Implementing Optimal Cancer Care Pathways Forum

8 May 2017
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Welcome to the Implementing Optimal Cancer Care Pathways forum, facilitated by Central Integrated Regional Cancer Service (CIRCS), Healthcare Improvement Unit (HIU) and Cancer Council Queensland.

The implementation of Optimal Cancer Care Pathways (OCCPs) will contribute to achieving Service Direction 1 of the Cancer Care Statewide Health Service Strategy 2014 by promoting the use of evidence-based treatment protocols, guidelines and standards and ensuring people affected by cancer are well-informed throughout their cancer journey.

The pathway for cancer patients is complex and sometimes poorly comprehended by those involved. It usually involves multiple healthcare providers and covers a range of institutions, both public and private.

The OCCPs map the journey for 15 specific tumour types, aiming to foster an understanding of the whole pathway and its distinct components to promote quality cancer care and patient experiences. The patient is the constant in the journey and the health system has a responsibility to deliver care in an appropriate and coordinated manner.

A wide range of clinicians, peak health organisations, consumers and carers were consulted and/or participated in the development of each of the OCCPs. These pathways were facilitated by the National Cancer Expert Reference Group and supported by the Australian Health Ministers’ Advisory Council. Now, each Australian state and territory is tasked with implementation.

The forum is designed to provide you with tools, information and support that will enable you to implement OCCPs in your local context. We are here to acknowledge the challenges faced by the current health system and work together on solutions to enable delivery of optimal cancer care.

I hope you find the forum informative and inspiring.

Adj Prof Liz Kenny AO
Medical Director
CIRCS
Queensland Health
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## Program

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<tr>
<td>8:30am</td>
<td>Registration, tea/coffee &amp; networking</td>
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<tr>
<td>9:00am</td>
<td>Early morning session</td>
<td>Adj Prof Liz Kenny AO - Medical Director, CIRCS</td>
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<tr>
<td>9:00am</td>
<td>Official welcome</td>
<td>Adj Prof Liz Kenny AO - Medical Director, CIRCS</td>
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<tr>
<td>9:00am</td>
<td>Facilitator’s welcome &amp; housekeeping</td>
<td>Karyn Schluter-White - Karyn Schluter-White &amp; Associates</td>
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<tr>
<td>9:00am</td>
<td>An introduction to Optimal Cancer Care Pathways</td>
<td>Professor Kwun Fong - Clinical Manager, Pulmonary Malignancy Unit, The Prince Charles Hospital &amp; Director, UQ Thoracic Research Centre</td>
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<tr>
<td>9:00am</td>
<td>The cancer problem</td>
<td>Joanne Aitken - Research Manager &amp; Director of Registries, Cancer Council Queensland</td>
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<tr>
<td>9:00am</td>
<td>My story</td>
<td>Jodi Fraser - Consumer</td>
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<td>10:30am</td>
<td>Morning tea &amp; networking</td>
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<td>10:50am</td>
<td>Late morning session</td>
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<tr>
<td>10:50am</td>
<td>Introduction to Health Pathways</td>
<td>Mandy Pengilly - General Manager, Operations &amp; Bernadette Praske - Senior Project Manager, Clinical Excellence, Darling Downs &amp; West Moreton Primary Health Network</td>
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<tr>
<td>10:50am</td>
<td>A quality improvement framework &amp; implementation tools</td>
<td>Peter McGuire - Service Performance Manager &amp; Barbara Page, Research &amp; Quality Manager, CIRCS</td>
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<tr>
<td>10:50am</td>
<td>The Victorian experience</td>
<td>Marita Reed - Program Manager, Quality &amp; Cancer Outcomes, Department of Health &amp; Human Services Victoria</td>
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<td>12:30pm</td>
<td>Lunch break &amp; networking</td>
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<td>1:30pm</td>
<td>Afternoon session</td>
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<td>1:30pm</td>
<td>Breakout discussion - What are the challenges and key enablers in my local context?</td>
<td>Karyn Schluter-White - Karyn Schluter-White and Associates</td>
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<tr>
<td>1:30pm</td>
<td>Breakout discussion - What solutions could be appropriate to overcome any barriers identified, including sharing of strategies between areas?</td>
<td>Karyn Schluter-White - Karyn Schluter-White and Associates</td>
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<tr>
<td>3:00pm</td>
<td>Afternoon tea &amp; networking</td>
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<td>3:20pm</td>
<td>Final session</td>
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<tr>
<td>3:20pm</td>
<td>Continuing the conversation</td>
<td>Peter McGuire - Service Performance Manager &amp; Barbara Page, Research &amp; Quality Manager, CIRCS</td>
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<td>3:50pm</td>
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About the forum

This forum was convened by a partnership between Queensland Health (CIRCS and HIU) and Cancer Council Queensland (CCQ). The workshop is for all people in Queensland wanting to improve cancer care by implementing OCCPs.

What are OCCPs?

OCCPs are national guides to the best cancer care for specific tumour types.

They describe the key stages in a patient’s cancer journey and expected optimal care at each stage to ensure all people affected by cancer get the highest-quality care, regardless of where they live or have their treatment.

Why and how to use OCCPs

OCCPs detail key principles and recommendations for optimal care at critical points in the cancer continuum, from prevention and identification through to survivorship or end-of-life care.

Detailed pathways, as well as quick reference guides and patient guides, have been developed for 15 tumour types:

- acute myeloid leukaemia
- breast cancer
- colorectal cancer
- endometrial cancer
- head and neck cancers
- hepatocellular carcinoma
- high-grade glioma cancer
- Hodgkin lymphoma and diffuse large B-cell lymphoma
- lung cancer
- melanoma
- non-melanoma skin cancers
- oesophagogastric cancer
- ovarian cancer
- pancreatic cancer
- prostate cancer.
Expected use and impact

Everyone involved in our cancer services contributes to safe and high-quality patient care and positive patient experiences. By following and referring to the OCCPs at critical points, we will ensure consistency, coordination and quality of care for patients across the cancer care continuum. Patient treatment regimens will vary, but the principles and expectations of optimal cancer care are constant.

OCCPs can be used by health services and professionals as a tool to identify gaps in current cancer services and inform quality improvement initiatives across all aspects of the care pathway. Using the pathways will help us plan and coordinate service delivery by identifying the investigations, therapies, clinical expertise, facilities and support needed at each key point of the patient journey, and resources required to enable optimal patient care and support.

Pathways can be used to promote multidisciplinary discussion, as well as to support collaboration and communication with people affected by cancer.

Improving patient communication and care

OCCPs can be used by clinicians and health professionals as an information resource and tool to promote discussion and collaboration with people affected by cancer.

Patient versions (“what to expect” guides) have been developed to help patients and other people affected by cancer to understand the usual stages during and after treatment and what to expect at each stage. Ideally, newly-diagnosed patients will be told about the pathways and given a copy of the relevant “what to expect” guide by their GP or specialist at or soon after diagnosis.

Using the tools in this booklet

The tools and information in this booklet are provided to help implement OCCPs. We suggest you make modifications to suit your local needs.

Templates are not intended to be completed by one person in an office. Better value will come from sharing your plan, discussing the key issues, analysing options for improvement and collaborating on solutions.
OCCPs information flyer

The pathway for cancer patients undergoing diagnosis and treatment for cancer is complex and poorly comprehended by those involved. It usually involves multiple health care providers and covers a range of institutions.

**The OCCPs are designed to be adopted nationally**

Optimal care pathways have been developed in consultation with the clinical community and consumers to:

- Reflect emerging areas of practice
- Improve patient experiences
- Map this journey for specific tumour types to foster an understanding of the whole pathway.

**Support:**
- assess supportive care needs at every step of the pathway
- refer to appropriate health professionals or organisations

**Step 1:**
- prevention
- early detection

**Step 2:**
- presentation
- initial investigations
- referral

**Step 3:**
- diagnosis
- staging
- treatment planning

**Step 4:**
- treatment

**Step 5:**
- care after initial treatment
- recovery

**Step 6:**
- managing recurrent, residual & metastatic disease

**Step 7:**
- end-of-life care

**Resources**

**Clinical OCCPs and quick reference guides**

Developed by multidisciplinary expert groups for healthcare professionals and administrators.

**“What to expect” – Information sheets**

To assist patients and carers navigate the care pathway at point of diagnosis and beyond.

- colorectal cancer
- hepatocellular carcinoma
- lymphoma
- lung cancer
- melanoma
- squamous cell carcinoma and basal cell carcinoma
- pancreatic cancer
- prostate cancer
- high grade glioma
- ovarian cancer
- endometrial cancer
- breast cancer
- head and neck cancer
- oesophagogastric cancer
- acute myeloid leukaemia

**Available for download**

Clinical OCCPs are available at:

The interactive consumer web portal with printable PDFs is now live at:
- www.cancerpathways.org.au
Plan, Do, Study, Act: A suggested quality improvement framework

The PDSA cycle was made popular by Dr W. Edwards Deming⁴. It encourages starting with small changes which can be built into larger improvements, through successive cycles of change. It emphasises starting unambitiously, reflecting and building on learning. PDSA can be used to test suggestions for improvement quickly, with overall objectives achieved through multiple cycles. PDSA could be a useful framework to implementing OCCPs.

**Plan.** A plan format is provided to document the emphasis of your work and how you will close any gap between current care and the optimal care described in the OCCPs. This phase includes choosing a set of meaningful measures to help show the impact of change. If you don’t have data about your area of interest, your plan might include how this will be collected. Your plan should be updated as required.

**Do.** This is the phase where actions are implemented. This phase will vary depending on your focus area and your planned actions.

**Study.** This is the phase where progress is measured. Measuring the achievement of the specific goals/objectives/key performance indicators in your plan will help show if the actions being undertaken are effective. You can use the report format to document your actions and outcomes. How often you measure or report will depend on the context of your work.

**Act.** This is the phase of reflection and improvement based on the learnings to date. It is important to celebrate successes, inform those involved about your work and make modifications to the approach to continually improve.
The plan

The plan below is modified from the A3 one-page project report tool and will help you to begin planning your implementation of OCCPs. Using this plan will enable you to structure problem solving and support communication through a common understanding of issues. It is provided to help you decide how to best implement OCCPs in your context.

Background

- Why are you talking about it?
- What is the case for change?
- What is the problem you are trying to solve or analyse?
- Be very concise – communicate WHY you are addressing this issue.

Focus area

- For example, the OCCP for people with high grade glioma.
- Step 2 - Presentation, initial investigations and referrals and Step 3 - Diagnosis, assessment and treatment planning.

Current conditions

- What is going on?
- What data sources prove there is a problem?
- Be visual (use diagrams and charts).
- Make the problem clear.

Problem analysis

Use the simplest problem-analysis tool to find the root cause of the problem, for example:
- Seven Basic Tools of Quality (7 QC Tools).
- Lean, Six Sigma, Kepner-Tragoe, Shainen, Taguchi or TRIZ tools.
- Other tools of your choice.
### Goal

- State the specific target(s).
- How will you prove that you have made a difference?
- How will you measure achievement of your goals?

### Proposal

- Your proposed solution to the problem or method(s) for achieving your goal.

### Your team

- Who are your team members/partners/alliance members?

### Action plan (who, where, when, what, how)

- What actions will be taken and when?
- How will this be approached?
- What resources will be used?
**Blank plan**

Below is a blank copy of the plan for you to write notes during the forum.

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<th>Background</th>
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<th>Focus area</th>
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<th>Current conditions</th>
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<th>Problem analysis</th>
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<th>Proposal</th>
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<th>Your team</th>
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<tr>
<th>Action plan (who, where, when, what, how)</th>
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The report

The report is a tool to help communicate progress towards implementing OCCPs in your setting. On one A3 page you can describe your original plan, overview the actions taken to date, measure progress against your stated aims/objectives and state how your work will evolve in the future. This page also shows the use of all four stages of the PDSA quality improvement cycle.

Focus area

• Copy from the plan

Original conditions

• Copy from the plan

Problem analysis

• Copy from the plan

Goals

• Copy from the plan
Activities completed and in progress (who, where, when, what, how)

• Provide a brief summary of work completed to date

Performance measures

• Specify what data and information you have gathered to measure achievement of your goals
• State what changes can be observed

Future activities (who, where, when, what, how)

• What activities will be done next (after this report)?
• Describe any changes to your approach
• State who will receive this report
• State any remaining challenges
Assessing your service

The following pages contain example questions to help assess your area of care. Answering these questions will help complete the “current conditions” and “problem analysis” sections of the 1-page plan. You should select and tailor the questions most relevant to your local needs.

Questions for all stages of the pathway

• Are the optimal time frames met for each tumour type?
• Is care tailored for populations with special needs, for example Aboriginal and Torres Strait Islander people, people from Culturally and Linguistically Diverse Backgrounds, older people, adolescents and young adults.
• Are supportive care needs assessed and what supportive care is provided/available?
• Are there any stages of the optimal care pathway where supportive care could be improved?
• Does your service use a validated screening tool (such as the National Comprehensive Cancer Network Distress Thermometer and Problem Checklist)?

Questions to help you define your focus area/s

• What are you trying to achieve?
• What is the problem/project? What are the root causes of the problem?
• What does good care look like?
• What data do you have to prove there’s a problem?
• If you make a change, how will you know it has made an improvement?
Step 1 - Prevention and early detection

- Are there screening programs for the tumour type/s you are interested in?
- If yes, what is the uptake for people in your area? Is there room for improvement in uptake of proven screening programs?
- What prevention activities are undertaken in your local context? What improvements could be made to services that promote reduction to modifiable risk factors?
- Are there prevention and early detection programs that could be improved?
- Are there areas of unmet need for preventative care services?
- What services exist for people at increased cancer risk? What is the current level of service utilisation?
- Are there opportunities for better management of people at increased risk?
Step 2 - Presentation, initial investigations and referral

- Are you familiar with the tumour-specific recommended timeframes in the OCCPs?
- What percentage of patients meet the recommended timeframe between referral and first specialist assessment?
- Are systems in place to support rapid access to specialist assessment?
- Are there opportunities for improvements to:
  - Referral pathways?
  - Referral systems?
  - Referral practices?
- Do referral documents provide the required information?
- Are patient/carer needs met in relation to communication about:
  - Explaining who the patient is being referred to and why?
  - Support while waiting for the specialist appointment?
Step 3 - Diagnosis, assessment and treatment planning

- What methods of diagnosis are used for the tumour type/s?
- What are the wait times for diagnostic imaging and diagnostic procedures?
- What are the timeframes between referral and diagnosis?
- What percentage of patients are discussed at a multidisciplinary team (MDT) meeting?
- What percentage of MDT discussions occur prior to the first treatment?
- What percentage of MDT discussions are documented, with an agreed treatment plan written?
- What percentage of patients have an agreed, MDT developed treatment plan provided to the patients GP?
- How often does the MDT meeting have all the required members?
- To what extent is support offered/provided to develop an advance care plan, where appropriate?
- What percentage of patients are screened for eligibility for clinical trials?
- What percentage of patients are enrolled in clinical trials?
- What percentage of patients are given written information about their cancer and their treatment plan?
- Are cancer stage and cancer recurrence recorded?
- Are patient/carer needs met in relation to communication about:
  - A timeframe for diagnosis and treatment;
  - The role of the multidisciplinary team in treatment planning and ongoing care; and
  - Appropriate written information or referral to support services required?
**Step 4 - Treatment**

- Is treatment intent recorded? For example, longer term survival, maintenance of quality of life, symptom palliation.
- What are the wait times for:
  - Surgery?
  - Radiotherapy?
  - Systemic therapies?
  - Specialist palliative care?
  - Supportive care?
  - Other treatments?

  Appropriate dates to measure could include from referral, from decision to treat or from MDT discussion date.
- What are the wait times between treatments?
- What are utilisation rates for each treatment type?
- What barriers prevent the uptake of treatments where indicated?
- Is support offered/provided to develop an advance care plan?
- How often is the treatment plan discussed with the patient’s GP?
- Are patient/carer needs met in relation to communication about:
  - Discussing treatment options including intent of treatment, prognosis, treatment risks and benefits; and
  - Discussing advance care planning where appropriate?
- What type of treatment outcomes are recorded?
- What type of treatment outcomes are most important to patients?
Step 5 - Care after initial treatment and recovery

- What percentage of patients and their GP receive a treatment summary?
- Do treatment summaries appropriately cover:
  - Diagnostic tests performed and results?
  - Tumour characteristics?
  - Type and date of treatments?
  - Interventions and treatment plans from other health professionals?
  - Supportive care services provided?
  - Contact information for key care providers?
- What percentage of patients have a documented follow-up care plan outlining:
  - Medical follow-up required (tests, ongoing surveillance);
  - Care plans for managing late effects of treatment; and
  - A process for rapid re-entry to medical services for suspected recurrence?
- Which aspects of follow-up care could be improved?
- How often does communication by the lead clinician meet patient/carer needs in relation to:
  - Explaining the treatment summary and follow-up care plan; and
  - Providing information/support about secondary prevention/healthy living?
- For what percentage of patients does the lead clinician discuss the follow-up care plan with the patient’s GP?

Step 6 – Managing recurrent or progressive disease
Step 6 - Managing recurrent or progressive disease

- Are there systems in place to support rapid re-entry to specialist care for patients with suspected recurrence?
- What is the wait time for first specialist appointment for patients with a recurrent cancer?
- Do systems support referral to palliative care, based on need, rather than prognosis?
- What percentage of patients are offered support to develop an advance care plan?
- What percentage of patients have an advance care plan?
- Is there appropriate support to have end of life discussions with patients and carers?
- What percentage of patients with recurrent/progressive disease are discussed at a multidisciplinary team meeting?
Step 7 - End-of-life care

- What palliative care services exist in your area/setting?
- Are systems in place for appropriate referral to specialist palliative care?
- Are GPs involved in patients’ palliative care?
- What barriers exist that would hinder the uptake of multidisciplinary palliative care?
- Is appropriate support provided to patients who choose home-based palliative care?
- How often does communication meet patient/carer needs in relation to:
  - Being open about the prognosis and discussing palliative care options; and
  - Establishing a transition plan to ensure patient needs and goals are addressed in the appropriate environment?
## Useful resources

<table>
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<th>Resource</th>
<th>Points of interest</th>
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| **Cancer Council Queensland** w: cancerqld.org.au | • Support services  
• Cancer research                                                                                                                                                                                                  |
• Multidisciplinary Team (MDT) resources  
• Clinical education                                                                                                                                                                                                     |
| **Clinical Pathways** w: qheps.health.qld.gov.au/caru/clinical-pathways | • Standardised, evidence-based multidisciplinary management plan, identifies the appropriate sequence of clinical interventions, timeframes, milestones and expected outcomes |
| **Clinical prioritisation criteria (CPC)** w: cpc.health.qld.gov.au | • Clinical decision support tools that help ensure patients referred for public specialist outpatient services are assessed in order of clinical urgency  
• Used by referring practitioners and specialist outpatient services  
• Improve referral and communication processes between referrers and specialist outpatient services                                                                                                                                 |
| **Data collections: Healthcare Improvement Unit** w: qheps.health.qld.gov.au/caru/data/collections/default.htm | • Emergency, Elective Surgery, Gastrointestinal Endoscopy, Radiation Therapy and Specialist Outpatient data collection                                                                                                                                 |
| **Data collections: Statistical Services Branch** w: qheps.health.qld.gov.au/hsu/datacollections.htm | • Queensland Hospital Admitted Patient Data Collection (QHAPDC)  
• Queensland Health Non-admitted Patient Data Collection (QHNAPDC)                                                                                                                                                     |
| **Grants and funding: National Health and Medical Research Council** w: nhmrc.gov.au/grants-funding | • Information on how NHMRC can work with you to partner in funding health and medical research                                                                                                                                 |
| **Grants and funding: Queensland, Australian and Local Governments** w: qld.gov.au/community/community-organisations-volunteering/funding-grants-resources/ | • Search for Australian Government grants  
• Contact your local council to find out what grants they offer  
• Find out more about other avenues to obtain grants                                                                                                                                                                         |
| **Grants and funding: Metro North HHS Innovation funding** w: qheps.health.qld.gov.au/metronorth/innovation/default.htm | • LINK funding builds partnership and community engagement capability, delivers efficiencies and improves continuity and quality of care  
• The SEED program finds new and improved ways of delivering health services for the benefit of patients                                                                                                                                 |
| **Grants and funding: Sunshine Coast Health Foundation Wishlist** w: wishlist.org.au | • Not-for-profit organisation dedicated to fundraising for the needs of the Sunshine Coast HHS  
• Four rounds each financial year                                                                                                                                                                                                 |

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**Implementing optimal cancer care pathways forum**
## Useful resources

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| **Grants and funding: Gold Coast Health Grants**<br>w: goldcoast.health.qld.gov.au/research-grants | • Partners with researchers to identify funding opportunities  
• Supports interdisciplinary research proposals |
| **Grants and funding: Local hospital foundations**<br>w: health.qld.gov.au/system-governance/health-system/managing/statutory-agencies/ foundations#foundations | • There are 13 foundations in Queensland offering support and funding opportunities to their associated hospital |
| **HealthPathways**<br>w: healthpathwayscommunity.org | • Each pathway is an agreement between primary and specialist services on how patients with particular conditions will be managed in the local context |
| **HHS Support (Metro South HHS)**<br>w: metrosouth.health.qld.gov.au/innovation/about-the-transformation-and-innovation-collaborative | • Transformation and Innovation Collaborative  
• A network of innovative people who together create the innovation culture in Metro South Health  
• Supports change and redesign projects |
| **Human Research Ethics**<br>w: health.qld.gov.au/ohmr/html/regu/regu_home | • Central portal for those seeking advice and direction on ethical and governance issues associated with the conduct of research in Queensland Health |
| **Management Information System (MIS)**<br>w: qheps.health.qld.gov.au/management-information-system/home.htm | • Automated, patient level, web-based visualisation tool to enhance the visualisation of healthcare information  
• A ‘Cancer Treatment Access Monitor’ is in development |
| **National Cancer Expert Reference Group (NCERG)**<br>w: health.gov.au/internet/main/publishing.nsf/content/cancer-national | • Jointly chaired by the Commonwealth Government and Victoria with representation from all jurisdictions, Cancer Australia, the Cancer Council Australia, the Clinical Oncological Society of Australia and consumer input  
• National Cancer Work Plan |
| **National Comprehensive Cancer Network**<br>w: nccn.org | • Not-for-profit alliance of 27 leading cancer centres devoted to patient care, research and education  
• Develops resources that present valuable information to the numerous stakeholders in the health system |
| **Primary Health Networks (PHNs)**<br>w: health.gov.au/internet/main/publishing.nsf/Content/PHN-Home | • Increasing the efficiency and effectiveness of medical services for patients  
• Improving coordination of care to ensure patients receive the right care in the right place at the right time |
| **Queensland Cancer Control Analysis Team (QCCAT)**<br>w: qccat.health.qld.gov.au | • Statewide program hosted by Metro South HHS  
• Undertakes analysis and interpretation of data  
• Advises on the best use of cancer data for service improvement |
References

Who are we?

Cancer Council Queensland is the state's leading non-government community organisation in cancer control.

Our research shows one in two Queenslanders will be diagnosed with cancer in their lifetime. We’re here to ensure no one goes on a cancer journey alone.

We understand that a cancer diagnosis can have an enormous impact on your patients. Cancer Council Queensland supports all Queenslanders affected by cancer - from patients and their families, caregivers and Health Professionals.

What we can do for you?

Cancer Council 13 11 20 is a free and confidential service available Monday to Friday 9am – 5pm (excluding public holidays) where your patients can speak to a qualified cancer care professional about anything to do with cancer. We are here to support and work with you and your patients.

The services we offer include:

**Emotional support**
- Speak with a qualified cancer care professional about anything to do with cancer.
- Talk to someone who has had cancer through our peer support network.
- Access our Cancer Counselling Service.

**Practical support**
- Financial and legal assistance.
- Travel and accommodation assistance.
- Access to our wig and turban service.

Access to information – we offer excellent online publications and resources.

All Queenslanders, all cancers