The Cancer Services Infrastructure Support Program (CSISP) is a funding program of the Cancer Institute NSW (Cancer Institute). Its purpose is to provide the basic structure for the development of integrated cancer services by providing temporary, demonstration model funding for six position types across Area Health Services (AHSs, now restructured into Local Health Districts) namely:

- directors/managers of area cancer services (DACS)
- cancer services development managers (CSDMS)
- lead clinicians
- cancer care coordinators, originally named cancer nurse coordinators
- psycho-oncology staff
- cancer genetics staff.

Each position was funded to make improvements in at least three of four key areas: clinical leadership, coordination of care, multidisciplinary care and patient-centred care.

The evaluation

An evaluation of the CSISP was conducted between February 2009 and October 2010. The Cancer Institute engaged HealthConsult Pty Ltd to conduct the evaluation. At the same time, data were gathered for a supplementary evaluation of the cancer care coordinator role.1

Data were gathered using two main methods: a survey of all 132 position incumbents (surveys were specific to each of the six position types), and eight service-level case studies — one in each AHS. The overall response rate to the survey was 88 per cent. The case studies included interviews with position incumbents, managers and clinicians, and open focus groups for interested staff — in total, approximately 190 people were consulted.

Findings for the program as a whole

As well as evaluating the impact of the six positions, the evaluation considered whether the CSISP has contributed to the goals of the Cancer Institute which are to reduce the incidence of cancer, to increase the survival rate for people diagnosed with cancer, and to improve quality of life for cancer patients and their carers.2

Most position incumbents felt the program had a high impact on improving quality of life for cancer patients and carers through better access to clinicians, education, care coordination and support.

Most position incumbents also felt the program has helped increase cancer survival rates, mainly through multidisciplinary team meetings, supporting patients to complete treatment and cancer genetics services.
overall impact of the CSISP on the incidence of cancer was felt to be small, apart from the effect of cancer genetics services in preventing cancer in high-risk populations.

There was strong consensus that the CSISP continues to be relevant and appropriate. Many respondents considered it critical to future cancer services. As cancer diagnosis and treatment are becoming more complex, a patient-centred multidisciplinary approach will become increasingly necessary. However, the evaluation found that not all positions achieved the improvements in at least three out of the four key areas (clinical leadership, coordination of care, multidisciplinary care and patient-centred care), and more work is needed to ensure all patients receive best-practice care.

Communication is vital to the success of the CSISP. Many position incumbents felt isolated as they have little direct communication with the Cancer Institute. Forums and training workshops organised by the Cancer Institute were highly valued.

The evaluation found that the program would benefit from:

• more leadership and support for position incumbents, and better articulated goals and objectives from the Cancer Institute
• better data collection systems and infrastructure so as to improve the timeliness, appropriateness and quality of data collected
• permanent funding of service delivery positions by health services.

Findings for the six position types funded by the CSISP

The DACS and CSDM positions are necessary for clinical leadership and strategic planning. However, the evaluation found these roles have not been as effective as they might have been because the roles have had little direction from, and accountability to, the Cancer Institute; some DACS have been unable to spend significant time in the role; and some CSDMS have become the operational managers for cancer services in some localities.

The DACS role has had more impact in AHSs where cancer is its own clinical stream and the DACS is the stream leader, which creates a clear place for the DACS in the organisational structure.

The success of the CSDM role depends on having a strategic focus, and very limited, if any, administrative, financial and operational responsibilities. It is important for the positions to operate outside the hospitals in which they are based, and focus on the development of cancer services across the AHS (LHDs).

Both roles need to better aligned to the strategic directions of the Cancer Institute and the Cancer Plan 2011-2015.

The lead clinician role has been integrated with less success and the evaluation found that funding directed to these positions would have more impact if it were redirected. This could include a discretionary budget allocation for each AHS tied to the achievement of agreed key performance indicators and/or projects to drive specific initiatives aligned with defined goals.
Some of the lead clinician funding has been temporarily used for direct service delivery staff. Health services will need to identify an alternative funding source if these services are to continue.

The evaluation found that cancer care coordinators and psycho-oncology staff have become an integral part of service delivery. Implementation of the cancer care coordinator role has varied, with a mix of full-time and part-time positions and tumour-specific and general roles. The cancer care coordinators have had a high impact on care coordination, multidisciplinary care and patient-centred care, and have improved the quality and capacity of cancer services in NSW. Given the success of the model, the challenge for cancer services is to expand care coordination activity, using the funding provided by the Cancer Institute as a foundation for further investment by health services. New models and a more standardised approach will be needed to respond to the increasing incidence of cancer.

The psycho-oncology positions have provided valuable support and improved aspects of patient care; require integration of positions within both the cancer service and the hospital department of their professional discipline to lessen isolation; should expand their impact and reach to facilities in addition to the ones in which they are based; should have input at the cancer service executive level; and be supported to enhance recognition by clinicians of the importance of psychosocial issues for cancer patients.

Funding of cancer genetics positions has improved access to genetics services. The positions provide valued resources in early detection and intervention options to prevent cancer in high-risk populations. The evaluation found that the current model, however, is fragmented and would benefit from centralisation of cancer genetics services in a small number of tertiary hospitals, with genetic counsellors in major cancer services.

Conclusion

The program has had a varied but often high impact on the four key areas for which funding was provided. The challenge remains to develop the program strategically and align all positions to the strategic directions of the Cancer Institute and the Cancer Plan 2011-2015 in order to meet the demands associated with of a rising cancer incidence; and to deliver contemporary and high-quality cancer care. Local Health Districts will need to resolve the ongoing funding of clinical positions within the national funding reforms in 2014, and provide required administrative, financial and operational support to the DACS and CSDM roles in particular. Health services will be well placed to learn from, and build upon, the findings of this evaluation to develop the highest quality cancer services to meet the needs of their population.

References