SUBMISSION SENATE CANCER INQUIRY

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Committee Secretary
Community Affairs Committee
Department of the Senate
Parliament House
Canberra ACT 2600
Australia

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Committee Secretary,

Please find our submission to Senator Cooks Cancer Inquiry. For the past four years SWS Cancer Service has been building the organisational infrastructure to deliver patient centred care. The submission is based on what we have learned and observed.

Unlike other health service groupings, the organisation of cancer services is complex because of the spectrum of diseases that constitute cancer

The key points are:

- The organisation to deliver cancer services needs to be built and managed according to well established business models
- The organisation needs to be managed.
- Health policy often fails because of the inability to operationalise. There needs to be a well managed organisation that can implement policy initiatives.
- The above requirements are not particular to health and are fundamental to any organisation.
- Organisations are not built by magic.

We would welcome the opportunity to expand on our submission in the public hearings.

Bill Kricker
Martin Berry
Kate Tynan

EXECUTIVE SUMMARY

Over the past two years cancer control in NSW has received unprecedented attention. The appointment of a special Minister for Cancer, Chief Cancer Officer and the foundation of the Cancer Institute NSW has provided State-wide direction for coordinating and building better cancer services, research, patient and professional support.

There is a policy for Optimising Cancer Care in NSW (1996), a NSW Cancer Plan, and a Clinical Service Framework for Optimising Cancer Care in NSW 2002-2004. In short, there is no lack of policy frameworks or plans and no disagreement about the underlying aim to reduce the burden of cancer on individuals and the community.

Given this high level support for cancer control, the current situation would point to a fundamental problem with policy implementation.

This submission is a distillation of knowledge gained over four years of hands-on experience building a cancer service organisation. The organisation aims to deliver cancer services to patients, and patient outcomes are a function of the quality of those services.

Many health organisations, including cancer services, are unsophisticated and cannot effectively manage complexity. The demand for care coordination for cancer patients is indicative of this problem. It is only when the organisational infrastructure is in place will in-roads be made and good ideas be translated into improvements in patient care.

The focus of this submission is on implementation of cancer policy by building an organisation based on good business management principles.

In summary:

- The organisation to deliver cancer services needs to be built and managed according to well established business models
- The organisation needs to be managed.
- Health policy often fails because of the inability to operationalise. There needs to be a well managed organisation that can implement policy initiatives.
- The above requirements are not particular to health and are fundamental to any organisation.
- Organisations are not built by magic.

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BACKGROUND

In 2001 a decision was made by the SWS Area Health Service to establish an Area Cancer Service in response to the Optimising Cancer Care in NSW Policy. The Area Cancer Director took the decision to establish a Cancer Services Development Project to support him and the development of an Area Cancer Service. The role of the project was outlined as follows:

The aim of SWS Cancer Service is:

- *To reduce the incidence of Cancer*
- *To increase survival from Cancer*
- *To improve quality of life for those living with Cancer*

By delivering a patient-centered, comprehensive and integrated cancer service to the population of South Western Sydney that is in accordance with good practice.

The aim of the Cancer Services Development Project is:

To develop and build the necessary organisational infrastructure and operational processes to achieve those goals

This submission is a distillation of knowledge gained over four years of hands-on experience building a cancer service organisation and what has been learnt in the process.

SUBMISSION

This submission focuses on the basics of delivering a cancer service. It is our experience that many good ideas and concepts never achieve their potential benefits. This is because the foundations (ie the organisational infrastructure) of a 'good practice' cancer service have not been established.

As an analogy, the health sector has a tendency to start constructing services at the 10th floor, in the absence of foundations and floors 1 to 9. This is a basic flaw and why many new services and initiatives are not successful. The organisational infrastructure is not present.

This submission is to describe how to convert ideas into operational reality in the Cancer Sector. It lists many issues elicited from patients and service providers that need to be addressed. The emphasis is firmly in building an organisation to achieve this.

1. THE DELIVERY OF CANCER SERVICES

<u>If</u> it is accepted that a current good practice cancer service would aim to:

- *Reduce the incidence of Cancer*
- *Increase the survival from Cancer*
- *Improve the quality of life for those living with Cancer*

By delivering a patient-centered, comprehensive and integrated cancer service to the designated population, which is in accordance with good practice.

<u>Then</u> the delivery of cancer services is currently suboptimal.

Many specific issues contribute to this suboptimal situation; however the main cause is the underdevelopment of a systemic approach to disease management at a population level. This situation is further complicated by the public / private split of cancer services in Australia. The main systemic issues are:

1. Inadequate understanding of:
   - The cancer patient's journey;
   - The key drivers of good practice cancer service delivery;
   - The current cancer service situation;
2. The implementation issue;
3. The embryonic stage of most cancer services;
4. Inadequate management of Cancer Services;
5. Poor access to cancer services.

2. THE CANCER PATIENT'S JOURNEY

2.1 THE PROBLEM

There is not a clear understanding of the main issues associated with a Cancer Patients Journey. The question arises as to how a 'good practice' or 'patient focussed' cancer service be developed when these are not known?

A patient may be treated for cancer over many years. This is a complex journey that can involve many organisations and service providers.

In general there is poor understanding by the health sector of the importance of a Cancer Patients Journey and consequently a specific patients cancer journey receives little attention.

Cancer patients can have multiple inpatient admissions for problems associated with their cancer but the cancer service is not aware or involved. For example a patient may be

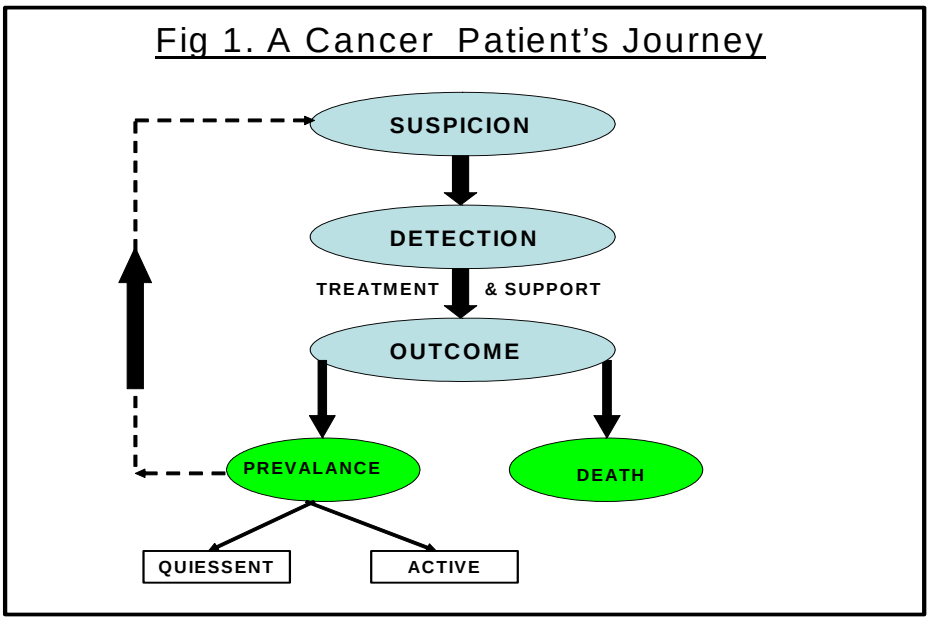
admitted with a fracture caused by the cancer, to the orthopaedic ward. There is no mechanism to flag this patient to the Cancer Service.

Note: The Cancer Patients Journey ≠ A Cancer Pathway. A Cancer Pathway is designed and managed process providing a roadmap for the patients treatment and follow-up.

The issues arising on a patient's journey encompasses all those matters of importance to the patient:

- The long time period between Suspicion and Diagnosis;
- The waiting lists;
- The economic decision to have radiotherapy or not, especially for country patients;
- The lack of information before definitive treatment begins;
- The repeated presentations to the emergency department;
- The lack of transport;
- The lack of parking for radiotherapy and chemotherapy patients;
- The lack of sensitivity from cancer service staff;
- Will I need a wig?;
- Do I have this treatment or Palliative Care?;
- Etc.

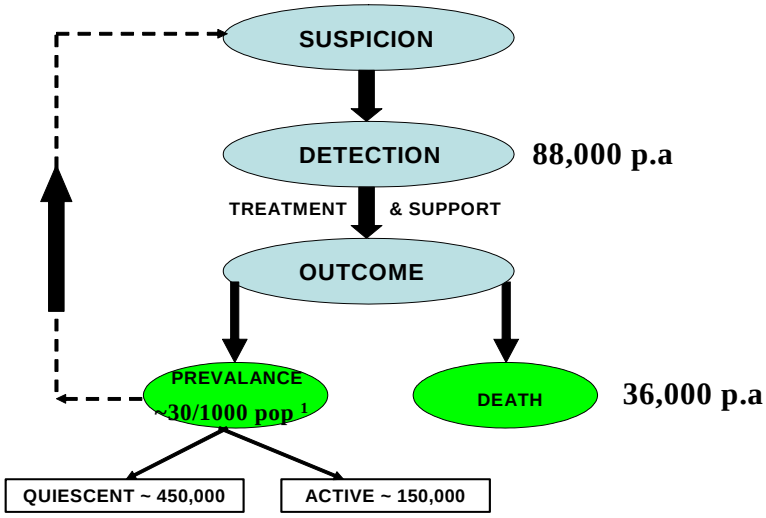
Figure 1. Illustrates a systemic view of a cancer patient's journey



2.2 THE OVERALL SITUATION

Figure 2. provides a rough estimate of the overall situation and consequently highlights a number of significant issues

Fig. 2 The Cancer Patient's Journey
An Estimate



1. Brameld et al. Increasing active prevalence of cancer in Western Aust and it implications for health services. Australian and New Zealand Journal of public Health Vol 26 #2 2002

- There is currently no estimate of the numbers of patients undergoing investigations for suspicion, or the time involved from Suspicion to Detection. Overseas studies indicate this is a very stressful period and can be up to 6 months duration

- Cure is not an outcome. People *Live with Cancer* either in an Active or Quiescent Phase. There has been little work to estimate the prevalence of cancer in general terms or by tumour type for Australia. To develop an adequate cancer service there needs to be an understanding of prevalence i.e. the total demand.

- Cancer Services do not plan well for the ~40% of patients who will die of their illness. Cancer services are seldom designed with strong links into palliative care and support. *"The emphasis is on an life as we want to take an optimistic approach to Cancer"*

3. THE KEY DRIVERS OF GOOD PRACTICE CANCER SERVICE DELIVERY

3.1 THE PROBLEM

*There is minimal understanding that **an Organisation Delivers Cancer Services: NOT clinicians.***

Magic seldom happens. If 'good practice' cancer services are to be delivered to patients then the key task is to build an organisation capable of delivering those 'good practice' cancer services.

This fundamental fact is generally unrecognised in the health sector.

3.2 ANALOGY: THE AIRLINE INDUSTRY

If a person flies Qantas between Sydney and Melbourne many aspects of a complex system come into play:

Reservations;
Timetables;
Tickets;
Boarding Procedures;
Luggage;
Aircraft Maintenance;
Aircraft Availability;
Food Services;
Etc.

For this system to work, the focus is on Qantas - the organisation delivering the airline service. It is recognised by all, that the customer /employee interaction, whilst important, is not the key variable in delivering the service - - the complex organisation (Qantas) is providing the service.

The same is true for all health services, especially cancer services, but this is seldom recognised.

AN ORGANISATION DELIVERS SERVICES

THE ORGANISATION MUST BE BUILT TO DELIVER THE REQUIRED SERVICES

3.3 HEALTH SERVICES

Figure 3. Illustrates how a Health Service functions:

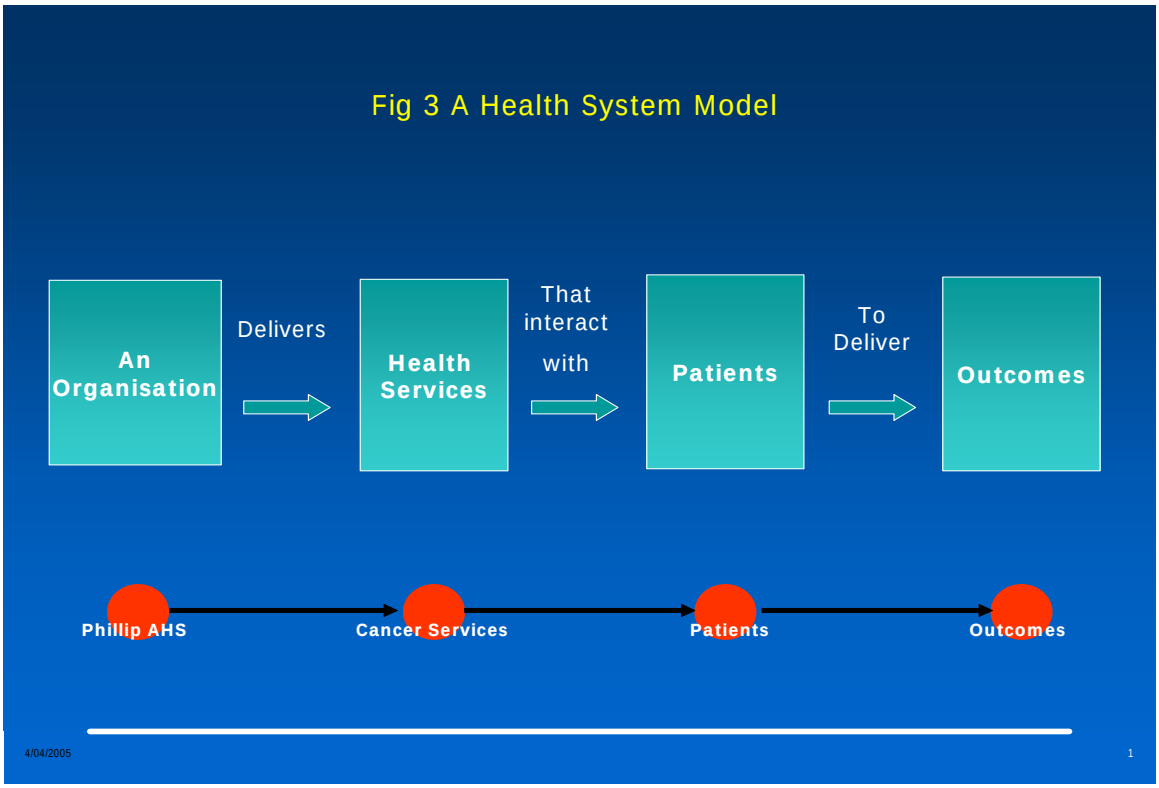
An Organisation delivers Health Services

⬇

Those Health Services interact with patients

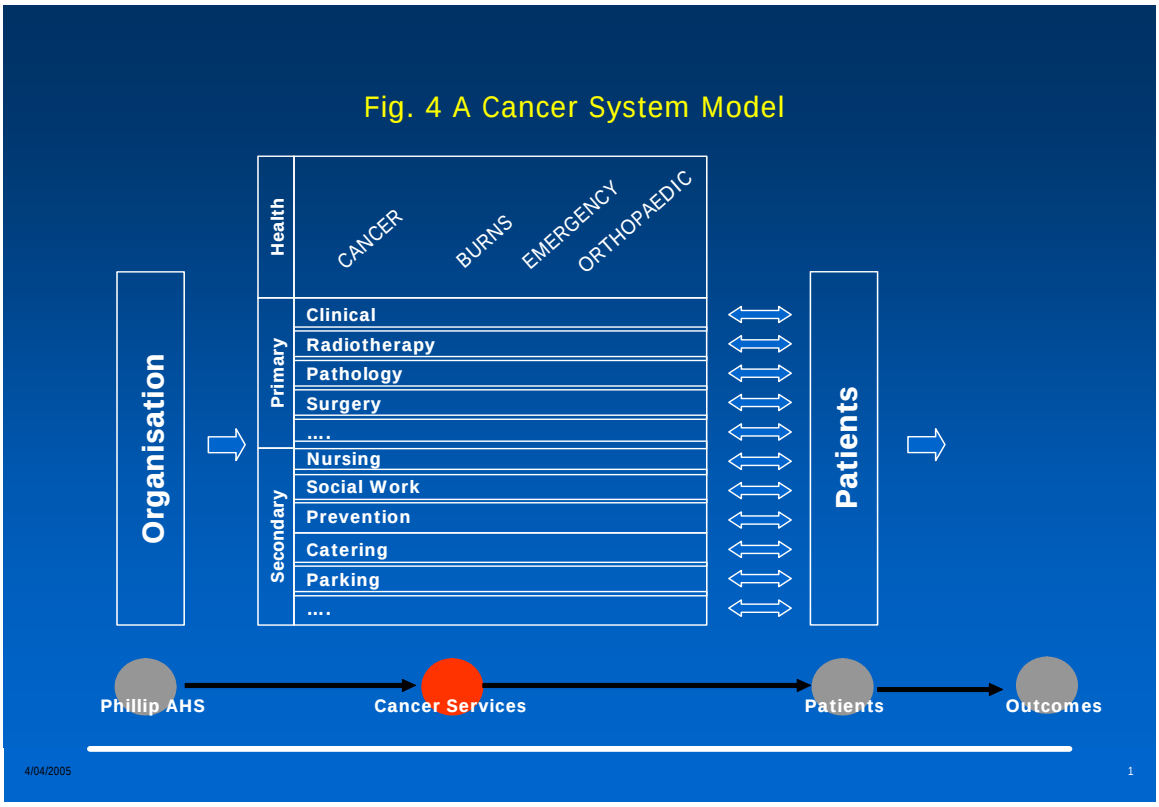
⬇

This interaction delivers the outcomes



3.4 CANCER SERVICES

Figure 4. Provides a more detailed view of a cancer service.



- The Phillip Area Health Service delivers a variety of Health Services

  Cancer Services;

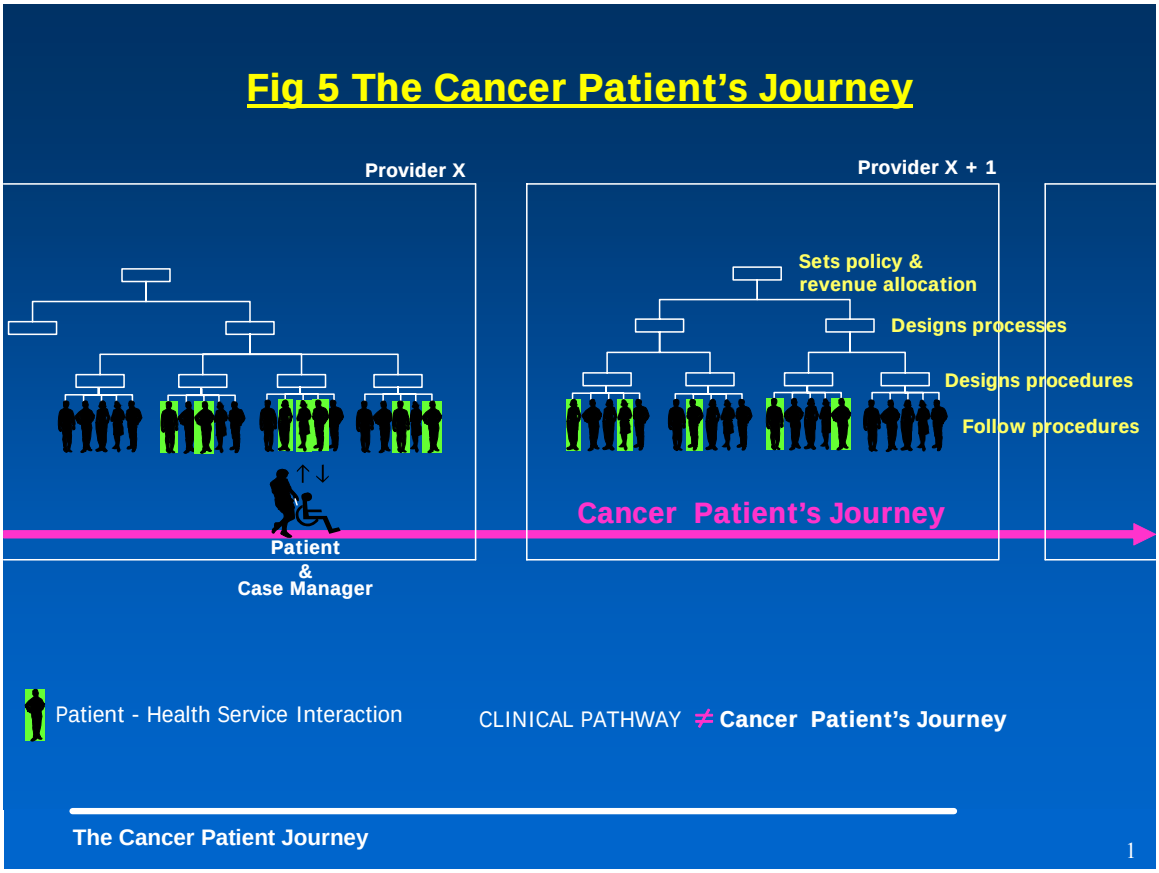
  Burns Services;

  Emergency Services;

  Orthopaedic Services.

- These health services utilise a number of Primary and Secondary services
- The employees in these services interact with the patients
- How the employees of these services interact with the patients determines the ultimate patient outcomes

Figure 5 provides a detailed view at the patient level



- The patient interacts over along period of time with many employees of many cancer service provided by many organisations
- To a large extent the dimensions of the interaction are determined by the organisation
- We may get "tired and emotional" with the airline staff at a flight check in counter, when a flight is delayed. However we do understand that problems are due to the organisation not the check in staff.
- In health services and in particular cancer services - 99% of the emphasis tends to be on the clinical interface with a patient. The root problem is that an organisation has never been built to deliver the required cancer services. Again magic seldom happens. It is not enough to articulate needs for multidisciplinary care and care coordination and improvements in services etc. There must be an organisation that can respond and implement the initiatives.

4. THE CURRENT CANCER SERVICE SITUATION

4.1 THE PROBLEM

Health in general is data rich and information poor. There is no clear information on the state of cancer services either historical or current. This makes it very difficult to improve the situation

4.2 ISSUES

- There is no clear understanding of how an individual cancer service functions.
- The health system has been established to manage acute episodes not a person with a chronic illness;
- A fundamental requirement to managing a cancer service at a region, Area or State level is a unique patient identifier. This is even more important for country patients;
- What are the most common issues that a patient faces on their cancer journey in a particular region?

5. THE IMPLEMENTATION ISSUE

5.1 THE PROBLEM

There are many good ides in Cancer but when it comes to implementing these ideas and concepts, it is assumed that magic will happen. Magic seldom happens. ***Operational Implementation is the issue.***

6. THE EMBRYONIC STAGE OF MOST CANCER SERVICES

6.1 THE PROBLEM

There are few comprehensive integrated cancer services in Australian that would meet the minimum cancer service standards recently published by NSW Health. Cancer Services are just beginning to develop

6.2 THE ISSUES

- Few Area Cancer Services;
- Few Cancer Service standards;
- Tumour Programs just commencing in many cases;
- Multi disciplinary Opinions not readily available in many cases;

7. INADEQUATE MANAGEMENT OF CANCER SERVICES

7.1 THE PROBLEM

An Area Cancer Service is a large complex entity. In general there is inadequate management of this entity to deliver the required outcomes

7.2 ENTERPRISE SCALE

The scale of an NSW Area Cancer Service is illustrated by the following example:

	ESTIMATES
Population Served	800,000
Cancer Incidence	2700
Cancer Mortality	1140
Total Prevalence	21,000(Est)
Cancer Related Inpatient Admissions	11,960
Cancer Related Inpatient Bed days	55,000 days
Unique Cancer Inpatients in a year	8000
Cancer Non-Inpatients (Occasions of Service)	100,000+
Cancer related expenditure	$75m+

7.3 THE ISSUES

- Lack of time by clinicians;
- Lack of management experience;
- Lack of support;
- All the normal management functions still need to occur: Service Planning, Organising, Leading, Operational Planning etc
- Inadequate management infrastructure in the sponsoring organisation.
- The service will be delivered across many organisations - Public and Private - this is a complex task
- Management is a significant issue, as in most cases the cancer services organisation must be built and there are few working examples.
- Management is seldom recognised as an issue by the sponsoring organisation.

8. POOR ACCESS TO CANCER SERVICES.

8.1 THE PROBLEM

A cancer specialist is not a cancer service. There are significant operational and cultural difficulties for a patient to access good practice cancer services in a timely manner. The problem is not simply resources or distance.

8.2 THE ISSUES

- Where are the good practice Cancer Services?
- How does a patient / GP / Specialist access them?
- Significant Operational Issues
- Significant Cultural issues
- Resource issues
- Distance issues

9 SPECIFIC ISSUES

Currently there are many issues associated with cancer service given the embryonic state of the cancer service concept. This list presents the top 25 issues to illustrate the situation

The list also serves to reinforce the statement that ***organisations must be built to deliver cancer services as magic seldom happens***

9.1 AN AREA CANCER SERVICE

In the ideal world there would be a cancer service for a defined geographic area and this would have a person appointed with responsibility for Cancer Services in that Area.

This situation is emerging in the public sector in New South Wales

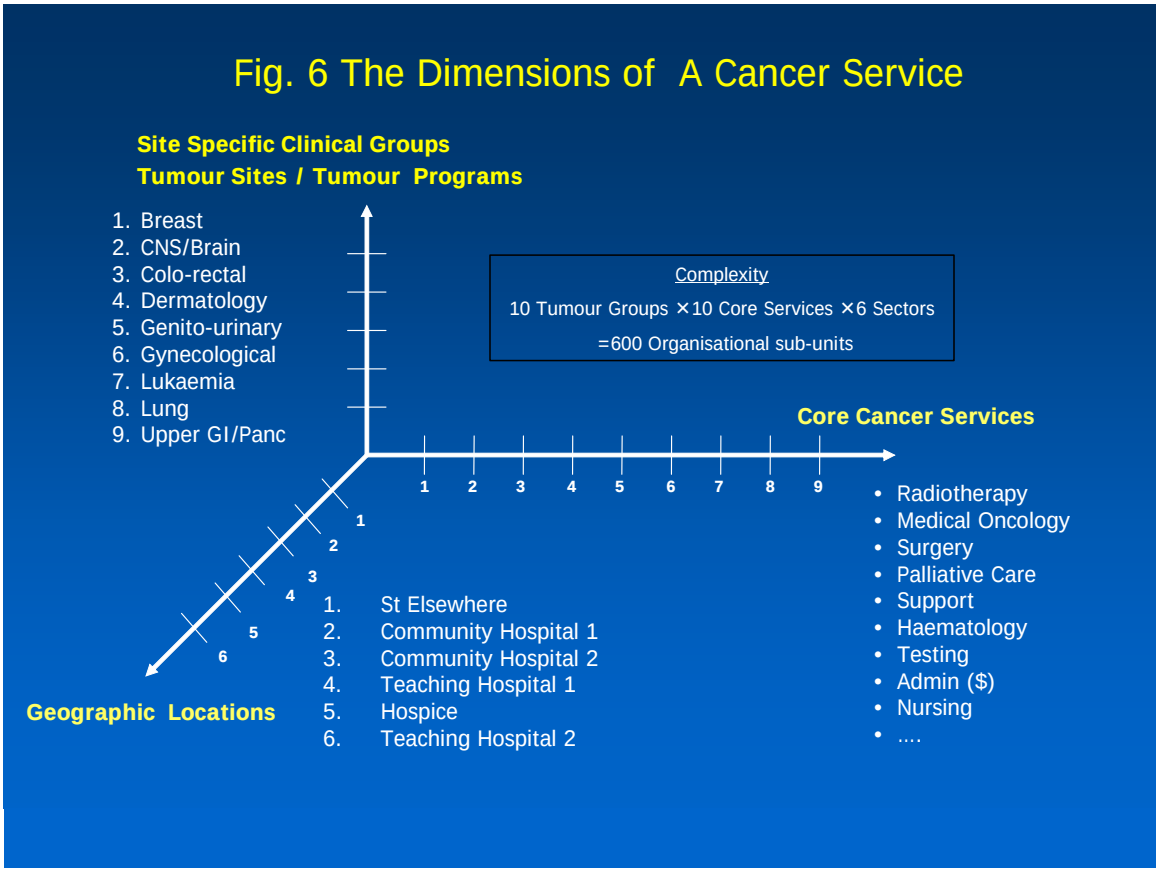
9.2 ESTABLISH TUMOUR PROGRAMMES

The complexity of cancer can been addressed by sub-specialising as this allows the clinicians to provide the best care for the patients. From a cancer service perspective, site-specific Tumour Programs are the major organisational platform to deliver services to patients. Many Areas are forming these groups for the common cancer groupings ie Breast, Colorectal, Lung, Genito-urinary, Haematological-oncology, Gynae-Oncology, Neuro-oncology, Upper GI oncology, Head and Neck oncology and Skin. The leaders of these Tumour Programs will play a pivotal role in ensuring patients have access to the appropriate services and specialists. The terms of reference for a Tumour Program mirror those of the Director of the Cancer Service, that is a population approach across the care continuum from screening and prevention to follow up and supportive care. Tumour

Program members are drawn from private and public sectors. As most cancer surgeons are VMOs this is a critical structure to communicate standards of service etc

9.3 An Area Cancer Service management structure

There must be a clear management structure for this complex service that comprises Core Cancer Services, Tumour Programs and different geographic locations. Figure 6



9.4 Palliative Care

40%+ of cancer patients die. It is essential that palliative service be adequately resourced and that clear protocols be developed by each tumour program for referral of patients to the palliative care services.

9.5 Symptom Management

How and by whom will symptoms be managed? There are perception problems in some quarters that palliative care means giving up on the patient. These attitudes are reflected in late referrals to palliative care or none at all. It also denies the patient and carer of tapping into community services and specialist service for symptom control.

9.6 GATEWAY AND REFERRAL

- How does a GP /patient access a Cancer Service as distinct from accessing a specialist
- What are the referral criteria, waiting times, booking processes etc
- This whole subject is a major issue for most if not all cancer patients.

9.7 CARE COORDINATION SERVICE

Given the length of time, the variety of providers and locations there is a need for a care coordination service for some patients to facilitate their Journey

The details on such a service are provided in Attachment 1. The cancer care coordination service -operating model.

9.8 SERVICE DIRECTORIES

- The development of service directories to support the care coordination service is a major ongoing task.
- This involves both community and hospital services
- These services are frequently of vital concern to the patient
- What are the patient eligibility criteria to access a service? What information is required? Who is to be contacted? etc
- A significant proportion of this information will vary by Area and Tumour

9.9 PATIENT INFORMATION

- The patients requirement for information will vary by tumour type and by time (i.e. Where are they on their Journey)
- How do patients obtain appropriate information before definitive treatment begins?

9.10 CLINICAL GUIDELINES AND POLICIES

The are many National and International Clinical Guidelines for the management of specific cancers. These guidelines are based on the best available evidence and are to be reviewed at regular intervals to keep current with new knowledge. There is a need to operationalise these guidelines

Each site specific Tumour Program should endorse the standards of practice from a relevant Guideline, if they exist. For example the Breast Tumour Program endorses the NH&MRC Guidelines for the Management of Early and Advanced Breast Cancers. At a local level

Guidelines need to be translated into clinical pathways or protocols, so it is clear what and when things need to occur in the context of local facilities and service providers.

Each Tumour Program would determine what the clinical pathways should be for patients to access and navigate the cancer service. For example breast cancer patients detected through the screening service would be referred through established protocols or clinical pathways to the services they need for diagnostic confirmation and treatment.

The clinical pathways form the baseline for audit trails that will be captured in the Clinical Cancer Registry and monitored by the Tumour Program. The Tumour Program has responsibility to ensure patients receive optimum treatment according to the endorsed Guidelines.

9.11 Cancer Service Standards

Just as there is a need for agreed Clinical Guidelines and Policies, there is a need for agreed standards at the cancer service level. There are few operational standards for a cancer service, however recently a phase 1 standard - A *Clinical Service Framework for Optimising Cancer Care in NSW* has been produced in NSW (Attachment 2). This standard has reasonably wide acceptance within NSW but there have been significant delays in implementing it

Standards are only useful if there is continual monitoring of a service against the standard and subsequent action on the variances.

9.12 Who are the Cancer Service Patients?

- When is a patient a patient of the cancer service?
- What are the Public /Private responsibilities?
- When does a patient cease being a patient of the cancer service?
- A patient with cancer presents at 2am in the emergency department: are they a patient of the service?
- If primary care resources are minimal, what is the role of the Cancer Service?

9.13 Cancer Inpatients

The definition of cancer inpatient is not clear as many patients may present in the emergency department months after definitive treatment being undertaken. A clear resolution of this issue will have major implications for the patient and the cancer service.

A working definition would appear to be:

> *The symptom and illness are a direct consequence of the existence of the disease in the patient*

It can also be defined in the negative:

> *The symptom and illness would not occur in the patient, if the disease did not exist in the patient*

Example: Patient admitted with pneumonia, is this a direct consequence of the patients cancer or not?

9.14 1800 CALL CENTRE

- Patients need advice on a 24×7 basis for emergencies, symptom management etc.
- Few Cancer Services can provide this.

9.15 DATA

- Many cancer Services lack basic operational data ie:
  - How many patients by Tumour type (eg Breast, Lung, CRC, GU etc)
  - How many inpatient admissions
  - How many unique patients
- This lack of basic operational data makes elementary management of a cancer service very difficult

9.16 CLINICAL CANCER REGISTRY

Clinical Cancer Registries will provide data for Area Health Services, Cancer Service Directors, Tumour Program Leaders and individual clinicians to monitor the treatment and outcomes for all cancer patients. It will enable the capture of patterns and timeliness of care. It will also capture the detailed caseload and be a useful tool for tracking the active prevalent patients as they interact with the service.

The collation of cancer staging and treatment information will permit clinicians and Areas to monitor patient survival. Patient treatment and survival data can be audited against best practice guidelines and benchmarked with other local clinicians' patients and world-best outcomes. This information needs to be regularly reported to the Director of the Cancer Service, the Tumour Program leaders and the individual clinician so that they can continually improve practice.

The Tumour Programs are integral to a meaningful Clinical Cancer Registry. There must be a conduit for the clinical treatment and outcome information to be fed back into the organisation for action. The Tumour Programs provide this function as they also hold the responsibility for setting, maintaining and improving the standards.

9.17 QUALITY

Quality must apply to the cancer patient's journey not just a clinical treatment protocols.

Quality involves professional accountability at an operational level. A cycle of - - Standard, Measurement, Variance, Action.

An organisations infrastructure must be designed and implemented to support quality.

Given the current embryonic state of many cancer services, significant development work will be required in this area.

9.18 EARLY DIAGNOSIS

For many tumours, the biggest influence on the ultimate outcome, is stage of cancer at diagnosis. **Early diagnosis is essential**

A cancer service must work closely with the GP's in its area to maximise early detection.

9.19 SUPPORT FOR CLINICIANS

- Clinicians time is a scarce resource
- Clinicians must have adequate support to work in a good practice cancer service
- Care Coordinators can be attached to Tumour Programs and this provides a minium level of integrated support

9.20 LINKS TO THE SPONSORING ORGANISATION

A cancer service is complex organisation, but it is only part of the larger sponsoring organisation. If the sponsoring organisation is sub optimal then it is difficult for the cancer service to deliver good practice health care. The Cancer Service will rely on the sponsor's management infrastructure and will need to interface with the sponsors operational planning processes and calendar.

9.21 CREDENTIALLING OF SERVICES AND CLINICIANS

The whole concept of credentialing and affiliation of services and professionals is important from a quality perspective and needs considerable work. This matter is important, as it will provide a process to establish minimum bench marks for services and clinicians.

In NSW the Cancer Institute has the power to undertake the role of accrediting services and clinicians.

9.22 NON METROPOLITAN PATIENT ISSUES

Comprehensive Integrated Cancer Services do not exist in Australia outside the metropolitan areas. Patients are seriously disadvantaged by reason of location. There is no reason why non -metropolitan patients cannot access many of the benefits of

comprehensive cancer services from non- metropolitan locations. The obstacles are mainly cultural, operational and managerial.

Hostel accommodation and travelling expenses are major issues.

9.23 NON-METROPOLITAN LINKS

Non-metropolitan Cancer Service need to have a formal links to a specific comprehensive cancer service to ensure all patients have access to the majority of benefits arising from comprehensive cancer services.

9.24 LIVING WILLS

40%+ are not cured or stabilised. Medical science continues to progress. There is a real need to integrate the concept of living wills into an appropriate holistic end of life culture and process.

9.25 THE PRIVATE SECTOR

An integrated comprehensive cancer service is easier to achieve in the public sector. The fragment nature of the private sector complicates the delivery of such a service. It would appear that the Tumour Program concept currently offers the best possibility of integrating the two sectors.

10. SUMMARY

- The organisation to deliver cancer services needs to be built and managed according to well established business models
- The organisation needs to be managed.
- Health policy often fails because of the inability to operationalise. There needs to be a well managed organisation that can implement policy initiatives.
- The above requirements are not particular to health and are fundamental to any organisation.
- Organisations are not built by magic.

Attachments

2 The Cancer Care Coordination Service -Operating Model

3. A Clinical Service Framework for Optimising Cancer Care in NSW

APPENDIX 1. SHORT BIOGRAPHIES

Ass Prof William Kricker A.M

- An appointment with the UNSW Faculty of Medicines, Western Sydney Clinical School
- A member of the Collaboration for Cancer Outcomes and Evaluation (CCORE)
- His main interests are health service delivery at all levels from National policy to individual patients
- He has a particular interest in Cancer Services and was a member of the AusAid team appointed to make recommendations on Cancer service in PNG.
- Director of the Cancer Services Development Project
- Developed and ran the 2004 Cancer workshop for The Health Roundtable. The 15 organisation(Australia and New Zealand) attending had a combined cancer inpatient admissions in2002-2003 of in excess of 120,000 inpatient episodes (Excluding Chemotherapy)

He has considerable health management experience with seven years as Chief Executive and Board of the Alfred Healthcare Group, Victoria's largest high acuity Public Hospital and provided a range of services covering all aspects of health.

In addition he was Managing Director of a private hospital group and Director of Strategy and Business Development for CSC Healthcare.

As part of this involvement in improving hospital effectiveness, Bill was the founder of The Health Roundtable – a consortium of major hospitals throughout Australia and New Zealand formed to address some of the major operational issues in the health sector. This major organisation of Hospital CEOs now encompasses 70% of all public patients in the 2 countries.

Prior to his involvement in the Health Sector he had an extensive and successful career in the Private Sector. As a result of this success, he was appointed to a number of Government bodies including 5 years as the founding Chairman on the Federal Governments Industrial Research and Development Board. In recognition of this work he was awarded the A.M.

He has had a wide variety of other experience including Monash University Council, the Faculty Board of the Monash University, Faculty of Medicine, The Board of the Baker Medial Research Institute, The Prime Minister's Coordinating Committee for Science and Technology.

Associate Professor Martin Berry MBBS FRANZCR

Martin was appointed as the first Director of the Liverpool Hospital Cancer Therapy Centre and Director of Radiation Oncology in 1994. He has facilitated the establishment of a comprehensive cancer service that includes multi-disciplinary practice, education and research programs. He has served on numerous State and National committees and major achievements have been the delivery of a sound policy framework for cancer in NSW and a state-wide radiotherapy information management system.

From 1999 to March 2005 Martin was Area Director of the SWS Cancer Service. Through the Cancer Services Development Project he has implemented site specific Tumour Programs across the Area and the first Cancer Care Coordination Service in Australia.

In 2005 he was appointed Chief Censor for the Faculty of Radiation Oncology in the Royal Australian and New Zealand College Radiologists. He holds a conjoint appointment with the UNSW SWS Clinical School as Associate Professor and his clinical interests are in paediatric and urological oncology. He was instrumental in establishing a number of pioneering efforts in education including a state wide multi-disciplinary group in urological cancer. He was a member of the Australian Cancer Network Group that devised National Best Practice Guidelines for prostate cancer.

Ms Kate Tynan BSc MPH

Kate Tynan has a science background in biochemistry and pharmacology and has worked in medical, veterinary research and immuno-diagnostic development. She graduated Masters of Public Health from UNSW in 2002. Kate has had considerable experience with quality improvement and was site facilitator for TQM at Silenus Laboratories ICI. She was a board director of Family Planning Association (FPA) Health from 1998-2002 and deputy chair of the FPA ethics committee.

Over the past six years she has worked in various positions in SWSAHS, including Business Manager for the Simpson Centre, Business and Project Manager for CCORE and is currently Project Manager for the SWS Cancer Service. Through these roles she has gained considerable experience in health service management and reform of cancer services.

Kate has worked with the Director of the Cancer Service Martin Berry and the cancer service development team to establish Tumour Programs across SWSAHS whose Terms of Reference incorporate Cancer Services from screening and prevention to follow-up and supportive care. She has overseen the implementation of the first Care Coordination Service in NSW that includes development of Multi-disciplinary Teams for treatment opinions.
Kate has considerable hands on experience with establishing Cancer Tumour Programs and Multi-disciplinary Opinion Groups

APPENDIX 2. TERMS OF REFERENCE

That the following matters be referred to the Community Affairs References Committee for inquiry and report by 23 June 2005:

(a) the delivery of services and options for treatment for persons diagnosed with cancer, with particular reference to:

> *(I) the efficacy of a multi-disciplinary approach to cancer treatment,*
>
> *(ii) the role and desirability of a case manager/case co-ordinator to assist patients and/or their primary care givers,*
>
> *(iii) differing models and best practice for addressing psycho/social factors in patient care,*
>
> *(iv) differing models and best practice in delivering services and treatment options to regional Australia and Indigenous Australians, and*
>
> *(v) current barriers to the implementation of best practice in the above fields; and*

(b) how less conventional and complementary cancer treatments can be assessed and judged, with particular reference to:

> *(i) the extent to which less conventional and complementary treatments are researched, or are supported by research,*
>
> *(ii) the efficacy of common but less conventional approaches either as primary treatments or as adjuvant/complementary therapies, and*

(iii) the legitimate role of government in the field of less conventional cancer treatment