network programme aligns with the national integrated cancer control programme priorities and policy, as well as expectations and needs of the Midland population. Members are responsible for supporting and advising the network, district health boards and communicating with their participating organisations or representative groups about issues, activities and priorities.

Any aspects of the network's work programme that affect the district health boards' strategic plans, district annual plans, district health needs assessments or any initiatives that require funding and/or prioritisation are referred to the Midland general manager planning and funding forum.

Stakeholder participation

To achieve its aims, the network engages with planners and funders, managers, health professionals, the community and voluntary sector, Māori and Pacific people and other key stakeholders such as patient and carer representatives to ensure people with cancer have access to the best possible quality of care to maximise the chance of the best possible outcome.

Māori

Māori participation in the network's activities builds on the Midland district health board governance structures (Lewis C. 2008). The general managers of Māori health are pivotal as they link directly with iwi governance bodies, Māori providers and Māori services within their respective district health boards. In recognition of this, one of these general managers in a constituent district health board represents the interests of Māori on the Executive Group. Māori representatives are appointed to work groups.

Pacific people

The Executive Group has a Pacific people's representative.

Consumers and carers

The network is progressing implementation of the network's consumer and carer participation strategy, which includes their participation on the Executive Group and work groups. In addition, patient focus groups or individual interviews inform the patient and service mapping programme.

The network's key resource for keeping stakeholders informed is the website www.midlandcancernetwork.org.nz. A quarterly newsletter Koha O Mātauranga is emailed to stakeholders and made available on the website. The network maintains a database of cancer service providers and stakeholders.

Network accountability

The Midland Cancer Network is funded through the lead district health board via a Crown Funding Agreement (Waikato).

The annual work programme is endorsed by the Midland district health boards' chief executive officers and provided to the Ministry of Health by 20 July each year.

The network is accountable through the provision of six monthly reports to the Ministry of Health and Midland district health board chief executive officers. Quarterly reports are provided to the Midland Cancer Network Executive Group, work groups, regional collaborative forums, Ministry of Health and New Zealand Cancer Control Steering Group, Cancer Control Council and stakeholders. These are also available on the network's website.

Resourcing

Resourcing for the network to achieve these strategic directions is through a crown funding agreement variation with Waikato District Health Board currently \$550,000 per annum to 30 June 2011.

Annual work programme

Prioritisation of the actions to achieve the strategic directions occurs annually and informs the annual work programme. Each annual work programme will also be aligned with the national cancer control work programme that is produced by the Ministry of Health.

The plan was informed by:

- *An Assessment of Cancer Health Needs in the Midland Cancer Network Region: 2009* (Population Health. 2009). Key themes are summarised in appendix one
- ongoing engagement with stakeholders. Key themes are summarised in appendix two
- review of regional and local progress against the action plan
- district health board Cancer Control Action Plans
- district health board strategic and annual planning documents.

In addition this plan describes how the network adds value by taking a regional population-based approach to engage and involve stakeholders, influence and support decision making to enable health gain attainments beyond what stakeholders could achieve alone.

Strategic framework

New Zealand Cancer Control Strategy Action Plan 2005-2010

1. Reduce the incidence and impact of cancer

2. Reduce inequalities with respect to cancer

Patient centred focus across the cancer continuum

Prevention, screening and early detection, diagnosis and treatment, rehabilitation and supportive care, palliative and end of life care, research and surveillance



Evidence based planning and implementation within available resources

Individual focus

- Information adapted to patients' and family/whānau needs
- Information adapted to meet needs of people who experience inequalities
- Information for providers and health professionals
- Promoting prevention and self responsibility

Service focus

- Clinical governance
- Guidelines and standards
- Patient management frameworks
- Service improvement initiatives
- Multidisciplinary teams and continuity of care
- Improved integration of services provided by Māori and Pacific peoples in the cancer continuum
- Improved access to services for people who experience inequalities

System focus

- Developing infrastructure
 - workforce
 - equipment
 - facilities
 - information systems
 - standardised and simplified processes
 - improved access to services e.g. transport and accommodation for people experiencing inequalities
- Service and tumour group improvement plans
- New service models for Māori and others experiencing inequalities
- Understanding cancer needs of new and emerging populations

Measuring success – audit, monitoring and evaluation

Waiting times

Intervention rates

Health targets

Improving patient experience

Strategic direction 1

Share knowledge and information to enable informed decision making

- Please note that the shaded areas in the tables below denote areas where there is a need for a strong inequalities focus.
- Short term is one to two years, medium term is two to three years and long term is three to five years.

What we intend to do	
1.1. Disseminate evidence-based information to prevent cancers	
1.1.1. Develop and maintain network website that promotes prevention, self responsibility and self care	
1.1.2. Promote implementation of the Cancer Society Policy for Outdoor Workers	
1.1.3. Promote and improve the regional hepatitis B immunisation rate in the Midland Cancer Network area	
1.1.4. Continue to support Smokefree Midland, Healthy Eating, Healthy Action initiatives and human papillomavirus immunisation	
1.2. Supporting the promotion of screening programmes	
1.2.1. Promote and support BreastScreen Midland to achieve screening targets	
1.2.2. Promote and support cervical screening providers to achieve screening targets	
1.2.3. Participate, where able, in the development of the national bowel cancer-screening programme	
1.3. Development and maintenance of cancer control service and provider directories	
1.3.1. Develop and maintain the network's website and stakeholder database	
1.3.2. Inform all stakeholders of cancer control services and providers and mechanisms to access these	
1.3.3. Develop and maintain a Midland supportive care services directory	
1.3.4. Develop and maintain a Midland palliative care services directory	
1.4. Disseminate and promote national and regional guidelines and pathways	
1.4.1. Promote and support implementation of the <i>Clinical Practice Guidelines for the Management of Melanoma in Australia and New Zealand</i>	
1.4.2. Promote and support implementation of the <i>Suspected Cancer in Primary Care: Guidance for Referral and Reducing Disparities Guideline</i> (publication due 2009)	
1.4.3. Promote and support implementation of <i>The Management of Early Breast Cancer Guideline</i> (publication due 2009)	
1.4.4. Promote and support implementation of bowel cancer guidelines (yet to be developed)	
1.4.5. Promote implementation of <i>The Early Detection of Prostate Cancer in General Practice: Supporting Patient Choice Guidance and Testing for Prostate Cancer – information for men and their families/whānau</i>	
1.4.6. Promote best practice <i>Guidance for Improving Supportive and Rehabilitative Care for Adults with Cancer in New Zealand</i> (publication due 2009)	
1.5. Share information on research, new and best practice initiatives with stakeholders	
1.5.1. Continue with regular Koha O Mātauranga email newsletter	
1.5.2. Promote sharing of information on the network website	
1.5.3. Participate and support the Northern Cancer Network primary lung cancer translational research proposal that includes Lakes District Health Board	
1.5.4. Support Oranga Tane Māori, a joint research project between Te Puna Oranga (Waikato District Health Board Māori Health Service) and The University of Auckland	
1.5.5. Jointly lead and facilitate annual national cancer control conference with other regional networks and the Ministry of Health	

This engages stakeholders at an individual level to share information to build stakeholder knowledge, enable informed decision making, promote evidence based best practice and reduce the risk of contracting cancer through:

- information for patients and family/whānau
- information for providers and health professionals
- promoting prevention and self responsibility.

When	Outcomes
Short term	Improved stakeholder understanding of the causes and symptoms of cancer
Medium term	Increased awareness of sun protection leading to a reduction in the incidence of melanoma/skin cancer
Medium term	Increased immunisation rates leading to a reduction in liver cancer especially in vulnerable populations
Medium - long term	Increased awareness of the risk factors for cancer leading to a reduction in incidence in future years
	Earlier detection of breast cancer especially in Māori and Pacific populations leading to a lower mortality rate
	Earlier detection of cervical cancer especially in Māori and Pacific populations leading to a lower mortality rates
Short term	Earlier detection of bowel cancer leading to lower mortality rate
	A comprehensive services directory is published and available to all across the cancer care continuum
Short term	Up to date information available for dissemination to cancer control stakeholders Improved communication and collaboration
Medium term	Improved access to cancer services and greater provider understanding of the cancer control continuum and their role within it
Short term	Patients and their family/whānau know what support is available to them and how to access those services
Medium term	Patients and their family/whānau know what palliative care support is available to them and how to access services
Medium term	Increased awareness of the guidelines contributing to standardised treatment of melanoma Implementation of best practice guidelines and reduced variation in practice
Short term for lung and bowel cancers	Consistent information for general practitioners referring people with suspected cancer to secondary services
Medium term	Increased awareness of the guidelines contributing to consistent treatment of early stage breast cancer Implementation of best practice guidelines and reduced variation in practice
Medium term	Increased awareness of the guidelines contributing to standardised treatment of bowel cancer Implementation of best practice guidelines and reduced variation in practice
Short term	Consistent information available for informed decision making by general practitioners and family/whānau about testing for prostate cancer
Short term for lung and bowel cancers	Better supportive care services available for patients and their family/whānau. Health professionals aware of services available and refer patients based on need
Short term	Stakeholders share and are informed of current Midland cancer control initiatives
Short term	Stakeholders share and are kept informed of new and best practice initiatives
Short term	Streamlined access to lung cancer pathway in Lakes
Short term	Greater understanding of the cancer journey for Māori men in Waikato
Short term	Sharing knowledge about cancer control activities and best practice initiatives

Strategic direction 2

Facilitate regional service quality improvement leading to better, sooner, more convenient services

What we intend to do

2.1. Promote clinical governance for the major tumour streams and associated service improvement work groups

2.1.1. Continue to support the established work groups and associated improvement plans:

•

Midland AYA Cancer Services Work Group

•

Midland Breast Cancer Work Group

2.1.2. Align the service/patient mapping and reducing inequalities work programmes when establishing the following tumour work groups:

•

Lung

2009-10

•

Colorectal

2009-10

•

Genitourinary

2010-11

•

Upper gastro-intestinal

2010-11

•

Head and neck

2011-12

•

Gynaecological

2011-12

•

Haematology malignancy

2012-14

•

Central nervous system

2012-14

•

Melanoma/skin

2012-14

2.1.3. Continue to support the established regional service improvement groups:

•

Midland Non-Surgical Cancer Treatment Work Group

•

Midland Care Coordination Forum

•

Midland Palliative Care Work Group

2.1.4. Establish the following service improvement work groups:

•

Research and audit

•

Supportive care

•

Paediatric oncology

2.2. Continue the service and patient mapping work programme to develop quality improvement plans for the major tumour streams

2.3. Implementation of best practice patient management frameworks, clinical guidelines and standards

2.3.1. Adopt and adapt the Victorian patient management frameworks for the Midland Cancer Network area – lung, colorectal, breast and prostate, then introduce other frameworks aligning with the establishment of work groups

2.3.2. Complete stocktake and review of recommendations of national guidelines and develop regional implementation plans within available resources for:

2.3.2.1. Clinical Guidelines on the Management of Melanoma in Australia and New Zealand

2.3.2.2. Guidance for Improving Supportive and Rehabilitative Care for Adults with Cancer in New Zealand

2.3.2.3. Suspected Cancer in Primary Care: Guidance for Referral and Reducing Disparities Guideline

2.3.2.4. The Management of Early Breast Cancer Guideline

2.3.2.5. Bowel cancer (when developed)

2.3.3. Develop and agree regional cancer guidelines and waiting time standards in the absence of national guidelines and patient management frameworks e.g. lung

This has a service level impact with a focus on quality improvement leading to better, sooner and more convenient services with:

- improved access, wait times between critical stages of the treatment journey, quality of care
- improved access to supportive care, palliative care and end of life programmes
- improved experience for the patient and family/whānau.

When	Outcomes
Short term	Promote and support clinical leadership Improved patient journey for the respective patient groups Support implementation of national service specifications Lead implementation of the Midland early stage breast cancer and AYA OHS plans recommendations
Phased - short, medium and long term	Improved clinical pathways with increased access for Māori and Pacific peoples resulting in an improved patient journey Clients all informed of what they can reasonably expect throughout the pathway Consistent regional access to diagnosis and treatment is achieved e.g. time to diagnosis, time to treatment Clinical audit will demonstrate compliance with clinical pathways
Short term	Clinical governance supporting improved patient journey resulting from ongoing improvements in service delivery and continuity of care
Short term – Research and audit and Supportive care Medium term for paediatric oncology	Better supportive care and paediatric oncology services across the region Improved dissemination of research and audit results across the network area Agreed research priorities for the network area
Short term	Better and more standardised patient pathways for each tumour stream. More consistent access to diagnosis and treatment. Improved patient journey
Short term – lung and colorectal	Patient management frameworks will assist in delivery of standardised diagnosis and treatment processes for each tumour group. Patients have a clear understanding what they can expect along each pathway
Long term	National guidelines support the development of standardised clinical pathways and improved patient journeys
Medium – long term	Regional cancer guidelines will support standardised care for patients across the Midland Cancer Network area and an improved patient journey

What we intend to do	
2.4. Lead and facilitate regional quality improvement initiatives which improve patient care and wherever possible reduce inequalities	
2.4.1. Improve access to diagnostic services	
2.4.2.1. Improve access to Positron Emission Tomography – Computed Tomography (PET-CT) for those cancer patients that meet the agreed clinical criteria	
2.4.2. Improve the lung cancer pathway and experience	
2.4.2.1. Develop lung cancer standards and criteria for primary referrals to secondary services	
2.4.2.2. Improve process from primary referral, access to diagnostics and to decision to treat	
2.4.2.3. Improve process flow and access to thoracic surgery	
2.4.2.4. Develop multidisciplinary team meeting criteria and framework for lung patients to be presented at regional chest conference	
2.4.3. Improve bowel cancer pathway and experience	
2.4.3.1. Develop standards and criteria for primary referrals to secondary first specialist assessment/colonoscopy	
2.4.3.2. Improve process from primary referral, access to colonoscopy and surveillance colonoscopy	
2.4.3.3. Improve process flow and access to colorectal surgery	
2.4.4. Improve breast cancer pathway and experience	
2.4.4.1. Identify barriers and improve waiting time access to critical stages of the breast cancer pathway for Māori women	
2.4.4.2. Improve timely access to breast cancer surgery	
2.4.4.3. Improve the process flow to stereotactic biopsy	
2.4.5. Promote best practice palliative care end of life	
2.4.5.1. Implementation of the Liverpool Care Pathway programme	
2.4.5.2. Scope best opportunities for the region to implement the Liverpool Care Pathway reflective data cycle	
2.4.5.3. Implementation of the Midland specialist palliative care education framework for generalists	
2.4.6. Improve access and process flow for people with acute illness admitted with suspected cancers	
2.5. Promote development of multidisciplinary teams and improve continuity of care	
2.5.1. Implement the multidisciplinary team meeting framework and quality improvement plan within available resources	
2.5.2. Complete a stocktake of the current situation and implement recommendations within available resources	
2.6. Promote development and implementation of programmes that support those people with cancer as a long term condition	
2.7. Promote and support development of culturally appropriate services that improve access and continuity of care for Māori	

When	Outcomes
Short term	Increased and equity of access to essential diagnostic services of Positron Emission Tomography – Computed Tomography (PET-CT) for diagnosis/treatment
Short term – 2.4.2.2, 2.4.2.3 and 2.4.2.4	Progress towards a standardised lung cancer pathway that includes culturally appropriate processes to increase access for Māori. Improved patient journey
Short term – long term	Progress towards a standardised bowel cancer pathway that includes culturally appropriate processes to increase access for Māori. Improved patient journey Readiness for implementation of national bowel cancer screening programme
Short term – 2.4.4.1	Progress towards a standardised breast cancer pathway that includes culturally appropriate processes to increase access for Māori. Improved patient journey
Short term	Progress towards improved palliative care options across the Midland Cancer Network area
Long term	Improved patient journey
Short term	Improved multidisciplinary care for people with cancer
Short term	Improved multidisciplinary care for people with cancer
Long term	Improved support and resources for survivors of cancer
Medium term	Improved access and continuity of care for Māori

Strategic direction 3

Support innovation and infrastructure development to reduce inequalities and build capacity and capability

What we intend to do	
3.1. Review, update and continue to implement the Midland Non-Surgical Cancer Treatment Services Plan (2004) within available resources	
3.1.1. Continue to implement the Plan to Develop Resident Medical Oncology Haematology Services based in Tauranga, Bay of Plenty District Health Board	
3.1.2. Develop and implement a regional chemotherapy framework and the quality improvement plan within available resources	
3.1.3. Develop and implement a regional radiotherapy framework and plan within available resources	
3.1.4. Promote and support more timely access to medical oncology services within the Network area	
3.2. Develop and implement a regional cancer control workforce framework and plan within available resources	
3.2.1. Develop and promote cultural competency and improved communication within the workforce	
3.2.2. Develop and implement a regional multidisciplinary team meeting framework and quality improvement plan within available resources	
3.2.3. Continue to develop and implement the Midland Cancer Network continuity of care framework for the major tumour streams	
3.3. Within the service and patient mapping work programme continue to map major tumour groups and develop and implement quality improvement plans within available resources	
3.4. Develop and implement a regional cancer surgery framework and quality improvement plan within available resources	
3.5. Develop and implement a regional palliative care framework that meets the national service specifications and quality improvement plan within available resources	
3.6. Build the network's information systems capacity for regional service planning, audit, monitoring and evaluation	
3.6.1. Continue to update the Midland cancer control health needs assessment	
3.6.2. Promote accurate and appropriate ethnicity data collection within cancer control providers	
3.6.3 Participate in national information system initiatives as appropriate i.e. timely access to cancer registry information, datasets	
3.7. Explore strategies to reduce Māori avoidable hospitalisation rates	
3.8. Explore new service delivery models, especially those with a reducing inequalities focus	
3.9. Develop and implement a Midland cancer supportive care quality improvement plan within available resources	
3.10. Develop network infrastructure capacity and capability to maintain surveillance of cancer control activity in the Midland Cancer Network area	

This focuses at a system level leading to the development of a more responsive infrastructure by:

- regional planning, collaboration, coordination of services and
- promoting integration of services, evidence based planning for workforce, equipment, facilities, information systems
- building capacity and capability with current resources wherever possible
- measuring success through audit, monitoring and evaluation.

When	Outcomes
Short term	Updated Midland Non-Surgical Cancer Treatment Services Plan contributing to an improved access and patient journey
Short term	Improved access, waiting times and service delivery for people in Bay of Plenty District Health Board
Short term	Improved waiting time and ongoing improvement in regional chemotherapy services
Medium term	Improved waiting time and ongoing improvement to radiotherapy services
Short term – lung and bowel	Improved waiting time and ongoing improvement to medical oncology services
Long term	Regional cancer control workforce plan implemented providing a workforce with the right skills at the right time and right place
Short term	Culturally competent cancer control workforce
Medium term	Improved multidisciplinary care and improved patient journey within the Midland Cancer Network area
Short term	Improved continuity of care and improved patient journey
	All tumour streams mapped and quality improvement plans implemented
Short term – lung and bowel	Improved access to cancer surgery
Short term – service specifications Medium term – framework	Regional palliative care framework and quality improvement plan that promotes regionalisation
Short term	Increased availability of information at key points along the patient journey
Long term	Health needs assessment updated regularly
Short term	Accurate ethnicity data collection leading to accurate data for service planning
Short – long term	Timely, accurate data available to inform network monitoring and evaluation Consensus dataset identified for each tumour stream
Long term	Māori avoidable hospitalisation rates reduced
Medium term	Innovative new services improving access and support for Māori and Pacific people
Medium term	Supportive care services are available and accessible
Long term	Ongoing cancer control surveillance for the Midland Cancer Network area

Measuring success

The national cancer control programme framework sets out a Leading for Outcomes Framework and the network has adapted this for measuring the success of the implementation of this strategic plan.

Performance and outcome monitoring

The monitoring framework links with the district health boards' accountability process.

The national strategy **outcomes** are indicators at a population level that have a long-term horizon to:

- reduce the incidence rate and to reduce the incidence rate by ethnicity
- improve the relative survival rate and to improve the relative survival rate by ethnicity.

The development of a performance monitoring framework with nationally and regionally agreed measures to monitor cancer control implementation for networks is evolving.

As a starting point, the New Zealand regional cancer networks collectively agreed to strive to develop the following intermediate indicators. Cancer network outputs contribute directly to the following **intermediate indicators** that measure the system performance over a medium term horizon:

- Wait times between the critical steps of the patient journey e.g.
 - “ referral to diagnosis and by ethnicity
 - “ decision to treat to first treatment and by ethnicity
- Intervention rates
 - “ staging
 - “ radiation therapy
 - “ medical oncology
 - “ chemotherapy
 - “ surgery
 - “ palliative care
- Supporting the national health targets that are related to cancer control
 - “ screening targets (breast, cervical)
 - “ human papillomavirus immunisation rates
 - “ radiation oncology target
 - “ elective services targets
 - “ tobacco control target
- Improving patient experience
 - “ service and patient mapping work programme
 - “ Cancer Control Council biennial patient survey

The Midland Cancer Network will have a range of **process inputs** and relevant indicators and milestones that work towards achievement of the intermediate indicators and long-term outcomes. The network's annual work programme will identify relevant milestones and indicators to achieving the longer-term strategic objectives. See appendix three for indicative intermediate and process indicators for this strategic plan.

The diagram on the next page links the network's strategic directions with the Leading for Outcomes Framework for measuring success.

Vision	Improved cancer control through increased regional collaboration		
Purposes	Reduce incidence and impact of cancer	Reduce inequalities	Improve patient journey

Midland Cancer Network strategic directions 2009-2014

	Knowledge and information sharing	Quality service improvement	Innovation and infrastructure development
What we intend to do	1.1 Promote prevention and self care 1.2 Support screening programmes 1.3 Develop service directories 1.4 Implement national guidelines 1.5 Share knowledge and information	2.1 Clinical governance for tumour and service groups 2.2 PMF, guidelines and standards for the 4 major cancers 2.3 Develop improvement plans for major tumours and service groups 2.4 Facilitate quality improvement initiatives 2.5 Promote MDT and continuity of care 2.6 Support people with cancer as long term condition 2.7 Services that improve access and continuity of care for Māori	3.1 Midland Non-Surgical Plan 3.2 Midland cancer workforce CQI plan 3.3 Tumour stream improvement plans 3.4 Midland cancer surgery CQI plan 3.5 Midland palliative care CQI plan 3.6 Midland supportive care CQI plan 3.7 Build MCN information systems capability capacity for planning, audit monitoring 3.8 Explore new service delivery models 3.9 Explore strategies to reduce avoidable cancer hospitalisations 3.10 Cancer control surveillance

Measuring our progress	Waiting times between critical steps of the patient journey - referral to diagnosis and by ethnicity - decision to treat to first treatment and by ethnicity	Intervention rates (by ethnicity) - staging - radiation oncology - medical oncology - surgery - palliative care	National cancer health targets - screening targets - radiation oncology wait times - elective services - tobacco	Improving patient experience - CCC patient survey (two yearly) - Mapping focus/whānau groups
-------------------------------	--	--	---	---

Intermediate outcomes	<ul style="list-style-type: none"> - 100% of regional service directories developed by 2014 - <i>Suspected Cancer in Primary Care: Guidance for Referral and Reducing Disparities</i> Guideline implemented by 2014 - adopt / implement clinical guidelines, patient management frameworks and wait time standards for the 4 top cancers (lung, colorectal, prostate, breast) by 2014 - proportion of patients presented at multidisciplinary meetings (target to be determined for each tumour stream) - 100% implementation of end of life Liverpool Care Pathway into Midland organisations by 2014
------------------------------	---

Inputs	<ul style="list-style-type: none"> - Crown funding agreement with network service requirements including funding for the network team and infrastructure - Network stakeholder communication, collaboration and participation; tumour and service specific work groups - Midland Cancer Network Operational and Quality Framework that describes the functions and form to accomplish the network's strategic objectives - Midland Cancer Network Strategic Plan, Health Needs Assessment and annual work programme - District Health Board DSPs, HNA, DAPs, Cancer Control Action Plans, Palliative Care Plans - National Cancer Control Programme Plan and associated strategic documents
---------------	---

Risk management

Risk	Mitigation
Availability of resources to support implementation of the network's strategic goals and objectives	<p>Utilise available resources well; use of prioritisation frameworks to identify critical workstreams and projects</p> <p>Alignment with integrated national cancer control programme policy, priorities and expectations</p>
Competing and changing priorities for resources	<p>Clear communication between all stakeholders using the network communications plan</p> <p>Reprioritisation using agreed frameworks as necessary</p> <p>Alignment with integrated national cancer control programme policy, priorities and expectations</p>
Access to affordable transport options is a barrier to diagnosis and treatment for people in rural and low socioeconomic groups	<p>Ensure people get information about eligibility for the National Travel Assistance Policy</p>
Large amount of data but not complete or easily accessible for planning and developing services, measuring success of initiatives, reporting against key performance indicators, promoting and informing continuous quality improvement through audit	<p>Implementation of Midland Cancer Network Information Systems Project</p> <p>Participate in national information systems projects/initiatives</p>
Stakeholders not actively engaged in the work of the network	<p>Align cancer control vision and strategic direction to "capture heart and mind" of stakeholders</p> <p>Implement communications plan and promote successes</p> <p>Alignment with integrated national cancer control programme policy, priorities and expectations</p>
The significant breadth and complexity of the cancer continuum and significant amount of work required makes it difficult to have a clear focus	<p>Prioritisation frameworks align and collaborative effort in agreed directions</p> <p>Alignment with integrated national cancer control programme policy, priorities and expectations</p>
Inadequate capital asset planning for technology	<p>Implementation of regionally agreed process</p>
Availability of funding to district health boards may impact on new technologies, and ability to meet the cancer control needs of the population including increasing costs of pharmaceuticals	<p>Network supports district health boards with expert advice and information and supports local risk mitigation strategies</p>

Appendix 1

Midland cancer health needs assessment

This section summarises key points from *An Assessment of Cancer Health Needs in the Midland Cancer Network Region: 2009* (Population Health. 2009).

Geography and Demographics

Population distribution

The Midland Cancer Network area covers 40,459 km², comprising 15% of New Zealand's total land area.

Approximately 16% of the New Zealand population reside in the network area with Waikato having the largest population.

The population distribution by age group for the network area is very similar to the New Zealand distribution, as is the gender distribution across all age bands.

The biggest projected growth rate by age group will occur in the 65 years and over age group. The projected growth rate for the network area for 2006-2026 is an estimated 16%.

Māori

The network area Māori population shows a high birth rate and young death rate in comparison to the non-Māori population with a steady birth rate and older death rate.

The Māori growth rate (2006-2026) will increase for all three district health board districts; 21% (Lakes), 25% (Waikato) and 35% (Bay of Plenty). In comparison the Māori growth rate for New Zealand will be 28%.

Pacific

The Pacific population will have the largest growth rate (2006-2026) in the Bay of Plenty (65%), followed by Waikato (28%) and the least growth in Lakes (-13%). The Pacific growth rate for New Zealand will be 42%.

Deprivation

Within the network area generally, a higher proportion of people live in a quintile five area (most deprived). For each of the three districts a high proportion of the urban populations live in a quintile five area. The highest proportion resides in Lakes (35%) followed by Waikato (28%) and the lowest in the Bay of Plenty (25%). These rates are all above the New Zealand rate (22%).



The burden of cancer in the Midland Cancer Network area

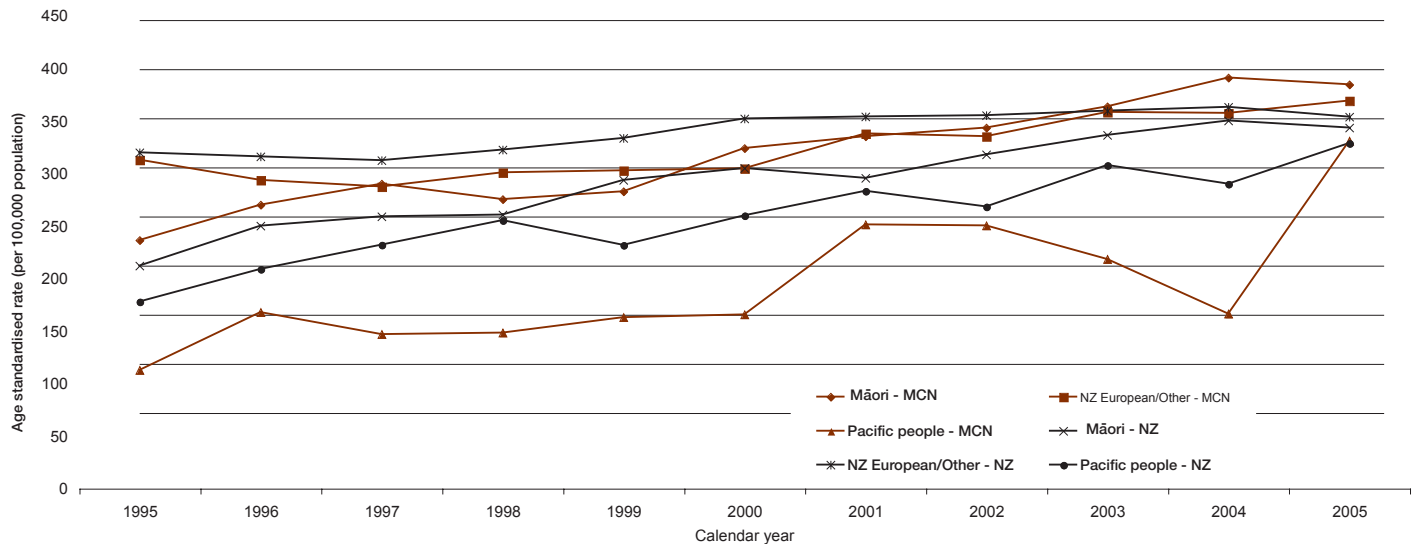
Cancer incidence

For the network area, there were a total of 2620 cancer registrations recorded in 1995 and 3192 cancer registrations in 2005, a 21.8% increase.

In 2005, the network area had an age standardised incidence rate of 368 per 100,000 population. This age-standardised rate was higher than the national rate of cancer registrations at 352:100,000. During 2005, 58 per cent of all Midland cancer registrations affected people who were 65 years or older.

Figure 1 shows the differences in the age standardised rates for the network area by ethnicity and for New Zealand. Note that the Māori age standardised rate is higher than that for Māori in New Zealand.

Figure 1: Age standardised rates for all cancer registrations, for the Midland Cancer Network area and New Zealand, by ethnicity, 1995 – 2005



Source: TAS Data Cubes: K00_CUBE_CANC

Table 1 below shows the top five cancers by ethnicity for the network area. Note that the four top cancers (lung, colorectal, breast and prostate) are in the top five cancers for each ethnic group.

Table 1: Common cancers as a % of all cancers, for the Midland Cancer Network area, by ethnicity, 2001 - 2005 combined

NZ European/Other	Māori	Pacific
Colorectal (16%)	Lung (21%)	Breast (24%)
Prostate (15%)	Breast (17%)	Colorectal (10%)
Melanoma (14%)	Prostate (9%)	Prostate (9%)
Breast (13%)	Colorectal (7%)	Stomach (9%)
Lung (9%)	Stomach (5%)	Lung (8%)
Total number: 13,286	Total number: 1861	Total: 113

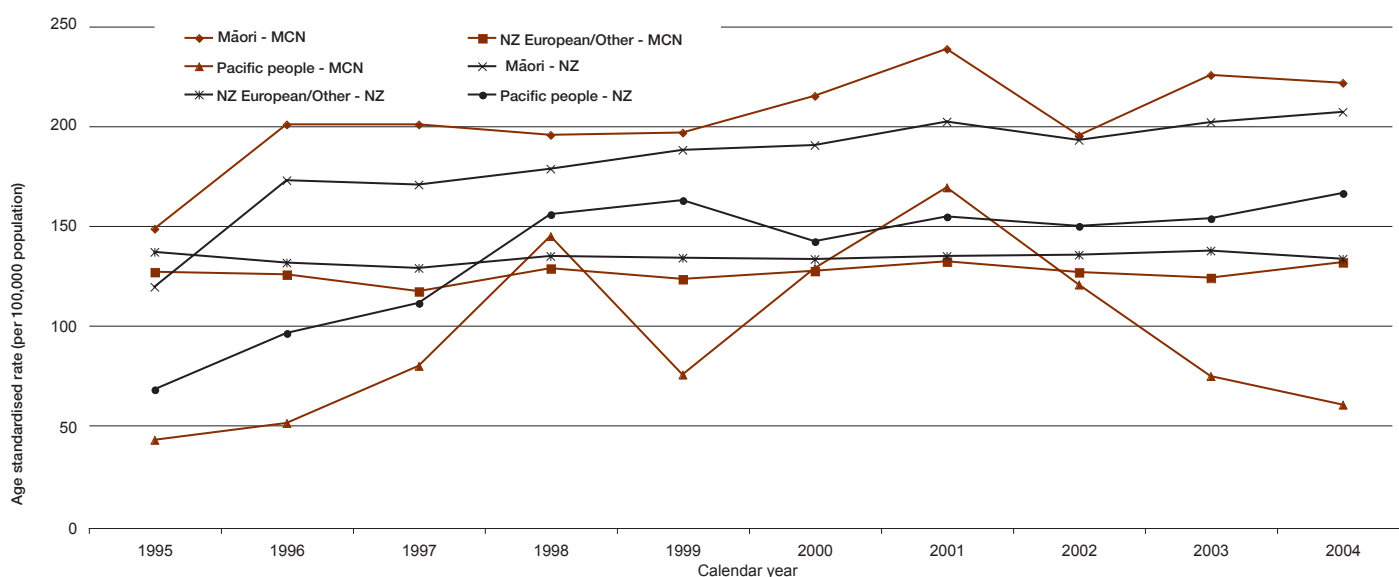
Source: TAS Data Cubes: N00_CUBE_MORT.

Cancer mortality

Cancer was one of the leading causes of death in the Midland area in 2004, 28 per cent of all Midland deaths were due to cancer. In 2004, the Midland age standardised mortality rate was higher than the national age standardised mortality rate.

Midland Māori had higher age specific cancer mortality rates across all age groups when compared to the New Zealand European/other ethnicity as shown in figure 2.

Figure 2: Age standardised rates for all cancer deaths, for the Midland Cancer Network area and New Zealand, by ethnicity, 2000 - 2004



Source: TAS Data Cubes: N00_CUBE_MORT and Statistics NZ; Census 2006

Midland Māori had nearly twice the age standardised cancer mortality rate (220:100,000) than that of New Zealand European/other at 142:100,000.

Table 2 shows the common fatal cancers by ethnicity for the network. While lung cancer is the common fatal cancer across all groups there are disparities evident in the proportion for Māori and Pacific peoples.

Table 2: Common fatal cancers as a % of all fatal cancers, for the Midland Cancer Network area, by ethnicity, 2000 - 2004 combined

NZ European/Other	Māori	Pacific
Lung (18%)	Lung (31%)	Lung (27%)
Colorectal (16%)	Breast (10%)	Breast (10%)
Prostate (8%)	Unspecified site (7%)	Unspecified site (10%)
Breast (7%)	Stomach (6%)	Colorectal (6%)
Unspecified site (5%)	Prostate (5%)	Prostate & Stomach (6%)
Total: 5315	Total: 1068	Total: 49

Source: TAS Data Cubes: N00_CUBE_MORT.

Cancer survival

Cancer survival is a useful indicator of the outcomes for those diagnosed with cancer. Within New Zealand, there are significant inequalities in cancer relative survival, especially between ethnic groups. Māori continue to have the poorest prognosis for colorectal, prostate and lung cancers.

Recent New Zealand cancer survival data has indicated geographic inequalities with people living in rural district health boards having poorer survival rates when compared with people living in predominately urban district health boards. There are also survival inequalities between socioeconomic groups and region.

For all five common cancers (breast, colorectal, lung, melanoma and prostate) within the network area, Lakes has the lowest relative survival rates; lower than the New Zealand rate.

Preliminary data (Ministry of Health, 2009) for the top four cancers (colorectal, breast, lung, and prostate) indicates for the periods 1994-2007 and 2002-2006 that:

- Waikato district had a poorer colorectal cancer five year relative survival rate compared to the national average of other district health boards
- Waikato and Lakes districts had a poorer lung cancer five year relative survival rate compared to the national average of other district health boards
- Lakes and Waikato districts had a lower prostate cancer five year relative survival rate compared to the national average of other district health boards.

Inequalities summary

Ethnic inequalities

Māori are disproportionately affected by the cancer burden compared to non-Māori, and have a higher rate of cancer registrations both in New Zealand and the network area. This is particularly true for Māori females.

In terms of cancer incidence and cancer deaths, rates are considerably increased in those aged 65 years and over. Still, Māori have the highest rates of cancer mortality compared to other ethnicities across all age groups, particularly for Māori aged 65 years and over.

Māori also have had considerably higher levels of cancer mortality in all network district health boards than non-Māori, as well as higher rates of avoidable cancer hospitalisations. Māori aged 65 and over had the highest rates of avoidable cancer-related hospitalisations; the incidence of which increased as age increased.

The national Māori rate for cancer registrations, cancer mortality and avoidable cancer related hospitalisations is lower than all Māori rates for the network area.

Proportionally, Māori had the highest incidence of lung cancer, while their New Zealand European/Other counterparts had the highest incidence of colorectal cancer. Pacific people had the highest proportion of breast cancer incidence.

The proportion of lung cancer mortality for Māori was highest in both New Zealand and the network area. Both breast and lung cancer registrations for Māori increased during 1995-2004. One of the key risk factors of lung cancer is smoking, for which Māori have a much higher daily rate.

For Māori males in the network area, the numbers for lung cancer registrations were the highest above other cancers for the period 1994-2004. Other important cancers for Māori males were stomach and liver and for females, cancer of the uterus and cervix.

Across all ethnicities and across the network area, Māori have the highest proportion of hazardous drinking.

In the network area, Māori had noticeably lower breast screening rates than their New Zealand European/Other counterparts, followed by Pacific women who also had lower rates.

For cervical screening, Māori and Pacific women show a coverage rate averaging 50% while for New Zealand European/Other the coverage rate is 82%.

Gender inequalities

Females have higher levels of daily and regular smoking than males, while men have a much higher prevalence of hazardous drinking than women.

More females are getting their daily recommended fruit intake than males. This is consistent across the network area.

Lung cancer appeared to be the number one common fatal cancer across ethnicities for males in New Zealand and the network area during 2000-2004.

In comparison to cancer incidence in males, prostate was more common than lung cancer.

Lung cancer was generally the common fatal cancer for all ethnicities in females, followed by breast cancer in the network area for the period 2000-2004. In comparison to cancer incidence in females, breast was the most common cancer, as opposed to lung cancer.

District health board inequalities

Findings indicate that of the three district health boards, Lakes showed the highest proportion of cancer risk factors including: regular smokers, parental smokers (as perceived by year 10 students), youth smokers, obese people and hazardous drinkers.

Lakes also had the highest proportion of its population residing in high deprivation areas, particularly the urban population. This, in relation to a high proportion of risk factors, poses health concerns for Lakes.

For all five common cancers within the Midland Cancer Network area, Lakes has the lowest relative survival rates; lower than the New Zealand rate.

For the 12-month period ending June 2008, hepatitis B immunisation coverage for the three district health boards across ethnicities was lower than the national coverage.

Midland patient and service mapping of the early breast cancer pathway

Key findings from an audit of waiting times by ethnicity in the early breast cancer pathway include:

- Māori women account for a higher percentage of the symptomatic sample than the screening-detected
- Māori women are more likely to present with symptoms
- Māori women may have longer waiting times from journey start points to first treatment
- Māori women may have longer waiting times for the interval between surgery and referral to oncology.

Appendix 2

Key themes from engagement with stakeholders

Inequalities

There is a need to know more about new and emerging population groups and source data to understand the impact of cancer and identify their issues and barriers to cancer services. Barriers to accessing services need to be addressed. People need greater awareness of how to recognise early warning signs of cancer. Earlier presentation increases the opportunity for cure.

Services for Māori and Pacific people

There are very limited cancer services provided by Māori and Pacific providers. While there are some initiatives being piloted these tend to be around specific roles rather than services. Evaluation results of these initiatives need to be shared and replicated if successful.

Supportive care

A 2005 national stocktake identified inequalities in the level and access to supportive care services within the region. Clinical staff have identified as a priority the publication of supportive care services directory and a need to establish psycho-oncology services and patient navigator roles within all districts. In some areas there needs to be improved access to social work services.

Patient education resources

Patients need access to quality information in a range of formats in order to understand their condition and make treatment decisions. This information needs tailoring to meet the needs of Māori, Pacific people, Asian peoples, refugees and new migrants.

Availability of information

Both patients and providers report that there is a lack of information (or fragmented information) on the range of services and support that are available and how to access them.

Prevention and early detection

There is a need for more public awareness about measures to prevent cancer and for people to recognise early warning signs so that cancers can be detected early thereby increasing the opportunity for cure. There is a need to improve fragmentation of programmes for primary prevention of cancer.

Care coordination

Consumers and staff report that there is sometimes confusion regarding who is clinically responsible as a patient transfers between services or providers. There is a need for clearly articulated patient pathways with an identified key contact person. There are care coordination workforce gaps.

Surveillance

Fragmentation of resources for surveillance of the cancer control sector at a regional level.

Lack of standardised treatment

There is a need for adoption of practice standards and clinical guidelines to ensure consistent regional access and treatment. Ideally, these would be adopted nationally. Lack of national patient management frameworks and clinical guidelines for the major tumour groups.

Improving early diagnosis and treatment

There are long delays to access diagnosis and treatment in some specialities. In most tumour streams, there are no standardised timeframes for diagnosis or treatment which means that patients do not know what they can reasonably expect.

Multidisciplinary care

Increasing the number of multidisciplinary meetings occurring and the effectiveness of these meetings will enable improved clinical decision making regarding treatment and will assist in increasing referrals where there may currently be under-treatment. Often key members of the health team are not available to attend multidisciplinary meetings. Multidisciplinary meetings are considered best practice for the planning of treatment.

Palliative care

The regional forum has identified opportunities to work collaboratively on a range of initiatives for the future. All district palliative care plans need review and updating.

Information systems

Clinicians often experience difficulties accessing patient information when patients transfer from one provider to another for treatment. While information technology exists to enable best practice it is not always available to clinicians e.g. video and imaging for multidisciplinary meetings.

Patient data for monitoring, audit and service planning is not easily accessible and not all information is available electronically. The point of diagnosis of cancer is difficult to identify and not always captured electronically. Data relating to staging of cancers is not routinely available. Data is also captured in private provider systems and therefore not always available.

Workforce

While a national workforce analysis is complete, there has been no regional planning response to this information. Workforce models need to recognise service requirements across the continuum and not only in diagnosis and treatment services.

Demand and capacity issues

There are issues relating to demand and capacity and future-proofing services.

Appendix 3

Measuring success - Intermediate and process indicators

Level	Impact	Indicator	Description	Data source	Measurement timeframes
Outcome	10+ years	Reduce the incidence and impact of cancer	Site specific age-standardised mortality rate by ethnicity	New Zealand Cancer Registry (NZCR)	Annually (two year lag)
	Population level – long term	Reduce inequalities with respect to cancer	Site specific five year relative survival rate by stage, ethnicity, age group, deprivation level etc	Provided by Ministry of Health based on NZCR and Statistics NZ	Occasional
			Site specific age-standardised mortality rate by ethnicity. (For reducing the incidence rate, note that the timeframe is longer than 10 years)	NZCR	Annually (two year lag)
Intermediate	Up to 5 years	Improve the wait times between critical steps of the patient journey	Details of the indicator will depend on the tumour stream and the ability to capture the information		
			Time from referral to diagnosis/MDM/decision on care plan	Local DHB patient management systems	Ongoing/three monthly
	Measures system performance medium term		Time from decision to treat to first treatment	Local DHB patient management systems	Ongoing/three monthly
	To show activities are contributing to reducing inequalities in outcomes indicators are reported by ethnicity	Intervention rates	Rates of intervention-radiation, chemotherapy, surgical and palliative care	National collections (NMDS, NNPAC, NZCR)	Annually
		<ul style="list-style-type: none"> • staging • radiation therapy • medical oncology • chemotherapy • surgery • palliative care 			
		Support attaining national health targets related to cancer control		DHBs	Annually
		Improve patient experience		Cancer Control Council patient experience survey	Biennial
				Consumer focus groups in Midland	Annual patient and service mapping programme

Level	Impact	Indicator	Description	Data source	Measurement timeframes
Process	1 – 3 years	<p>100% of regional service directories developed by 2014</p> <p>Suspected cancer guidelines in primary care for referral and reducing disparities implemented by 2014</p> <p>Adopt / implement clinical guidelines, patient management frameworks and patient journey wait time standards and intervention rates for the three top cancers (lung, colorectal, bowel) by 2014</p> <p>Proportion of patients presented at multidisciplinary meetings (target to be determined for each tumour stream)</p> <p>100% target for all relevant Midland organisations to implement end of life Liverpool Care Pathway by 2014</p>	The network's annual work programme will identify milestones and indicators that work towards the strategic objectives		



Bibliography

- Barber J. (2004). Non-Surgical Cancer Treatment Services Plan for the Midland Region. Tauranga, Midland District Health Boards.
- Barber J. (2007). Midland District Health Boards Regional Collaboration Principles. Tauranga, Midland District Health Boards.
- Bay of Plenty District Health Board. (2007). Cancer Control Action Plan 2006-2010. Tauranga, Bay of Plenty District Health Board.
- Bay of Plenty District Health Board (2005). District Strategic Plan 2005-2015. Tauranga, Bay of Plenty District Health Board.
- Bay of Plenty District Health Board. (2006). Bay of Plenty District Health Board Health Needs Assessment - District Annual Plan 2007/08. Tauranga, Bay of Plenty District Health Board.
- Bay of Plenty District Health Board. (2008). District Annual Plan 2008-2009. Tauranga, Bay of Plenty District Health Board.
- Cancer Control Council of New Zealand. (2007). Mapping Progress: The First Two Years of the Cancer Control Strategy Action Plan 2005-2010. Wellington, Cancer Control Council of New Zealand.
- Cancer Control Council of New Zealand. (2008). Mapping Progress II: Phase 1 of the Cancer Control Strategy Action Plan 2005-2010. Wellington, Cancer Control Council of New Zealand.
- Cancer Control Council of New Zealand. (2008). Mapping Progress II: Phase 2 Prioritisation. Wellington, Cancer Control Council of New Zealand.
- Cancer Control Taskforce (2005). The New Zealand Cancer Control Strategy: Action Plan 2005 - 2010. Wellington, Ministry of Health.
- Hewitt J. (2006). Midland Region Cancer Control Project: A Proposal for Establishing the Midland Cancer Network. Hamilton, Midland District Health Boards.
- Hewitt J. (2008). Plan to Develop Resident Medical Oncology and Haematology Services based in Tauranga, Bay of Plenty District Health Board. Hamilton, Midland Cancer Network.
- Hudler M. (2008). Midland Cancer Network AYA OHS Progress Report and Action Plan 2008-2010. Hamilton, Midland Cancer Network.
- Lakes District Health Board. (2005). Lakes District Health Board Strategic Plan 2005-2015. Rotorua, Lakes District Health Board.
- Lakes District Health Board. (2007). Cancer Control Action Plan 2006-2010. Rotorua, Lakes District Health Board.
- Lakes District Health Board. (2008). An Assessment of Health Needs in the Lakes District Health Board Region: Te Tirohanga Hauora O Lakes – Summary Report. Rotorua, Lakes District Health Board.
- Lakes District Health Board. (2008). District Annual Plan 2008-2009. Rotorua, Lakes District Health Board.
- Lewis C. (2008). Midland Cancer Network - Māori and Pacific Governance Links. Hamilton, Midland Cancer Network.
- Midland Cancer Network. (2008). Midland Cancer Network Consumer Participation Framework and Plan 2008-2010. Hamilton, Midland Cancer Network.
- Midland Cancer Network. (2008). Midland Cancer Network Payment Policy for Stakeholder Consultation and Participation. Hamilton, Midland Cancer Network.
- Midland District Health Boards (2009). Midland District Health Boards Māori Health Regional Plan 2008-2011. Tauranga, Midland District Health Boards.
- Ministry of Health. (2000). The New Zealand Health Strategy. Wellington, Ministry of Health.
- Ministry of Health. (2001). Improving Non-Surgical Cancer Treatment Services in New Zealand. Wellington, Ministry of Health.
- Ministry of Health. (2001). The New Zealand Palliative Care Strategy. Wellington, Ministry of Health.
- Ministry of Health. (2001). The New Zealand Primary Care Strategy. Wellington, Ministry of Health.
- Ministry of Health. (2002). He Korowai Oranga: Māori Health Strategy. Wellington, Ministry of Health.
- Ministry of Health. (2002). Reducing Inequalities Intervention Framework. Wellington, Ministry of Health.
- Ministry of Health. (2002). The Pacific Health and Disability Plan. Wellington, Ministry of Health.
- Ministry of Health. (2003). The New Zealand Cancer Control Strategy. Wellington, Ministry of Health.
- Ministry of Health. (2009). Cancer Control Programme; Programme Overview and Work Programme 2009/10. Wellington, Ministry of Health.
- New Zealand Guidelines Group. (2008). The Management of Early Breast Cancer: Consultation Draft. New Zealand Guidelines Group, Wellington.
- Population Health. (2008). NZDep2006 Index of Deprivation Waikato District Health Board. Hamilton, Health Waikato, Waikato District Health Board.
- Population Health. (2009). An Assessment of Cancer Health Needs in the Midland Cancer Network Region; 2009. Hamilton, Health Waikato, Waikato District Health Board.
- Robson B. Harris R. (eds). (2007). Hauora: Māori Standards of Health IV. A Study of the Years 2000-2005. Wellington, Te Rōpū Rangahau Hauora a Eru Pūmare.
- Scanlan L. Hewitt J. (2005). Midland Region Non-Surgical Cancer Treatment Service; Progress Report 2005; Implementation Plan 2005-2010. Hamilton, Midland District Health Boards.
- Scanlan L. Hewitt J. (2008). Midland Early Stage Breast Cancer Patient Mapping: Report and Action Plan 2007-2010. Hamilton, Midland Cancer Network.
- Waikato District Health Board. (2006). District Strategic Plan 2006-2015. Hamilton, Waikato District Health Board.
- Waikato District Health Board. (2006). He Huarahi Oranga 2006-2009. Hamilton, Waikato District Health Board.
- Waikato District Health Board. (2006). Māori Health Workforce Development 2006-2010. Hamilton, Waikato District Health Board.
- Waikato District Health Board (2007). Cancer Control Action Plan 2006-2010. Hamilton, Waikato District Health Board.
- Waikato District Health Board. (2007). Reducing Inequalities Action Plan 2007-2010. Hamilton, Waikato District Health Board.
- Waikato District Health Board. (2008). District Annual Plan 2008-2009. Hamilton, Waikato District Health Board.



Strategic Plan 2009-2014

Improved cancer control through increased regional collaboration