CANCER SERVICES RHH, IN RESPONSE TO

OUR HEALTHCARE FUTURE – IMMEDIATE ACTIONS AND CONSULTATION PAPER

February 2021

Attention: www.health.tas.gov.au/ourhealthcarefuture

Kathrine Morgan-Wicks

Secretary, Department of Health

From: Rosemary Harrup

Director, Cancer Services RHH

CCS & SAC Stream

Rosemary.harrup@ths.tas.gov.au

1. BACKGROUND

The Cancer Services RHH comprises the Medical Oncology, Clinical Haematology and Radiation Oncology Units and includes a combined Clinical Trials unit. In 2017, there were 1,738 newly diagnosed cancers in Southern Tasmania (excluding non-melanoma skin cancers) and 634 deaths.[1] It is calculated that one in three hospital attendances in Australia are cancer related resulting in significant economic impacts on the health system. As the proportion of Tasmanians aged 65 years and over is expected to grow from 19 per cent in 2017 to around 25 per cent by 2052 the burden of cancer diagnosis and treatment within the health system is anticipated to rise proportionally.

The combination of an ageing Southern Tasmanian population, rising cancer rates and increased longevity following a cancer diagnosis, means the cancer services at RHH are at capacity and require an increase in resources to match the rising demand for services, especially in the outpatient setting, providing opportunities for an innovative and proactive approach going forward. The approaches undertaken should be informed by an updated version of a Tasmanian Cancer Strategic Plan in conjunction with RHH based Cancer Services strategic planning.

[1] Tasmanian Cancer Registry, *Cancer in Tasmania: Incidence and Mortality 2017*, Menzies Institute for Medical Research Tasmania, Hobart, Nov 2019

Reform Initiative 1 – Better Community Care

Question 1: How can we better target our current investment as well as future investments in health to ensure a sustainable and balanced mix of services is delivered across the whole of the health system to provide right care in the right place at the right time?

- Cancer diagnosis is often delayed in certain groups of patients, notably adolescent and young adults and the cognitively impaired. Targeted education for primary caregivers regarding "red flag" symptoms in these age groups could be funded cost effectively by using the existing health pathways in many cases.

- Supportive care for cancer patients e.g. blood transfusion for transfusion dependent patients, should be provided in local community centres and District hospitals where appropriate. This requires funding for development of protocols, education and accreditation where appropriate. At present this occurs "off the side of the desk" in Cancer Services, necessitating extremely slow progress resulting in the ongoing consumption of tertiary hospital resources for supportive care delivery (see below)

Question 2: How can we shift the focus from hospital-based care to better community care in the community?

- RHH Cancer Services have undertaken to provide cancer treatments and supportive care where possible at the Clarence and Glenorchy community centres with a certain measure of success and with very positive consumer feedback. Identified barriers include costs incurred in the development of protocols and extensive stakeholder engagement and education, physical space restriction, barriers to increasing pharmacy, administrative, nursing and medical resources to support the rollout of community-based services which would be overcome by modest investment in what is now a proven model of care. This has enabled the 8A Chemotherapy Unit to direct resources to complex anti-cancer treatments that cannot (yet!) be safely delivered closer to the patient's home.

Question 3: How can we facilitate increased access to healthcare, in particular:

a. After-hours and on weekends
b. In rural and regional areas
c. For low-income and vulnerable clients
d. For extended treatment options

- RHH Cancer Services provide a weekend chemotherapy service from 0800-1500 Saturday and Sunday on 8A. With a modest increase in nursing and medical resources this could be expanded to provide a telephone triage service based on the successful model currently operating from the 1A Cancer outpatient clinics 0800-1630 Monday to Friday when funded (see below). This innovation is aimed at preventing emergency

department presentations for cancer and cancer treatment related symptoms that can be managed in the community by phone review or permitting direct admission to the inpatient ward (during hours of operation) where appropriate again avoiding DEM presentation. This innovative model could also be developed and applied to other Chronic disease models of care with the appropriate investment.

Question 6: How can we make better use of our District hospitals?

- Extending the Chemotherapy in the Community model (see Q2) to involve delivery of cancer chemotherapy and supportive care at District hospitals would fulfil this aim.

Question 7: How can we improve integration across all parts of our health system and its key interfaces? What should be our priorities for integration?

- The priority aim for Cancer Services is to allow treating teams to access the patient Cancer Electronic Medical Record (EMR) in ARIA which permits overview of the scheduling, dosing, ordering and delivery of all past, present and future chemotherapy and radiotherapy treatments. This involves a sustained education program for end users and an investment in licences to enable safe care delivery at community centres and potentially District hospitals in the future.

Question 9: How can we make the best use of co-located private hospitals?

- Encourage a team approach to the delivery of services including where possible the use of the same EMR for delivery of cancer treatment at private and public centres in Tasmania and resourcing to permit read only access to patient's records when they attend at the two sectors.

Question 10: How can we build health literacy, self-management and preventative health approaches into the day-to-day practices of our health services across the whole of the health system?

- Provide education at schools and workplaces in all of the above.
- Fund promotion of screening programs to all Tasmanians including culturally and lingually diverse Tasmanian groups to decrease the healthcare burden.

Question 11: How can we better incorporate preventative health and health literacy initiatives into current and future care, across the range of settings, including acute, community, primary and private?

- In Cancer Services the ideal opportunity exists at the point the patient transitions to survivorship care. This is an area that is not currently resourced at either the hospital, State or Commonwealth level despite being identified as a key point in the cancer patients' journey.

Reform Initiative 2 – Invest in modern ICT infrastructure to digitally transform our hospitals, improve patient information outcomes and better manager our workforce

Question 2: What digitisation opportunities should be prioritised in a Health ICT plan 2020-2030 and why?

- Cancer Services would advocate for increased investment in the clinical and operational support of the State-wide ARIA EMR to ensure the maximum potential is realised.

Question 3: What information should be prioritised for addition to My Health Record to assist clinicians in treating patients across various health settings?

- Cancer Services advocate that patient Survivorship plans should be prioritised. This requires an investment of resources to develop comprehensive plans for each patient.

Question 6: What technology would best help you to deliver improved patient outcomes?

- Ongoing investment in radiotherapy delivery techniques and infrastructure, particularly proactive forward planning for replacement of equipment as it comes due.
- Utilisation of technology, including big data analysis, to strategically plan for increased resources to manage increasing burden of treating cancer at RHH

Question 7: How can we use technology to empower patients with their own self care?

- Provide SMS, letter and email reminders as selected by the patient in an automated fashion to ensure that necessary tests and investigations and reminders are made available prior to clinic and treatment appointments. The non-attendance rate at Cancer Outpatients is lower than that for most services however there continues to be a resource waste related to simple demographics including inaccurate contact details on referrals from Primary care, systems that don't talk to one another e.g. upgrading demographics in one system does not transfer across to other systems etc.

Question 8: What is the key paper or manual administrative process that would provide the most benefit to digitise / bring online?

- Inpatient records (never available at time of discharge) meaning that the DMR acts as an archive not an active medical record.
- Chemotherapy Day Unit discharges require inefficient manual processes which results in discharge summary following a chemotherapy or day ward treatment not being available on the same day if discharge occurs after approximately 3pm. This creates a safety risk for patients and makes it hard to track accurate data for resource allocation.

Reform Initiative 3a – Planning for the future

3a – Develop a long-term health infrastructure strategy for Tasmania

Questions 1 – 5: What are the major priorities that should be considered in the development of a 20-year infrastructure strategy to ensure the right care in the right place? Etc.

- Cancer Services needs to be located in a designated Cancer Centre to create an identity for patients, carers and staff to belong to. The current space is antiquated and inadequate adversely impacting safety, efficiency and staff and patient morale.

3b – Build a strong health professional workforce, aligned to a highly integrated health service, to meet the needs of Tasmanians.

Questions 1-6:

- Develop a comprehensive State Cancer Plan which identifies the required human resources and allows forward planning for all key staff renewal.

3c – Strengthen the clinical and consumer voice in health service planning.

Question 1: How could a State-wide Clinical Senate assist in providing advice to guide health planning in Tasmania?

- The previous top down approach did not deliver the anticipated outcomes as strategies were not operationalised in many cases. Empowering clinical leaders of all services to innovate, develop and deliver is required in addition to high level strategic planning.

Question 5: How can we improve opportunities for consumers to feed back on their healthcare including following discharge from care?

- Request community support to engage as many voices as possible. Ask visitors / carers to contribute.