Loddon Mallee Integrated Cancer Services

Loddon Mallee Region Cancer Services Plan

Summary Report

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1.1 INTRODUCTION

In 2016, Bendigo Health Care Group, on behalf of the Loddon Mallee Integrated Cancer Service (LMICS), engaged HealthConsult to develop a Loddon Mallee Region (LMR) Cancer Service Plan to set the direction for cancer service development and cancer system improvement in the LMR for the next ten years.

The service planning process examined the cancer services system in the Loddon Mallee Region (LMR) and the role of LMICS in responding to service demand and service system requirements. In order to complete this Service Plan, we collected, analysed and triangulated data with respect to:

- **Expressed and Comparative Need:** We examined demographic, socio-demographic, epidemiological and service utilisation data from multiple sources. This work identified the scale and distribution of population characteristics, service demand and current service provision and also made comparison with State and regional data.
- **Normative Need:** We undertook detailed interviews with 92 informants, including clinicians, health administrators, and representatives of key external agencies. We used a combination of individual interviews and focus groups to gather information on stakeholder's perspectives of the cancer system in the LMR and priorities for its further development.
- **Felt Need:** We conducted a survey of consumers of cancer services (people in the LMR who have/ have had cancer and their carers) within the LMR over a four-week period, as well as focus groups and individual interviews of consumers across the LMR. A total of 45 survey responses were received and an additional 18 consumers were consulted through individual interview or focus group.

Quantitative and qualitative data from these sources are described in this report as are the findings from their triangulation. Through this process we identified five pillars of cancer service delivery in the LMR: cancer services in the LMR are consumer directed, integrated, high-quality and safe, provided by a skilled, supported and sustainable workforce, and accessible.

Overall, the findings were both positive and cautionary. The strengths of the existing LMR cancer service system include: individual clinical leaders who drive positive change in the LMR cancer service system; a multidisciplinary approach to cancer care; specialist regional oncology nurses help to increase access to cancer care for people in rural and regional areas; an increased focus on survivorship and supportive care; and a commitment to quality assurance. There is a broad range of services available for people with cancer in the LMR, which is a credit to the clinicians and service managers involved. Also, consumers (cancer patients and their carers) consulted were generally positive about cancer services in the region.

That said, the demographic profile of the LMR speaks to need for investing in strategies to engage those most at risk of cancer and mitigate the risk of increased demand on health services. The plan also highlights opportunities for cancer service providers in the LMR and for LMICS to build on achievements to date.

Service plans can focus on consolidating existing services, quality improvement and/or service expansion. A key finding in this report is that some of the major planning challenges and priority areas for cancer services in the LMR relate to quality improvement and consolidating existing services. More specifically, the plan highlights the need to enhance clinical governance and clinical leadership, continue to support workforce capacity and capability building, further integrate services across the LMR and better engage consumers in co-designing cancer services. For these reasons, many of the recommendations included in this plan relate to service consolidation and quality improvement. There are also recommendations related to service expansion and several sections of the full report highlight additional areas for service expansion in the future.

This summary document should be read in conjunction with the Loddon Mallee Region Cancer Plan Final Report (Final Report), which provides considerable detail concerning the data collected and its analysis. There is also an Implementation Plan in Appendix A of the Final Report which provides an overview of suggested actions, output measures, and contribution to outcomes relative to each recommendation.

1.2 POLICY AND PLANNING CONTEXT

The Loddon Mallee Region Cancer Plan is being developed at a time when Victorian state government policy and program documentation is undergoing important developments relevant to cancer services. The release of the new Victorian Cancer Plan; Targeting Zero, the report of the Review of Hospital Safety and Quality Assurance in Victoria; and the draft Victorian Cancer Clinical Services Capability Framework, are important events in the development of Victoria's cancer care system. These documents indicate a strong direction for future service system development. They also build upon a range of other policy and program directives and objectives which outline priorities for integrated cancer services facilities, clinical quality assurance measures such as Optimal Care Pathways (OCPs) and Multidisciplinary Cancer Care Meetings (MDMs), a focus on service integration, and measures to enhance access to services for children, adolescents and young people and Aboriginal and Torres Strait Islander people.

A strong direction emerging from review of this policy documentation is a focus on the integration of services through enhanced service coordination and increased accountability for service quality through the implementation of the service capability framework. There is also a focus on increased clinical leadership and clinical reporting, and responsiveness to consumers who may be disadvantaged as a result of rural isolation, have particular needs related to life stage and development, or who are from underserviced populations, including Aboriginal and Torres Strait Islander people.

The Loddon Mallee Region Cancer Plan, as well as addressing issues of service access and availability, must also address issues related to the integration of services and the requirements of providing safe and high quality services.

1.3 LODDON MALLEE SERVICE DEMAND PROFILE

The demographic profile of the LMR indicates a need to plan for increased service demand in the future as the population ages and its care needs become increasingly complex. Further, the characteristics of the LMR speak to the need for investing in health promotion and cancer prevention strategies to engage those most at risk of cancer and mitigate the risk of increased demand on health services. Chapter 3 of the Final Report provides a more detailed account of the LMR service demand profile.

1.3.1 Population and health profile

The Loddon Mallee Region (LMR) covers a large section of North Western Victoria which extends from the outer Melbourne metropolitan area to the New South Wales and South Australian border. It has an ageing population and a large Aboriginal population. The LMR has a relatively low socio-economic profile and associated adverse social determinants of health and higher rates of poor health indicators.

The LMR has relatively high rates of newly diagnosed malignant cancers. The LMR also has high rates of reported risk behaviours including smoking rates, risky consumption of alcohol and poor diet. Life expectancy is relatively low there are relatively high rates of avoidable death.

1.3.2 Cancer rates

The five most common new cancer diagnoses in the LMR were prostate, bowel, breast, lung and melanoma. A high proportion of cancers are experienced in older people. The cancer incidence per 1,000 population is much higher for the LMR compared to rural Victoria and the state. The less populated areas of Buloke, Central Goldfields, Gannawarra and Loddon have historically had much higher rates of cancer per capita.

1.3.3 Cancer Services utilisation

In the 2015 calendar year, there were 10,624 inpatient chemotherapy services provided to patients residing within the LMR. There were also 1,054 services provided to residents outside of the LMR.

There were 6,093 cancer related surgical services provided to patients residing within the LMR in the 2015 calendar year, and in 2014/15, there were 1,022 courses of radiotherapy treatments provided to residents of the LMR.

1.4 LODDON MALLEE CANCER SERVICES MAPPING

A description of the cancer services provided in the LMR is given in Chapter 4 of the Final Report. In addition, a data base has been developed which provides a detailed description of all services provided. These data are included in Appendix C of the Final Report.

There are a wide range of services provided in distinct sub-regions within the LMR. There are various organisations involved in the provision of cancer services with diverse clinical pathways between regions and sub-regions.

In addition to providing direct cancer care services, clinicians play an important role in outreach services to rural areas and have clinical leadership roles across the region. Respondents identified demand pressures with respect to endoscopic procedures. These pressures may be addressed with the expansion of surgical facilities in the new Bendigo Hospital.

The Mildura sub-region, including a substantial catchment located in south-western New South Wales, operates largely independently of the LMR. The transition of the Mildura sub-region to a greater level of self-sufficiency will place greater demands upon available resources. The development of radiation oncology, for instance, will create a demand for an extension of chemotherapy services to provide for simultaneous services. Although the arrangement whereby clinicians from the Epworth Hospital in Melbourne provide a visiting service allows for some improved management of service continuity, there are less established arrangements for those consumers who travel to Adelaide for treatment.

In terms of the informal arrangement between Swan Hill District Hospital, Bendigo Health, and Kerang District Health Services, the provision of two chemotherapy services within 60 kilometres of one another is questionable given the size of the population cohort and the difficulties in attracting and retaining qualified staff. This service model may need to be revisited.

Similarly, it remains unclear what the demand for chemotherapy services at Kyabram will be. Its location between two established services in Echuca and Shepparton may impact upon patient numbers and service viability.

Maryborough Health Service faces a similar challenge as it is located between Ballarat and Bendigo – two larger cancer services. At the time of writing this report, we were informed that chemotherapy services at Maryborough Health Service were in the process of being reduced due to insufficient demand.

There is currently no chemotherapy service in the Southern sub-region to serve the rapidly growing population on the Calder Highway transport route. Any service which might be developed in this area should be developed as part of an LMR cancer service continuum, with appropriate linkages to other treatment services and to primary care and post treatment services.

1.5 CONSUMER PERSPECTIVES

Information was obtained from consumers through a combination of focus groups, individual interviews and a survey. In total, feedback was received from 63 consumers with approximately 48% of respondents being men and 51% women. Forty-five survey responses were received from patients that either have received or are currently receiving a cancer related service in the LMR. Most survey respondents were over the age of 50. No respondents identified as Aboriginal or Torres Strait Islander. Given the modest response rate, the findings need to be interpreted with caution and cannot confidently be taken as representative of all consumers in the LMR.

In addition, 18 consumers, eight men and 10 women, were consulted through focus groups and individual interviews. There was some disparity between survey responses and consumer feedback obtained from focus groups and interviews. While most survey respondents reported sufficient access to information; those consulted suggested room to improve this aspect of care. Further, survey respondents did not identify issues with transfers of care, while those consulted identified poor transfers of care as an issue. In what follows there is an overview of consumer feedback. Chapter 5 of the Final Report provides a more detailed discussion of the findings, as well as the data limitations.

1.5.1 Cancer Diagnosis and Treatment

Approximately half of the survey respondents were seen by a specialist within two weeks of receiving a cancer diagnosis. For those respondents who had to wait longer than two weeks for an appointment, this was caused by specialist waiting times, hospital waiting times or waiting for the completion of tests. Most survey respondents were diagnosed with either breast or prostate cancer. GPs were the most common medical physicians that provided a cancer diagnosis.

Two thirds of respondents required more than one form of treatment. Treatment of cancer solely through radiation therapy was the least common method. Respondents received treatment - whether it was surgery, radiation therapy or chemotherapy - within two weeks of being ready to receive treatment. Where this was not the case, the reason was specialist waiting times, hospital wait times or waiting for the completion of tests.

Most survey respondents reported that they played a primary role in determining their treatment. In some cases, the doctor made treatment decisions after considering their opinion and in a minority of cases, decisions were determined without their input.

1.5.2 Awareness of cancer research

About half the respondents did not receive information about possible participation in clinical trials and identified that they would have liked to have access to clinical trials. That said, it is possible some respondents may have expressed interest in clinical trials and not been eligible for them.

1.5.3 Information about cancer and treatment, care coordination and satisfaction

Most survey respondents were provided information about their cancer, the treatment options and how they should prepare and manage their treatment. Respondents reported to be least informed on how to manage anxiety or stress prior to treatment and at the point of diagnosis.

Most respondents had a health professional or team that they could contact during treatment and they received follow up from a health professional. Medical oncologists were most often responsible for follow-up care. A small number reported that they would have liked access to counselling or other personal services, local key contacts to discuss symptoms experienced, mutual support groups relevant to their diagnosis, wellness programs and practical support with finances, transport, equipment, and home modifications.

Survey respondents generally considered that coordination between health professionals during their treatment was good. This may be because most respondents had either breast or bowel cancer and thus had access to specialist nurses such as the McGrath Breast Care Nurse. In interviews, however, consumers reported challenges in finding their way around the care system and problems related to transfer of care between clinicians and organisations. Some reported feeling 'abandoned' in the post treatment phase. Difficulties in accessing equipment post discharge were also reported. These consumers describe a disaggregated care system with internal silos within health services and between health services.

Overall, respondents were satisfied with the care they received, though a number indicated that they were unhappy with some aspect of their care at some stage such that they wanted to complain. Various suggestions were made by respondents concerning additional services that would be of assistance. These are outlined in Chapter 5 of the Final Report.

1.5.4 Early intervention and diagnosis

Early intervention and timely intervention is critical. For many consumers, when they received their diagnosis, the cancer was advanced. In some cases, their own reticence was the reason for delay in screening or diagnosis and in other cases, GPs failed to identify the cancer. Concern was expressed about isolated community members without access to primary health care.

1.5.5 Access to transport, accommodation and financial support

Consumers experience significant costs in accessing care and several consumers reported an inability to travel whilst unwell or frail as a barrier to accessing cancer care. Consumers and stakeholders identified cost efficient and effective transport options as a priority. The eligibility requirements and the reimbursement arrangements for the Victorian Patient Travel Assistance Scheme (VPTAS) were also identified as a barrier to accessing services. Access to financial support for and assistance in booking accommodation in treatment centres is also an issue for rural consumers.

1.5.6 Supportive care and support groups

Consumers identified the need for enhanced supportive care from the point of diagnosis. The McGrath Breast Care Nurses were consistently identified as a valued model which provides social and emotional support as well as clinical information.

People who are at different stages in their cancer journey require different types of support and access to support networks that are responsive to their individual needs. Support groups should ideally be responsive to different ages, genders, cultures and cancer types. Consumers also identified a need to increase support for carers.

1.6 CLINICIANS' AND HEALTH ADMINISTRATORS' PERSPECTIVES

The following is a summary of the issues raised and perspectives of the clinicians and health administrators consulted by means of focus groups and semi-structured interviews. Ninety-two stakeholders were consulted in total.

1.6.1 Strengths of the existing LMR Cancer Service System

Stakeholders identified the strengths of the current service system in the region as being the individual clinical leaders and interpersonal relationships which facilitate referral pathways and transfers of care; the multidisciplinary care model, supported by MDMs; the regional oncology nurse care coordinators and nurse practitioners where they exist; the focus on increasing screening rates amongst vulnerable consumers; the focus on survivorship and supportive care; and the focus on quality assurance.

1.6.2 Clinical governance and clinical leadership

Stakeholders identified that a robust clinical governance structure which includes clinical leadership and clear mechanisms of accountability across the LMR, needs to be developed as a matter of priority. Most stakeholders identified the need for formalising arrangements between organisations and standardising the quality of patient care across the region.

1.6.3 MDMs

Stakeholders regarded MDMs as valuable and a critical mechanism for the promotion of service quality. That said, several limitations were identified. The resources involved in participation was identified by some service providers as prohibitive. The range of MDMs is limited by tumour type and participation by some rural service providers is limited.

1.6.4 Quality of information and transfers of care

Stakeholders identified a range of information management and transfer of care issues which require attention. These included: illegible medication charts, the lack of an e-Prescribing system, diverse patient information and records management systems, as well as poor transfers of care and discharge summaries.

Some stakeholders questioned the array of outreach service models across the region and identified the importance of formalising agreements about who the medical records belong to and where they should be kept.

There was some concern about variable information sharing between treating clinicians for patients with comorbidities such as renal disease, cancer, and cardiovascular problems.

1.6.5 Isolated cancer services

Stakeholders identified risks associated with cancer services operating in geographically isolated regions with limited access to clinical leadership.

1.6.6 Audits and evaluation

Some respondents regarded the culture of health services in the LMR overall as insufficiently invested in auditing and evaluation. They thought it important to ensure case audits and clinical review were core business across LMR cancer services.

1.6.7 Workforce

Attracting and retaining suitably qualified clinicians in regional areas is an ongoing challenge. Stakeholders raised concerns about the risk of losing clinical leaders to metropolitan areas and the risk of burnout amongst clinical leaders and isolated clinicians. Succession planning is a priority.

A range of workforce needs were identified across the LMR such as recruiting an additional medical oncologist for the region. These are documented in Chapter 6 of the Final Report. There was also a need for specialist allied health professionals such as psycho-oncologists identified as a priority for the LMR.

There is a need to make optimal use of existing workforce resources. Strategies include engaging La Trobe University to support oncology nurse training, and investing in training nurse practitioners.

Minimum competencies across the oncology workforce should be supported through sufficient access to ongoing training and education. This access should be supported by additional nurse educators in the regions and the tertiary hospitals.

GPs need to be better supported to provide cancer screening, symptom management and surveillance post treatment.

1.6.8 Service integration

Where there are established relationships between referring and treating clinicians or between organisations, services tend to be better integrated and transfers of care more streamlined. Many stakeholders see that current services are fragmented and there are silos within and between organisations. Integration between the acute and primary health care sectors is highly variable and the relationships between hospitals and health centres in the LMR can be 'patchy'. There is also fragmentation along the cancer care continuum i.e. between cancer prevention and screening initiatives; and diagnosis, treatment and survivorship.

Respondents identified that more needs to be done to bridge gaps between the mainstream primary health care system, the acute sector, and ACCHOs.

There is fragmentation between the health systems of different jurisdictions such that it is difficult to track the care provided to consumers in other states. There is also fragmentation between metropolitan and regional health services and between public and private health services.

Care pathways are strongly influenced by professional networks and there is a lack of knowledge within the services system of what is available or could be provided by other local services.

The level of knowledge of and hence adherence to the Optimal Care Pathways is mixed.

1.6.9 Consumer engagement

Stakeholders reported low levels of awareness of the needs of Aboriginal consumers and low levels of uptake by Aboriginal consumers in cancer services. Aboriginal stakeholders identified the need for mainstream cancer services to more effectively engage the Aboriginal community and ensure their services are more flexible and culturally responsive. There is a need for more culturally appropriate services applied across the continuum of cancer care from health promotion and prevention through to palliation.

Relatively little had been done to engage Culturally and Linguistically Diverse (CALD) groups or to assess whether current cancer services were meeting their needs, or able to meet their needs in the future as the population ages.

Respondents identified a risk that services were potentially more clinician-centred than consumer-directed. Respondents also identified the need to support the cancer workforce to provide developmentally appropriate care to younger consumers.

1.6.10 LMICS

There is a lack of understanding about LMICS's role in the cancer service system and the constraints around LMICS's funding. Respondents also thought the onus was on LMICS to develop understanding amongst cancer service providers that 'do not know what they do not know'.

1.6.11 Identified service needs

Stakeholders identified a range of clinical and non-clinical service needs. These are elaborated in Chapter 6 of the Service Planning Report. Table 1 provides an overview of priority specific service and workforce needs identified by stakeholders (a more detailed version of these data is available in Chapter 6 of the Final Report). Table 2 provides an overview of identified cancer service system needs.

Table 1: Main identified service gaps

Service gap	Location	Expressed need	Normative need	Proposed service response
AYA specialist	LMR	✔	✔	Local clinician with expertise supporting young people with cancer and their families who could provide telehealth support and outreach visits as needed
Clinical cancer care coordinators	LMR various	✔	✔	Invest in recruiting and retaining clinical cancer care coordinators to help improve transfers of care and integrate services.
Continence physio	Mildura	✔	✔	Recruit a continence physio for Mildura
Exercise physiologists	LMR various	✔	✔	EPs to run pain and fatigue management programs, reconditioning exercise programs, lymphedema massage and rehabilitation
Medical Oncologist	Mildura	✔	✔	To improve sustainability of existing service model
Mental health clinicians	LMR various	✔	✔	Clinicians specialising in bereavement support and developmentally appropriate psycho social support for cancer patients and carers
Nurse Practitioners	LMR various	✔	✔	additional oncology nurse practitioners who could support cancer specialists and patients in the region
Occupational therapists	LMR various	✔	✔	Assistance with home modifications, returning to work, assessments, and timely access to equipment
Oncology Nurses	Bendigo	✔	✔	Addressing recruitment and retention barriers in Bendigo
Palliative care specialist	LMR various (based in Bendigo)	✔	✔	Regional palliative care physician linked in with Bendigo who provides clinical leadership for regional hospitals
Psycho-oncologist	Bendigo and Mildura	✔	✔	Invest in psycho-oncology support for the region and, if necessary, organise telehealth support to increase access to limited resources.
Satellite chemo clinics	SW Loddon Mallee	✔	✔	LMICS and key stakeholders to investigate the feasibility of chemotherapy services in the Southern area.

Service gap	Location	Expressed need	Normative need	Proposed service response
Specialist oncology nurses across tumour streams	LMR various	✔	✔	Resource additional MBCNs across the LMR and consider options for resourcing other specialist oncology nurses with expertise in specific tumour streams
Survivorship programs (allied health led)	LMR	✔	✔	Resource additional programs across the LMR

The Table above is not an exhaustive list of identified needs and should be read in conjunction with the discussion in Chapters 5 and 6 of the Final Report. Table 1 does cover the main service needs identified by both consumers and clinicians / health administrators.

Table 2 provides and overview of the relationship between some of the key themes, issues and solutions that emerged in consultation with clinicians and consumers. These have informed some of the main recommendations in the report.

Table 2: Overview of issues identified by stakeholders

Theme	There is a need to
Consumer-directed care	• Ensure all cancer services are consumer-directed • Treat consumers as equal partners in shared care arrangements • Ensure cancer services are culturally appropriate and responsive • Ensure consumers and carers have access to psychosocial support • Resource and recruit psycho-oncologists for the region • Partner with consumers and carers • Meet increased demand for supportive care and survivorship programs • Reduce unnecessary travel to attend follow up appointments where possible • Ensure the cancer workforce can tailor information to suit individual needs
Integration	• Consolidate and clarify pathways between existing cancer services • Improve integration of services across the LMR • Improve and increase discharge planning • Improve integration and coordination of care between the acute and the primary care sectors • Improve the consistency of integration between LMR cancer services • Improve linkages between different parts of the cancer care continuum • Increase collaboration and streamline care between ACHOS's and mainstream cancer services • Address interjurisdictional fragmentation and poor transfers of care • Improve integration between the private and public cancer services systems
Quality and safety	• Support and expand clinical leadership across the LMR • Champion and model a multidisciplinary approach to cancer care • Ensure audits, mortality and morbidity reviews, and evaluations are core business • Formalise and standardise clinical leadership and clinical governance arrangements • Address quality and safety risks associated with clinically isolated cancer services • Resource shared patient information management systems such as the EMR • Investigate opportunities for shared information across health services • Use data to facilitate research and inform evidence-based best practice • Improve the quality and consistency of MDM records • Continue to improve the consistency and quality of discharge plans

Theme	There is a need to
Workforce capacity and capability	• Meet increased demand for services across the LMR • Address the increasingly complex support needs of elderly patients with cancer • Build on survivorship and supportive care initiatives • Build relationships between primary and tertiary care • Support the general practice workforce to manage and support peoples with cancer • Identify and address skill gaps • Ensure minimum competencies are developed and maintained across the cancer workforce • Mitigate the risk of single-person dependency • Recruit additional clinicians as required • Address recruitment and retention barriers • Continue to support and expand on service capability frameworks and existing training and education initiatives • Consider developing a comprehensive cancer workforce plan for the LMR
Access	• Resource regional oncology nurses who can help coordinate care and assist patients navigating the cancer system • Ensure services are environmentally and culturally accessible for vulnerable consumers • Increase access to clinical trials • Maximise telehealth to reduce unnecessary travel • Improve access to an appropriate range of safe, high-quality cancer services including screening, survivorship programs and supportive care • Work with Aboriginal Community Controlled Health Services (ACCHOs) to redress poor uptake in cancer services • Improve access to developmentally appropriate cancer care for paediatric and AYA patients • Ensure timely access to cancer diagnosis and treatment • Resource and support transport for consumers in more remote locations • Improve access to current information about local services for consumers and clinicians

1.7 OPTIMAL CANCER SERVICE SYSTEM

In reviewing the cancer services for Loddon Mallee Region, we have examined the 'systemic' aspects of cancer service arrangements, i.e. not just the service elements of the care arrangements but also the way in which these elements work together to deliver a coherent and comprehensive service experience for consumers.

Key elements of an effective cancer care system as indicated by the policy and program documentation analysis are:

- Patients, their families and carers affected by cancer are at the centre of care;
- Consideration is given to the continuum of care including the various health sectors involved in delivering care across tumour streams;
- Care coordination takes into consideration rural/regional and metropolitan contexts of care;
- Continuity of care is promoted as a whole-of-system response; initiatives occur across several key levels including the health system, health service, team and individual;
- Improving care coordination is the responsibility of all health professionals involved in the care of individual patients and is considered in their practice;
- Clinical networks set clear and measurable safety and quality improvement goals, and publicly reports on the system's progress against them;
- Small hospitals have ongoing partnerships with larger health services to ensure they receive adequate expert support for case audit and other clinical governance activities;
- Compliance with capability frameworks are monitored, actioned and evaluated; and

- Clinical networks work to reduce clinical practice variation in all hospitals (health services), including by developing or sharing best practice protocols for common use.

1.8 THE HALLMARKS OF EFFECTIVE REGIONAL CANCER SERVICES

In addition to these prescriptions for the system of care, findings from our consultations with consumers, clinicians and health service managers suggest that the key features of an effective cancer services for the LMR are as follows:

- Safe, high-quality cancer services are available as close to home as possible
- Services are integrated with smooth transfers of care and effective linkages between different organisations and sectors of the health system
- Consumers have access to a range of cancer services across the continuum from education about prevention through to end of life care
- All stakeholders have access to up to date information about what cancer care services are available locally
- The cancer workforce is supported through clinical leaders, access to and support for developing and maintaining clinical competencies, and adequate resources
- There is a clear shared understanding about the role of each cancer service in the region and shared accountability between services for ensuring consistently safe, high-quality care
- There is a commitment to maximise available resources and develop innovative solutions to workforce shortages and service gaps
- There is a shared investment in quality initiatives such as data sharing, conducting audits, measuring outcomes, and evaluating cancer services
- Build on existing clinical networks to facilitate joint governance and planning and the development systems and policies that apply across organisations

1.9 RECOMMENDATIONS

The recommendations below are aligned to five key pillars of cancer service delivery in the LMR drawn from the literature scan in Chapter 2 and the data in Chapters 2-6 in the full report. Namely, that LMR cancer services are: consumer-directed, integrated, high-quality and safe, provided by a skilled, capable workforce, and accessible.

The recommendations are mainly directed at cancer service providers in the LMR (this includes but is not limited to hospital and health service CEOs, clinicians, managers and policy makers) and/or at LMICS. Broadly speaking, recommendations that relate to cancer service provision are directed at cancer service providers, while those that relate to supporting the development of an integrated cancer network in the LMR are directed at LMICS. That said, since the combined recommendations relate to improving the cancer service system in the LMR overall, many of them are directed at both cancer service providers and LMICS, and some are directed at additional stakeholders such as the Loddon Mallee Aboriginal Reference Group (LMARG) and the Murray Primary Health Network (PHN).

1.9.1 LMR cancer services are consumer-directed

Vision: All clinicians involved in cancer services will practice in a consumer-directed, holistic way that respects the unique circumstances, needs and choices of individual patients and carers. The LMR cancer service system will be well-equipped to meet the needs of a diverse demographic.

Recommendations:

- That cancer service providers in the LMR, in collaboration with LMICS, engage consumers and carers to obtain their input to the resolution of issues identified in Chapters 5 and 6 of this report and involve them in all components of planning, delivery and evaluation of high quality cancer care in the LMR.
- That cancer service providers in the LMR, in collaboration with the Loddon Mallee Aboriginal Reference Group (LMARG), and LMICS, put strategies in place to improve uptake from Aboriginal consumers, and ensure cancer services are culturally appropriate and accessible.
- That cancer service providers in the LMR, with support from LMICS, put strategies in place to increase early intervention, prevention and diagnosis of cancer for all consumers in the LMR.
- That cancer service providers in the LMR and LMICS continue to support the work commenced on survivorship and supportive care and extend these initiatives across the LMR so that all consumers have access to survivorship programs and supportive care services.
- That cancer service providers in the LMR, with support from LMICS, put strategies in place to more effectively engage consumers from Culturally and Linguistically Diverse (CALD) backgrounds in cancer services.
- That cancer service providers in the LMR work with LMICS to put strategies in place to support consumers to navigate the cancer service system. This might include compiling a database of local cancer care providers in the LMR.

1.9.2 LMR cancer services are integrated

Vision: There are formal agreements in place between all cancer service providers in the LMR that ensure a collaborative, integrated approach to cancer service provision across the region. There are also effective systems and processes in place to support the provision of smooth transfers of care within and between organisations and health care sectors at all stages of the cancer care continuum.

Recommendations:

- That cancer service providers in the LMR, together with LMICS and the Loddon Mallee Regional Clinical Council (LMRCC) put joint strategies in place to enhance clinical integration of cancer services across the LMR and reduce fragmentation within and between cancer services.
- That cancer service providers in the LMR, together with LMICS, build on successful models of coordinated care such as the prostate cancer nurses and cancer care coordinators, to help improve continuity and coordination of care for people in the LMR.
- That LMICS partner with tertiary hospitals to enhance service linkages through information exchange, shared care planning and effective referral/discharge arrangements between regional and referral hospitals.
- That cancer service providers in the LMR, work with LMICS, to streamline and improve patient information management systems to support information sharing and better integrate care.

- That cancer services providers in the LMR, together with LMICS and the Murray PHN put strategies in place to ensure consumers and clinicians in the LMR have access to a database of local service providers and referral pathways.
- That cancer service providers in the LMR, with support from LMICS, put strategies in place so that clinicians in regional health centres can access discharge summaries in cases where cancer patients present at their local hospital/health service with an acute cancer-related condition post discharge from a larger hospital.

1.9.3 LMR cancer services are high-quality and safe

Vision: LMR cancer services, together with LMICS, strive for a culture of excellence and quality improvement. It requires that there be a shared commitment across cancer services in the region to the establishment of clinical standards, the monitoring and review of quality, the utilisation of quality improvement instruments, and the provision of organisational support, particularly for rural services.

Recommendations:

- That cancer service providers in the LMR, with support from LMICS, put strategies in place to increase access to clinical leaders with expertise in cancer for oncology nurses and other key staff in more isolated health services.
- That cancer service providers in the LMR, with support from LMICS, put strategies in place to increase capacity across the cancer service system to conduct clinical audits, measure morbidity and mortality outcomes, use clinical data to build on the cancer evidence-base for the LMR and, where necessary, improve clinical practice.
- That LMICS works with LMR cancer services to: explore options to increase access to and participation in MDMs across the region; and put strategies in place to ensure ongoing involvement in MDMs is sustainable for all disciplines involved.
- That cancer service providers in the LMR, with support from LMICS, build on existing strategies to increase the utilisation of OCPs.
- That cancer services in Swan Hill and Kerang work with Bendigo Cancer Centre (BCC), with support from LMICS, to increase access for consumers at Swan Hill by consolidating the service, expanding the visiting medical oncology service from BCC to include outreach to Swan Hill, and strengthening clinical leadership.
- That cancer service providers, together with LMICS and the Department of Health and Human Services, and cancer services in the LMR, work towards the implementation of the Cancer Services Capability Framework and the monitoring of its application.
- That, given the possible development of a radiation oncology service in Mildura, cancer service providers in Mildura, together with BCC and LMICS, put strategies in place to integrate the new service with the broader LMR, and support access to clinical leadership and referral pathways as required.

1.9.4 The LMR cancer workforce is skilled, supported and sustainable

Vision: The LMR cancer workforce has access to workforce development and training opportunities to ensure that they are equipped to provide clinically safe, consumer-directed care. There are recruitment and retention strategies in place to ensure the cancer workforce is sustainable and has sufficient capacity to respond to likely increase in service demand.

Recommendations:

- That cancer service providers in the LMR, together with LMICS, partner with Paediatric Integrated Cancer Service (PICS) and the Victorian Adolescent and Young Adult Cancer Service (OnTrac) to support LMR clinicians in the provision of developmentally appropriate cancer care and screening survivors of paediatric and / or AYA cancer.
- That cancer service providers in the LMR, together with LMICS, put strategies in place to develop minimum competencies and training for allied health professionals across the LMR who provide cancer care.
- That cancer services in the LMR, together with LMICS, continue to drive, model and promote a multidisciplinary approach to cancer care.
- That cancer service providers in the LMR, together with LMICS and the PHN, put strategies in place to support GPs in the LMR to care for consumers with cancer, refer appropriately and effectively, and screen for cancer / cancer-related conditions and side effects.
- That cancer service providers in the LMR, with support from LMICS, assess which of the cancer service and workforce gaps identified by stakeholders in Chapter 6 of the Final Report can and should be resourced.
- That in order to build consistent clinical capacity and excellence amongst oncology nurses in the LMR, LMICS support local universities in the LMR and the Bendigo Cancer Centre to work together in the management, accreditation and delivery of post-graduate and continuing professional education programs for oncology nurses.
- That cancer services in the LMR, in conjunction with LMARG, the Victorian Aboriginal Community Controlled Health Organisation (VACCHO), Aboriginal consumers, and LMICS, put strategies in place to support the cancer workforce to provide more culturally appropriate care.

1.9.5 LMR cancer services are accessible

Vision: Patients in the LMR will have access to an appropriate range of cancer services across the continuum of care regardless of where they live. Cancer services in the LMR must be responsive to all consumers and their carers in the LMR, including those living in isolated areas who need to travel for treatment.

Recommendations:

- That LMICS, in collaboration with cancer service providers, develop a support services framework to help services to ensure consistent, timely delivery of relevant support services, including linkages with primary and community service providers
- That cancer service providers in the LMR, with support from LMICS, put strategies in place to increase access to clinical trials for consumers in the LMR.
- That cancer service providers in the LMR, with support from LMICS, put strategies in place to increase access to telehealth for follow up appointments that do not need to be done face-to-face, clinical supervision, and engaging GPs in case reviews.
- That cancer service providers in the LMR, with support from LMICS, put strategies in place to increase access to local allied health led rehabilitation programs and services for consumers across the LMR.
- That LMICS engage with cancer service providers in the LMR and volunteer organisations to identify and promote transport solutions for consumers from rural and remote areas.

- That LMICS advocate for investigating the feasibility of a cancer service located in the Macedon Ranges Shire which is integrated with the other cancer services in the LMR.
- That cancer service providers in the LMR, in collaboration with consumers and LMICS, cancer service providers, develop strategies to improve access to services for vulnerable consumers.