
Introduction

The policy subgroup of COSA's Survivorship Group is pleased to provide feedback on the draft of the Australian Cancer Plan (ACP). The policy subgroup, like the broader COSA membership, is multidisciplinary, including medical (oncology and general practice), nursing, and allied health professionals. We also include focus on the care of adults affected by cancer, as well as children and adolescents. This feedback also includes consumer and patient input.

The policy subgroup is very pleased to work with Cancer Australia on the development, implementation and monitoring of the ACP. We are very pleased that almost all of the priority actions that we described in our March 2022 submission have been included within the draft ACP. Below, we have made some brief comments regarding the 10 priority areas that we described in March 2022 and have included some additional comments. We provide this feedback in addition to our online survey responses.

1. Establish a monitoring / evaluation framework to accompany the ACP, which describes responsibility and accountability.

We note (page 1 of the summary version, and of the full consultation draft) that an implementation plan and a monitoring and evaluation framework are in development. While disappointed that we are not able to review these documents currently, we remain open to assisting in their development.

Our previous document (March 2022) includes suggestions regarding each priority area, as well as a section 'How can we help?' We have included these for this priority area, but encourage the reader to review the March document, in conjunction with the current feedback.

Previous suggestions regarding this priority area:

- Years 1- 2: Establish a plan for the framework, implementation strategies and associated timeframes, set key performance indicators.
- Years 3- 5: Pilot some measures at jurisdiction or national level.
- Years 6- 10: A fully functioning monitoring and evaluation framework for the ACP.

How can we help? As an example, the COSA Survivorship Policy Group can help review the implementation plans that sit alongside existing jurisdictional cancer plans.

Key performance indicators will obviously be a key requisite in implementing and monitoring the Australian Cancer Plan. We would welcome the opportunity to be involved in their development.

- 2. Establish appropriate funding mechanisms to enable implementation of evidence based supportive care interventions**, especially those with proven benefit that are not routinely funded or implemented, for example exercise physiology, psychology and other allied health interventions, multidisciplinary rehabilitation, and prehabilitation programs.

We believe that this priority area is not well covered within the draft ACP. Several supportive care interventions are known to be effective for patients and survivors, including psychological therapies, diet and exercise interventions. Currently patients and survivors do not receive effective, evidence-based interventions. A future-focussed ACP should address these gaps.

We note that currently funded allied health sessions are inadequate for people living with cancer. Recently published data suggests the reach of GP management plans and team care arrangements are poor. Along with our colleagues from the COSA Exercise and Cancer Group, we advocate for expansion of the currently available quota to better meet the needs of cancer survivors.

- 3. Develop and streamline navigation and information support for all cancer survivors.** Survivors need direction to information and resources to support them post-treatment. Survivors may need multiple services; they need services to be: (i) available, and (ii) accessible, affordable.

We support the strong emphasis on navigation and support in the ACP (objective 2). It is important that the proposed focus of navigation is not only on specialist nurses in cancer settings, but a range of navigation strategies / activities, covering the whole continuum from pre-diagnosis through to end of life should be explored (which may include both professional and non-professional navigators). This should effectively integrate primary / community-based care with acute / tertiary care. Navigation should aim to reduce fragmented care.

- 4. Establish agreed standards for quality cancer survivorship care for health services – this should form an excellence framework or a national accreditation system.**
We can learn from existing Australian jurisdictions' cancer plans and quality frameworks, as well as the US experience.

We note that consideration of quality care is included in broad terms in objectives 3 and 4. We believe that more detail could be provided. The Policy Subgroup of COSA's Survivorship Group can assist.

We would recommend that the ACP reference the following internationally recognised quality framework:

Nekhlyudov L, Mollica MA, Jacobsen PB, Mayer DK, Shulman LN, Geiger AM. Developing a Quality of Cancer Survivorship Care Framework: Implications for Clinical Care, Research, and Policy. *J Natl Cancer Inst.* 2019 Nov 1;111(11):1120-1130. doi: 10.1093/jnci/djz089. <https://pubmed.ncbi.nlm.nih.gov/31095326/>

And also this Australian reference:

Lisy K, Ly L, Kelly H, Clode M, Jefford M. How Do We Define and Measure Optimal Care for Cancer Survivors? An Online Modified Reactive Delphi Study. *Cancers (Basel)* 2021 May 11;13(10):2299. doi: 10.3390/cancers13102299. <https://pubmed.ncbi.nlm.nih.gov/34064957/>

We emphasise too that comprehensive cancer centres (action 3.2.2) must include survivorship care, as well as effective integration with community and primary care.

5. Implementation of national survivorship outcome measure/s that account for minority populations.

Use of patient-reported outcome measures (PROMs) and patient-reported experience measures (PREMs) is covered in objectives 3 and 4, including in action 4.2.1.

6. Implementation of different models of survivorship care and personalised stratified pathways of care.

This is included within the draft ACP, including in objective 3, and specifically at action 3.1.3 'Pilot innovative, evidence-based models of care for people living with and beyond cancer.' We note that there is good evidence to support many models of care, including nurse-led, GP-led and shared care. Suggest including this recent review:

Chan RJ, Crawford-Williams F, Crichton M, Joseph R, Hart NH, Milley K, Druce P, Zhang J, Jefford M, Lisy K, Emery J, Nekhlyudov L. Effectiveness and implementation of models of cancer survivorship care: an overview of systematic reviews. *J Cancer Surviv* 2021 Nov 16;1-25. doi: 10.1007/s11764-021-01128-1. <https://pubmed.ncbi.nlm.nih.gov/34786652/>

We would recommend that the wording around "piloting" be changed to include 'implementation of effective models,' recognising the available data. We should note that England is leading implementation of novel models of care. The English cancer plan should be referenced within the ACP (please see reference, later).

We would agree that, for some circumstances, piloting may be appropriate, for example for people living with advanced cancer.

Discussion regarding appropriate models of care is included in

Jefford M, Howell D, Li Q, Lisy K, Maher J, Alfano CM, Rynderman M, Emery J. Improved models of care for cancer survivors. *Lancet* 2022 Apr 16;399(10334):1551-

1560. doi: 10.1016/S0140-6736(22)00306-3.
<https://pubmed.ncbi.nlm.nih.gov/35430022/>

Also, Australian models should be referenced within the ACP:

Vardy JL, Chan RJ, Koczwara B, Lisy K, Cohn RJ, Joske D, Dhillon HM, Jefford M.
Clinical Oncology Society of Australia position statement on cancer survivorship care.
Aust J Gen Pract. 2019 Dec;48(12):833-836.
<https://pubmed.ncbi.nlm.nih.gov/31774985/>

7. Survivors receive care close to home, including telehealth

We note that there are several mentions of new, flexible, technology-assisted models – including within objectives 3 and 4.

8. Establish national agreement on cancer prevalence data and burden of disease.

As with our 4th priority area above, we note that this is covered, in broad terms, within objective 4. Data collection must move beyond basic incidence and mortality data. We need to know who is living *with* (rather than beyond) cancer. We need to have data regarding recurrence and development / diagnosis of advanced disease. Ideally also, we should have data regarding functional outcomes / disability. The Policy Subgroup can help with defining these important data elements.

9. Establish Survivorship Centres of Excellence or accreditations for Supportive Care Centres of Excellence. Similar to the US National Cancer Institute (NCI) designated Cancer Centers.

We note action 3.2.2 to “establish a National Comprehensive Cancer Centre Network (NCCCN)...” We would support elaboration to include focus on survivorship care and integration with primary / community-based care. The NCCCN should focus on excellent clinical care but also research excellence. The NCCCN should support networking, training, referral pathways, etc. This priority area might also relate to the 6th priority area above (models of care), as some survivorship services might be centralised (e.g. late effects services, paediatric long term follow up).

10. Cancer survivors have equity in access to best possible outcomes and supports, regardless of their cancer type, cancer stage, cultural background, geography or age.

We note, and support, the very strong emphasis on equity with the draft ACP, including at action 3.2.3. We would be pleased to contribute to review of the measurement and evaluation framework, to accompany the ACP.

Additional comments regarding the draft ACP

Workforce

We note the important recommendations regarding workforce (objective 5). We note that, in addition to existing medical, nursing and allied health workforce, there should be focus on scoping and developing non-clinical roles – these will be essential to support new models of care, for example remote monitoring and shared care between acute / oncology and primary care providers. Related, objective 5 might have a greater emphasis on development of new roles within cancer care beyond the above traditional (medical, nursing and allied health) roles, for example peer support / navigation, and administrative roles.

Background literature

We note that some sections seem to have extensive supporting literature, whereas others have less. We have suggested some useful survivorship-focussed references, above, but would be happy to assist with others.

Jurisdictional cancer plans

We strongly support inclusion of cancer plans from England, for example: NHS Long Term Plan ambitions for cancer, <https://www.england.nhs.uk/cancer/strategy/>

And possibly also

Achieving world-class cancer outcomes: a strategy for England 2015 – 2020, <https://www.england.nhs.uk/publication/achieving-world-class-cancer-outcomes-a-strategy-for-england-2015-2020/>

We are pleased to provide this feedback to Cancer Australia regarding the draft ACP. We would welcome the opportunity to continue to contribute to discussions regarding the ACP, perhaps in particular regarding data measurement and quality; system and navigation objectives; models of care, and workforce. While we have particular interest in care and outcomes for people living with and beyond cancer, we represent health professionals working across the cancer continuum, and including the perspectives of those with lived experience.

We are very keen to continue to work with Cancer Australia, and the broader community, on the roll out, evaluation and monitoring of the ACP.

This submission was authorised by:

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