ACT Government | ACT Health

Our reference: **ACTHDFOI22-23.42**

Dear

**DECISION ON YOUR ACCESS APPLICATION**

I refer to your application under section 30 of the *Freedom of Information Act 2016* (FOI Act), received by ACT Health Directorate (ACTHD) on **Wednesday 22 March 2023**.

This application requested access to:

- *All documents of correspondence between Calvary Public Hospital Bruce and the ACT Health Directorate between 2019-2023 concerning the former not being able to meet accreditation standards of governance for oncology and haematology services (in accordance with the Australian Commission on Safety and Quality in Health Care 2020 Guidelines for Medication Management in Cancer Care).*

- *All government briefing notes between 2019-2023 concerning:*
  - *Calvary Public Hospital Bruce and the accreditation standards of governance for oncology and haematology services (in accordance with the Australian Commission on Safety and Quality in Health Care 2020 Guidelines for Medication Management in Cancer Care);*
  - *The consequent shutting down of chemotherapy, medical oncology and haematology outpatient services at the Calvary Public Hospital Bruce (Zita Mary Clinic) due to not being able to meet the accreditation standards in the short to medium term.*

I am an Information Officer appointed by the Director-General of ACT Health Directorate (ACTHD) under section 18 of the FOI Act to deal with access applications made under Part 5 of the Act. ACTHD was required to provide a decision on your access application by **Monday 15 May 2023**.

I have identified 13 documents holding the information within scope of your access application. These are outlined in the schedule of documents included at Attachment A to this decision letter.

**Decisions**
I have decided to:

- grant full access to relevant information in 11 documents; and
- grant partial access to two documents.

My access decisions are detailed further in the following statement of reasons and the documents released to you are provided as Attachment B to this letter.

In reaching my access decision, I have taken the following into account:

- The FOI Act;
- The contents of the documents that fall within the scope of your request;
- The views of relevant third parties; and
- The *Human Rights Act 2004*.

**Full Access**

I have decided to grant full access to the information in scope of your application within 11 documents at references 1, 3-6 and 8-13.

**Partial Access**

I have decided to grant partial access to two documents at reference 2 and 7 that are partially comprised of information that I consider, on balance, to be contrary to the public interest to disclose under the test set out in section 17 of the Act.

Public Interest Factors Favouring Disclosure

The following factors were considered relevant in favour of the disclosure of the documents:

- Schedule 2, 2.1 (a)(i) promote open discussion of public affairs and enhance the government's accountability;
- Schedule 2, 2.1 (a)(ii) contribute to positive and informed debate on important issues or matters of public interest; and
- Schedule 2, 2.1 (a)(v) allow or assist inquiry into possible deficiencies in the conduct or administration of an agency or public official.

Public Interest Factors Favouring Non-Disclosure

The following factors were considered relevant in favour of the non-disclosure of the documents:

- Schedule 2, 2.2 (a)(ii) prejudice the protection of an individual's right to privacy or any other right under the Human Rights Act 2004.

These documents are partially comprised of information that is personal information such as name and email address of a person who is not an ACT Government employee.

On balance, the factors favouring disclosure were outweighed by the factor favouring non-disclosure as the redacted information is personal information of non-Government employees. Therefore, I have determined the information identified is contrary to the public interest and would not advantage the public in disclosing this information.

**Charges**

Processing charges are not applicable to this request.

**Disclosure Log**

Under section 28 of the FOI Act, ACTHD maintains an online record of access applications called a disclosure log. The scope of your access application, my decision and documents released to you will be published in the disclosure log not less than three days but not more than 10 days after the date of this decision. Your personal contact details will not be published.
https://www.health.act.gov.au/about-our-health-system/freedom-information/disclosure-log.

**Ombudsman review**
My decision on your access request is a reviewable decision as identified in Schedule 3 of the FOI Act. You have the right to seek Ombudsman review of this outcome under section 73 of the Act within 20 working days from the day that my decision is published in ACT Health's disclosure log, or a longer period allowed by the Ombudsman.

If you wish to request a review of my decision you may write to the Ombudsman at:

The ACT Ombudsman
GPO Box 442
CANBERRA ACT 2601
Via email: ACTFOI@ombudsman.gov.au
Website: ombudsman.act.gov.au

ACT Civil and Administrative Tribunal (ACAT) review
Under section 84 of the Act, if a decision is made under section 82(1) on an Ombudsman review, you may apply to the ACAT for review of the Ombudsman decision. Further information may be obtained from the ACAT at:

ACT Civil and Administrative Tribunal
Level 4, 1 Moore St
GPO Box 370
Canberra City ACT 2601
Telephone: (02) 6207 1740
http://www.acat.act.gov.au/

**Further assistance**
Should you have any queries in relation to your request, please do not hesitate to contact the FOI Coordinator on (02) 5124 9831 or email HealthFOI@act.gov.au.

Yours sincerely

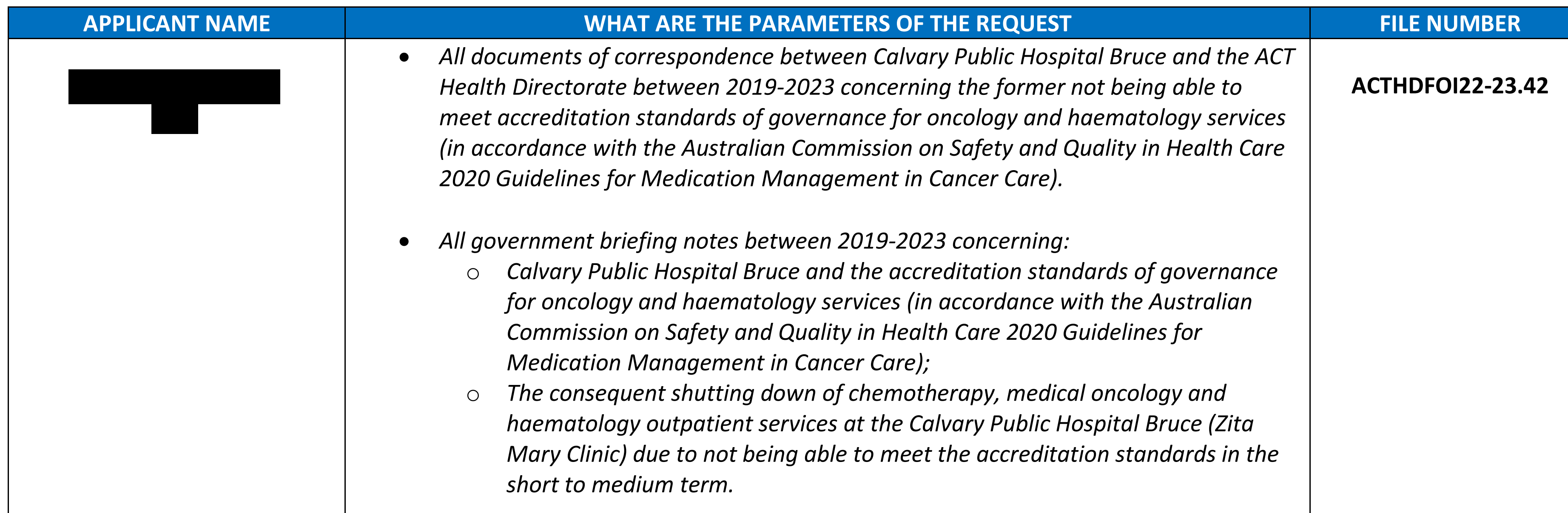
Jacinta George
**Executive Group Manager**
Health System Planning and Evaluation
ACT Health Directorate

8 May 2023

ACT Government | ACT Health

# FREEDOM OF INFORMATION SCHEDULE OF DOCUMENTS

Please be aware that under the *Freedom of Information Act 2016*, some of the information provided to you will be released to the public through the ACT Government's Open Access Scheme. The Open Access release status column of the table below indicates what documents are intended for release online through open access.
Personal information or business affairs information will not be made available under this policy. If you think the content of your request would contain such information, please inform the contact officer immediately.
Information about what is published on open access is available online at: http://www.health.act.gov.au/public-information/consumers/freedom-information



| APPLICANT NAME | WHAT ARE THE PARAMETERS OF THE REQUEST | FILE NUMBER |
| --- | --- | --- |
| | • *All documents of correspondence between Calvary Public Hospital Bruce and the ACT Health Directorate between 2019-2023 concerning the former not being able to meet accreditation standards of governance for oncology and haematology services (in accordance with the Australian Commission on Safety and Quality in Health Care 2020 Guidelines for Medication Management in Cancer Care).*<br><br>• *All government briefing notes between 2019-2023 concerning:*<br>○ *Calvary Public Hospital Bruce and the accreditation standards of governance for oncology and haematology services (in accordance with the Australian Commission on Safety and Quality in Health Care 2020 Guidelines for Medication Management in Cancer Care);*<br>○ *The consequent shutting down of chemotherapy, medical oncology and haematology outpatient services at the Calvary Public Hospital Bruce (Zita Mary Clinic) due to not being able to meet the accreditation standards in the short to medium term.* | **ACTHDFOI22-23.42** |

| Ref Number | Page Number | Description | Date | Status Decision | Factor | Open Access release status |
|---|---|---|---|---|---|---|
| 1. | 1 – 3 | Caveat Brief – MIN20/1757 Calvary Public Hospital Bruce – Options for sustainable Chemotherapy services | 13 November 2020 | Full Release | | YES |
| 2. | 4 – 19 | Ministerial Brief – MIN21/632 Consultation about proposed changes to chemotherapy service arrangements at Zita Mary Clinic, Calvary Public Hospital Bruce<br>*Attachments A-C included at pages 11-19 | 19 May 2021 | Partial Release | Schedule 2, 2.2 (a)(ii) Privacy | YES |
| 3. | 20 – 21 | Ministerial Brief – GBC21/345 Minister's Weekly Brief<br>*All attachments out of scope | 18 June 2021 | Full Release | Out of scope | TP CPHB |
| 4. | 22 – 31 | Ministerial Brief – MIN21/1062 To provide an update on the progress of the proposed changes to chemotherapy service arrangements at the Zita Mary Clinic, Calvary Public Hospital Bruce<br>*Attachments A & B included at pages 26-31 | 05 July 2021 | Full Release | | YES |
| 5. | 32 – 37 | Director-General Minute – DGC21/521 Chemotherapy Services at the Zita Mary Clinic, Calvary Public Hospital Bruce<br>*Attachment A included at pages 36-37<br>*Attachment B @ ref 4 pages 28-31 | 12 July 2021 | Full Release | | YES |
| 6. | 38 – 39 | Ministerial Brief – GBC21/469 Minister's Weekly Brief<br>*All attachments out of scope | 13 August 2021 | Full Release | Out of scope | YES |
| 7. | 40 – 89 | Director-General Minute – DGC21/616 – Future of Public Chemotherapy Services in the | 25 August 2021 | Partial Release | Schedule 2, 2.2 (a)(ii) Privacy | YES |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | ACT – Response to issues raided by Australian Nursing and Midwifery Federation<br>*Attachments A-C included at pages 43-89 | | | | |
| 8. | 90 – 92 | Ministerial Brief – GBC22/8 Minister's Weekly Brief<br>*All attachments out of scope | 14 January 2022 | Full Release | Out of scope | YES |
| 9. | 93 – 94 | Talking Points on Zita Mary Clinic – Update | 03 June 2022 | Full Release | | YES |
| 10. | 95 – 99 | Email and attachment – FYI – Minister for Health – Update – transfer of Zita Mary oncology patients<br>*Attachment to email – Ministerial Brief MIN22/702 included at pages 96-99<br>* Attachments to brief –<br>Attachment A @ ref 1 pages 1-3<br>Attachment B @ ref 2 pages 4-19 | 08 June 2022 | Full Release | | YES |
| 11. | 100 – 103 | Ministerial Brief – MIN22/702 Update – transfer of Zita Mary oncology patients<br>*Attachment A @ ref 1 pages 1-3<br>*Attachment B @ ref 2 pages 4-19 | 18 July 2022 | Full Release | | YES |
| 12. | 104 | Dot Points for Executive Group Manager briefing – Changes to the Zita Mary Clinic | 22 August 2022 | Full Release | Out of scope | YES |
| 13. | 105 – 107 | Ministerial Brief – GBC22/501 Minister's Weekly Brief<br>*Part of attachment C included at page 107<br>*All other attachments out of scope | 19 August 2022 | Full Release | Out of scope | YES |
| **Total Number of Documents** | | | | | | |
| **13** | | | | | | |

**ACT Health**

**CAVEAT BRIEF**

SENSITIVE

| | |
|---|---|
| **To:** | **Minister for Health** |
| **Through:** | **Kylie Jonasson, Director-General**<br>**Bernadette McDonald, Chief Executive, Canberra Health Services** |
| **From:** | **Meg Brighton, Deputy Director-General, ACT Health Directorate** |
| **Subject:** | **Calvary Public Hospital Bruce – Options for sustainable Chemotherapy services** |

- Calvary Public Hospital Bruce (CPHB), following review of Australian Commission on Safety and Quality standards, has determined that it will not be able to meet accreditation standards for governance (medical support and comprehensive care) for oncology and haematology services.
- The main issue identified by CPHB and senior cancer clinicians at Canberra Health services (CHS) is that, as employees of CHS, there are no consistent and clear mechanisms to monitor care provided at CPHB.
    - Oncology and haematology consultation and review clinics at CPHB are conducted weekly or fortnightly by doctors employed by CHS.
    - There are 9 chemotherapy chairs with approximately 15 patients a week receiving chemotherapy at CPHB.
    - CHS oncologists/haematologists provide chemotherapy supervision remotely. A junior doctor provides limited support to the chemotherapy patients but is appointed to, and works under the governance of, the CPHB Hospital in the Home service.
- Whilst many of the gaps against the standards are rectifiable, this will be resource intensive and will not be able to be fully resolved in the short to medium term.
- In addition CPHB and CHS senior oncology and haematology clinicians have agreed the service is not sustainable given several of the specialists have indicated they are not in a position to continue providing clinics at CPHB due to increasing clinical commitments elsewhere, predominantly at Canberra Hospital (CH).
- The issues of clinical governance and service sustainability have also been identified during development of the Territory-wide Health Service Plan.
- Cancer care is developing at a rapid rate and new and more complex agents are being incorporated into routine care rapidly. There is concern that the safety of chemotherapy at CPHB is not assured in the current arrangements.

- A group of executives from CPHB, CHS and ACT Health Directorate (ACTHD) have met to hear the evidence of senior clinicians and to discuss the development of options and communication and actions required to address safety concerns as quickly as possible.
- Advice will be provided to you as the options and implications are more fully developed.

Options

- A number of options have been considered during initial discussions, including investment in additional resources at CPHB. This option has not been fully explored at this stage, however early clinical advice indicates that there is insufficient clinical mass to support this option at this stage.
- At this stage it appears, in the interests of patient safety, the best option is to move all chemotherapy and medical oncology and haematology consultation services to Cancer Centre at CH.
- Capacity for the increased chemotherapy will need to be released by transferring additional Medical Day Unit activity to CPHB in order to free up chairs at CH.
- One of the consequences of this option would be the removal of onsite oncology/haematology presence at CPHB for inpatient consultations. This would need to be met through a formalised agreement including agreed response time for inpatient consultations either by telehealth or in person by either the haematologist or medical oncologist on call.
- CPHB and CHS are discussing the opportunity for a joint appointment of a medical oncologist, who would have access to subspecialty clinicians at CHS for support as required.
- A full analysis of the cost implications and potential transfer of budget from CPHB and CHS for services needs to be undertaken.
- For chemotherapy, pharmacy, administration and medical staff currently paid by CPHB would need to occur and the appropriate budget transferred to CHS.
- Territory service planning will provide for services at the northside hospital to be re-established when a critical mass of activity that is considered safe to be supported locally is met.

Background

- The Zita Mary clinic opened in 2001. It currently provides consultation and review clinics by 3 medical oncologists and 1 haematologist. These doctors all attend as part of their employment at CH, paid for by TCH. Each holds weekly or fortnightly all day sessions. Sessions have up to 20 people attending per all day clinic. There is no wait time to get into a clinic. An Advanced Trainee attends with one of the medical oncologists.

Consultation

- Executives from CPHB, CHS and ACTHD have agreed to continue to meet to develop recommendations on appropriate consultation mechanisms and to progress a decision on the appropriate way forward. ✓
- Executives involved in early discussions include:
  - Barb Reid, Regional Manager, LCMHC, CPHB executive and senior medical specialists;
  - Cathie O'Neill, Executive Director, Cancer and Ambulatory Services and Associate Professor Paul Craft, Clinical Director, Capital Region Cancer Centre, CHS; and
  - Jacinta George, Executive Group Manager, Health System Planning and Evaluation, ACTHD.

| | |
|---|---|
| Contact Officer: | Jacinta George |
| Contact Number: | 5124 9699 |
| Date: | 13 November 2020 |
| Cc: | Dr Dinesh Arya, Chief Medical Officer, ACTHD |

Thank you. Communication to patients will be critical. Please discuss response time / wait time.

21/11/20

ACT Government

OFFICIAL SENSITIVE MINISTERIAL BRIEF

**ACT Health Directorate**

| | | |
|---|---|---|
| **To:** | Minister for Health | Tracking No.: MIN21/632 |
| **CC:** | Bernadette McDonald, Chief Executive Officer, Canberra Health Services<br>Barb Reid, ACT Regional Chief Executive Officer, Calvary Health Care ACT<br>Rebecca Cross, Director-General | |
| **From:** | Meg Brighton, Deputy Director-General | |
| **Subject:** | Consultation about proposed changes to chemotherapy service arrangements at Zita Mary Clinic, Calvary Public Hospital Bruce | |
| **Critical Date:** | 19 May 2021 | |
| **Critical Reason:** | To meet timeframes for consultation and transition planning for proposed services changes to take effect from 12 July 2021. | |

- DG .../.../...

## Recommendations

That you:

1. Agree to proceed with Option 1, subject to consultation with stakeholders;

   **Agreed / Not Agreed / Please Discuss**

2. Agree to announce a service review is being undertaken prior to the commencement of consultation;

   see below

   **Agreed / Not Agreed / Please Discuss**

3. Agree to distribute the Consultation Paper (Attachment C) to stakeholders identified in the Consultation Paper; and

   but

   **Agreed / Not Agreed / Please Discuss**

4. Note the information contained in Attachment A and Attachment B.

   **Noted / Please Discuss**

Rachel Stephen-Smith MLA ........[signature]........ 20/5/21

Minister's Office Feedback

Any public announcement would simply raise anxiety before any conversations could take place. However, it might be good to write to key stakeholders advising of the review and the rationale for it?
Please discuss consultation paper – it needs to be clear about the problem – ZMC cannot meet standards in short to medium term, even with injection of significant resources. We need to be upfront about this otherwise rationale is unclear. The "issues with current approach" section in Att B does this & should be inc. in paper.

**Background**

1. Currently, public chemotherapy services in the ACT are provided from the Canberra Region Cancer Centre (CRCC) at Canberra Hospital and through the Zita Mary Clinic at Calvary Public Hospital Bruce (CPHB).

2. The Zita Mary Clinic opened in 2001, with nine chairs for the provision of chemotherapy, with approximately 15 patients a week receiving chemotherapy at the clinic. The Zita Mary clinic also provides a range of day treatment services including immunotherapy infusions.

3. Following discussion with you about a Caveat Brief submitted in November 2020 (MIN20/1757), which highlighted current issues with the sustainability of chemotherapy services at CPHB, ACT Health Directorate (ACTHD) undertook to progress development of recommendations on appropriate consultation mechanisms and to progress a recommendation on the appropriate way forward. This work was to include consideration of and communication with patients on proposed service changes.

**Issues**

4. Hospital cancer services will be assessed against the National Safety and Quality Health Service (NSQHS) Standards User Guide for Medication Management in Cancer Care (2020) developed by the Australian Commission on Safety and Quality in Health Care (ACSQHC) during accreditation. A review of compliance against these standards was undertaken at CPHB and the CRCC after the user guide was released in 2020.

5. Whilst the review identified minor changes required at CRCC, which are currently being progressed for completion by mid-2021, the assessment of compliance for the Zita Mary Clinic identified a series of issues related to clinical governance and sustainability of existing services. These issues included, but are not limited to, access to clinical staffing, limitations in delivering a multi-disciplinary team model, limitations in access to a range of comprehensive treatments including clinical trials and lack of consumer representation in service delivery. These issues are compounded by already identified concerns with sustainability of services related to low volumes of patients receiving specialised chemotherapy treatment at the Zita Mary Clinic.

6. Further detail on the review against the standards is provided at Attachment A. While many of the gaps identified are rectifiable, it will be resource intensive to address them

and some standards cannot be met in the short to medium term. Future directions also need to be considered in the context of ensuring services can achieve a critical mass of activity to support safe and sustainable service provision.

7. Several options for chemotherapy services delivery at the Zita Mary Clinic were identified following the initial review and are outlined below. Consideration of the options to date indicate that Option 1 is the preferred option for the short to medium term. However, it is recommended that consultation is undertaken with clinical staff, consumer and carer representative and advocacy groups, unions and hospital executive at CPHB and Canberra Health Services (CHS) to identify whether other options exist and to ensure that all relevant considerations are taken into account when making an assessment of available options.

Option 1: Transfer chemotherapy and medical oncology same day and outpatient services from CPHB to CRCC in the short to medium term

8. Transfer all same day and outpatient chemotherapy and medical oncology services to the CRCC at Canberra Hospital in the short to medium term.

9. Cancer services related to Emergency Department presentations and overnight admissions would continue to be facilitated at CPHB for cancer patients who present to the Calvary Emergency Department and need admission, and for those patients who receive a cancer diagnosis as part of their inpatient stay with consultation liaison support to be provided by clinical staff at CHS.

10. Consideration would then be given to provision of services at the future Northside hospital when clinical activity reaches a level that will support safe and cost-effective services in a second unit.

11. Some medical day unit activity from CHS would be transferred to the Zita Mary Clinic to provide additional capacity at the CRCC to accommodate the increased chemotherapy activity, and to ensure optimal use of resources at CPHB.

12. A proposed timeline on how this transition could occur is provided at Attachment B, including circulation of an information paper in May alongside transition planning, consultation with staff and unions from the end of May to late June and implementation of the transition plan from 12 July 2021.

13. Additional funding is not required to implement this option. A full analysis of the budget implications for transfer of services between sites across both chemotherapy and medical day unit activity and related pharmacy, administration and medical staff implications would need to occur across CPHB and CHS, and adjustments made to budgets for both hospitals as appropriate.

14. The key advantages of this option are:

    a. Improved clinical governance arrangements for cancer services across the ACT;

    b. Equity of access to multi-disciplinary patient services and supports;

    c. Ensuring alignment of services to national standards is maintained; and

d. A more sustainable approach to service provision in the short to medium term.

15. The key disadvantages of this option are:

    a. Staff currently delivering chemotherapy services at the Zita Mary Clinic may feel disenfranchised and may lose valuable skills over time. One option to address this issue may be facilitation of secondments or transfers to CRCC;

    b. Patients may have to travel further to receive their chemotherapy at CRCC, though it is noted that other cancer services they may be accessing, including radiation therapy, are already provided through CRCC;

    c. Relocation of day and outpatient chemotherapy and medical oncology services from the Zita Mary Clinic to CRCC will place increased pressure on capacity at CRCC. This may be alleviated in part by redistribution of medical day unit type services to the Zita Mary Clinic to free up capacity at CRCC.

<u>Option 2: Invest additional resources at CPHB to meet standards and support service sustainability</u>

16. This option would require a significant investment of time and resources to address current areas of non-compliance with standards and some standards cannot be met in the short to medium term.

17. This option would also require further work to assess what additional chemotherapy and medical oncology services could be redistributed to CPHB to achieve a sustainable volume of service activity. Consideration could be given to the Zita Mary Clinic operating as a satellite from CRCC or investing in substantial development of capacity and capability for CPHB.

18. It is anticipated that additional resourcing would be required to implement this option. A full analysis of the budget implications for this option across chemotherapy, pharmacy, administration, medical and other clinical staff implications would need to be undertaken to further pursue this option.

19. The key advantages of this option would be continuity of access to limited same day and outpatient chemotherapy and medical oncology services at CPHB and increased service sustainability.

20. The key disadvantages of this option are that CPHB may not be able to achieve the changes necessary for compliance with new national standards within an acceptable timeframe and it is likely that significant additional investment will be required to achieve compliance and ensure the service is sustainable.

<u>Option 3: Status Quo</u>

21. The safety and sustainability of chemotherapy services for patients receiving care at the Zita Mary Clinic is not assured under the current service and clinical governance arrangements.

22. Continuing to provide chemotherapy services at the Zita Mary Clinic does not comply with the NSQHS Standards User Guide for Medication Management in Cancer Care (2020).

Other considerations and future planning

23. The future requirements for chemotherapy services will be considered in clinical services planning for the future Northside hospital.

24. There are a number of potential sensitivities related to undertaking consultation about the review of medical oncology services at CPHB which are detailed below.

25. The goods and services contract for supply of chemotherapy drugs at CPHB expires in September 2021 and would need to be renegotiated from July 2021 at the latest if Options 2 or 3 are to be pursued. Planning for, and implementation of, Option 1 also needs to be considered in this context.

**Financial Implications**

26. A full analysis of the current budget for chemotherapy, pharmacy, administration and medical staff currently allocated to CPHB and the costs of the transfer of additional medical day treatment services to CPHB will need to be undertaken as part of further implementation planning.

27. Implementation of Option 1 is not expected to have an additional cost impact across the Territory, however there will likely be a need to redistribute budget from CPHB to CHS.

**Consultation**

Internal

28. The following ACTHD executives have been consulted in the development of this brief:
    - Jo Spencer, Executive Branch Manager, Communications and Engagement; and
    - Maria Travers, Executive Branch Manager, Policy Partnerships and Programs.

Cross Directorate

29. The following executives have been consulted in the development of this brief:
    - Suzanne Smallbane, Medical Director of Clinical Services, CPHB;
    - Barb Reid, ACT Regional Chief Executive Officer, Calvary Health Care ACT;
    - Roz Everingham, former A/g General Manager, CPHB;
    - Robin Haberecht, General Manager, CPHB;
    - Cathie O'Neill, Executive Director, Cancer and Ambulatory Support, CHS;
    - Paul Craft, Desmond Yip and James D'Rosario, Clinical and Unit Directors, CHS;
    - Tony Kwan and Ken Khoo, Calvary Unit Directors; and
    - The Chief Executive Officer, CHS has signed off on this Brief.

External

30. Not applicable.

**Work Health and Safety**

31. As identified in Attachment A, assessment against the 2020 standards indicates a potential risk posed by ongoing provision of services under current governance and service delivery models at CPHB.

**Benefits/Sensitivities**

32. Consolidating the provision of same day and outpatient chemotherapy and medical oncology services to the CRCC will improve equity of patient support, streamlined patient management, better clinical governance and attainment of accreditation against the Guidelines for Medication Management in Cancer Care. Efficiencies are also anticipated in relation to medical consultant time and pharmaceutical provisions.

33. Sensitivities in relation to the preferred Option (Option 1) include that some patients will not be satisfied with having to attend CRCC rather than the Zita Mary Clinic due to proximity and that staff currently delivering chemotherapy services at the Zita Mary Clinic may be disenfranchised and potentially lose skills over time.

34. Moving chemotherapy services from the Zita Mary Clinic to the CRCC will put further pressure on the chair capacity at the CRCC, however further work will be undertaken to transfer some medical day unit type services from CRCC to the Zita Mary Clinic to alleviate these pressures.

35. There may be some concern from some patients whose medical day treatment moves from Canberra Hospital to CPHB, although it is planned to move treatment location for those patients living closer to CPHB.

36. The Calvary Network Agreement (CNA) provides that (clause 5) *The Territory must not alter the* [CPHB] *Role Delineation without the prior written consent of Calvary.* The role delineation level for medical oncology (including chemotherapy) documented in the CNA is Level 4, which is currently being reviewed in consultation with CPHB. This role level provides for a level of acuity that CPHB is not able to sustain and requires linkages to a Territory-wide service.

**Communications, media and engagement implications**

37. It is proposed that consultations be undertaken with key stakeholders based on the information contained in Attachment C. Key stakeholders to be consulted include but are not limited to:

- Consumers undergoing treatments at both sites;
- CHS Cancer Consumer Reference Group;
- Cancer, haematology and medical day unit advocacy and support groups;
- Health Care Consumers Association;

- Medical consultants and Visiting Medical Officers at both hospitals;
- All relevant nursing, pharmacy, allied health and administration staff;
- Unions and peak bodies – AMA, ASMOF, AMNF, HSU, CPSU, Professionals Australia' and
- Governance bodies at both hospitals.

38. ACTHD will work with managers at CPHB and CHS to plan and coordinate consultations with these groups. Staff and managers will be available to speak to interested stakeholders who would like to discuss the proposal in more detail. Managers at CPHB will make early contact with patients who are currently receiving chemotherapy at the Zita Mary Clinic to discuss the proposed service changes. It is anticipated that the transition to chemotherapy at CRCC will be undertaken in such a way that new patient referrals for chemotherapy at the Zita Mary Clinic will not be accepted if their chemotherapy will be disrupted by the transition, and patients will instead be referred to CRCC.

39. Your advice is sought as to whether you would like to announce that a service review is being undertaken prior to consultation commencing.

40. Once the consultation phase is complete and the implementation plan finalised, communications with stakeholders will be planned and implemented that consider the sensitivities outlined in this brief and any other issues identified during consultations.

Signatory Name: Meg Brighton, Deputy Director-General, Health Systems, Policy and Research — Phone: 5124 6240

Action Officer: Jacinta George, Executive Group Manager, Health System Planning and Evaluation — Phone: 5124 9699

**Attachments**

| Attachment | Title |
|---|---|
| Attachment A | Zita Mary Clinic Service Gaps |
| Attachment B | Transfer of Chemotherapy Services from Zita Mary Clinic to Canberra Region Cancer Centre |
| Attachment C | Consultation Paper for Stakeholders |

# Attachment A – Zita Mary Clinic Service Gaps

## 1. Purpose

To provide an overview of the findings from the desktop review of Zita Mary against The Australian Commission on Safety and Quality in Health Care 2020 Guidelines For Medication Management In Cancer Care.

## 2. Background

The Zita Mary Clinic opened in 2001 with nine chairs for the provision of chemotherapy. Over the last two decades with emerging treatments for a range of medical conditions, particularly with the introduction of infusional immunotherapy, the Zita Mary Clinic now provides a range of day treatment services.

Zita Mary is supported by consultants visiting from the Canberra Hospital at Canberra Health Service (CHS). Chemotherapy services at the Zita Mary Clinic are prescribed and monitored remotely by the consultants at CHS. As treatments have become more complex, the consultants have selected appropriate patients for Zita Mary. Consultation and review clinics are currently provided by three medical oncologists and one haematologist. These doctors all attend as part of their employment at CHS, paid for by CHS. Each holds weekly or fortnightly all-day sessions. Sessions have up to 20 people attending per all-day clinic. An advanced trainee attends with one of the medical oncologists.

On site administrative support for these clinics is provided by Calvary Public Hospital Bruce (CPHB). Administrative staff from CHS assist with triaging of referrals and booking patients. Clinical records and activity data is all recorded in CPHB. Any facility fee through Medicare billing obtained goes entirely to CPHB.

There are approximately 15 patients a week receiving chemotherapy. Chemotherapy agents for Zita Mary are prepared by the on-site pharmacists. The oncologists/haematologists provide chemotherapy supervision remotely. The junior doctor who supports the CPHB Hospital in the Home provides limited support to the chemotherapy patients funded at 0.5FTE but provides as little as 0.1 FTE.

In addition to the Zita Mary Clinic, the Canberra Region Cancer Centre (CRCC) has 45 chairs for the provision of chemotherapy, other infusions and haematological day treatment services. This service opened in 2014 and brought together a range of previously disparate cancer services across CHS.

## 3. The Australian Commission on Safety and Quality in Health Care 2020 Guidelines For Medication Management In Cancer Care

### 3.1. Revised standards

The Australian Commission on Safety and Quality in Health Care 2020 Guidelines For Medication Management In Cancer Care are mandatory for all health service organisations to implement. As a result, a review of both sites' compliance against these standards has been undertaken.

Following a desk top review of the guidelines it has been identified that Zita Mary does not meet the standards. While many of the gaps identified are rectifiable it will be resource intensive and some standards will not be able to be met in the short to medium term.

At the CRCC a number of minor gaps were identified and an action plan developed. All actions are expected to be completed by the middle of 2021 with the CRCC being fully compliant with the standards.

### 3.2. Clinical Governance

As the consultants providing the oversight to chemotherapy at Zita Mary are employees of CHS there are no mechanisms to monitor care provided at CPHB. There is no regular data provided by CPHB on activity or outcomes for the patients receiving treatment at Zita Mary. With no oncologist on staff at CPHB there is no direct oversight other than the review of significant events through their critical incident processes.

Medical support for oncology and haematology in its current form is not sustainable. Several of the consultants have indicated they do not wish to continue providing clinics at CPHB as their overall workloads are increasing significantly and the amount of follow up work required after each clinic is occurring at the expense of their other commitments.

Gaps in Clinical Governance for cancer patients at Zita Mary relate to:

- Limited access to oncologists while patients are receiving chemotherapy
- Limited protocols available to be given at CPHB
- Limited to no training of Chief Medical Officer responsible for chemo delivery
- No daily oversight for the non-specialists delivering care
- Limited access to Multi-Disciplinary Team (MDT) review – patients are presented at CHS MDTs but presentation rate for patients at Calvary seem to be less than others. This will be in part as a result of the triage process which sees the less complex cases allocated to CPHB
- Nil integrated IT systems (to be replaced by Digital Health Record)
- Significant burden on the pharmacist to double check to ensure that prescription of agents is appropriate for correct diagnosis
- Lack of specific consumer representation in the delivery of services in the Zita Mary clinic
- Little or no access to clinical trials
- Patients accessing cancer care at CPHB have limited access to the supportive care staff available at CHS.

While many of these gaps are rectifiable it will be resource intensive and some standards will not be able to be met in the short to medium term.

Cancer care is developing at a rapid rate and new and more complex agents are being incorporated into routine care all the time. The safety of chemotherapy at CPHB is not assured in the current arrangements.

# Attachment B – Transition of Zita Mary Chemotherapy Services to Canberra Region Cancer Centre

## 1. Purpose

To outline the proposed high-level approach for transitioning chemotherapy services from the Zita Mary Clinic at Calvary Public Hospital Bruce (CPHB) to the Canberra Region Cancer Centre (CRCC) at The Canberra Hospital, Canberra Health Services (CHS).

## 2. Background

### 2.1. Zita Mary

The Zita Mary Clinic opened in 2001 with nine chairs for the provision of chemotherapy. Over the last two decades with emerging treatments for a range of medical conditions, particularly with the introduction of infusional immunotherapy, the Zita Mary Clinic now provides a range of day treatment services.

There are approximately 15 patients a week receiving chemotherapy. Chemotherapy agents for Zita Mary are prepared by the on-site pharmacists. The oncologists/haematologists provide chemotherapy supervision remotely.

### 2.2. Canberra Region Cancer Centre

The CRCC opened in 2014 and has 45 chairs for the provision of chemotherapy, other infusions and haematological day treatment services. The CRCC brought together a range of previously disparate cancer services across CHS.

The CRCC provides chemotherapy to up to 120 patients per day, five days a week and up to 40 patients a day on Saturdays and Sundays. Chemotherapy is supervised via on-site consultants with both advanced trainees and junior doctors supporting the work of the unit. Chemotherapy agents are provided through a combination of inhouse and outsourced preparations through Slade.

## 3. Issues with current approach

### 3.1. Revised standards

The Australian Commission on Safety and Quality in Health Care 2020 Guidelines For Medication Management In Cancer Care are mandatory for all health service organisations to implement. As a result, a review of both sites compliance against these standards has been undertaken.

At the CRCC a number of minor gaps were identified and an action plan developed. All actions are expected to be completed by the middle of 2021 with the CRCC being fully compliant with the standards.

Following a desk top review of the guidelines it has been identified that Zita Mary does not meet the standards. While many of the gaps identified are rectifiable it will be resource intensive and some standards will not be able to be met in the short to medium term.

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Cancer care is developing at a rapid rate and new and more complex agents are being incorporated into routine care all the time. The safety of chemotherapy at CPHB is not assured in the current arrangements.

## 4. Future Model

In line with the increasing complexity of chemotherapy, adjuvant treatment, supportive care and sub specialisation it is proposed to move all non-admitted cancer and acute haematology care to the CRCC.

Cancer inpatient care will still be provided to those patients who present to the Calvary Emergency Department and need admission, and for those patients who receive a cancer diagnosis as part of their inpatient stay. A memorandum of understanding will be developed in order to assure the community and medical staff at CPHB that they will receive timely and appropriate support from cancer and haematology specialists at CHS.

### 4.1. Benefits of the future model

Consolidating the provision of cancer care, and in particular chemotherapy in the one tertiary centre allows for all patients to access the same level of support and standards of care. It will provide some efficiencies with respect to medical consultant time and pharmaceutical provisions.

This would allow for:

- Equity of patient support
- Streamlined patient management
- Better clinical governance
- Attainment of accreditation against the Guidelines for Medication Management in Cancer Care

### 4.2. Unintended consequences of the future model

Zita Mary has had a proud tradition of supporting their cancer patients through their services and this proposal in no way diminishes the quality care they have provided in the past.

Some patients will not be satisfied with having to attend CRCC rather than CPHB due to proximity, though many of the other cancer services they may require are only available at CHS such as radiation therapy and some interventional procedures.

Staff who have invested in developing their chemotherapy knowledge and skills may feel disenfranchised by this proposal. It would be the intent of the CRCC to accommodate any Calvary staff who may wish to continue to work in cancer care through secondments, transfers or joint rosters. This will be managed on an individual basis.

Moving the chemotherapy from the Zita Mary Clinic to the CRCC will put further pressure on the chair capacity at the CRCC, noting that the Medical Day Unit at CHS was recently amalgamated into the Day Treatment Unit. To provide sufficient capacity for chemotherapy patients, and to ensure an

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ongoing viable Zita Mary day treatment service it would be the intent to transition additional medical day treatment patients to the Zita Mary Clinic. This will require more analysis to determine which treatment types, which patients and which consultants will work best for all involved.

Clinic capacity at CRCC is close to capacity. Minor upgrades have commenced to increase the number of consulting rooms in the centre and this work will provide the necessary capacity to accommodate both the oncology and haematology clinics undertaken at the Zita Mary Clinic to transitioned to the CRCC.

A full analysis of the budget implications for transfer of services between sites across both chemotherapy and medical day unit activity and related pharmacy, administration and medical staff implications would need to occur across CPHB and CHS and adjustments made to budgets for both hospitals as appropriate.

### 4.3. Implementation approach

Following agreement on the way forward, a detailed implementation plan will be developed between both sites. The implementation plan will include:

a. A confirmed start date

b. A process to transition patients – ie. to complete current patients' treatments at the Zita Mary Clinic and commence new patients at CRCC

c. Identification of criteria and process for transitioning medical day treatment patients to the Zita Mary Clinic

d. Full budget analysis and subsequent relevant adjustments

e. Working with affected staff to meet their individual wishes to maintain competency in chemotherapy

f. Memorandum of understanding for inpatient cancer and haematology care at CPHB

g. Updated relevant communication material eg websites, referral information

### 4.4. Proposed Timeline

Please see below for the proposed timeline for the transition of services:

| Task | Duration | Start Date | Finish Date |
|---|---|---|---|
| Consultation and feedback open on consultation paper | 4 weeks | 31 May 2021 | 25 June 2021 |
| Consideration of feedback and development of transition plan | 2 weeks | 28 June 2021 | 9 July 2021 |
| Consultation on service changes with staff and unions | 4 weeks | 5 July 2021 | 30 July 2021 |
| Implementation of transition plan | TBC | 2 August 2021 | TBC |

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# Attachment C – Consultation Paper for Stakeholders

## 1. Purpose

To provide information to stakeholders on the future provision of chemotherapy services in ACT public services.

## 2. Current Service Provision

Chemotherapy services in the ACT are currently offered at both the Zita Mary Clinic at Calvary Public Hospital Bruce (CPHB) and the Canberra Region Cancer Centre (CRCC) at The Canberra Hospital, Canberra Health Services (CHS).

### 2.1. Zita Mary

The Zita Mary Clinic opened in 2001 with nine chairs for the provision of chemotherapy. Over the last two decades with emerging treatments for a range of medical conditions, particularly with the introduction of infusional immunotherapy, the Zita Mary Clinic also provides a range of day treatment services.

There are approximately 15 patients a week receiving chemotherapy at the Zita Mary Clinic. The Zita Mary Clinic is supported by consultants visiting from CHS. Chemotherapy services at the Zita Mary Clinic are prescribed and monitored remotely by the consultants at CHS. As treatments have become more complex, the consultants have selected appropriate patients for the Zita Mary Clinic. Consultation and review clinics are currently provided by three medical oncologists and one haematologist. An advanced trainee attends with one of the medical oncologists.

Chemotherapy agents for Zita Mary are prepared by the on-site pharmacists. The oncologists/haematologists provide chemotherapy supervision remotely. The junior doctor who supports the CPHB Hospital in the home provides limited support to the chemotherapy patients funded at 0.5 Full Time Equivalent (FTE) but provides as little as 0.1 FTE.

### 2.2. Canberra Region Cancer Centre

The CRCC opened in 2014 and has 45 chairs for the provision of chemotherapy, other infusions and haematological day treatment services. The CRCC brought together a range of previously disparate cancer services across CHS.

The CRCC provides chemotherapy to up to 120 patients per day, five days a week and up to 40 patients a day on Saturdays and Sundays. Chemotherapy is supervised via on-site consultants with both advanced trainees and junior doctors supporting the work of the unit. Chemotherapy agents are provided through a combination of in-house and outsourced preparations.

## 3. Future of Chemotherapy Services in the ACT

Cancer care is developing at a rapid rate and new and more complex agents are being incorporated into routine care all the time. There is increasing complexity of chemotherapy, adjuvant treatment, supportive care and sub specialisation within cancer care. The standards are increasing continually.

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It is therefore proposed that all future non-admitted public cancer and acute haematology care services for the territory will be offered at the CRCC at CHS.

If this proposal is accepted cancer inpatient care will still be provided to those patients who present to the Calvary Emergency Department and need admission, and for those patients who receive a cancer diagnosis as part of their inpatient stay. A memorandum of understanding will be developed in order to assure the community and medical staff at CPHB that they will receive timely and appropriate support from cancer and haematology specialists at CHS.

The Zita Mary Clinic has had a proud tradition of supporting their cancer patients through their services and this proposal in no ways diminishes the quality care they have provided in the past.

### 3.1 Impact on Patients

It is anticipated that the transition to chemotherapy at CRCC will be undertaken in such a way that new patient referrals for chemotherapy at the Zita Mary Clinic will not be accepted if their chemotherapy will be disrupted by the transition, and patients will instead be referred to CRCC.

Managers from CPHB will contact patients receiving chemotherapy at the Zita Mary Clinic to discuss the impact that this change will have on them.

### 3.2 Impact on Staff

It is recognised that this proposal has implications for those staff who work at the Zita Mary Clinic, in particular.

Staff who have invested in developing their chemotherapy knowledge and skills may feel disenfranchised by this proposal. It would be the intent of the CRCC to accommodate any Calvary staff who may wish to continue to work in cancer care through either secondments, transfers or joint rosters. This will be managed on an individual basis.

### 3.3 Impact on the Community

Consolidating the provision of cancer care, and in particular chemotherapy in the one tertiary centre allows all patients to access the same level of support and standards of care. It will provide some efficiencies with respect to medical consultant time and pharmaceutical provisions.

The main benefits the community are likely to see as a result of this service consolidation are:

- Equity of patient support
- Streamlined patient management
- Better clinical governance.

Some patients may not be satisfied with having to attend CRCC rather than CPHB due to proximity, however many of the other cancer services they may require are only available at CHS such as radiation therapy and some interventional procedures. Consolidation of services at CCRC therefore allows patients to access a 'one-stop shop' for treatment.

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### 3.4 Impact on Canberra Region Cancer Centre

Moving chemotherapy services from the Zita Mary Clinic to the CRCC will put further pressure on the chair capacity at the CRCC, noting that the Medical Day Unit at CHS was recently amalgamated into the Day Treatment Unit. To provide sufficient capacity for chemotherapy patients, and to ensure an ongoing viable Zita Mary day treatment service it would be the intent to transition additional medical day treatment patients to the Zita Mary Clinic. This will require more analysis to determine which treatment types, which patients and which consultants will work best for all involved.

Minor upgrades have commenced to increase the number of consulting rooms in the centre and this work will provide the necessary capacity to accommodate both the oncology and haematology clinics undertaken at the Zita Mary Clinic to transition to the CRCC.

## 4 Feedback

This information contained in this paper will be used as the basis for discussion with key stakeholders including but not limited to:

- Consumers undergoing treatments at both sites
- CHS Cancer Consumer Reference Group
- Cancer and haematology advocacy and support groups
- Health Care Consumers Association
- Medical consultants and VMOs at both hospitals
- All relevant nursing, pharmacy, allied health and administration staff
- Unions and peak bodies – AMA, ASMOF, AMNF, HSU, CPSU, Professionals Australia
- Governance bodies at both hospitals.

### 4.3 Implementation approach

Following feedback from consultations, a detailed implementation plan will be developed between both sites. The implementation plan will include:

- A confirmed start date
- A process to transition patients – ie. to complete current patients treatments at the Zita Mary Clinic and commence new patients at CRCC
- Identification of criteria and process for transitioning medical day treatment patients to the Zita Mary Clinic
- Full budget analysis and subsequent relevant adjustments
- Working with affected staff to meet their individual wishes to maintain competency in chemotherapy
- Memorandum of understanding for inpatient cancer and haematology care at CPHB
- Updated relevant communication material eg websites, referral information

Managers are available to undertake sessions with any interested stakeholder who would like to discuss their feedback, or the proposal in more detail.

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At CHPB - contact Schedule 2.2(a)(ii) to arrange.
At CHS - contact CHS.CAS@act.gov.au to arrange.
At ACTHD - contact XXX to arrange.

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**MINISTERIAL BRIEF**

**ACT Health Directorate**

**Tracking No.: GBC21/345**

| | |
|---|---|
| **To:** | Minister for Health |
| **From:** | Meg Brighton, Deputy Director-General |
| **CC:** | Rebecca Cross, Director-General |
| **Subject:** | Minister's Weekly Brief |
| **Critical Date:** | Friday, 18 June 2021 |
| **Critical Reason:** | To ensure you are briefed on current issues and events. |

**Recommendations**

That you note the:

- Information in the Minister's Weekly Brief for 9-14 June 2021;
- Media and Communication forecast at (Attachment A);
- Freedom of Information requests update (Attachment B);
- Cabinet Forecast at (Attachment C);
- Assembly Forecast at (Attachment D);
- Overdue report at (Attachment E); and
- WhOG Cabinet Forecast at (Attachment F).

**Noted / Please Discuss**

Rachel Stephen-Smith MLA ............................................ 7/7/21

Minister's Office Feedback

Out of Scope

**KEY TOPICS/EMERGING ISSUES**

1. Nil.

**UPDATES ON KEY PROJECTS/PIECES OF WORK**

**Chemotherapy service arrangements at Zita Mary Clinic, Calvary Public Hospital Bruce**

1. On 10 June 2021, ACT Health Directorate (ACTHD) project team met with Calvary Public Hospital Bruce (CPHB) and Canberra Health Services (CHS) to commence the planning for stakeholder consultation.
2. CPHB recommended that the preferred approach to stakeholder consultation in the first instance be to hold a targeted forum to brief stakeholders about the identified issues and the intended consultation process. At the conclusion of the forum stakeholders will be provided with a letter and information sheet. This approach was recommended on the basis that it would be more personable and would provide opportunity to address any immediate concerns. This recommendation was supported by CHS representatives.
3. To ensure due care and consideration is given to consultations and transition planning, the proposed timeframe for commencement of transition is now likely to be extended to early September 2021.
4. Planning is underway for a forum with CPHB stakeholders which will be held in late June-early July. This will be followed by a CHS forum. Both forums will be facilitated by representatives from ACTHD, CPHB and CHS and will provide opportunities for stakeholders to ask questions and seek further clarification.

5. Consultations with other stakeholders including patients and families will follow in mid-late July 2021.
6. A detailed transition plan is under development and will be submitted for final approval at the conclusion of the consultation process.

Out of Scope

ACT Government

OFFICIAL MINISTERIAL BRIEF

**ACT Health Directorate**

| To: | Minister for Health | Tracking No.: MIN21/1062 |
|---|---|---|
| CC: | Bernadette McDonald, Chief Executive Officer, Canberra Health Services<br>Barb Reid, ACT Regional Chief Executive Officer, Calvary Health Care ACT | |
| From: | Rebecca Cross, Director-General | |
| Subject: | To provide an update on the progress of the proposed changes to chemotherapy service arrangements at the Zita Mary Clinic, Calvary Public Hospital Bruce | |
| Critical Date: | 5 July 2021 | |
| Critical Reason: | The Consultation launch is scheduled for 7 July 2021 | |

- DG 2/7/21

**Recommendations**

That you:

1. Note the proposed approach for consultation for transitioning chemotherapy and oncology consultation services from the Zita Mary Clinic at Calvary Public Hospital Bruce to the Canberra Region Cancer Centre at the Canberra Hospital;

   **Noted / Please Discuss**

2. Note the Director-General stakeholder letter at Attachment A; and

   **Noted / Please Discuss**

3. Note the Information for Stakeholders paper at Attachment B.

   **Noted / Please Discuss**

Rachel Stephen-Smith MLA ............ 6/7/21

Minister's Office Feedback

Please discuss with my office (Ms Brassgrove) re a couple of places document could be clearer. Thank you.

**Background**

1. On 20 May 2021, you were briefed on the consultation about proposed changes to chemotherapy and oncology consultation service arrangements at the Zita Mary Clinic, Calvary Public Hospital Bruce (CPHB) (MIN21/632).

2. You agreed to proceed with Option 1: Transfer of Chemotherapy and Oncology Consultation Services from the Zita Mary Clinic to Canberra Region Cancer Centre (CRCC), subject to consultation with stakeholders.

3. A consultation process is now planned to inform stakeholders of the decision to transition chemotherapy and oncology consultation services from the Zita Mary Clinic to the CRCC at Canberra Health Services (CHS), and to seek feedback and input on how this transition can best occur.

**Issues**

4. Following your agreement to proceed with Option 1, ACT Health Directorate (ACTHD), CPHB and CHS stakeholders (including the Territory-wide Oncology Services Leadership Group) have been meeting regularly to progress the planning for the transfer of chemotherapy services from the Zita Mary Clinic to CRCC at CHS for the short to medium term.

5. It is planned that the consultation process will occur over one month and consist of:

   - A consultation launch titled "Update of Chemotherapy Services in the ACT" scheduled for 7 July 2021;
   - A letter from the ACTHD Director-General at Attachment A which will be provided to attendees along with a paper providing further information titled 'Information for Stakeholders' at Attachment B;
   - Staff forums at CPHB and CHS facilitated by senior management from CHS and CPHB;
   - Current patients will be informed of the changes as part of their therapeutic relationship by either their chemotherapy oncologist/ haematologist or by the staff they are familiar with at the Zita Mary Clinic;
   - A targeted community forum with relevant community stakeholders identified by CHS, CPHB and ACTHD;
   - Manager sessions as requested with any interested stakeholder/s who would like to discuss their feedback or the proposal in more detail; and
   - A generic email inbox where staff can provide written feedback or comments on the changes to oncology services in the ACT.

6. To support the above consultation sessions a joint Communications Plan has been developed with input from the Communications and Engagement teams from ACTHD, CPHB and CHS.

7. A letter has been sent to Unions informing them of the commencement of the consultation process and the upcoming service changes which will impact staff.

**Consultation**

Internal

8. Danielle Winslow, Digital Health Record Analyst, Pharmacy Oncology was consulted in the development of this brief.

Cross Directorate

9. The following persons were consulted in the development of this brief:
   - Cathie O'Neill, Executive Director, Cancer, Ambulatory & Community Health Division, CHS;
   - Katherine Wakefield, Director of Nursing, Cancer Services, CHS;
   - Desmond Yip, Director Medical Oncology Unit, CHS;
   - Alison Davis, Medical Oncologist, CHS;
   - Paul Craft, AM Medical Oncologist, CHS;
   - James D'Rozario, Haematologist, CHS;
   - Daniel Lalor, Director of Pharmacy, CHS;
   - Kate O'Hara, Lead Pharmacist Women's Youth & Children's Services, CHS.

External

10. The following persons were consulted in the development of this brief:
   - Barbara Reid, ACT Regional Chief Executive Officer, Calvary Health Care ACT;
   - Robin Haberecht, General Manager, CPHB;
   - Dr Suzanne Smallbane, Medical Director of Clinical Services, CPHB;
   - Narelle Comer, Director of Clinical Services- Nursing & Midwifery, CPHB;
   - Ken Khoo, Calvary Unit Director, CPHB;
   - Tony Kwan, Calvary Unit Director, CPHB; and
   - Emily Diprose, Director of Pharmacy, CPHB.

**Benefits/Sensitivities**

11. The consultation process will allow all impacted stakeholders an opportunity to provide their feedback and input on this process.

12. It is intended that the consultation process will also alleviate any staff concerns that arise throughout this process.

13. Current patients will continue to receive their chemotherapy at CPHB until such time as their treatment is complete or until there is a natural break in their chemotherapy cycle.

14. Transition planning will identify a date from which new patients will not be accepted at CPHB and will be seen in clinic at CHS.

**Communications, media and engagement implications**

15. Relevant stakeholders who will be consulted as part of this process include but are not limited to:

- CHS Cancer Consumer Reference Group;
- Cancer and haematology advocacy and support groups;
- The Health Care Consumers' Association;
- Medical consultants and VMOs at both hospitals;
- All relevant nursing, pharmacy, allied health and administration staff;
- Unions and peak bodies – AMA, AMNF, VMOA, Professional Australia, HSU, CPSU;
- Capital Health Network and General Practitioners; and
- Governance bodies at both hospitals.

Signatory Name: Meg Brighton, Deputy-Director General, Health Systems, Policy and Research — Phone: 5124 6240

Action Officer: Jacinta George, Executive Group Manager, Health System Planning and Evaluation — Phone: 5124 9699

**Attachments**

| Attachment | Title |
|---|---|
| Attachment A | Letter from ACTHD Director-General to stakeholders |
| Attachment B | Information for Stakeholders |

ACT Health

Office of the Director-General

Dear (Stakeholder)

**Zita Mary Clinic, Calvary Public Hospital Bruce**

I am writing to inform you of stakeholder engagement about proposed changes to Cancer Services in the ACT.

After 20 years of the delivery of chemotherapy services at the Zita Mary Clinic, Calvary Public Hospital Bruce (CPHB), these services will be transitioned to the Canberra Hospital in the short to medium term, to provide a consolidated and streamlined service in a single tertiary centre.

Zita Mary Clinic has provided a dedicated service and excellence in care for the ACT community. However, recent changes in the guidelines for medication management for cancer care (The Australian Commission on Safety and Quality in Health Care 2020 Guidelines for Medication Management in Cancer Care), and a resultant review of service provision at the Zita Mary Clinic, have highlighted difficulties that CPHB will face to comply with these standards, and to provide a sustainable, multi-disciplinary service for cancer patients.

Cancer care is developing at a rapid rate and new and more complex agents are continually being incorporated into routine care. Expert advice about the increasing complexity of chemotherapy, adjuvant treatment, supportive care and sub specialisation has informed a decision to consolidate future non-admitted public chemotherapy administration for the territory at the Canberra Region Cancer Centre (CRCC), operated by Canberra Health Services (CHS).

Cancer inpatient care will still be provided to those patients who present to the CPHB Emergency Department and require admission, and for those patients who receive a cancer diagnosis as part of their inpatient stay. The main benefits the community are likely to see following the transition include:

- equity of patient access for all patients to a fully constituted multidisciplinary team, and
- streamlined patient management for those receiving a range of oncology services.

Unfortunately,

I understand that some patients may prefer, on balance, to receive services at CPHB because of proximity to where they live. The option to enhance services at CPHB was considered before the decision was made to consolidate services as it was not feasible to meet all the standards in the short to medium term and the outcome would not have delivered an ongoing viable multidisciplinary chemotherapy service.

To provide sufficient capacity for chemotherapy patients, and to ensure an ongoing viable Zita Mary day treatment service, it is planned to transition some non-chemotherapy day treatment services from Canberra Hospital to the Zita Mary Clinic. This will require further analysis to determine treatment type, and which patients are most suited to transition to the Zita Mary Clinic. It is likely that services will enable more residents of the northern suburbs to receive care at Zita Mary Clinic, rather than at CRCC.

Planning has commenced for minor upgrades to increase the number of consulting rooms in the CRCC. This work will provide the necessary capacity to accommodate increased demand for oncology and haematology outpatient medical consultations as a result of the transition.

ACT Health Directorate will be working with stakeholders to undertake service planning to inform future decisions about provision in the longer term of expanded cancer services on the northside. This work will cascade from the current work being undertaken on the Territory-wide Health Services Plan.

I would like to take this opportunity to acknowledge the exceptional care and dedicated quality service the Zita Mary Clinic has provided to ACT haematology and oncology patients in the past. Current patients at the Zita Mary Clinic will continue to receive high quality care for the remainder of their treatment regimen. Current and future Medical Day Care patients of the Zita Mary Clinic will continue to enjoy the healing, hope and nurturing care provided by CPHB. Nursing, medical, and allied health, and support staff will receive timely support through both CHS and CPHB senior management and be updated regularly on the transition process as it evolves over the coming months.

ACT Health Directorate will work with managers at CPHB and CHS to plan and coordinate further consultations with staff and key stakeholders.

Managers are available to undertake sessions with any interested stakeholder who would like to discuss their feedback, or the planned service changes in more detail. Please email all feedback and suggestions to feedbackforzitamary@calvary-act.com.au.

Yours sincerely

Rebecca Cross
**Director-General**

# Information for Stakeholders

## 1. Purpose

To provide information to stakeholders on the future provision of public chemotherapy services in the ACT.

## 2. Current Service Provision

Public Chemotherapy services in the ACT are currently offered at both the Zita Mary Clinic at Calvary Public Hospital Bruce (CPHB) and the Canberra Region Cancer Centre (CRCC) at Canberra Hospital, Canberra Health Services (CHS).

### 2.1. The Zita Mary Clinic

The Zita Mary Clinic opened in 2001 with nine chairs for the provision of chemotherapy. Over the last two decades the Zita Mary Clinic has evolved to provide treatments for a range of medical conditions, particularly infusional immunotherapy and day treatment services.

There are approximately 15 patients a week receiving chemotherapy at the Zita Mary Clinic. The Zita Mary Clinic is supported by consultants visiting from CHS. Chemotherapy services at the Zita Mary Clinic are prescribed and monitored remotely by the consultants at CHS. As treatments have become more complex, the consultants have selected appropriate patients for the Zita Mary Clinic. Consultation and review clinics are currently provided by three medical oncologists and one haematologist. An advanced trainee attends with one of the medical oncologists.

Chemotherapy agents for the Zita Mary Clinic are dispensed by the on-site pharmacists. The junior doctor who supports the CPHB Hospital in the Home provides limited support to the chemotherapy patients funded at 0.5 Full Time Equivalent (FTE) but provides as little as 0.1 FTE.

### 2.2. Canberra Region Cancer Centre

The Day Treatment Unit (DTU) in the CRCC has 45 chairs for the provision of chemotherapy, other infusions, and treatment services. The CRCC brought together a range of previously disparate cancer services across CHS.  In 2020, the Medical Day Unit patients and treatments were integrated into the DTU in the CRCC.

The CRCC provides treatment for to up to 120 patients per day, five days a week and up to 40 patients a day on Saturdays and Sundays. Chemotherapy is supervised via on-site consultants with both advanced trainees and junior doctors supporting the work of the unit. Patients are supported by a team of cancer nurse coordinators, social workers and psychologists. Chemotherapy agents are provided through a combination of in-house and outsourced preparations.

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# 3. Future directions for Chemotherapy Services in the ACT

The Australian Commission on Safety and Quality in Health Care 2020 Guidelines for Medication Management in Cancer Care are mandatory for all health service organisations to implement. As a result, a review of both sites' compliance against these standards has been undertaken. The review found that the Zita Mary Clinic does not meet the standards and that while many of the areas of non-compliance are rectifiable it will be resource intensive, and some standards will not be able to be met in the short to medium term. At the CRCC, several minor gaps were identified, and an action plan developed. All actions are expected to be completed by mid-2021; with the CRCC being fully compliant with the standards by that time.

Cancer care is developing at a rapid rate and new and more complex agents are being incorporated into routine care all the time. In line with the increasing complexity of chemotherapy, adjuvant treatment, supportive care, and sub specialisation, all future public out-patient chemotherapy administration for the territory will be offered at the CRCC at CHS.

Cancer inpatient care will still be provided to those patients who present to the Calvary Emergency Department and need admission, and for those patients who receive a cancer diagnosis as part of their inpatient stay. Some cancer low risk supportive care treatments such as blood transfusions would continue to be provided at the Zita Mary Clinic.

The Zita Mary Clinic has had a proud tradition of supporting their cancer patients through their services and this proposal in no way diminishes the quality care they have provided in the past.

## 3.1. Impact on Staff

A memorandum of understanding will be developed in order to assure the community and medical staff at CPHB that they will receive timely and appropriate support from cancer and haematology specialists at CHS.

Staff who have invested in developing their chemotherapy knowledge and skills may feel disenfranchised by this proposal. It would be the intent of the CRCC to work with Calvary staff who wish to continue to work in cancer care to explore options for secondments or transfers. This would be managed on an individual basis.

## 3.2. Impact on the Community

Consolidating the provision of cancer care, and in particular chemotherapy in the one tertiary centre would allow all patients the opportunity to access the same level of support and standards of care. It would also provide some efficiencies with respect to medical consultant time and pharmaceutical provisions, improving access to care by reducing waiting times.

The main benefits the community are likely to see as a result of this service consolidation are:

- Equity of patient support,
- Streamlined patient management, and
- Better clinical governance.

DRAFT Not For Circulation

It is anticipated that some patients may not be satisfied with having to attend CRCC rather than CPHB due to proximity, however many of the other cancer services they may require are only available at CHS such as radiation therapy and some interventional procedures. Consolidation of services at CCRC would therefore allow many patients to access a 'one-stop shop' for treatment.

### 3.3. Impact on Canberra Region Cancer Centre

We want to provide services closer to where people live where possible and safe to do so. It is also recognised that moving chemotherapy services from the Zita Mary Clinic to the CRCC may put further pressure on the CRCC and free up capacity at the Zita Mary Clinic. It is intended to provide services for additional medical day treatment patients at the Zita Mary Clinic. Further analysis is required to determine which treatment type, and which patients could have their treatments transitioned to the Zita Mary Clinic.

Minor upgrade plans have commenced to increase the number of consulting rooms in the CRCC. This work will improve CRCC's capacity to accommodate both the oncology and haematology clinics, which are currently provided at the Zita Mary Clinic.

## 4. Feedback

This paper is to be distributed widely to all relevant stakeholders including but not limited to:

- Consumers undergoing treatments at both sites
- CHS Cancer Consumer Reference Group
- Cancer and haematology advocacy and support groups
- Health Care Consumers Association
- Medical consultants and VMOs at both hospitals
- All relevant nursing, pharmacy, allied health and administration staff
- Unions and peak bodies – AMA, ASMOF, AMNF, HSU, CPSU, Professionals Australia
- Governance bodies at both hospitals.

### 4.1. Implementation approach

Following feedback on this information paper and from other feedback mechanisms, a detailed implementation plan will be developed between both sites. The implementation plan will include:

- A confirmed start date,
- A process to transition patients – i.e. to complete current patient treatments at the Zita Mary Clinic and commence new patients at CRCC,
- Identification of criteria and process for transitioning medical day treatment patients to the Zita Mary Clinic,
- Full budget analysis and subsequent relevant adjustments,
- Working with affected staff to meet their individual wishes to maintain competency in chemotherapy,

DRAFT Not For Circulation

- A Memorandum of Understanding between CHS and CPHB for inpatient cancer and haematology care at CPHB, and
- Updated relevant communication material e.g. websites, referral information.

Managers are available to undertake sessions with any interested stakeholder who would like to discuss their feedback, or the planned service changes in more detail. Feedback should be provided by close of business 28 July 2021, via email at feedbackforzitamary@calvary-act.com.au

DRAFT Not For Circulation

ACT Health

DIRECTOR-GENERAL MINUTE

TRIM Reference No. DGC21/521

| **SUBJECT:** | Chemotherapy Services at the Zita Mary Clinic, Calvary Public Hospital Bruce |
|---|---|

| **Cc:** | Michael Culhane, A/g Deputy Director-General |
|---|---|
| **From:** | Jacinta George, Executive Group Manager, Health System Planning and Evaluation |

| **Critical Date:** | *12 July 2021* |
|---|---|
| **Reason:** | *Stakeholder consultation launch is scheduled for 14 July 2021* |

## Recommendations

That you:

| | |
|---|---|
| Note the information contained in this Minute | ***NOTED**/*<br>~~*PLEASE DISCUSS*~~ |
| Agree to sign the letter at Attachment A that will be provided to key stakeholders at the consultation launch on 14 July 2021. | ***AGREED**/*<br>~~*NOT AGREED/*~~<br>~~*PLEASE DISCUSS*~~ |
| Note the Information for Stakeholders paper at Attachment B. | ***NOTED**/*<br>~~*PLEASE DISCUSS*~~ |

…………………………………………………………………….

*Rebecca Cross*
***Director-General***
*ACT Health Directorate*

*9 July 2021*

ACT Government | ACT Health

DIRECTOR-GENERAL MINUTE

## Purpose
To seek your agreement to sign the letter at Attachment A that will be provided to relevant stakeholders to inform them of proposed consultation about changes to Cancer Services in the ACT.

## Background
A Caveat Brief was submitted in November 2020 (MIN20/1757), which highlighted current issues with the sustainability of chemotherapy services at Calvary Public Hospital Bruce (CPHB).

In May 2021, ACT Health Directorate (ACTHD) briefed the Minister for Health on proposed changes to chemotherapy and oncology consultation service arrangements at the Zita Mary Clinic, CPHB (MIN21/632).

The Minister for Health agreed to proceed with Option 1: Transfer of Chemotherapy and Oncology Consultation Services from the Zita Mary Clinic to Canberra Region Cancer Centre (CRCC) at Canberra Hospital, subject to consultation with stakeholders.

## Issues
Following the agreement by the Minister for Health to proceed with this option, ACTHD, CPHB and Canberra Health Services (CHS) stakeholders (including the Territory-wide Oncology Services Leadership Group) have been meeting regularly to progress the planning for the transfer of chemotherapy services for the short to medium term, subject to consultation with stakeholders. As a part of the stakeholder consultation, the Minister for Health requested that stakeholders receive correspondence on the consultation process including the basis for the proposed service changes in relation to service sustainability and compliance standards.

The Minister for Health has agreed to distribute the Information for Stakeholders paper (Attachment B) to identified stakeholders but asked that this paper be clear about the issue underpinning the change, that is, that the Zita Mary Clinic cannot meet standards in short to medium term, even with injection of significant resources.

At the Territory-wide Oncology Services meeting held 10 June 2021, CPHB recommended that the preferred approach to stakeholder consultation in the first instance is to hold a targeted forum to brief stakeholders about the identified issues and the intended consultation process. At the conclusion of the forum, stakeholders will be provided with a letter and information sheet. This approach was recommended on the basis that it would be more personable and would provide opportunity to address any immediate concerns. This recommendation was supported by CHS representatives.

CPHB and CHS will be holding a stakeholder consultation launch on 14 July 2021. At the launch all stakeholders will be provided with a copy of the letter, signed by you and the Information for Stakeholders paper.

ACT Health



Stakeholder consultation forums will be scheduled following the consultation launch. All forums will be facilitated by representatives from ACTHD, CPHB and CHS and will provide the opportunity for stakeholders to ask questions and seek further clarification.

Community Forums will be scheduled for late July 2021.

A detailed Transition Plan is under development and will be submitted for final approval at the conclusion of the consultation process.

## Benefits/Sensitivities

Resistance to change amongst stakeholders and staff is likely to occur as a result of the transfer of chemotherapy services from CPHB to CHS. The stakeholder forums will give the opportunity for any concerns to be raised and discussed.

Stakeholders and staff will have the opportunity for further discussions with managers from their areas after the stakeholder forums have been held, and this information is provided in the attached letter.

Stakeholder consultation forums and community forums are subject to change as a result of new or revised public health orders issued by the ACT Chief Health Officer.

## Consultation

External – CPHB

Robin Haberecht, General Manager, and Dr Suzanne Smallbane, Director of Clinical Services-Medical have reviewed and endorsed the stakeholder letter and Information for Stakeholders paper.

Cross Directorate – CHS

Katherine Wakefield, A/g Executive Director, Cancer and Ambulatory Services and Denise Patterson, former Chief Operating Officer have reviewed and endorsed the stakeholder letter and Information for Stakeholders paper. Cathie O'Neil, former Executive Director, CRCC has been involved in drafting the consultation paper.

## Media

A communications strategy is being developed in consultation with the Communications and Engagement Teams from ACTHD, CPHB and CHS.

| | | | |
|---|---|---|---|
| *Have relevant communications material to support this brief been attached (communications plan, draft media release, talking points etc)?* | ☐ Yes | ☐ No | ☑ N/A |
| *Has the Communications Branch been consulted?* | ☑ Yes | ☐ No | ☐ N/A |

ACT Health

DIRECTOR-GENERAL MINUTE

| Signed off by: | Jacinta George | Phone: | 5124 9969 |
|---|---|---|---|
| Title: | Executive Group Manager | | |
| Branch/Division | Health System Planning and Evaluation | | |
| Date: | 2 July 2021 | | |
| | | | |
| Action Officer: | | Phone: | |
| Unit: | , | | |

ACT Health

Office of the Director-General

Dear Stakeholder

**Zita Mary Clinic, Calvary Public Hospital Bruce**

I am writing to inform you of stakeholder engagement about proposed changes to Cancer Services in the ACT.

After 20 years of the delivery of chemotherapy services at the Zita Mary Clinic, Calvary Public Hospital Bruce (CPHB), these services will be transitioned to the Canberra Hospital in the short to medium term, to provide a consolidated and streamlined service in a single tertiary centre.

Zita Mary Clinic has provided a dedicated service and excellence in care for the ACT community. However, recent changes in the guidelines for medication management for cancer care (The Australian Commission on Safety and Quality in Health Care 2020 Guidelines for Medication Management in Cancer Care), and a resultant review of service provision at the Zita Mary Clinic, have highlighted difficulties that CPHB will face to comply with these standards, and to provide a sustainable, multi-disciplinary service for cancer patients.

Cancer care is developing at a rapid rate and new and more complex agents are continually being incorporated into routine care. Expert advice about the increasing complexity of chemotherapy, adjuvant treatment, supportive care and sub specialisation has informed a decision to consolidate future non-admitted public chemotherapy administration for the Territory at the Canberra Region Cancer Centre (CRCC), operated by Canberra Health Services (CHS).

Cancer inpatient care will still be provided to those patients who present to the CPHB Emergency Department and require admission, and for those patients who receive a cancer diagnosis as part of their inpatient stay. The main benefits the community are likely to see following the transition include:

- equity of patient access for all patients to a fully constituted multidisciplinary team, and
- streamlined patient management for those receiving a range of oncology services.

GPO Box 825 Canberra ACT 2601 | Ph: (02) 5124 9400 | Email: DGACTHealth@act.gov.au | www.act.gov.au

I understand that some patients may prefer, on balance, to receive services at CPHB because of proximity to where they live. The option to enhance services at CPHB was considered before the decision was made to consolidate services. Unfortunately it was not feasible to meet all the standards in the short to medium term and the outcome would not have delivered an ongoing viable multidisciplinary chemotherapy service.

To provide sufficient capacity for chemotherapy patients, and to ensure an ongoing viable Zita Mary day treatment service, it is planned to transition some non-chemotherapy day treatment services from Canberra Hospital to the Zita Mary Clinic. This will require further analysis to determine treatment type, and which patients are most suited to transition to the Zita Mary Clinic. It is likely that services will enable more residents of the northern suburbs to receive care at Zita Mary Clinic, rather than at CRCC.

Planning has commenced for minor upgrades to increase the number of consulting rooms in the CRCC. This work will provide the necessary capacity to accommodate increased demand for oncology and haematology outpatient medical consultations as a result of the transition.

ACT Health Directorate will be working with stakeholders to undertake service planning to inform future decisions about provision in the longer term of expanded cancer services on the northside. This work will cascade from the current work being undertaken on the Territory-wide Health Services Plan.

I would like to take this opportunity to acknowledge the exceptional care and dedicated quality service the Zita Mary Clinic has provided to ACT haematology and oncology patients in the past. Current patients at the Zita Mary Clinic will continue to receive high quality care for the remainder of their treatment regimen. Current and future Medical Day Care patients of the Zita Mary Clinic will continue to enjoy the healing, hope and nurturing care provided by CPHB. Nursing, medical, and allied health, and support staff will receive timely support through both CHS and CPHB senior management and be updated regularly on the transition process as it evolves over the coming months.

ACT Health Directorate will work with managers at CPHB and CHS to plan and coordinate further consultations with staff and key stakeholders.

Managers are available to undertake sessions with any interested stakeholder who would like to discuss their feedback, or the planned service changes in more detail. Please email all feedback and suggestions to feedbackforzitamary@calvary-act.com.au.

Yours sincerely

Rebecca Cross
**Director-General**

SENSITIVE - CABINET

MINISTERIAL BRIEF

ACT Health Directorate

Tracking No.: GBC21/469

| | |
|---|---|
| To: | Minister for Health |
| From: | Meg Brighton, Deputy Director-General |
| CC: | Rebecca Cross, Director-General |
| Subject: | Minister's Weekly Brief |
| Critical Date: | Friday, 13 August 2021 |
| Critical Reason: | To ensure you are briefed on current issues and events. |

**Recommendations**

That you note the:

- Information in the Minister's Weekly Brief for 2-6 August 2021;
- Media and Communication forecast at (Attachment A);
- Freedom of Information requests update (Attachment B);
- Ministerial & Government Services Report (Attachment C); and
- WhOG Cabinet Forecast at (Attachment D).

Noted / Please Discuss

Rachel Stephen-Smith MLA .............................................. 20/9/21

Minister's Office Feedback

Out of Scope

**UPDATES ON KEY PROJECTS/PIECES OF WORK**

**Zita Mary Clinic**

7. Staff forums are underway in relation to considerations for changes to chemotherapy service arrangements at Zita Mary Clinic. The ACT Health Directorate (ACTHD) project team is working with Canberra Health Services (CHS) and Calvary Public Hospital Bruce (CPHB) to assess and address feedback and issues as they arise.
8. Planning for consultations with other stakeholders including patients and families is underway and will commence this month. Correspondence has been drafted for patients and families and will be sent out imminently.
9. The Australian Nursing and Midwifery Federation (ANMF) has written to the Director-General ACTHD and the Minister for Health detailing concerns around the consultation process and potential industrial implications of the change in service provision. ACTHD, CHS and CPHB representatives have been meeting with the ANMF to address their concerns and a formal response is being finalised to the ANMF.
10. A detailed transition plan is under development and will be submitted for final approval at the conclusion of the consultation process.
11. To ensure due care and consideration is given to consultations and transition planning, the proposed timeframe for commencement of transition is now likely to be extended to early September 2021.

ACT Health

DIRECTOR-GENERAL MINUTE

TRIM Reference No. DGC21/616

| **SUBJECT:** | Future Provision of Public Chemotherapy Services in the ACT – Response to issues raised by Australian Nursing and Midwifery Federation |
|---|---|

| **CC:** | *Meg Brighton, Deputy Director-General* |
|---|---|
| **From:** | *Jacinta George, Executive Group Manager, Health System Planning and Evaluation* |

| **Critical Date:** | *25 August 2021* |
|---|---|
| **Reason:** | *To provide a response back to Australian Nursing and Midwifery Federation as soon as possible.* |

## Recommendations

That you:

| | |
|---|---|
| Note the information contained in this Minute. | ***NOTED*** */* ~~*PLEASE DISCUSS*~~ |
| Agree to sign the letter (Attachment A) to Mr Matthew Daniel, ACT Branch Secretary, Australian Nursing & Midwifery Federation (ANMF) in response to issues and questions raised. | ***AGREED*** */* ~~*NOT AGREED /*~~ ~~*PLEASE DISCUSS*~~ |
| Agree to send the letter with Attachments A-C to Mr Daniel. | ***AGREED*** */* ~~*NOT AGREED /*~~ ~~*PLEASE DISCUSS*~~ |

RM Cross

…………………………………………………………………….

Rebecca Cross
**Director-General**
ACT Health Directorate

25 August 2021

ACT Health

DIRECTOR-GENERAL MINUTE

## Purpose

To provide you with a response letter at Attachment A to the correspondence from Australian Nursing and Midwifery Federation (ANMF) ACT Branch Secretary, Mr Matthew Daniel regarding Chemotherapy Services at the Zita Mary Clinic (ZMC), Calvary Public Hospital Bruce (CPHB).

## Background

On 16 July 2021, Mr Daniel wrote to you in relation in relation to the transition of Chemotherapy Services from ZMC at CPHB to the Canberra Region Cancer Centre (CRCC) at Canberra Health Services (CHS).

On 20 July 2021, Ms Jacinta George, Executive Group Manager, Health System Planning and Evaluation, My Anthony Dombkins, ACT Chief Nursing and Midwifery Officer and Ms Cathie O'Neill, Executive Director, Cancer and Ambulatory Services, CHS met with Mr Daniel and ANMF representatives to discuss the issues raised and next steps.

On 21 July 2021 a holding response was sent from your office to Mr Daniel to advise that the ACT Health Directorate (ACTHD) is working work CPHB and CHS to address the issues raised.

Following the meeting on 20 July 2021, a further meeting was scheduled between ANMF, CPHB and ACTHD to discuss how Calvary will approach the engagement, consultation and subsequent steps. This meeting was held on 3 August 2021.

## Issues

Currently, public chemotherapy services in the ACT are provided from the CRCC at Canberra Hospital and through the ZMC at CPHB.

It is proposed that the delivery of chemotherapy services at the ZMC will be transitioned to the CRCC at Canberra Hospital in the short to medium term, to provide a consolidated and streamlined service in a single tertiary centre.

On 13 July 2021 a consultation process was launched to inform stakeholders of the proposed transition of chemotherapy and oncology consultation services, and to seek feedback and input on how this transition can best occur. The consultation period is scheduled to be open until 30 August 2021, inclusive of community consultation.

The correspondence from the ANMF details the concerns raised in relation to this proposal.

## Benefits/Sensitivities

It is acknowledged the timeframe to provide the response to the ANMF has been delayed. Key staff have been involved in the COVID response. There was also some delay associated with coordinating responses from the hospitals and within the directorate.

## Consultation

Dr Suzanne Smallbane, Director of Clinical Services, CPHB reviewed and provided input to the ACTHD response.

Anthony Dombkins, ACT Chief Nursing and Midwifery Officer reviewed and provided input to the ACTHD response.

James Harmer, Director, People Strategy reviewed and provided input to the ACTHD response.

## Media

*Have relevant communications material to support this brief been attached (communications plan, draft media release, talking points etc)?* ☐ Yes ☐ No ☑ N/A

*Has the Communications Branch been consulted?* ☐ Yes ☐ No ☑ N/A

## Financial

Not applicable.

| Signed off by: | Jacinta George | Phone: | |
|---|---|---|---|
| Title: | *Executive Group Manager* | | |
| Branch/Division | Health System Planning and Evaluation | | |
| Date: | 20 August 2021 | | |
| | | | |
| Action Officer: | | Phone: | |
| Unit: | | | |

ACT Health

Office of the Director-General

Mr Matthew Daniel
Branch Secretary
Australian Nursing & Midwifery Federation (ANMF)
anmfact@anmfact.org.au

Dear Mr Daniel

**Chemotherapy Services at the Zita Mary Clinic, Calvary Public Hospital Bruce**

Thank you for your correspondence of 16 July 2021 in relation to the transition of Chemotherapy Services from the Zita Mary Clinic (ZMC) at Calvary Public Hospital Bruce (CPHB) to the Canberra Region Cancer Centre (CRCC) at Canberra Health Services (CHS).

The following responses address the issues and questions raised in your correspondence:

**Breach of the consultation requirements of the ACT Public Sector Nursing and Midwifery Enterprise Agreement, clause 155.**

I apologise that the ANMF was not notified in a timely manner of the proposed consultation with staff about the transition of Chemotherapy Services in the ACT. A consultation plan timeline is at Attachment A detailing the consultation process for this project that ensures adequate consultation with unions and affected staff.

Processes have been put in place for future projects delivered by the Program Support Unit (PSU) to ensure notification to the ANMF and consultation provisions described in Section P of the *ACT Public Sector Nursing and Midwifery Enterprise Agreement 2017-2019* and any future agreements are followed.

**ANMF seeks clarification confirmation that a decision has, in fact, been made to transition public chemotherapy services from Calvary to CHS as the correspondence creates ambiguity.**

A final decision has not been made. The consultation is genuine and suggestions about other options for meeting the requirements of the standards are welcome and will be given full consideration. The proposed solution was the only feasible solution able to be identified by the senior staff responsible for the project.

**ANMF seeks clarification of the relevant express power or delegation relied on by the Minister to make the operational decision to no longer offer these services, particularly as these services are currently delivered by Calvary as a private enterprise.**

Under the Calvary Network Agreement (CNA) Section 5.2, CPHB is obligated to notify ACT Health Directorate (ACTHD) when they are unable to operate the public hospital services within Relevant Standards. Calvary did this because CPHB is unable to comply with all of the actions in the Australian Commission on Safety and Quality in Health Care 2020 Guidelines for Medication Management in Cancer Care.

**ANMF seeks the provision of the finding from the "desk top review" of the relevant guidelines that identified that Calvary do not comply with the applicable standards.**

In the "desk top" review, CPHB identified that the hospital was unable to comply with Action 1.16e, specifically "A fit-for-purpose electronic medication management system for cancer services should be used and should be integrated with other electronic medication management systems used by the healthcare services involved."

CPHB and senior cancer clinicians at CRCC identified a number of other areas of concern in relation to the Clinical Governance Standard. The main issue identified was remote supervision of junior doctors.

The National Safety and Quality Health Service (NSQHS) Standards User Guide for Medication Management in Cancer Care is available as a reference at: https://www.safetyandquality.gov.au/sites/default/files/2020-04/nsqhs_standards_user_guide_for_medication_management_in_cancer_care_april_2020.pdf

**ANMF seeks confirmation of whether such a surface-level review was the only review undertaken (as other correspondence outlines a 'service provision' review was undertaken) before making a significant decision.**

The "desk top" review and consideration of the outcomes was the only review undertaken. Hospital Cancer Services are assessed against the National Safety and Quality Health Service (NSQHS) Standards User Guide for Medication Management in Cancer Care (2020) developed by the Australian Commission on Safety and Quality in Health Care. The review of compliance against these standards was undertaken at CPHB and the CRCC after the user guide was released in 2020.

Once ACTHD was notified of the inability to comply with the Standard, a project team was implemented comprising CPHB, CRCC and ACTHD executives and senior clinicians.

**Termination of the employment of employees through redundancy**

No staff members of the ZMC will be made redundant as a result of the proposed changes.

The ZMC would operate as an Infusion Service. It is anticipated that identified Medical Day Unit (MDU) activity will be transferred from the CRCC to ZMC to ensure chemotherapy patients can be accommodated at CRCC.

CPHB has had engagement with several health professionals during feedback sessions held to date, including one-on-one meetings at the request of some personnel. Only one nursing staff member has requested a transfer to pursue a career in Oncology Nursing. This staff member will be supplying their Curriculum Vitae and references to CRCC to enable an Instrument of Permanent Transfer for the staff member to be employed by CHS CRCC.

**The elimination or diminution of job opportunities.**

There is no elimination of job opportunities for staff at the ZMC. During the consultation it has been identified that more complex infusion therapies could be provided at ZMC. As consultation is still in progress the specific therapies are still to be identified. These will be identified as part of the Transition Plan, as will the training that will be required for staff to perform these infusions.

As noted above, CPHB has commenced discussions with the one nursing staff member who has identified that they would like to continue developing their oncology nursing skills and career.

**The alteration of hours of work**

There will be no alteration of hours of work at ZMC. The hours of employment for the staff member requesting transfer to CRCC will remain as full-time.

**Need to retrain employees**

As the ZMC currently provides infusion therapies it is not anticipated there will be a requirement for the current staff to be retrained. However, when consultation about the provision of transfer of infusion therapies from CRCC to ZMC has been completed, there may be a requirement to develop a comprehensive education and training plan to ensure staff receive the required training to treat these patients.

The staff member requesting a transfer to CRCC will continue to provide the same service currently provided at ZMC.

**The number of employees affected, which health professionals will be, and to what extent the effects will be.**

There are currently five nursing staff employed at ZMC. Oncology patients needing chemotherapy will be transferred to CRCC. If, following the consultation process, there is a change to services provision, additional training will be provided. No employment conditions will change for other health professionals.

**The ANMF requests clarification as to how the ANMF can participate in effective consultation if a decision has already been made.**

Whilst only one feasible option for the treatment of chemotherapy patients being treated at ZMC has been identified, any other suggestions raised by your members will be welcome and considered.

Any suggestions that the ANMF can provide in relation to the Draft Transition Plan that will be developed through the consultation process will be welcome, in particular about:

- Any training or support the nursing staff will require when the cohort of MDU patients able to be treated appropriately at ZMC are identified as being of a different cohort than already treated at ZMC.
- The timeline that this "change" process follow. The project team welcomes advice about whether the change timelines identified in the Draft Transition Plan are realistic and will meet industrial process requirements.
- Issues concerning staff employment conditions that are raised at the consultation forums or within the Draft Transition Plan.
- Issues regarding service provision that are raised at the consultation forums, that will be identified in the Territory Wide Oncology Services Project Consultation Feedback Register.
- The policies, procedures and guidelines required to ensure staff and patient safety.

**The provision of information that would allow the ANMF to participate in effective consultation, including exploring all avenues that may be available to ensure no adverse outcomes for employees (and patients).**

ACTHD will provide the ANMF with the following to ensure effective consultation:

- Draft Transition Plan – it is anticipated as per the consultation plan timeline (Attachment A) the draft plan will be distributed for consultation on 13 September 2021. With the emerging COVID-19 situation within the ACT this date may change.
- Territory Wide Oncology Services Project Consultation Feedback Register – (Attachment B). The PSU anticipates providing further documentation on the feedback received through consultation processes and action taken as the project progresses.

**Clarification on the issue of where these standards are being, or cannot be, met including in the short term, how will "current patients at the Zita Mary Clinic continue to receive high quality care for the remainder of their treatment regimen"**

Current patients at ZMC will continue to receive high quality care for the remainder of their current treatment regimen. Prescribing meets the previous standards.

**ANMF seeks clarification regarding the actual number of patients this will affect.**

There are approximately 15 patients a week receiving chemotherapy at the ZMC. Once the consultation process has been completed the project team will work with CPHB and CRCC to identify the cohort of patients expected to transition to ZMC for infusion therapies.

**The ANMF was not aware that CRCC had "gaps" and is unaware of to what these gaps pertain. However, it is noted that actions to address these "gaps" were expected to be completed by mid-2021. As such, the ANMF requests provision of the relevant information regarding the "gaps" and confirmation that the relevant actions have now been completed.**

The Medication Management Map and Gap that has been provided by CRCC detailing the relevant actions required to meet the Standards is at Attachment C.

I again apologise for the lack of communication, collaboration, and consultation on this matter. I also regret the incorrect spelling of your name in the correspondence to the ANMF.

I have been advised a meeting was held with the ANMF, Ms Jacinta George, Ms Cathie O'Neill and Mr Anthony Dombkins on 20 July 2021 to address some matters raised in the original correspondence, and that you met also on 3 August 2021 with Ms Jacinta George and Ms Narelle Comer.

I would like to thank you for continuing to work with all parties to ensure a progressive and responsive approach to the matters affecting your members.

Yours sincerely

Rebecca Cross
**Director-General**

27 August 2021

**Zita Mary Clinic Calvary Public Hospital Bruce Consultation Timeline**

| Date | Action |
|---|---|
| 14 July 2021 | Consultation launch held at both Calvary Public Hospital Bruce (CPHB) and Canberra Health Services (CHS) - Director-General (DG) letter and Information sheet provided to stakeholders in attendance at both sites. |
| 14 July 2021 | letter and Information sheet emails to CPHB stakeholders<br>Managers at CHS provided stakeholders with DG Letter and Information |
| 14 July 2021 | Website advising of consultation launched https://actgovernment.sharepoint.com/sites/intranet-ACTHealth/SitePages/Chemotherapy-to-be-provided-at-Canberra-Region-Cancer-Service.aspx |
| 19 July – 13 August 2021 | Staff consultation – including 4 scheduled forums and any requested 1:1 consultation |
| 16 August – 25 August 2021 | Project team working to address feedback received from staff consultations<br>NOTE:<br>• all feedback will be logged<br>• when appropriate feedback will be addressed at time of forum or in the individual consultations |
| 26 August 2021<br><br>(Note: a second forum will be scheduled if required) | Community forum planned (Note: this will be determined closer to the date on whether this will be a virtual or face-to-face consultation depending on COVID-19) |
| 30 August – 10 September 2021* | Project Team to draft Transition Plan |
| 13 September – 24 September 2021* | Distribute Transition Plan for consultation |
| 27 September – 28 September 2021* | Project team to incorporate feedback into Transition Plan |
| 29 September – 15 October 2021* | Endorsement of Transition Plan from:<br>• ANMF<br>• CPHB<br>• CHS<br>• ACTHD |
| 18 October 2021* | Transition Plan sent to Minister for Health for endorsement |

*These dates will be changed if there is a requirement for a second community forum

Note: CPHB will consult with any patients currently being seen at ZMC as they are required even throughout the staff consultation period

# Territory Wide Oncology Services Project

## First Pass Consultation Feedback Register

Program Support Unit
programsupportunit@act.gov.au

**Consultation Feedback must include:**

- A log of the feedback received and the initial response given at the consultation session. For this reason, responses provided at subsequent meetings may differ as a reflection of the ongoing refinement of the approach being considered for the transition. .
- A lack of feedback should be noted as a 'nil response', where feedback received is 'no comment' then this should be recorded as such.
- A summary feedback report will be developed post the initial consultation period to provide themed feedback, details of the action taken and whether and how this has been included in the Draft Transition Plan.
- A second pass consultation feedback register and feedback log will be developed for consultation on the Draft Transition Plan

| Name/Title/Area Represented | Date Received | Feedback | Response | Comment/ Action |
|---|---|---|---|---|
| **Consultation Launch: 14 July 21** | | | | |
| **Item 1**<br>Consultation Launch (CHS)<br>Various staff from CRCC and key stakeholders. | 14/7/21 | • 1.1. What standards weren't met by ZMC? | Y | Issues around scale of operations, ZMC won't pass accreditation r/t chemotherapy treatments. Bio agents are ok.<br><br>Prescribing of chemotherapy drugs (electronic and prescribing and governance issues-costly to rectify)<br><br>Pts at ZMC miss out on care coordination and medical support for chemo treatments. |
| | | • 1.2. Patients from CRCC shift to ZMC, Monoclonal? | Y | Low chemotherapy treatment numbers through ZMC. |

| | | | | |
|---|---|---|---|---|
| | | | | Need to determine how CPHB and CHS can work together, would depend on medical admitting rights. |
| | | • 1.3. Is CPHB going to DHR next year? | Y | Yes, DHR being implemented at CPHB next year. Will be on same system, review how to provide an integrated/ flexible TW service. Feedback welcome. |
| | | • 1.4. When will patients be advised | Y | From Mon19/7: one month of staff consultations including 4 staff forums over 4 weeks. Staff can also provide feedback via email in the information provided, and forums. 2 community forums will take place after the staff consultation.<br><br>Part of Pt/ health professional therapeutic relationship. Talking points can be provided. |
| | | • 1.5. When will patients start to be transferred? | Y | This will be a phased approach so current patients can continue their treatment at ZMC. Medical admitting rights need to be worked through. Oncologists still must go to CPHB to do the consults, won't be admitting to the wards. Need to build more clinic space at CRCC. |
| | 14/7/21 | • 1.6. Long term survivor clinics and follow-ups, could this continue at ZMC? | Y | If patient having treatment at CRCC, expect they stay at CRCC. This is to be discussed at the forums. If the service, other clinics and clinical staff are based at CRCC, it would make sense that these clinics would be located at CRCC.<br><br>**ACTION: Project team to ensure this is resolved when developing the Draft Transition Plan** |

| | | | | |
|---|---|---|---|---|
| | | • 1.7. Are private patients included? | Y | Only public patients.<br><br>**ACTION: Project team to review current patient profile for private patients being treated at ZMC. Comms to be updated to clarify that the transition refers to ZMC only not services at Calvary Private.** |
| | | • 1.8. Is it only MDU patients that are being considered to transfer? | Y | No decision has been made at this stage. Understand that there is no safety issue to continue this service at ZMC. |
| | | • 1.9. Patient access to Allied Health services? | Y | If a patient at CHS then yes, they can access all CHS allied health services as all CHS patients are able to. |
| | | • 1.10. Outreach team has more funding, is it possible for outreach service to be provided at CPHB? | Y | Depends upon standards. |
| | | • 1.11. Patients who start treatment at CHS are likely to want to stay for remainder of treatment schedule. | Y | If patient having treatment at CRCC, expect they stay at CRCC.<br><br>Patients who start treatment at CHS are likely to want to stay here for remainder of treatment as familiar with staff. |
| | 14/7/21 | • 1.12. Already have issues with booking in the numbers of patients at CRCC. How will it be managed? | y | Will need to consider all treatments that can be safely transferred to CPHB, to free up capacity at CRCC. |

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| | | • 1.13. Chronic Disease cohort will benefit from the changes, however horrible for patients to move location. Day care patients will be moved again. | y | Speak honestly with patients, and be cognisant of the disruption service changes may cause for patients and taking individual circumstances into account. |
| | | • 1.14. Volunteer transport, and patients who rely on this, will it be provided for CPHB? | y | This service is donated to CRCC, and the service will continue to be offered for those who are eligible. We can still offer community transport, needs further consideration as we don't have the capacity to take patients to CPHB. |
| **Consultation Launch: 14 July 21** | | | | |
| **Item 2**<br>Consultation Launch (CPHB)<br>Various staff from ZMC and key stakeholders | 14/7/21 | • 2.1. Opportunity to transfer Nursing Staff contract from ZMC to CRCC? | y | One on one interviews with Narelle encouraged. |
| | | • 2.2. Will there be any clinics at CPHB? | y | No clinics at CPHB. Doctors will be located at CHS. |
| | | • 2.3. Will there be new Immunologists (Immunology Doctors)/ other Specialists sending patients to ZMC? How do we accommodate their work practice if care is 'remote'/ off site? | Y | Specialist and medical staff provision of care will be discussed over the coming months (ie: HITH may provide medical cover) |

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| | | • 2.4. Staff would like to see doctors back 'on site' at ZMC. Accountability for medical care at ZMC? | N | For further discussion in coming weeks.<br><br>**Note: ensure this is resolved when developing Draft Transition Plan** |
| | | • 2.5. Is there capacity at CRCC for extra Chemotherapy patients? CRCC response to change in presentation numbers? | y | New clinic rooms are being constructed to accommodate increased demand.<br><br>Note: the project team identified clinic expansion was already planned prior to the service changes being put forward. |
| | | • 2.6. How do we get services back here – whole patient services i.e. complete care? | y | North-side hospital a consideration for future oncology services. To be scoped out.<br><br>These consultations will inform the roadmap – step through process for transition.<br><br>Timeframes – 1 month for internal stakeholder discussions. Then will have external stakeholder discussion e.g. GPs, referrers, consumers and finally general community.<br><br>**Note: ensure this is resolved when developing Draft Transition Plan** |
| | | • 2.7. Staff concerned re: patient transport to CHS, particularly of Northside patients with ambulatory issues.<br>• 2.8. Parking also a concern at CPHB. | Y | Staff concern noted re: transport and parking issues for patients. Transport options can be reviewed and feedback welcome. Courtesy bus between hospitals, for further discussion. |

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| | | | | **Note: ensure this is resolvedwhen developing Draft Transition Plan** |
| | | • 2.9. Could ICON Oncology Services provide a viable service for Northside Patients? ACTH could fund services at ICON for some patients unable/ unwilling to attend CHS. Is this an option? | Y | ICON to be discussed further and considered.<br><br>ICON Oncology services to be considered – possibility of ACT Health to pay for services at ICON.<br><br>**Note: ensure this is resolved when developing Draft Transition Plan** |
| **Forum 1: WebEx 22 July 2021** | | | | |
| **Item 3.**<br>CHS: Senior Staff Specialist voicing concerns in general from others. | 22/07/21 | • 3.1. Concern re: CHS workload for chemotherapy patients. Level 4 almost at capacity. | Y | MDU patients transferred to ZMC will aid capacity.<br><br>Meeting required to work through MDU patient transition to ZMC, post staff consultation (Staff consultation will work through issues, build mechanisms for shared referrals). |
| Nurse CRCC | | • 3.2. Changes to infrastructure and workspaces happened earlier this year without consultation with nursing staff. More infrastructure changes to clinic spaces to accommodate extra chemotherapy patients planned. Level 2 intake RNs now required to work in suboptimal working space. Not enough room for staff, patients, or their family members. May be problematic if MET Team required. | Y | Whilst the additional capacity is anticipated to provide for CRCC to absorb the increased demand that will be generated by the transition of services from ZMC, the changes at CRCC regarding accommodation in the clinic area was already being progressed well before this project was initiated.<br>CRCC management has had all WHS inspections performed to ensure the accommodation changes are fit for the intended purpose. |

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| | | • 3.3. There are other vacant rooms that could be better utilised. | | |
| Nurse CRCC | | • 3.4. Concerns re: Some MDU patients that transferred across from HITH (previous year) to CRCC were distressed and took time to settle into CRCC, despite it being in same hospital. Concerns it may be difficult to transition MDU patients from CRCC to ZMC. | Y | Senior staff will work with all areas to facilitate a seamless transition. There will be some hurdles to overcome.<br><br>Review Lessons Learnt from HITH MDU Transition: Discuss with Sarah Mogford.<br><br>Discussion with Sarah Mogford identified the lessons learnt.<br><br>**Note: ensure this is reviewed when developing Draft Transition Plan** |
| | | • 3.5. It was suggested that several Oncology patients have threatened to stop treatment if they must transfer to another service. | Y | Treating Oncologists need to advise patient on best course of action and options for further treatments. |
| Nurse from Breast Care | | • 3.6. Option for ICON Oncology services to offer treatments for Northside patients. Costs Involved? Private vs Public. | N | ICON to be discussed further and considered.<br><br>ICON Oncology services to be considered – possibility of ACT Health to pay for services at ICON.<br><br>**Note: ensure this is resolved when developing Draft Transition Plan** |
| **Forum 2: WebEx 29th July 2021** | | | | |
| **Item 4**<br>BC Nurse | 29/7/21 | 4.1. Is there an option to utilise the rehabilitation hospital, University of Canberra Hospital? | Y | This would depend on the Governance and medication requirements. |

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| | | | | **Note: ensure this is reviewed when developing Draft Transition Plan** |
| General discussion | | 4.2. Has there been consultation with community support groups? | Y | Bosom buddies should be included.<br><br>A Community Forum is tentatively scheduled for the 26th of August. Unable to determine if this will via WebEx or face to face due to COVID 19.<br><br>There has been previous success with community forums. **ACTION: Project Team to talk to ACTHD Community Sector Contracts and Grants Unit to get contacts. This has been actioned.** |
| General Discussion | | 4.3. Concerns about Transport options (to/from CHS and Calvary Hospital) has also been raised. | Y | The Cancer Council should be involved. They may be able to provide community transport.<br><br>CRCC capacity for bus service – residents and hospital about 95% full. No scope presently to run a service between CPHB and CRCC.<br><br>**ACTION: The Project team to contact Community Groups and Organisations that may help with transport options. This will be discussed at the Community forum 26 August 2021**<br><br>Cancer Council can also help with procedures.<br><br>Community Services Directorate are involved in community transport service contract. |

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| | | | | Transport for CRCC patients from their residence to CPHB. Need to look at the number of patients that will be transitioned from CRCC to CPHB.<br><br>Need to look at the list of support services we are inviting to the Community Forum and see who else should be involved.<br><br>We will have a better idea after the meeting next week with CPHB what still needs to be addressed.<br><br>**Note: ensure this is resolvedwhen developing Draft Transition Plan** |
| Oncologist/ Staff Specialist | | 4.4. Is there a list of Community based organizations currently? | Y | The Project Team will talk with **ACTHD Community Sector Contracts and Grants Unit** to get details and the best time to hold forums with Community groups. |
| General discussion | | 4.5. Any decisions on what patients what will be moved over? Level 4 is full and feeling the pressure currently. | Y | This hasn't occurred formally yet.<br><br>Consider: future consultations should be around a specific topics including profile of MDU activity to shift to ZMC. The project team have offered to come to CRCC and do a special consultation with Level 2 CRCC nursing and admin staff.<br><br>Yes, this is important as the numbers on Level two will increase with the changes. At the moment there isn't the capacity to book patients have to double book. |

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| | | | | Need to make sure that the Level 2 staff are included. And the FTE that will be required to support this. |
| General discussion | | 4.6. Any further discussions about what services each facility will be taking? | Y | Over the next few weeks there will be some smaller consultations sessions with staff at CRCC and CPHB. |
| Pharmacist (CPHB) | | 4.7. When patients are transferred, the main consultants are still practicing at CRCC in regards to Governance and transparency with progress notes from CHS that are non- oncology related? | Y | HITH doctor at CPHB has been suggested previously as a solution, no decision made until the consultations are finalised and we are not looking at consultations being completely finalised until October.<br><br>**Note: ensure this is resolved when developing Draft Transition Plan** |
| Pharmacists (CPHB) | | 4.8. What decisions have been made to date? | Y | No decisions have been made except that this will go ahead, and consultations will continue until October, any decisions that are made will be with everyone involved. |
| Pharmacist (CPHB) | | 4.9. Has patient consultation occurred? | Y | Patient consultation is currently happening at ZMC as the staff see their patients. We are still working on what community consultation will happen, until we know the plan, we can’t discuss this further with patients.<br><br>We have sent out some talking points and a patient letter will be finalised soon for clinicians to distribute to their patients. |

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| Pharmacist (CPHB) | | 4.10. Where do the clinicians sit, what's the view? | Y | There has been mostly positive feedback received from clinicians, they are supportive. Some concerns around MDU patients, and some staff may want to transition. |
| General | | 4.11. What about logistical planning? | Y | This will be discussed further down the track through the consultations.<br><br>**Note: Project team will progress dedicated discussions on logistical planning and ensure this is resolved through the Draft Transition Plan** |
| **Forum 2: WebEx 29th July 2021** | | | | |
| **Item 5.**<br>Staff | 29/7/21 | 5.1 Colleagues working for NSW rural health provide an oncology service without onsite medical cover, similar to Calvary. If we are moving to meet National Standards, why can Rural NSW continue to run a service? Is it not the same national standard? | N | **ACTION: The Project Team to follow up responses to these questions with leadership team** |
| Staff | | 5.2 Seeking confirmation that oncology patients receiving monoclonal antibody therapy will continue to have access to this treatment as the patients currently rely on a HiTH Medical Officer. | N | **ACTION: The Project Team to follow up responses to these questions with leadership team** |
| Staff | | 5.3 ZMC staff currently administer IMI Methotrexate for patients diagnosed with an ectopic pregnancy. Who will administer if there is no electronic prescribing available at Calvary? | N | **ACTION: The Project Team to follow up responses to these questions with leadership team** |
| Staff | | 5.4 Is there an estimate on how many patients ZMC can expect from CHS? | N | **ACTION: The Project Team to follow up responses to these questions with leadership team** |

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| Staff | | 5.5 Patients are being turned away from CHS when referred for symptom management-what is to happen to these patients? They currently re-present to ZMC. | N | **ACTION: The Project Team to follow up responses to these questions with leadership team** |
| Staff | | 5.6 What plans are there to manage an increase in patients? Currently ZMC only has 8 chairs (reconfigured due to meet COVID restrictions). | N | **ACTION: The Project Team to follow up responses to these questions with leadership team** |
| Staff | | 5.7 When will the patients be informed on the plan to relocate the oncology service? | Y | Patient letter provided to CPHB and CRCC for distribution to patients. |
| Staff | | 5.8 Is it anticipated there will be an increase demand for Medical Imaging? | Y | Current workforce will need reviewing.<br><br>**ACTION: The Project Team to follow up responses to these questions with leadership team** |
| Staff | | 5.9 Clerical staff currently booking 3, 6 and 12 month advanced appointments-what do we tell these patients? will there be scripting available to staff? | N | **ACTION: The Project Team to follow up responses to these questions with leadership team**<br><br>**ACTION: Talking points provided to staff and will be updated as planning progresses including addressing appointment booking arrangements** |
| Staff | | 5.10 What impact will there be on peri operative services? Currently administer Epirubicin to Urology patients-how can this continue without electronic prescribing? | N | **ACTION: The Project Team to follow up responses to these questions with leadership team** |
| Staff | | 5.11 Medical Imaging currently supported by ZMC staff to access Port-a-caths because staff not | N | **ACTION: The Project Team to follow up responses to these questions with leadership team** |

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| | | credentialed to do so. Who will provide this support to Medical Imaging? | | |
| Concerns raised by staff | 29/7/21 | 5.12 Noted that there was no representation from the Oncologists at the Forum-How are they engaged? | Y | Oncologists are a part of the leadership team and are engaging in this forum. |
| | | 5.13 Concerned for long term ZMC patients may not manage navigating CRCC due to age and fragility. Concerned about the impact on the elderly patients | N | **ACTION: The Project Team to follow up responses to these questions with leadership team** |
| | | 5.14 The times for the next forums do not suit the clinical teams which will result poor representation and capacity to engage with the consultation process. | Y | Extra Forums have been organised for the future. Small group sessions (at both CRCC and CPHB) and individual one-on-one sessions are also available with senior managers, and the PSU Team.<br><br>PSU have scheduled regular meetings with staff at ZMC for their continued consultation. |
| **Forum 3: WebEx 3rd August 2021 0800-0900hrs** | | | | |
| **Item 6.**<br>Social Worker | | 6.1 Role of social workers is unclear at Zita Mary. Social workers see a lot of people with serious issues including domestic violence. Have been told that social workers don't go to Zita Mary, but it has happened regularly over the past year, some clarity would be good. | Y | Letter sent to Karen Dell to provide clarity. |

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| Nursing staff | | 6.2 DHR talks about Oncology patients coming back? | Y | Issue is that we don't do electronic prescribing at CPHB currently, the DHR will have this capability but there are other issues, it's not that simple.<br><br>**ACTION: Project team to liaise with DHR team to update comms related to ZMC.**<br><br>**ACTION: Project team to refer issue of DHR considerations for consideration in longer term planning.** |
| | | 6.3 In the next 5 years is it potential to get back oncology services at CPHB How will this impact on CHS. How do we keep up with the skills at CPHB if not doing Oncology? | Y | Continuity of skills needs to be addressed. In relation to high level questions, will need to find out answers. |
| | | 6.4 What is the time frame for the change to occur, and the timeframe for the project? | Y | It will be a tight timeframe. Expect it will be before the end of the year. It depends on the feedback that we get and the planning that is involved.<br><br>**ACTION: The Project Team to follow up responses to these questions with leadership team** |
| | | 6.5 This is the first time have heard that cancer service may come back? | Y | The Directorate is planning for future services, as the population grows on the North side, and the North side hospital. Until we have clarity on what this will involve, unable to answer. |

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| | | 6.6 Has there been an executive decision on the line sand (date) of when no new patients will be treated at Zita Mary? | Y | Not at this stage. This decision will be made as part of transition planning and as consultations are finalised and the plan moving forward is bedded down.<br>**ACTION: The Project Team to follow up responses to these questions with leadership team** |
| | | 6.7 Has the Community been consulted? | Y | Community forums have not occurred yet. There is a Community Forum scheduled for the 26th of August. After community consultations we will then come back to staff. If you know of community groups that need to be involved, please let us know. |
| | | 6.8: Can we send the papers out (stakeholder letter and info sheet) to the consumer groups that are on the list? | Y | Papers and invitations have been sent to consumer groups |
| Operational manager | | 6.9 Can meeting occur on Wednesday 4/8 with Admin staff at CRCC? | Y | Consultation for Level 2 meeting to occur tomorrow at the clinics at CRCC, Wednesday the 4th August 2020. ACTHD project team attended this meeting. |
| **Forum 4: WebEx 3rd August 2021, 1100 - 1200hrs** | | | | |
| **Item 7.**<br>Staff | 3/08/21 | 7.1 Which services are going where and what is the process? | Y | There is four weeks of staff consultation. Chemotherapy services currently being provided through Zita Mary will be transitioning to CRCC, CHS. Information has been sent out to affected staff and includes the reasons in regards to unable to comply with standards, and the streamlining of services. Current patients will continue to have their treatment |

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| | | | | at Zita Mary Clinic until it is either finished or until can be transitioned to CRCC. We will be looking at what medical day unit activity could be transitioned to ZMC to facilitate capacity for the transfer of chemotherapy services. Discussions on how to do this will occur. Zita Mary Clinic will continue as a service, the focus is on transition of chemotherapy services to CRCC. |
| Staff | | 7.2 Does that mean that Oncology trained nurse have an option to move to CRCC to continue to work in Oncology? | Y | Inpatient Oncology services are still continuing at CPHB. Nurses wishing to discuss their future career options are encouraged to have discussions with Narelle. The transition of staff across to CRCC may be an option and is open for further discussion. |
| Staff | | 7.3 Have conversations occurred one on one with staff involved? | Y | Yes. Narelle Comer, CPHB is having one on one consultations with staff and Sarah Mogford at CRCC, CHS is also talking with staff about how the changes will affect them. If any staff would like to discuss further or have a one on one meetings please contact Narelle or Sarah. |
| Staff | | 7.4 How will the medical Governance of Patients at Zita Mary work as this has been a longstanding issue, currently there are two CMOs who cover Zita Mary but without more senior medical oversight on site? | Y | At the moment we are taking all feedback, and will come up with solutions that will then be feedback to staff. This will be worked through after the consultation period.<br>**ACTION: The Project Team to follow up responses to these questions with leadership team** |

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| GP Liaison | | 7.5 Will correspondence be sent out to GPs particularly on the North side about how they go about referring their patients? | Y | There will be information going out to GPs and community organisations. The project team is working with Comms Teams to draft this documentation. Invites will go to GPs to attend the Community Forums as well as information about the changes. The first Community Forum is scheduled for the 26th August. |
| GP Liaison | | 7.6 How is that correspondence being sent out to them? | Y | This is currently being worked out with Comms Teams. GP liaison units are able to email the GP practices and the Capital Health Network can assist. |
| | | 7.7 Is the information available on the 3 intranets available to external stakeholders like GPs? | Y | The ACTHD Project Team is working with Comms Teams on this and how to get the information out and also onto our external site. |
| | | 7.8 What consultations are happening with medical teams about patients that are being sent to Zita Mary Clinic? | Y | Meetings are scheduled to hold discussions with medical staff on what sort of patients will be involved, and to look at the best options.<br><br>Although the staff consultation period is 4 weeks the overall consultation process will continue until October. The Transition Plan will be part of the consultations. |
| | | 7.9 Clinical staff will think of things to contribute, will they be involved in the design of the implementation plan? | Y | Meetings are occurring with medical staff at CHS, and will be organised with CPHB.<br><br>PSU have scheduled regular meetings with staff at ZMC for their continued consultation. |

| Meeting with CHS Level 2 Clinic staff in person – 4th August, 21 | | | | |
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| Item 8 | 04/08/21 | 8.1 Service Coordinators look after referrals and manage bookings, will there be any additional support staff at CRCC? | Y | We are not sure yet until all the feedback has been received it is unclear what staff will be required and how many additional clinics are required yet. **ACTION: The Project Team to follow up responses to these questions with leadership team** |
| ACTHD | | 8.2 Will the transfer of MDU patients balance out the demand at CRCC? | Y | No, MDU patients fall under a different division so it won't balance out and have less demand on Level 2. It's the clinics that will be affected the most. **ACTION: The Project Team to follow up responses to these questions with leadership team** |
| Staff | | 8.3 Patients will have their consultations at CRCC? | Y | Yes at this stage it is intended no oncology clinics will be held at CPHB they will all occur at CRCC. |
| Staff | | 8.4 So you don't know the number of patients that are not chemo that will be seen by consultants yet? | Y | No, we shouldn't know yet until consultations formalised, so we consider all feedback. It is unclear at the moment the number of patients that are affected by this change at Zita Mary Clinic. CPHB have made it clear that they want current patients who are being treated at Zita Mary to continue their treatment there. There will be a date where no new patients will be seen at Zita Mary, but those that are current will continue. |

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| | | | | **ACTION: The Project Team to follow up responses to these questions with leadership team** |
| | | 8.5 But they will have their consultations at CRCC? | Y | Yes as there will be no oncology clinics held at CPHB. |
| Staff | | 8.6 The workload concern is across all services including nursing, admin, medical and the allied health supporting care team. | Y | We will see if we can get the data on patients sooner to determine the impact.<br><br>**ACTION: The Project Team to follow up responses to these questions with leadership team** |
| Staff | | 8.7 Nurses on Level 2 concern raised with the change of the smaller room proposed to perform patient vitals, as unable to have a second staff member or others in the space. | Y | These decisions were made prior to this project commencing. How could it work?<br>Nurse: If we were to stay in the current room, or a bigger room provided. |
| ACTHD | | 8.8 How many clinic rooms are there? | Y | There are 15 clinic rooms currently that are full Monday to Thursday and Friday mornings, there is a bit of capacity on Friday afternoons. The addition of the two clinic rooms will make a total of 17.<br><br>The air ventilation will be fixed in the new spaces, but why do we have to work like this?<br><br>There are 3 areas that the nurses work from.<br><br>We are unable to provide the answers today. Once the draft Transition Plan is ready we will require further feedback. |

| Staff | | 8.9 Staffing less staff with more patients to manage is an issue. | | Meeting at CRCC next Thursday 12th August at 3pm – MDU Patients. |
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| Staff | | 8.10 Concern: Transport for patients. | Y<br>Y | This will be included in the Community Consultations. Paul Craft will be involved. We can meet again if required or organise one on one meetings. You can provide feedback via email feedbackforzitamary@calvary-act.com.au>, or email megan.wall@acthealth.gov.au, or talk to your managers. The best decision we make will be one with all feedback considered both positive and negative.<br><br>Opportunity to review current practices and address space issues. It has been a long standing issue with how to bet more clinic rooms at CRCC. We can come up with solutions on what can be changed.<br><br>The PSU will come back once the draft Transition Plan is ready to consult further. No decision have been made yet except that chemo patients need to come to CRCC.<br><br>**ACTION: The Project Team to follow up responses to these questions with leadership team** |
| Staff | | 8.11 What about the patients that want to finish chemo at Zita Mary Clinic? | Y | These patients will stay, CPHB is clear about that, it's the new chemo patients that will be seen at CRCC. |
| **TW Oncology Service Meeting with CPHB in person, 5th August 2021** | | | | |

| **Item 9** | 05/08/21 | 9.1 Staff concerns raised around losing jobs. | Y | One on one meetings offered for staff. Feedback emails and forums to discuss concerns.<br><br>Advised staff that there would be no job losses. |
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| Staff | | 9.2 Neurologist, Rheumatologist and Gastro have they been consulted? | Y | Ken and Tony have been involved in the TW Oncology Service Leadership Group Meetings. They are all aware. |
| Staff | | 9.3 Do we have a copy of the review as mentioned in the Stakeholder letter? | Y | Not public, as sensitive information, and includes details around Governance issues. People are welcome to read the Quality Standards. |
| Staff | | 9.4 Patients presenting to ED at CPHB and patients in wards? | Y | Consultation service not done in the clinics at CPHB this has always been an issue. CO was clear to address how we get better consultation for patients and how we prioritise patients. Inpatients should be getting a better service.<br><br>**Note: ensure this is resolved when developing Draft Transition Plan** |
| Staff | | 9.5 Wednesday is chemo day at ZMC. Questions around medications prescribed. Methotrexate and chemo agent, and if needs to be ordered electronically and can be done at ZMC or not? | Y | Issues have been giving the chemo meds. Issues with prescriptions written and then transcribed incorrectly or potential to be, trying to prevent these issues.<br><br>Drs to be encouraged to come to the Consultation Forum. |

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| | | | | Medical Governance for infusions coming to ZMC. Require a review of the current MoC. Issues currently with the Governance of other infusions also.<br><br>Could be the HITH consultant of the day or the Team of the Day to cover the hours of ZMC.<br>Registrar and CMO training would be required.<br><br>To have discussions with Registrars and CMOs about MoC. This is a good opportunity to write a new MoC.<br><br>Think it will be like an RFA unit for day surgery at ZMC. This could alleviate some stress with staff.<br><br>**ACTION: RH to send the current MoC for Zita Mary Clinic and MDU to ACTHD.**<br><br>**ACTION: Suzanne Smallbane to talk with Lisa and the team in regards to this.** |
| Staff | | 9.6 Need to explore the option of transfer of patients to ICON further. Would need to include all public patients from the whole of Canberra, not just the North side. Need to re-engage with McGrath. | Y | Need to set up some workshops for discussion of MDU patients. This needs to include CPHB and CHS.<br><br>**ACTION: ACTHD to set up workshops for discussions of MDU.**<br><br>**Note: ensure this is resolved when developing Draft Transition Plan** |
| Staff | | 9.7 What are the current transport arrangements for chemo patients currently? | Y | No transport currently provided at CPHB, there is a community volunteer run service for CRCC patients. |

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| | | | | Community Forum scheduled for the 26th August at 9:30 to 11:30am.<br><br>Patient letters, for staff to give to their patients. Need to have a discussion with the staff first about how to answer questions and redirect queries.<br>Could email patient letter to the Oncologist so that they can personalise with name and then provide to the patient.<br><br>Need to provide patients with information about where to park at the CHS.<br><br>A Patient Forum to be offered.<br><br>**Note: ensure this is resolved when developing Draft Transition Plan**<br><br>**Note: COVID-19 may have an impact on the Forums.** |
| **Forum 5: WebEx 10th August 2021, 1100 - 1200hrs** | | | | |
| **Item 10**<br><br>Radiographer | 10/8/21 | 10.1 What will be the impact on Medical Imaging area, is all the support services going to be directed to TCH or will they still have access to MI?<br><br>MI more than happy to provide this service for northside patients. Use the Alpac system that is TW | Y | We will add this information to the feedback register. We will invite to the workshops where the final detail will be worked through.<br><br>**ACTION: The Project Team to follow up responses to these questions with leadership team** |

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| | | so that the Drs will have access to all the patient scans. | | |
| General | | 10.2 What's the access at CHS like for patients in relation to parking and transport? | | Improvements have been made to the car parking at CHS. It is now disabled parking only on the ground level of the car park and 3 or more hourly parking on the other levels. Staff parking at the old CIT site is now in place to free up visitor parking at CHS.<br><br>Volunteer patient transport options are provide at CRCC. |
| General | | 10.3 This will have a massive impact on TCH Oncologist services? | | We are working on and collating all the feedback, there are going to be some non-cytotoxic services that will be referred to Zita Mary.<br><br>CHS: We are looking at the numbers of patients to see what can go from CRCC. We wouldn't be able to take onboard with the current load.<br><br>Zita Mary will still run as an infusion day unit, it is not shutting down, they are hoping to grow this service at CPHB. |
| General | | 10.4 Clarification on what patients will be seen at Zita Mary? | | We are still working on this, but it will probably be non-cytotoxic transfusions. Workshops will be held after the community consultations, and we will look at the patients suitable for Zita Mary and the polices and working closely with CHS and Zita Mary on this. |

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| | | | | We are open to any suggestions on what sort of patients should be seen at Zita Mary.<br><br>**ACTION: The Project Team to follow up responses to these questions with leadership team** |
| General | | 10.5 Have we looked at other infusion sites in other states to see what we can model off? | | ACTHD: The project team hasn't however, Suzy CPHB and Cathy CHS may have, will need to look into.<br><br>**ACTION: ACTHD to check if we have looked at other infusion sites in other states to see what we can model off.**<br><br>Could take patients that need transfusions at CHS, but they did not have capacity.<br><br>Immunotherapies and other day treatments that are not linked to chemo.<br><br>CHS: Currently looking at their Charm system and the percentage of non-cytotoxic work they do and if this will work to come over to Zita Mary.<br><br>Patients coming over to CRCC from Zita Mary - patients will start doing their clinics at CRCC, need to factor in extra admin resources to cope with this.<br><br>This might come up with consumers forum.<br>CHS: Someone was told their next appointment will be at CRCC, it is not clear in the wording and comms that |

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| | | | | some clinics will be going to CRCC as well and not just the treatments.<br>**ACTION: Project team to review and update comms, seek advice regarding any changes to clinic arrangements being made concurrently with this service transition consultation process.** |
| General | | 10.6 Will more clinics be opening at TCH, and what does this mean for medical oncology are we recruiting extra oncologists to meet the KPIs and timeframe that patients are seen within? | | CHS: Clinics that move to CRCC, will be Drs already here and not extra clinics, they will be fitting into the current clinics.<br>**Note: ensure this is resolved when developing Draft Transition Plan** |
| General | | 10.7 Is the timeline for the transition known yet? | | ACTHD: Unknown yet, as doing a true consultation process that may go until October, including the draft Transition Plan hopefully the next phase of consultation we will know. Expect it will be by the end of the year beginning of next year.<br>**ACTION: The Project Team to follow up responses to these questions with leadership team**<br>**Note: ensure this is resolved when developing Draft Transition Plan** |
| General | | 10.8 No cytotoxic meds given at CPHB at all? | | ACTHD: Not at the Zita Mary Clinic, will continue as normal elsewhere at CPHB.<br>CHS: It won't affect inpatients only the outpatients. |

<table>
<tr><td>General</td><td></td><td>10.9 Advised that a permanent clerical staff member was coming to work in birth centre from Zita Mary? Why would this occur if Zita Mary is still open? Currently have a casual and this person would take that role.</td><td></td><td>ACTHD: We are not aware that anyone is moving. ACTION: ACTHD to investigate this further.<br><br>This might have been raised at an earlier meeting.<br><br>No changes should be occurring yet. Could be a change that was previously planned and not part of the project.</td></tr>
<tr><td colspan="5">Meeting with Zita Mary Clinic staff – Webex, 16 August, 2021</td></tr>
<tr><td><u>Item 11</u></td><td></td><td>11.1 Clarity on Chemotherapy Patients or Cancer patients on treatment?</td><td>N</td><td>It's patients that are receiving chemotherapy drugs.<br><br>ACTION: The Project Team to follow up responses to these questions with leadership team</td></tr>
<tr><td>Staff</td><td></td><td>11.2 Need to consider other types of patients like those who see Haematologist 3 monthly but pick up drugs once a month. If these patients stay at ZMC and no Haematologist attached they won't have their drugs subsidised. It will cost patients more.</td><td>N</td><td>ACTION: James to send ACTHD detail and examples of types of patients that will be affected.</td></tr>
<tr><td>Staff</td><td></td><td>11.3 Will counselling services be available for patients as some are quite distressed already of the unknown and having to transfer?</td><td>Y</td><td>ACTHD – The plan is for patients to continue their active chemo at ZMC.<br><br>ACTION: ACTHD to clarify.<br><br>Note: ensure this is resolved when developing Draft Transition Plan</td></tr>
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| Staff | | 11.4 The Haematologist at ZMC is unwell at the moment and has been replaced by another on an adhoc basis. Question - Do we envisage that this service will cease at ZMC as this is already happening? Haematologist were coming weekly, now it is fortnightly. This is not impacting patients at ZMC currently. | N | **ACTION: ACTHD to clarify.** |
| Staff | | 11.5 What's the transition period for when those being treated at ZMC will diminish? The deadline for no new treatments at ZMC? | Y | The Leadership Group will discuss based upon feedback received. No date as yet. |
| Staff | | 11.6 How to categorise patients in different treatment phase including non- treatment, treatment and break phases? | Y | Please send ACTHD an email with different patient categories and we will take to the Leadership Group to work through and come back to you. |
| Staff | | 11.7 How will the funding work into the future? | Y | Once we know the detail we look at the impact of the funding. We are working CPHB and other work units in ACTHD to try to determine the costs of services..<br><br>**Note: project team to follow up the email** |
| Staff | | 11.8 DTU patients are we going to offer similar treatments or others? | Y | To workshop this with both sites, CPHB and CHS. |

| Action Officer Details | Name: ## | Phone: ## | Position: ## | Division: ## | Branch: ## |
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Note: Leadership Team will meet after the community consultation. This meeting may be impacted by the ACT COVID situation.

| Task Name | Responses/ Criteria compliance | % complete | | Actions to be taken | Responsible Officer |
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| **Medication Mx in Cancer Care** | | | | | |
| **Governance Structure** | | | | | |
| Determine existing governance committees and reporting | Clinical Governance Framework 2020-2023<br><br>CHS Corporate Plan (strategic priorities for July 2020-June 2021<br>CHS "Reflect" Reconciliation Action Plan developed by December 2020<br><br>Exceptional Care Framework<br><br>CHS 2020 Strategic Plan (strategies are: Personal Health Services, A great place to work, A leading specialist provider, A partner to improve people's health.<br><br>Partnering with Consumers Framework (Partnering for Exceptional Care Framework)<br><br>https://healthhub.act.gov.au/governance/chs-governance-frameworks | | See CAS Divisional Meetings spreadsheet in Q drive | | |
| Define existing CAS working groups and staff meetings and reporting | Nursing<br>**Medical Oncology Inpatients:**<br>Ward meetings are held monthly. During COVID they have not been happening. During this period staff have been sent regular emails.<br>Ward meeting, L2 and chemo meeting<br>**Haematology and Med Oncology Outpatients**<br>Staff meetings once per month, education meetings weekly, handover meetings daily with pharmacy<br>•Monthly haematology RN meeting which is minuted<br>•Weekly haem/ med onc / immunology education for 1/24<br>•Haematology unit meeting<br>•Bone marrow MDT monthly<br>**L2 and Rad Onc**<br>•Rad Onc- staff meetings will recommence monthly.<br>•Rad Onc general meeting monthly | | | | |
| Investigate medication mx reports and frequency of these submitted to CGC | Q&S Summary Report submitted to CAS Clinical Governance and Our Care (organisation wide meeting) each month which contains (i) Q&S Data Summary; KPI on Consumer feedback 35/7 response; MET calls and details for improvement; HRT HAC data - Clinical incidents excluding MET, Medication Incidents from RiskMan and trends; Signficant incidents (Major and Extreme); Discharge summary sent within 48 hours of separation % sent on time, consumer feeback - compliments and complaints against riskman;<br>TopCat data found an oudit library Sharepoint with quarterly measures. These cover many aspects. eg labelling of injectable medicines, fluids and lines;written documentation inpatient; adult paper medication chart, schedule 8 drig register, cognitive impairement, clinical handover, community clinical documentation, Patient ID and Procedure matching, | | See CAS Q and S data report for CGC; see audit library Sharepoint for CAS and CHS. | | |
| Investigate what capacity & capability CAS has to support safe treatment | ED colocated, RAU, Inpt beds, credentialled staff, 24 hour services etc, EVIQ protocols regularly reviewed. Pharmacy compounding on site and from vendor | | Tumour streams are collaborative approaches to care and service improvement between consumers and health care professionals. These ensure a consistent approach to care, and reduce unacceptable variations to care. Supported by agreed treatment protocols, monitoring of best practice, idenfiying areas for service improvement<br>Collaboration with QSII unit.<br>Based on best practice and EB care<br>Peer review, case review, systematic analysis of health service and feedback<br>Clinical governance, workforce credentialing and scope of practice (+ performance review), measurement for improvement, consumer participation in improvement<br>Report and respond to patient safety risks and adverse outcomes (HACs) | | |
| Determine how consumers are involved in cancer care governance planning, design, measurement and evaluation of care provided | Schedule 2.2(a)(ii) as consumer rep on CGC.<br>Clinician and consumer led service improvement<br>Cancer Consumer Reference Group established September 2020 for planning, design, measurement and evaluation of care provided. Will be guiding L3 development especially. | | Consumers can contribute to QI by:<br>Surveys, consumer/ carer colaboration in individual care episodes, including treatment decisions, consumer advice on clinical and process related information, sharing first hand experiences of care and services to help improve common understanding and target areas for improvement, consumer collaboration in planning and improvement activities, identification/planning/ management of research to imrpove qualith and safety of health care.<br>involving consumers requires resources including leadership, education and training for health service staff, consumers etc.<br>Consumer complaints are reviewed and acted upon to improve service as appropriate. | | |
| **ATSI Care** | | | | | |
| Determine differences between ATSI cohort & general cohort for med mx | Nursing<br>**Medical Oncology and Haematology Inpatients:**<br>No. There is no difference in how medication is managed.<br>**Haematology and Med Onc Outpatients:**<br>The ALO is able to access CHARM for ATSI pts.<br>L2 B19 notify the ALO who may accompany the pt and may be there as the pt is first told their diagnosis. There is close collaboration with the ALO in managing ATSI pts. ATSI have greater support with the ALO.<br>**L2 and Rad Onc:**<br>no<br>**Pharmacy TBA**<br>No difference | | | | |

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| Develop process for ATS clients and family - linking to OCP | Cancer Consumer Reference group established with representative from ATSI and HCCA and others with a diverse background<br><br>CHS Corporate Plan Strategic Priorities for July 2020 to June 2021: "A Partner to Improve People's Health"<br><br>Initiative is - Committed to Aboriginal and Torres Strait Islander peoples".<br>Deliverable (1) - Improve how we care by developing a CHS "Reflect" Reconciliation Action Plan in collaboration with ATSI peoples = measured by CHS "Reflect" Reconciliatio Action Plan developed by Dec 2020.<br>Deliverable (2) - Review CHS performance data to establish a key suite of quality and safety measures for ATSI peoples, including benchmark data and targets = measured by development and commencement of reporting on an ATSI Health Measurement Plan by December 2020. | | A retrospective audit of 40 ATSI pt records against the OCP recommedations was undertaken. Included 21 ACT based pts and 19 NSW based pts. Key results: Audit showed adequate concordance for a few key OCP recommendations for ATSI pts: 1. Comorbidities were assessed for all audited pts, 2. overall 84% of audited pts were supported by an ALO at some point during their care 3. 67.6% of audited pts were discussed at an MDT for initial treatment planning and 66.7% during step 6 and metastatic disease management 4. Out of the 12 audited pts who died during treatment at CRCC< 10 had been referred to PC (83.33%), 1 died with unknown details, 1 refused any further treatment towards EOL. 5. GPs of all audited pts (100%) were regularly informed by letter detailing the diagnosis, treatment plan and decisions, including MDT meeting outcomes, treatment progress as well as medical treatment summary and follw up care plans. Key results requiring improvement: A. improve consistency of early referral to ALO service, especially during initial referral and investigations, diagnosis, staging and tratment planning phase B. Only 7.5% of the audited pts had supportive care needs formally assessed with a tool and recorded = improve supportive care needs assessment process and support C. Majority of audited pts no formal record in regards to clinical trial discussion/eligibility (10% of audited pts participated in a clinical trial, 5% were considered, but did not qualify, 2.5% declined clinical trial consideration).<br>Key results requiring improvement:<br>- pain monitoring tool not implemented as standard of care<br>- only 34.5% referred to PC during initial treatment with 4 additional PC referrals during management of recurrent, residual and metastatic disease - early palliative care referral process to be reviewed<br>- no written discharge summaries and follow up care plans provided to pts (GPS informed by frequent letters)<br>- only 50% of audited pts had a formal record of advanced care discussion, 43% had advanced care plan in place- advanced care discussion and planning process to be reviewed.<br>Over the next few months key activities include:<br>- improve consistency of and early referral to ALO service through automatic reports of new ATSI outpts<br>- Implementation of supportive care needs screeening with Supportive Care Needs Assessment Tool for | Engagement with Cancer Supportive Care team to increase support provided to Aboriginal and Torres Strait Islander clients. | Cancer supportive care team - lead by CNC |
| Examine how we incorporate the needs of ATSI patients | Aboriginal and Torres Strait Islander Consumer Reference group member is on the CCRG. This allows for reliable communication and representation.<br>All pts are asked if they identify with ATSI. Some do not disclose this.<br>Admin response (Caroline):<br>Commitment to identify new pts; Med Onc: the team ring new pts and go through the ACTPAS demographic information to try to ensure we identify all ATSI pts. Previously this was only done through the NEW PT REGISTRATION form which was completed on arrival for the first appointment. Joyce and her team are able to access this information. (Caroline)<br>The ALO will be involved in care and supporting the pt and family . The ALO can attend with the pt L2 for consults and L4 for education and treatment. Clinicians identify ATSI pts as receiving the same high quality care as all other pts. THere are additional supports in place for this vulnerable group however.<br>-do have a dedicated room in B1 for ATSI pts<br>-ATSI elders open the ward when new<br>-often will try to have courtyard facilities that encorporate the needs of ATSI pts | | | | |
| Propose changes | Optimal Cancer Care Pathway for ATSI people Implementation Plan V1.0 1/5/20 - see Q drive<br>based on OCP for ATSI people map and gap analysis from 14/3/19<br>Additional to this Toni Ashmore is dveloping ATSI and cultural diversity EOL material. | | **Audit results**<br>○ Out of the 12 audited patients who deceased during cancer treatment at CRCC, 10 patients had been referred to palliative care (83.33%), 1 patient (8.33%) refused any further treatment towards end of life, 1 patient (8.33%) died with unknown details -> palliative care referral is generally in place for patients nearing end of life<br>○ GPs of all audited patients (100%) were regularly informed by letter detailing the diagnosis, treatment plan and decisions, including multi-disciplinary team meeting outcomes, treatment progress as well as medical treatment summary and follow-up care plans<br>16 ACT Canberra Health Services | **Audit results requiring improvement**<br>Key results requiring improvement<br>• Improve consistency of early referral to ALO service, especially during initial referral and investigations, diagnosis, staging and treatment planning phase.<br>• Only 7.5% of the audited patients had supportive care needs formally assessed with a tool and recorded -> Improve supportive care needs assessment process and support.<br>• Majority of audited patients no formal record in regards to clinical trial discussion/eligibility (10 % of audited patients participated in a clinical trial, 5% were considered, but did not qualify, 2.5% declined clinical trial consideration).<br>17 ACT Canberra Health Services<br><br>**Audit results requiring improvement**<br>Key results requiring improvement<br>• Pain monitoring tool not implemented as standard of care<br>• Only 34.5% referred to palliative care during initial treatment with 4 additional palliative care referrals during management of recurrent, residual and metastatic disease -> early palliative care referral process to be reviewed<br>• No written discharge summaries and follow-up care plans provided to patients (GPs informed by frequent letters)<br>• Only 50% of audited patients had a formal record of advance care discussion, 43% had advance care plan in place -> advance care discussion and planning process to be reviewed<br>18 ACT Canberra Health Services | **OCP for Aboriginal & Torres Strait Islander people Implementation – Next steps**<br>Key implementation activities planned over the next few months:<br>• Improve consistency of and early referral to ALO service through automized reports of new Aboriginal & Torres Strait Islander outpatients<br>• Implementation of supportive care needs screening with the *Supportive Care Needs Assessment Tool for Indigenous People* (SCNAP-IP)<br>• Commence "Clinical handover of patients who identify as Aboriginal and Torres Strait Islander in Cancer Services" project (providing supportive care discharge letter to GPs, 2 year research project)<br>19 ACT Canberra Health Services |
| **Education and Training** | | | | | |
| Collate list of required training for nurses to administer anti-cancer medications | **Medical Oncology Inpatients:**<br>ADAC modules 1-7. ADAC 1-4 EN's. ADAC annual refresher. Oral chemo competency.3 week training B19 L4.<br>**Haematology Inpatients:**<br>Same as Med Onc Inpatients<br>**Haematology and Med Oncology Outpatients :**<br>New nurses:<br>•CHARM training<br>•eviQ ADAC 7 modules for chemo<br>•IV cannulation<br>•CVAD, IDC<br>•Blood Safe<br>•Face to face chemo safety + precautions<br>•ADAC 2 for CHARM use and protocols<br>•Individual ongoing assessments based on drug properties starting with neutral, then irritants, irritants with vesicant properties, finally vesicants ( of ADAC 2 + CHARM)<br>For experienced staff or those from other facilities with experience annual assessments including :<br>•CHARM training<br>•eviQ ADAC reassessment module<br>•IDC<br>•PICC, IV, access reassessed<br>•Management of extravasation<br>•Assessment of handling and knowledge of chemo. Staff member picks a CHARM protocol and quizzed on all elements of this.<br>New Graduates:<br>•Supernumerary in many respects.<br>•IV cannulation (taught in house - only area endorsed to train/ assess outside SDU)<br>•CVADs, IDC<br>Commence with blood and blood products moving through to more complex infusions/ administration (individual | | | | |
| Investigate process for medical officer training/ credentialling for prescribing & administering anticancer meds | **Haematology**: need to be on a training prgram (advanced trainee in haematology) to prescribe anticancer meds. Some RMOs may transcribe from CHARM to EMM but are never allowed ot prescribe oral anticancer meds. EMM is the system for admitted patients medications. Only the level of an AT can order and this only with the Consultant's approval. BPT cannot. Pharmacy unlock CHARM for those approved to prescribe.<br>Need to be on a training program as an AT in Heamatology to prescribe.<br>**Med Onc:**<br>MOs will need to be in the medical oncology advanced training program to prescribe anticancer medication. Medical officers also undergo CHARM training with Linda Taylor for familiarity with the software before prescribing. Medicine administration - follows as above - although the majority of medication administration is performed by nursing staff | | | | |
| Determine if only evidence based treatment is prescribed by MO's | Nursing: all report yes. **Haem and Med Onc Outpatients**: For rare tumours it may be necessary to use a different treatment however this is supported by a journal article and must be entered into CHARM. Yes: recent incident where a consultant wished to order a non standard treatment.Pharmacy would only upload the treatment protocol when evidence was provided.<br>All IUP must have evidence attached and then approved by the CAS Clinical Director before pharmacy accept the IUP for uploading into CHARM. Supporive medications in CHARM are being reviewed as part of updating all CHARM protocols. Supporive medications in MedChart hava a pharmacy review and are evidence based or queried.<br>**Haematology Medical**<br>Yes<br>there may be cases of treatment prescribed with a limited evidence base however this is minimal and found with pts who have had many treatments (as above) with relapses. Haematologists always put a comment in CHARM to validate choice of treatment so that this is available to pharmacy, nursing and other MOs.<br>**Med Onc Drs** | | | | |

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| Investigate how this is monitored and recorded and reported | CHARM protocols are monitored by the Oncology Pharmacists. The supply of medication comes from pharmacy hence this is trackable. All are captured either within CHARM or for supportive meds in MedChart. Any CHARM deviations are refused unless supplied with EB articles and approval from clinical director. Also have RISKMAN for adverse outcomes and M&M and rotating Med ONcology consultants for inpatients which allows for review of treatments. Haematology consultants regularly liaise with one another and also discuss cases in MDTs as does Med Oncology consultants.<br>**Med Onc:**<br>Written doucmentation with regular monitoring of treatment efficacy. toxicity and cost-benefit assessment. | |
| Review process for variations to EB treatment, detailed consent & escalation process | As above. Variations in defined treatments in CHARM require an IUP as detailed above. The patient has to sign a consent form which is then put into CHARM. Any variations on a NIMC are not dispensed by pharmacy and escalated to the CAS clinical director.<br>**Haematology Medical:**<br>Team discussion and discussion with pt.<br>Inpts: all are presented at a Tuesday clinical meeting. All pts are discussed and a plan taken forward. Some MDTs eg Leukaemia and lymphoma but not for myeloma as the disease follows a standard pattern and does not vary therefore there is not a need. The Haematology team have a "ward service model" where a consultant is rostered on for 2 weeks to look after all haematology pts. This ensures different specialists review each pt and their treatment and variations to this are discussed.<br>Outpts: variations in treatment may or may not have a group consultation. However consultants do regularly discuss pt treatments infomrally during clinics as they are a tight team and collaborate regularly. | |
| Review pharmacy skill mix to safely & competently provide pharmacy r/v. compounding & dispensing | New roles and responsibilities. Enhanced team. Clearer boundaries for technicians. Appointment of a lead cancer pharmacist with overall accountability for the service to cancer pts and who provides clinical, professional and strategic leadership for staff. Finalise training programs, prepare and maintain SOPs, develop KPIs. Review and expansion of the technical workforce. and administration assistants. Business case for improved resourcing across the service and to allow for staff absences. The Senior Cancer Pharmacist and Dept Director of Pharmacy (Clinical and Operations) to implement a training program for all pahrmacists/ technicians in cancer care that includes education and training, supervision, ongoing mentorship and regular assessment of competency. | |
| Ensure safe disposal practices of anticancer medications & how this is reinforced | Nursing<br>**Medical Oncology and Haematology** Inpatients:<br>-Chemotherapy safe handling is one of the courses staff must complete through EVIQ ADAC modules as well as practical demonstrations during orientation<br>-Safe disposal is governed by policy and evidenced based practice<br>-Unsafe practice is identified, and education provided<br>-Any disposal of unused chemotherapies is handled by the oncology pharmacy (unused stays untouched and sent back; used is put into a specially marked box and sent back to B19 L3.<br>**Haematology and Med Onc Outpatients**<br>•Anticancer meds are disposed of into a purple bin which when full is segregated in dirty utility room.<br>•Unused anticancer meds are sent back to pharmacy L3 B19 using a specific esky with spill kit packing.<br>•Anticancer are delivered to the treatment room on L4 B19.<br>•Sorted by 0730hrs nurses into maxi bins with all supportive meds for each pt.<br>•Chemo precautions + handling following guidelines<br>Oral chemo for trials which is not administered is sent back to pharmacy.<br>**L2 and Rad Onc**<br>•Purple bins for antineoplastic meds and equipment<br>•Yellow bins for all others.<br>•Zoladex standard bin.<br>**Haematology**<br>Yes<br>**Med Onc**<br>Majority of these aspects eg Riskam are covered in the General Medical Officer Hospital orientation<br>**Pharmacy**<br>Follow the same practices mandated by the hospital policies. Staff are trained and have additional training when they come to CRCC and safety is always impressed on pharmacists. No need for reinforcement as L3 Pharmacy is open and practice can be easily observed if needed. | |
| Ix ongoing training needs assessment & formal training plans in place | Nursing<br>**Medical Oncology Inpatients**: ongoing education, currently in process of making formal list of yearly refresher due dates for curent chemo trained nurses, inservices on safe handling, feedback from staff if they need more.<br>**Haematology and Med Onc Outpatients**:<br>As above .<br>**L2 and Rad Onc**<br>Annual refresher will be required: ADAC refresher and annual competency.<br>**Medical Oncology:**<br>Assessment of training needs and training plans as per the RACP college guidelines.<br>**Haematology Medical:** Training needs are assessed and planned as per college requirements. Specific training regarding drugs on clinical trials occurs at the time of trial commencement. | |
| Ix scope of orientation to include disposal cytotoxics, having difficult conversations with cancer pts | Nursing<br>**Medical Oncology & Haematology Inpatients**:<br>-Safe handling of chemotherapy (incl; disposal of contaminated waste, handling of medications, patient education etc)<br>-We talk about difficult conversations and the role of different people within the MDT (not a formal education topic)<br>-We talk largely about team work on the ward and working collaboratively within the MDT<br>-Safe administration is not covered in orientation as new staff will not be administering chemotherapy; they are however educated on what to do when it is identified that their patient is due for chemotherapy.<br>-Staff are educated about supportive therapies as it is commonly their role to administer them (non-cytotoxic supports such as antiemetics following chemo administration)<br>-Depending on where staff have come from, they are offered education on the use of our IV Braun Pumps and Syringe drivers<br>-Riskman is not formally covered but is one of the education items in the list of essential education that staff are provided with during orientation<br>**Haematology and Med Onc Outpatients:**<br>All staff do hospital orientation which covers Riskman and CPF<br>•Yes – disposal of cytotoxic meds<br>•Difficult conversations – often ongoing skill development with mentoring. SDU course not mandatory.<br>•Yes – collaboration<br>•Yes – safe admin and maintenance<br>•No – B Braun pumps. Found to be unsafe as protocols very complex and pumps do not have the sophistication for this. Instead 2 x chemo trained RNs check protocols and administration dose/ time/ route etc and do separate calculations to ensure comprehensive checking<br>All staff who are preceptors have completed formal training. All junior staff are preceptored until deemed competent which may be 6/52 -6/12.<br>**L2 and Rad Onc:**<br>•Disposal – yes | |
| **Protocols** | | |
| Determine what systems are currently being used to prescribe treatment protocols | CHARM for anticancer meds; MedChart for supportive meds; NIMC for outpatient areas in some instances<br>See CHARM protocol tempate - interim individualised protocol (eNote) and Protocol template CAS in Q Drive<br><br>Occassionally supportive medications eg antiemetics, or corticosteroids for immune mediated side effects are prescribed on paper charts for administration in Rapid Assessment Unit<br><br>Pharmacy: Only accept paper charts in an emergency | |

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| Establish the safety of these | Biggest safety gap is keeping the information in CHARM up to date. This includes pt informaton (wt and ht) and the prescribing pathways. No committee responsible for CHARM- Linda as administration manager and Medical Officers, Nursing and Pharmacy review protocols.<br>Merlin is a dispensing and inventory management software and occassionally produce labels from this. Merlin management oversee Merlin operations, security and maintenance.<br>BCP for MedChart as backup if system goes down.<br>CHARM has system administrator for backup | | The consultant/ AT is called directly before administration to confirm if the full dose is to be given or a lesser dose.<br>Pharmacy print the CHARM protocol, (only pharmacy can print) and it has a log of how many charts are printed so nurses know which is the most current. this provides safety. 2 chemo RNs check the protocol and pt details and drug provided by pharmacy which reduces risk of error. They also check pathology separately and enter it daily onto the printed protocol.<br>Pre meds are in CHARM which can only be given by the CHEMO RN on the ward.<br>We have a Chemo email for inpatients and one for outpaitents to ensure instructions have not been changed and to review the latest communication from a consultant.<br>Rescue drugs are prescribed on MedCHart and documented in the handover sheet wich is safe to remind staff of administration requirements and timeframes.<br>CLinical verification of the order and protocol is completed by pharmacy prior to the protocol being printed and released. |
| **Riskman Review** | | | |
| Review CAS riskman data for last 12 months | As reported in the Oncology Pharmacy Working Group: Kate O'Hara and Robyn Coble pulled a Riskman report to identify error prone areas, systems and processes that required remediation or treatment protocols. It was noted in the 24/9/20 meeting that there were no areas of obvious concern | | Medication Riskman from October 19 - Sept 2020. 98 incidents. 4= notice; 68 = insignificant; 24 = minor; 2 = moderate<br>See document of themes. Data given to ADON and DON CAS |
| Ix CAS process for Ix incidents & process for improvement | Nursing<br>**Medical Oncology and Haematology Inpatients:**<br>Receive relevant Riskmans for 8B. Address any ward issues that arise from them.<br>Complete Riskman when incidents occur.<br>**Haematology and Med Oncology Outpatients :**<br>These are discussed in ward meetings.<br>•CNC receive the Riskman and may discuss at monthly RN meeting if deidentified and appropriate. This may help in mitigating measures to stop this happening again<br>•1:1 follow up<br>•Patients may be involved<br>**L2 and Rad Onc:**<br>Staff meetings to improve service.<br>**Haematology Medical:**<br>Investigated by allocated consultant, discussed with team, recommendations and improvements discussed and implemented.<br>**Medical: Oncology:**<br>Investigated by allocated consultant, discussion in monthly Morbidity and Mortality meeting if appropriate.<br>**Pharmacy:**<br>Depends on the classification as to whether this goes to Kate or another lead pharmacist. However it is acted upon. If it is unavoidable then this is established. if it is part of a process this is reviewed for improvement and lessons learnt. Follows same process as required hospital wide. | | |
| **Audit of Safety & Quality Indicators** | | | |
| Investigate if regular review and reporting of clinical practice | **Haematology Medical:**<br>Via MDTs for some cases.<br>Auditing of Riskman. Paul Craft investigates incidents with Haematologists. CHARM has a traceable and transparent record which is monitored by pharmacy and available to all the treating team to read.<br>Tuesday clinical meeting review practice for inpatients.<br>Outpatients: more casual reporting of practice however regular conversations between consultants occur on Level 2 in clinics about each pt and their treatment regime.<br>**Medical Oncology:**<br>Periodic review of CHARM treatment protocols by consultants in relevant sub-specialties | | Nursing with Hospital based audits (TopCat) etc |
| Investigate if regular review and reporting of prescribing patterns in accordance with Advance Care Plans, anticancer meds within 30 days of dying, Mx SE's | **Haematology Medical:**<br>Yes. Fortnightly ward services model. Tuesdays clinical meeting. Pallicative Care attend when they can (staffing issues may be a barrier). COT (Outpt service home based) attend the Tuesday meeting and discussions include current treatment and requirements for close monitoring.<br>**Medical Oncology:**<br>Weekly ward meeting reviews advanced care plans including cytotoxic treatment plans for relevant pts.<br>Individual clinician based review of anticancer medication side effects, although severe adverse events (eg febrile neutropenia resulting in intensive care hospitalisation) will also be reviewed in monthly Morbidity/ Mortality meetings as part of audit. | | |
| Investigate if regular review and reporting of compliance with CAS policies and procedures | Policies and procedures are reviewed regularly as determined by the CHS Policy Committee.<br>Compliance is a new feature under 'evaluation' for new policies/procedures and when they are reviewed. This is an organisational decision and approach.<br><br>Pharmacy follow hospital processes. Dont seperately audit currently - like other services. | | |
| **Policy** | | | |

| Action | Findings | Status | Notes / Links |
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| Identify current policies on policy register related to CAS med mx | 1. Medication Fridge Temperature Monitoring Procedure<br>2. Medication Handling Policy<br>3. CHARM Protocol Management Clinical Procedure<br>4. Chemotherapy: Care of the Adult Patient (eviQ)<br>5. Cytotoxic Precautions (Inc Epirubicin Instillation): Cytotoxic Precautions of the Adult Patient in the Perioperative Unit<br>6. Intrathecal Chemotherapy Administration including Lumbar Puncture (Adults)<br>7. High Risk Medicines Policy<br>8. Cancer and Blood Disorders - Care of Paediatric Patients (infants, children, adolescents)<br>9. Accessing, De-Accessing and Changing VASCATHS/GamCaths and "Combi" stopper Change for Apheresis (not for haemodialysis) - Adults only<br>10. CVAD Management - Children, Adolescents, Adults (not Neonates)<br>11. WHS Policy<br>12. Cancer Multidisciplinary Meeting<br>13. Management of Patient Pathways within CHARM<br>14. Medication Fridge Temperature Monitoring<br>15. CHS Approved External Website for downloading and printing handouts for consumers<br>16. Clinical Handover procedure<br>17. Haematology Shared Care - your treating team<br>18. Informed Consent policy<br>19. Open Disclosure procedure<br>20. Credentialing and Defining the scope of Clinical Practice for Senior Medical and Dental Practitioners procedure<br>21. Supervised Practice - Enrolled Nurses, Registered Nurses and Registered Midwives Guidelines<br>22.Credentialling and Defining the Scope of Practice for Allied Health<br>23. Consumer and Carer Participation in ACT Health policy<br>24. Waste Management Policy | | Medication Fridge Temperature Monitoring Procedure.docx<br>https://actgovernment.sharepoint.com/:w:/r/sites/intranet-health/PPR/Policy and Plans Register/Medication Handling Policy.docx?d=w2c43968a9e6d40efac7aa39ce626d1e9&csf=1&web=1&e=9undJb<br>https://actgovernment.sharepoint.com/:w:/r/sites/intranet-health/PPR/Policy and Plans Register/CHARM Protocol Management.docx?d=w4438f77983a942a1a63ae5131cbc42ef&csf=1&web=1&e=0LePFe<br>https://actgovernment.sharepoint.com/:w:/r/sites/intranet-health/PPR/Policy and Plans Register/Chemotherapy Care of the Adult Patient (eviQ).docx?d=wed369ae8b1df4a14a828c7a697291174&csf=1&web=1&e=njVMrl<br>https://actgovernment.sharepoint.com/:w:/r/sites/intranet-health/PPR/Policy and Plans Register/Cytotoxic Precautions (inc. Epirubicin Instillation).doc?d=w5d55172161874a51a5fec381764066ea&csf=1&web=1&e=moaaNA<br>https://actgovernment.sharepoint.com/:w:/r/sites/intranet-health/PPR/Policy and Plans Register/Intrathecal Chemotherapy Administration.doc?d=w3702e5b42c9947f1a07699dd47c8d04c&csf=1&web=1&e=ied3Lk |
| **Consumers** | | | |
| Investigate current informed consent practices for anticancer and supportive meds | Nursing<br>**Medical Oncology and Haematology Inpatients:**<br>-C1D1 patients receive a full education session prior to administration.<br>-Patients are frequently asked if they have any questions<br>-Patients are provided with extensive education materials<br>-Patients are educated around chemo safe handling<br>-Where possible patients are educated with a family member/carer present<br>-Prior to administration, chemo staff always confirm/site that a written consent has been done by the team<br>**Haematology and Med Oncology Outpatients :**<br>This is mostly implied during education sessions. Consent is always checked before chemo administration.<br>PICCs- consent is done by RNs for this. MOs are always contacted to advise this is needed or MOs may ask RNs to insert this. •The consent form is scanned into CHARM.<br>•Consent is documented by medical officers<br>•Nurses check the consent aligns with the protocol as consent is often quite specific to the protocol and not generic.<br>• If there is no consent – nurses cannot proceed with administration<br>Any issues with consent are addressed. RN always documents the pt has agreed to a procedure before it is carried out.<br>**L2 and Rad Onc**<br>•Education covers consent however much of the consent process resides with medical officers in the first instance<br>•Consent is visualised in CHARM.<br>**Haematology Medical:**<br>Consnet form singed. Interpreter for non english speaking. all pts need consent before they can have treatment. Medical officers determine capacity and call in help if they feel capacity is not obvious.<br>**Medical Oncology:**<br>Written consent is obtained for all cytotoxic therapy. Nursing staff aid in cross checking; consent is scenned in CHARM document prior to treatment commencement. Interpreters used for non-English speaking pts.<br>Treating MOs assesses pt's capacity for consent, and if concerns, seeks additional consultation eg clinical ethics | | |
| Investigate how open disclosure works in CAS | Nursing<br>**Medical Oncology and Haematology Inpatients:**<br>Including patients in their care. Inform patient and medical team if an error is made<br>No data to prove this but Riskman and medical notes would indicate how often it is done.<br>**Haematology and Med Oncology Outpatients :**<br>If a problem/ error occurs the patient is advised, the MO is informed and a Riskman is filled out. Pts are also give a Patient feedback form to complete however this is anecdotally not often completed by pts.<br>•Staff encouraged to complete the eLearning<br>•All RNs encouraged to be as open as possible<br>**L2 and Rad Onc**<br>Encouraged and done<br>**Haematology Medical:**<br>This is practiced<br>**Medical Oncology**<br>Observed as practiced<br>**Pharmacy**<br>No incidents recently requiring this. Usually the senior pharmacist involved in the process or a consultant if the | | |
| Ensure consumer representation on CGC +/- med mx group | Schedule 2.2(a)(ii) is on CGC. | | Open Disclosure training is being rolled out across the organisaiton and eLearning is available.<br>CGC and CCRG with consumer representation. Nil else needed<br>Do follow the Consumer and Carer Participation in ACT Health Policy |
| Determine if in home cancer care (not palliative) has a reporting mechanism + if any incidents in the last 12 months | **Medical Oncology and Haematology Inpatients:**<br>dont know<br>**Medical Oncology and Haematology Inpatients:**<br>none for medical oncology.<br>**Haematology and Med Onc Ouptatients:**<br>•COT – generally supportive care only<br>•May do sub cut chemo<br>•Reports to CNC but no issues in the last 12 months<br>•The scope of COT may increase in the future<br>**L2 and Rad Onc:**<br>N/A<br>**Haematology Medical:**<br>Incidents logged in Riskman. COT weekly presentation on Tuesdays. COT CNC, Ward CNC, all consultants, advanced trainees and Allied Health attend | | |
| Ensure there is a mechanism for treatments given in the home performance + risk reporting | COT - Haem pts. Treatment and assessment and scheduling nursing care required + observations + advice + follow up. Riskman for incldents however noted to be limited (as per Sally) | | |

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| Identify how clinicians involve pts/ family in plan, goal setting, communication, making decisions for now and the future | Nursing<br>**Medical Oncology and Haematology Inpatients:**<br>Family meetings<br>Bedside handover<br>Family meetings are organised, Ward consultant talks to all patients daily<br>**Haematology and Med Oncology Outpatients :**<br>Encouraged to attend all appointments in clinic and treatment.<br>•Goal setting is a consultant responsibility<br>•Mostly done in clinics<br>•RNs do include family.<br>•Where a pt is dropped off for treatment the RNs do contact the family through the day to update on progress if appropriate **L2 and Rad Onc:**<br>•Comprehensive appointment for one hour. Involves family and treatment options in Rad Onc.<br>Family members are welcome at appointments for support and education.<br>**Haematology Medical:**<br>Discussons at appointments<br>**Medical Oncology**<br>These issues are discussed at clinic consultations, and family meetings are arranged especially for ward pts for treatment planning. | | | |
| Analyse how pts/ families/ carers participate in MDTs | Nursing<br>**Medical Oncology and Haematology Inpatients:**<br>Attend family meeting which are MDT<br>At bedside, and family meetings.<br>**Haematology and Med Onc Ouptatients:**<br>There are family meetings on wards.<br>Outpatients follow a path of being seen in the clinic (+/- CSM). Where treatment changes discussions for treatment is done after a PET and with a CSN. (but not in MDTs).<br>**Haematology Medical:**<br>No but hte discussion is fed back to them.<br>**Medical Oncology:**<br>No, but pts are informed of the discussion outcome. | | | |
| Determine if patients receive a copy of the treatment plan or comprehensive care plan | **Medical Oncology and Haematology Inpatients:**<br>Chemo protocols are given, care plans are not<br>**Haematology and Med Onc Ouptatients:**<br>Yes - eviQ and comprehensive. From CHARM. Termed more a treatment plan rather than a care plan. It is in plain english. •They are given consumer appropriate information from eviQ<br>**Haematology Medical:**<br>The EVIQ protocol is given to the pt which is comprehensive. Addiitonal material and information related to the treatment is given by the CSN and chemo nurses before treatment. For a "one off" treatment: the pt may not receive the treatment plan however they receive education. These pts may receive material from companies who produce informaton for "novel treatments".<br>**Medical Oncology**<br>Pts on treatment are routinely given an EVIQ protocol handout of their regimen.<br>**Pharmacy**<br>Inpatients - discharge summary which includes supportive meds. Chemotherapy is not included in the list (may be in the summary of care given as an inpt).<br>Outpatients - list comes from L4 usually post nurse education session. Pharmacy educate based on this list +/- one that the patient may bring from home for supportive meds/ comorbidity meds.<br>Pharmacists always check the meds are safe (dose/ interactions etc) and may check with local pharmacists if appropriate (not commonly). | | | |
| Review how pts with poor health literacy are supported | Nursing<br>**Medical Oncology and Haematology Inpatients:**<br>-Education sessions are tailored to each individual patient.<br>-Staff always try to ensure that patients have appropriate people present during education<br>-Patients have access to MDT's such as social work and psychology<br>-Any concerns are escalated<br>**Haematology and Med Onc Ouptatients:**<br>Information from nursing diary. Cancer council has resources which is provided to pts to support them. Drug companies also have patient friendly information that supports health literacy. A support person is always asked to attend education sessions to assist with information sharing and understanding. Additionally CSNs and SW regularly maintain contact with pts and explain / educate. Family/ Carer and nurse speak in a non confrontational way. •This is captured in patient education sessions.<br>•Nurses tailor their education to suit the patient/ family.<br>•Use translators as needed<br>•Only nurses who have completed all their eviQ training and assessments detailed above provide education to patients. These are fully competent nurses who may have a less experienced nurse attend a session for training purposes.<br>Some do not always comprehend the information given by doctors. RNs can explain if appropriate. (Monica Gagel-conducted a QI on how we educate pts and this may shed light on health literacy.<br>**L2 and Rad Onc**<br>•CSNs play a key role in bridging any gaps<br>•Education is tailored by nurses on L2 and in Rad Onc to the level of the pt<br>**Haematology Drs:**<br>MOs determine capacity and call in help if they feel capacity is not obvious<br>**Medical Oncology Drs:**<br>Treating MOs assesses pts capacity for consent, and if concerns, seeks additional consultation eg clinical ethics committee | | | |
| **Information Technology** | | | | |
| Investigate current IT med mx systems (CAS/ Pharmacy/ Suppliers/ EMM) | CHARM. MedChart. Merlin (imprest and ordering) | | | |
| Investigate suitability | CHARM appropriate for anticancer medication protocols. Not good for integration with other systems eg EDIS if pt presents to ED. Does not integrate with MedChart either, Noting that a DHR is proposed for ACT Health mid 2022. This may replace much of CHARM however this needs to be clearly establshed. | | Transition to DHR - pathways for oncology care still being developed. | |
| Determine integration of CAS IT system and future works | As above. EPIC is the new DHR and CRCC along with Pharmacy need to work with the Vendor and DSD for integration of CHARM or replacement. + ARIA integration | | | |
| Explore DHR progress & impact on CHARM and others | Too early to determine. CRCC had been involved in the procurement process however not clear what EPIC can do and what it cannot do. Some work with Vendor scheduled for 2021 | | | |
| Analyse 14A and 8B EMM process for printing for outpt appts | **8B - don't print charts. Everyone has access to EMM and Patientrack.**<br><br>14A - yes do print off MedChart and Ptrack for outpt services. This is generally OT and gastro. | | | |
| Check Rad Onc use of EMM and Patientrack for inpatients | This had not been done well. ADON has reviewed MoC which was never endorsed and work being done to update then endorse MoC by Julie O'Rourke. Patientrack and MedChart had not been used despite staff being trained and the provisioning of COWs for access. Staff are now being requested to use Patientrack and MedChart for inpatients to ensure continuity of patient care and to reduce hybrid systems which introduce risks. | | For review with team and follow up - this has been improved since initial report completion. | ADON to provide feedback by 30/8/2021 |
| Assess how the "record of care" + "discharge summary" is uploaded to My Health Record where MHR is in use | CHARM and ARIA send a number of different document types to CPF including progress notes, and discharge summaries. HIS also manually scan all hardcopy CAS inpt records that they receive into CPF. | | | |

| Criteria | Findings | Status | Comments |
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| Determine if there are paper based systems in prescribing treatment protocols & the mx of cancer care | Nursing<br>**Medical Oncology and Haematology Inpatients:**<br>When they come from ED or RAU - not chemotherapy.<br>**Haematology and Med Onc Ouptatients:**<br>Occassionally for supportive meds never for chemotherapy.<br>yes for supportive medications<br>**L2 and Rad Onc**<br>•Can be in Rad Onc<br>•EMM being accessed more for inpatients attending Rad Onc<br>Inpatients do not visit B 19 L2. All meds are in CHARM.<br>**Haematology Medical:**<br>Only when the pt is given a drug via a script.<br>for a limited number of pts described above who relapse after many courses and may have an IUP that is a one off. This is closely monitored and updated by hand as the pt progresses through treatment.<br>**Medical Oncology**<br>Occassionally for supportive medications eg antiemetics or corticosteroids for immune mediated side effects for administration in the Rapid Assessment Unit<br>**Pharmacy**<br>Paper charts are only accepted in an emergency and this is a CHEMOTHERAPY chart not the NIMC. Note: Individual pathways are added to CHARM as quickly as possible so only one dose is given off a paper chart.<br>Example of an emergency where paper chart accepted for chemo: ICU pt with rare HIV tumour where needed chemo STAT. It would take a couple of hours to build the protocol in CHARM and this did not meet timeframe. Pharmacy used Chemo chart as a result. Likely < 5 per year of instances such as this. NOTE: there is an issue in that chemo is ordered on chemo charts for pts of other specialties eg urology in OT, nephrology, paeds, opthalmology. These specialties which sit outside CRCC dont have approved access to CHARM. This was a decision made by CRCC hence paper charts used and chemo dispensed by Onc Pharmacy. A bit of an anomoly however will be addressed | | |
| **Heatlhcare Record** | | | |
| Investigate if drs/ RNs/ Pharmacy need to enter duplicate data for prescribing, dispensing and adminsitration in different data bases | Nursing<br>**Medical Oncology and Haematology Inpatients:**<br>-Nursing staff who have administered IV chemotherapy must document in both the patients progress notes and on CHARM (in the inpatient setting)<br>**Haematology and Med Onc Ouptatients:**<br>no<br>**L2 and Rad Onc**<br>There is no integratio between CHARM and ARIA so this may result in duplication.<br>**Haematology Medical:**<br>Sometimes ie when an inpatient<br>**Medical Oncology**<br>Sometimes for inpatients<br>**Pharmacy TBA**<br>Yes- information in CHARM needs to be entered into Merlin if produced/ compounded by CRCC pharmacists. Ideally this should not occur | | |
| Establish if protocols can be altered without approvals or detection | no | | Only CHARM pharmacist can modify protocols |
| Explore access to protocols & who has this | CHARM protocols: AT, consultants, chemo nurses, CRCC nurses, pharmacy. | | |
| Assess if pathology and pt data is quickly available to staff | Nursing<br>All responded with yes<br>**Medical Oncology:** yes<br>**Haematology:** yes<br>**Pharmacy**<br>acceptable but not optimal. Do transcribing into CHARM from pathology when chemotherapy doses are released to | | |
| Investigate if BSA & renal clearance is automatically calculated | Nursing<br>**Medical Oncology and Haematology Inpatients:**<br>-It will be filled in by pharmacy on the CHARM order but staff during a chemo check will do the calculations independently<br>(more for pharmacy to advise if it is automatically calculated. Nurses always do their own checking independent of what pharmacy put in)<br>**Haematology and Med Onc Ouptatients:**<br>Yes in CHARM<br>•BSA and renal clearance is written on CHARM chart by pharmacy.<br>•The CHARM protocol is not made available unless the patient's renal clearance or other necessary test results (i.e. neutrophil count, GHPS) have been provided.<br>•Nurses always check prior to administration for a recent height and weight but only recheck it if there is a recent hx of anorexia or weight gain related to symptoms. Nurses calculate the BSA and drug calculations together against CHARM chart.<br>•Bloods for renal clearance should be taken in the last 2 days.<br>•Medical staff may advise nurses to still administer despite a pathology result being outside the acceptable eviQ range or chemo dose outside of calculated parameters. However nurses always must check abnormal pathology results and dosage with doctors and have the Drs approval to go ahead with treatment documented in CHARM. Pharmacy add this and RNs always check these prior to administration.<br>**L2 and Rad Onc**<br>•Nurses manually calculate to check the dosage in CHARM. This is done immediately prior to administration at the bedside. **Haematotolgy Medical:**<br>Yes<br>**Medical Oncology:**<br>Yes | | |
| Determine if programs have an automatic dose calculation check and safety prompts if prescribed dose differs | Nursing<br>**Medical Oncology and Haematology Inpatients:**<br>CHARM charts/notes will usually always have an explanation from any deviation from protocol<br>-Staff will do independent calculations when checking chemo and have access to different calculators on the EVIQ website **Haematology and Med Onc Ouptatients:**<br>•Medical officers chose the protocol in CHARM or uploaded into CHARM<br>**L2 and Rad Onc**<br>No<br>**Haematology Medical:**<br>yes<br>**Medical Oncology:**<br>yes<br>**Pharmacy**<br>Yes. CHARM protocols are built and doses cannot vary outside these. MedChart has some features that alert to prescribed doses. | | Yes in CHARM. |
| Investigate if inbuilt safety alerts & prompts to reduce the likelihood of meds or treatment booking related errors | Nursing<br>**Medical Oncology and Haematology Inpatients:**<br>-For oral chemotherapy there is a safety alert on EMM, and a co-signature now required.<br>-CHARM charts will usually have clear documentation of any deviation from protocol (Eg; dose reduction)<br>**Haematology and Med Onc Ouptatients**:<br>CHARM prompts inserted by pharmacist. Protocols mandated by eviQ or evidence.<br>•RNs cannot change the protocols. They are locked.<br>•RNs do not check anticancer meds if a second nurse is not available.<br>•B Braun library not used<br>**Pharmacy**<br>Not in CHARM or MedChart . Dosing alerts both have. | | MedChart does have dosing alerts |
| Establish if there is a committee responsible for development, operation, security & maintenance of electronic documentation systems | MedChart- Medication Systems Hub. Merlin - Pharmacy. CHARM - system administrator and Clinical Director and Lead Oncology Pharmacist however current process and governance is under review (Sept 2020). The current decision making process is very clear with the clinical director Paul making decisive calls. Paul did not want more committees as there are too many already and the work can be covered in his role and Kate's role | | Other Governance structures in place:<br>DTC, Med Management Committee, DSD has Steering commitees which has oversight and reports back to the system administrators and the Med Hub of DSD<br>DSD also employ Chief Information Security Officer |
| **Contractors for Medicines** | | | |
| Ensure safety and quality responsibilities documented in contract | This was carefully developed and Slade abide by these. Also meet COSA requirements. | | |
| **Scope of Practice and Credentialling** | | | |

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| Review handover to community pharmacies for dispensing oral anticancer meds | Cancer meds provide by onc pharmacy<br>Community pharmacists are not involved in anticancer meds for medical oncology pts. They are responsible for supportive medications (a couple of doses may be given by CRCC only). Eg 1st doses of analgesia given at CRCC – then pt for follow up by GP who can then prescribe more and monitor usage.<br><br>.<br>When a patient starts oral chemotherapy and require a Webster pack, CRCC pharmacy work with community | | |
| Investigate how junior clinicians are supervised, credentialled or follow protocols | **Medical Oncology and Haematology Inpatients:**<br>-New graduate nurses are not chemo credentialed but must still complete ADAC 1, 2 and 4.<br>-Junior chemo staff are trained in building 19 for 3 weeks and then when they return to the ward are supported by their senior chemo staff as well as CDN and CNC<br>-When administering chemotherapy, they use evidence-based protocols and seek clarification from treating teams and pharmacy as appropriate.<br>**Haematology and Med Onc Ouptatients**:<br>As above.<br>From day 1 junior nurses start the above and are taught, supervised and assessed.<br>**L2 and Rad Onc**<br>L2 only have 2 protocols to work to but need CHARM access for this.<br>CDN assesses and reviews practice<br>**Medical Oncology**<br>Junior clinicians are supervised by staff specialist clinicians - direct supervision from the consultant which they are | | |
| Establish if there is a credentialling policy for doctors that defines scope of practice & requirements for effective supervision & support | **Haematology:**<br>Scope of practice for advanced trainees follows the college guidelines. All other medical officers are restricted in their practice given the high risk associated with treatments in oncology.<br>**Medical Oncology:**<br>Credentialing performed through The Canberra Hospital. Scope of practice for ATs follow college guidelines. | | |
| Pharmacy compounding: if done on site, assessment of practice | Observed senior pharmacist and another senior pharmacist doing checks of chemo before being released and also compounding.<br>-Don't make the chemo until the pt is here (cost and waste)<br>- 3 checks (scanned) by 2 pharmacists before 1 pharmacist goes into suitably designed facility (equipped, maintained) for 2 hour bracket max. Checked by another pharamacist before giving to RN<br>Full PPE, Isolation -ve pressure room with cabinet and 2 way cupboard for entry of medication into and out of the room. Hepa filters.<br>- all items wiped down with 70% alcohol before going in<br>- pharmacy education program in place which all staff abide by<br>- legible drug orders from CHARM and documentation from Slade typed<br><br>- Ht, Wt, BSA and blood counts etc are available for dispensed<br><br>Abides by COSA guidelines<br><br>**RECOMMENDATION:** Room for compounding has not been approved by TGA - is currently inspected by a specialist company every 6 months. Our room does not meet the standards to be able to apply for TGA approval. | | Rectification: Current plans for redevelopment of L3 (including pharmacy) will ensure compliance.<br>Construction due for completion by mid 2022. |
| Assess nursing knowledge for policies, COSA guidelines, required education | **Medical Oncology and Haematology Inpatients:**<br>-Part of their competency assessment is to show an understanding of accessing and utilising common protocols<br>-We currently use EVIQ for our assessments, protocols and supportive documentation (Eg; patient assessment tools prior to chemotherapy administration)<br>-Education materials for both staff and patients is also sourced form EVIQ<br>-Staff have easy access to the cytotoxic safe handling policy on the intranet<br>**Haematology and Med Onc Outpatients**<br>•Nurses use local policies in their day to day work and are familiar with accessing CHARM and the policy register<br>•Go above and beyond the COSA requirements. Rationale: there is evidence that monoclonal antibodies require much greater precautions as staff who handle these may develop hypersensitivity or resistance. A blanket rule was made that all staff wear PPE to ensure appropriate protection.<br>•CNSA – yes<br>•Safe handling – yes. Nurses must know what they are giving and appropriate handling and disposal practices. Unsure of practices across the hospital.<br>**L2 and Rad Onc**<br>•eviQ – meet the level required | | |
| **Evidence Based Care** | | | |
| Investigate if MDTs plan care | **Haematology Medical:**<br>yes<br>**Medical Oncology:**<br>Yes | | |
| Determine if clinicians follow current best practice guidelines, integrated care pathways, clinical pathway & decision support tools | Nursing<br>**Medical Oncology and Haematology Inpatients:**<br>yes<br>**Haematology and Med Onc Ouptatients:**<br>Yes<br>**Haematology Drs:**<br>Use these together<br>**Medical Ocnology Drs**<br>Do follow best practice guidelines, Evidence based protocols, pathways and decision support tools balanced by clinician judgement and pt preferences.<br>**Pharmacy**<br>CHARM protocols are being updated to align with evidence base.<br>MedChart have decision support tools.<br><br>Ongoing implementation and utilisation of OCPs for Cancer Care | | |
| Analyse if guidelines, clinician judgement and pt preference is utilised | Use these together - any variation to eViQ guidelines must be supported by evidence. | | |
| Document the approval process for protocols + demonstrate how currency is maintained | CHARM protocols are undergoing regular review. This process is used for Immunology, Medical Oncology and Haematology protocols. Protocols are reviewed by senior nursing staff, medical consultants and pharmacy. There are a number still overdue for review. | | Outstanding protocols are monitored through the Clinical Governance Committee. Medical Oncology - up to date, immunology - 26 overdue, haematology - protocols for 13 conditions overdue. |

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| Review how protocols (may) include compassionate access programs, medicines access programs + pt familiarisation programs | Options include:<br>Off Label Prescribing<br>1.'Off-label' prescribing occurs when a drug is prescribed for an indication, a route of administration, or a patient group that is not included in the approved product information document for that drug.<br><br>Unregistered drugs<br>Access to unregistered drugs is possible under certain circumstances in Australia. Patients can access unregistered drugs through:<br>2.Special Access Scheme (SAS). This allows for the importation and supply of an unregistered drug for an individual under the supervision of a medical practitioner. Circumstances where these drugs might be acquired are that they are experimental and are investigational products for terminally ill patients. Drugs that the patient has accessed as part of a clinical trial but is not yet approved by the TGA and drugs that are available overseas but not marketed in Australia.<br>3.Authorised Prescriber Scheme. This provides access for the prescriber to an unregistered drug for a patient group for a particular indication. Being under this scheme eliminates the need to seek individual approval.<br>4.Clinical Trials. Patients can be given unregistered drugs is they are participating in a clinical trial. The World Health Organization (WHO) definition for a clinical trial is<br>'any research study that prospectively assigns human participants or groups of humans to one or more health-related interventions to evaluate the effects on health outcomes.'<br>Clinical trial interventions include but are not restricted to:<br>•experimental drugs, cells and other biological products.<br>•cells and other biological products[2]<br>Clinical trials might also compare existing interventions, test new ways to use or combine existing interventions or observe how people respond to other factors that might affect their health (such as dietary changes).<br>5.Personal Importation. Individuals can bring into Australia medications, either on their person or shipped, from overseas. There are restrictions imposed by customs regulations that prevent some drugs from being imported for personal use. Drugs of abuse, growth hormones and antibiotics are some examples.) If the drug requires a | | |
| Assess if Individual Patient Use (IPU) protocols are restricted | IUPs have been presented to CGC for consideration. Proposal that IUP are to be proposed by consultant on CHARM chart with accompanying evidence and Clinical Director to endorse +/- peer review. Following this, CHARM pharmacist will enter into system. | | The pathways are given a 2-year review date from when they are activated |
| Analyse how clinical trials are offered to patients | In consultation with the medical team. Through medical staff and treating team. Outpatients: offered to any pt that may fit the criteria for a trial.<br><br>If they qualify and they would be a good candidate it is discussed with them. | | |
| Investigate if clinical trials have a Clinical Governance Framework | **Med Oncology:**<br>yes<br>**Haematology:**<br>yes | | |
| **Variations in Clinical Practice and Health Outcomes** | | | |
| Ensure that medication orders that differ to approved standard treatment protocols are prescribed on a prebuilt electronic form that includes supportive meds | CHARM; uploaded by pharmacy. | | |
| Consultants document nature of variation, provide EB references + rationale, include supporting meds, dose adjustments + treatment frequency | **Haematology Medical:**<br>Yes<br>**Medical Oncology:**<br>yes | | |
| Demonstrate IPU restricted | as above | | |
| Paper based systems are working towards an EMM | Inpts on CHARM and EMM. Outps on CHARM and NIMC. DHR will replace EMM and NIMC | | |
| A periodic review of compliance occurs and report to CGC | Compliance is monitored by Pharmacy when using CHARM protocols. Any deviations are carefully monitored and rare. Do need to be approved by the Clinical Director of CAS. | | |
| **Medication Safety** | | | |
| Analyse the current medication review process in cancer | Recently reintroduced pharmacists to the wards for all inpts. Medication reconciliation occurs with MedChart for inpatients. Pts on chemo are reviewed first then those not on chemo.If pharmacist # are reduced, non chemo pt reconciliation is not done until the next day.ICU pts on Metavision have reconciliation completed within the Metavision system.<br>All outpt medications are reviewed by Pharmacy however medications for chronic conditions are not reviewed always<br>Clinical verification occurs- for CHARM protocols prior to dispensing | | |
| Identify who undertakes review process + what happens if discrepencies identified | Can be an intern pharmacist reporting to a registered pharmacist or the ward pharmacist undertakes this duty.Discrepencies have been found and are taken to the MO's for correction and discussion. Documented in MedChart and EMM - field to demonstrate pharmacy review has occured. | | |
| Explore what med info is provided to pts, when and by who | **Medical Oncology and Haematology Inpatients:**<br>Chemo education, ongoing basic education on med rounds by staff.<br>Patients are educated prior to chemotherapy. This is done by the doctor and again by the nursing staff (chemo trained) **Haematology and Med Onc Ouptatients:**<br>eviQ informaton at education by nurses and in clinics by CSNs or floor coordinator on L2 B19.<br>•During education – written and verbal. This is eviQ based or printed material.<br>•Pharmacists educate pts on the 1st treatment day. Called Pharmacy Counselling and a record of this is entered into CHARM<br>**Haematology Medical:**<br>Drug information includign Chemotherapy safety at Home<br>**Medical Oncology:**<br>Eviq handout, MIMS drug information<br>**Pharmacy**<br>Inpatients - discharge summary which includes supportive meds. Chemotherapy is not included in the list (may be in the summary of care given as an inpt).<br>Outpatients - list comes from L4 usually post nurse education session. Pharmacy educate based on this list +/- one that the patient may bring from home for supportive meds/ comorbidity meds. | 100% | |
| Establish if a medication list is given to the patient | This criteria is partially met.<br>Inpatients= MediList and discharge summary +/- CHARM Protocol<br>Outpatients = CHARM protocol; may or may not have review of comorbidity meds. Supporting meds for the CHARM protocol are included in the CHARM documentation. | | For ongoing auditing and feedback to clinical staff. |
| Document how temperature sensitve medications are transported to ensure integrity | **Medical Oncology and Haematology Inpatients:**<br>Esky provided by onc pharmacy<br>Chemo drugs via esky and then place in temperature controlled and monitored fridge<br>**Haematology and Med Onc Ouptatients:**<br>Meds are only taken from L3 to L4 in B19.<br>•Yes for COT<br>•Esky used<br>•Short trips so no long delays<br>**Pharmacy**<br>Some chemo that shoudl be refrigerated is not on L4 B19. THis is being addressed through a redesign of L3 B19 Pharmacy to be able to store the chemo. | | Redevelopment of L3 pharmacy will resolve this issue. |
| Document the process for handling and disposal of anticancer meds | https://www.eviq.org.au/clinical-resources/administration-of-antineoplastic-drugs/188-safe-handling-and-waste-management-of-hazardou<br><br>CHS policy<br><br>Work Health and Safety Management System | | |

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| Investigate policies/ processes that address risks associated with cytotoxic and other hazardous anticancer meds | 1. Medication Fridge Temperature Monitoring Procedure 2. Medication Handling Policy 3. CHARM Protocol Management Clinical Procedure 4. Chemotherapy: Care of the Adult Patient 5. Cytotoxic Precautions (Inc Epirubicin Instillation): Cytotoxic Precautions of the Adult Patient in the Perioperative Unit 6. Intrthecal Chemotherapy Administration including Lumbar Puncture (Adults)<br><br>** Chemotherapy: Care of the Adult Patient (eviQ) CHS Guideline - references Safe Handling and Waste Management of Hazardous Drugs. Includes Hazardous Drug Spill Management. an safe handling of monoclonal antibodies in the cancer care setting. Definition of Hazardous drugs, minimising Exposure to Hazardous drugs, PPE, Handling Body Waste, Spill and Accidental Exposure Management, Health Surveillance, Pt education,<br><br>NB: Chemotherapy Safety At Home (EVIQ) information is provided to pt/family/carer if oral chemo given and for general handling of body waste. Pts also get pump information on clamping should it leak or they experience S/E eg chest pain | | |
| Analyse what clinical services are needed to manage medicaton specific adverse events should they eventuate | 1. Pharmacy Review. 2. Riskman reporting 3. Adverse outcomes register 4. Executive review or M&M if appropriate 5. Spills kit /WHS/ Medical and nursing teams for pt care | | |
| **Information for Patients** | | | |
| Review documentation provided to consumers | Triage letter for ED.<br>Information on particular cancer<br>Separate information on side effects<br>EviQ information re chemo, booklets on specific diseases<br>Clinical practice guidelines which are very user friendly. Cancer Council brochures, tumour specific drug specifics<br>•Appointment information and contact numbers eg RAU/ CSN<br>CHARM protocol, medication list given as part of discharge summary | | |
| Investigate if risks and benefits are discussed with the patient | Risks and beneifts of having chemotherapy is done be the medical team prescribing treatment. This is part of informed consent thus allowing the pt to make a decision based on risks and benefits. Trials may be discussed at this point. | | |
| Determine if pts are referred to educational programs if available | Not provided by external sources. Sessions provided one on one to patient and carers through Level 4.<br>**Pharmacy**<br>Each outpt is given individual education on medications and when inpts have education at the bedside | | |
| Assess comprehensiveness of information provided to the patient | Pts are presented with comprehensive information related to the disease, treatment, facility and general plus after hours services. Psychosocial provide information relating to financial and mental health support. Nurses provide information on what to expect, symptom management and education and possible side effects. Medical staff provide information on medications either building on what has been given to them or providing them independently. They also provide discharge summaries. ALlied Health can provide information for ward pts. Pharmacy explain medications and may provide lists depending on inpt or outpt. Ward staff provide hospital orientation material. If the pt comes from a diverse background or identies as ATSI more information may be provided.<br>Pts are also given letters from CSNs with contract information to support them in their journey. CSNs may also point pts in the direction of digital information such as accredited websites or groups (CANTEEN). Clinical Trials also provide information after screening for suitability.<br>Triage letter for ED. INformation on the particular cancer.<br>Pharmacists educate pts on the 1st day of treatment (Outpt Haem). Called Pharmacy Counselling and a record of this is entered into CHARM | | |
| Establish policies/ procedures/ guidelines cover patient information | Inpatients must be given CHS Welcome Booklet (falls/ PI/ other risk material given) and depending on interventions other handouts eg radiation oncology services.<br>Any material handed out to pts must be approved by the Consumer Handout Committee and be in line with the Consumer Hanodut Policy.<br>IF developed inhouse, there is a Consumer Handout Tookit that is to be followed.<br>L4 Med Onc and Haem provide comprehensive education from EVIQ which is endorsed and evidence based.<br>L2 and Rad Onc provide EVIQ information also.<br>May be provided information on National bodies for support eg CANTEEN or for financial support for travel assistance, wig services etc.<br>No information is to be provided to pts/ family / carers which is not endorsed by the Consumer Handout committee. | | |
| **Provisioning of Medication List** | | | |
| Determine if pts and carers receive a current med list | **Inpatients :**<br><br>Yes on discharge as part of the discharge summary.<br><br>**Outpatients:**<br>Yes in education sessions. Pts are given an EVIQ print out, if changes occur, new lists are printed out for med onc pts. | | |
| Establish required fields | Table 3 COSA Guidelines Suggested information to be provided to pts:<br>1. **The treatment process**<br>expected location of treatment, expected duration of appointments/ lab tests/ other procedures, method of delivery, other therapeutic modalities involved (eg radiation), overall treatment length and follow up<br>2. **Name and Indication of each anticancer med and related supportive medication that the pt will receive.**<br>The generic drug name and common name, where medicines form part of a protocol the protocol name should be provided<br>3. **General and Specific Side Effects expected from treatment**<br>Immediate effects (eg hypersensitivity), Short term effects (eg nausea, neutropenia), Long term effects (infertility, cardiotoxicity). Where appropriate- teratogenic effects and pregnancy precautions.<br>4. **The Management of Expected Side Effects**<br>eg mucositis and month care, neutropenia, diarrhoea<br>5. **How and When to take each medicine on Discharge**<br>What to do if dose missed? What to do if pt vomits after administration? Max daily dose.<br>**6. Need and suppply of Supportive Meds**<br>What can be obtained through GP and those through Consultant<br>**7. Details of 24 hour contact**<br>Medical, nursing and pharmacy - for effects of treatment<br>**8. Provided in written and verbal form** | | |
| Assess if medication management is communicated in handover | **Nursing Inpatient wards:**<br>Yes- at the bedside as per hospital policy<br>**Nursing outpatient areas:**<br>Handover occurs on L4 prior to the first patient (0845-9am)and includes all patients for the day with nurses (Haem and Med Onc) and pharmacy attending. | | |
| **Safe & Secure Storage and Distribution of Medicines** | | | |
| Confirm compliance with manufacturers directions, legislation and jurisdictional requirements | •Does CRCC comply with manufacturers directions, legislation and jurisdictional requirements for the safe and secure storage and distribution of medicines? – Storage space effects the ability to comply.<br>•Is there any auditing of policies related to the safe and secure storage and distribution of medicines?- Yes inspected by pharmacy. S8 audits | | Redevelopment of L3 pharmacy will resolve storage issues in Building 19. |

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| Audit compliance with policies for handling, storage, and distribution of meds | Cold chain products are collected from the dock and transported directly to pharmacy where they are checked in and sotred in temporary fridges. Once cleared, these are stored in the main pharmacy cool room until dispersion to clinical area. Cold chain products are transported in eskys with cold bricks.<br><br>2 pharmacists = do spot audits for safe and secure storage and distribution as reported by Kate.<br><br>S8 audits and medication storage audits conducted in clinical areas.<br>Monitored fridges (wifi) and reports can be provided from pharmacy - outlining any cold chain breaches. | | | |
| Audit refrigerators and cool rooms against regulations | Yearly testing same as all electrical equipment.<br>Monitored by WiFi through to Pharmacy. | | | |
| Check alarms on fridges and store rooms have back to base notifications or audible | All areas have Wifi monitoring through pharmacy. Temp range of 2-8 C. Back to base alarm is activated if there is an excursion beyond this. | | | |
| Determine power supply is maintained at all times to fridges and cool rooms | essential power to fridges noting the hospital is also on generator brack up | | | |
| Determine regular testing & maintenance of temp alarms and temp recording devices occur | cool rooms and fridges are tested and tagged 12 montly by facilities management.<br>Tags are checked and rotated every 12 months with batteries replaced and units calibrated.<br>Tags send readings every 5 minutes to the monitoring software. | | | |
| Review process for transporting or t/f of temp sensitive meds between storage areas/ facilities | Vaccine cold chain management + Medication Management Policy | | | |
| Identify a policy for stock management | Medication Management Policy | | | |
| **High Risk Medications** | | | | |
| Identify a policy for reducing risks to the workforce and environment | Incident Management Policy DGD18-017<br>Risk Management Framework CHS19/168<br>Fatigue Management DGD18-007<br>Risk Management Policy CHS19/200<br>High Risk Medicine Policy CHS20/240<br>Work Health and Safety Management System<br>Incident Management Procedure DGD18-016<br>Chemotherapy Care of the Adult Patient EVIQ | | | |
| Audit compliance with policies for prescribing, administering and monitoring of anticancer meds | TopCat. CHARM monitoring. | | | |
| Assess how differentiation of look alike sound alike meds occurs | **Medical Oncology and Haematology Inpatients**<br>No except for separate safe for hydromorphone.<br>Labels on all shelves.<br>**Haematology and Med Onc Ouptatients:**<br>Educated and trained staff.<br>•There are some drugs that are look alike sound alike but not separated currently<br>•All individually allocated into maxi-bins for each person<br><br>**Pharmacy**<br>Use Tall man letter and consider the placement of look alike and sound alike drugs when setting up medication storage spaces<br>A/- Deputy Director Pharmacy Operations advised Tall Man lettering and differentiation in other ways does not occur with non anticancer medications. Instead all pharmacy imprest is arranged in alphabetical order which is required for stock management. (Note: after looking at the Riskman for the last 12 months there have not been incidents with general stock. Only Oxynorm and Oxycodone which are S8s and in different drug safes) | | DON to engage with Pharmacy director and lead pharmacist to ensure appropriate medication storage in all areas. | Complete by 30 August 2021 |
| Clarify if pharmacists compounding anticancer meds understand govening processes | COSA review has ensured this occurs. Comply with high standards and policies. Those compounding are senior staff only. | | | |
| Assess safe administration practices using infusion pumps | **Medical Oncology and Haematology Inpatients**<br>-Yes | | | |
| Analyse administration checks | **Medical Oncology and Haematology Inpatients**<br>-Charm chart<br>-2 competent registered nurses (who have previously been assessed as competent in the administration of cytotoxics)<br>-CHARM charts are checked against the computer (calculations, doses, making sure paper chart is the most recent order, patient identifiers, checked against EVIQ protocol, IV bags are checked to make sure they match the CHARM order, patient identifiers are checked again bedside)<br>-All rates are checked by 2 nurses<br>**Haematology and Med Onc Outpatients**<br>•Check by 2 RNs – experienced nurses in chemotherapy who have completed ADAC training and been assessed in the area.<br>•Check the order in CHARM<br>•Check consent<br>•Check pathology and BMI<br>•Calculations done<br>•Protocol not available to nursing staff if pathology or other components not available to pharmacy for checking prior to administration. 3 person check if a training nurse is involved which ensures 2 fully trained nurses check. Training nurse may have been in the unit for only 2/52 and not completed evIQ modules. Bedside checks as above and rate check which involves 2 experienced nurses separately checking the flow rate.<br>**SUPPORTIVE MEDICATIONS - NURSING**<br>**Medical Oncology and Haematology Inpatients**<br>-Supportive medications are identified on the CHARM chart and when required transcribed into EMM by the medical team so that nursing staff can administer when required. The administration check will be dependent on the supportive medication that is being administered.<br>**Haematology and Med Onc Outpatients**<br>•Part of CHARM not EMM | | | |
| **Comprehensive Care** | | | | |
| Establish if pts diagnosed with cancer are routinely presented to a MDT for comprehensive care planning | **Given volume of patients, this is not always possible. However, patients with increased complexity are definitely presented.**<br>**Haematology Medical:**<br>Yes<br>**Medical Oncology:**<br>Yes especially if there is complexity in their treatment requiring multidisciplinary input | | | |

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| Assess if care plans are developed with the pt/family and carer | **Medical Oncology and Haematology**<br>Careplans are developed when patient admitted to the ward. They are done with the patient and may be completed with family if that is what the patient wishes<br>Care plans are filled out, at times done with family but not on a regular basis . Comprehensive care plans implemented in May/June 2021 include involvement of patient/family. This will see an increase in involvement of patients in their care.<br>**Haematology and Med Onc Outpatients**<br>GPs get a letter from the consultant each time the patient is seen on L2 or L4. Not a formal care plan but does cover the treatment proposed which is discussed with the pt and carer (much the same assuming some shared care with the GP).<br>•Yes if an outpt being admitted to a ward<br>•If remaining an outpatient – no.<br>•Family and pt are involved in care planning<br>**Rad Onc and L2**<br>no<br>**Haematology Medical:**<br>Yes<br>**Medical Oncology**<br>Yes- pts treatments are planned with their input | | |
| Investigate if the care plan is used by other clinicians | **Medical Oncology and Haematology Inpatients:**<br>Very rarely. New comprehensive care plan is designed for multidisciplinary input.<br>**Haematology and Med Onc Ouptatients:**<br>Yes. CHARM treatment plans: Drs, Nurses, CSNs, Pharmacy, LINK<br>**Rad Onc and L2**<br>No<br>**Medical TBA**<br>Develop an outpatient treatment plan which is accessed by Pharmacy and nursing. Do develop a care plan only for the inpatien stay which articulates with an outpatient treatment plan | | |
| Explore if changes to the care plan are discussed by the lead clinician with the pt through informed consent | **Haematology Medical:**<br>Yes<br>**Medical Oncology**<br>yes | | |
| Determine if the care plan is comprehensive | **Medical Oncology and Haematology Inpatients:**<br>Comprehensive Care plan meets this criteria.<br>**Haematology and Med Onc Ouptatients:**<br>Yes - eviQ and comprehensive. From CHARM. Termed more a treatment plan rather than a care plan. I | | |
| Assess if MDTs have appropriate processes | 1.Governance and escalation processes in place?<br>Yes – the governance structure is described in the MDM Guidelines and the TOR.<br>2.Templates for recording decisions?<br>There are templates for each of the MDMs – they contain standard information and also specific information that is tailored to the MDM.<br>3.Infrastructure to support referral to non-core staff/ processes to exchange knowledge?<br>Referrals generated by the MDM are processed by the admin staff. | | |
| Identify MDT member education | MDTs have been established for many years with core senior staff developing the process. Mentoring of medical and nursing can occur when needed within the meetings. Limited changes to membership.<br>Recent introduction of MDT governance structure and documentation.<br>CRCC Administration has relevant education/SOPs for administration staff involved in MDTs. | | |
| Investigate if community pharmacies receive the whole treatment plan, protocol and monitoring requirements | **Haematology Medical:**<br>GPs get a list of medications from CHARM. Heamatologists actively manage all medications given the risks involved and risks from GPs inadvertently impacting treatment. GPs do order analgesia. Palliative care may also order analgesia. All other medications/ treament plans are tightly controlled and monitored by consultants which ensures pt safety.<br>**Medical ONcology:**<br>Indirectly- patients' referring GP are kept in communication with changes to patients' treatment plans | | |
| Explore the current implementation practices for care plans | Currently implementing the Comprehensive Care plan across the orgnaisation. | | Audit of comprehensive care plan implementation - results due 30 August 2021 |
| **Communicating for Safety** | | | |
| Identify when safe communicaton + clinical h/o is required during the pt journey | Nursing<br>**Medical Oncology and Haematology Inpatients:**<br>At patient bedside at the commencement of each shift<br>T/L to T/L at the commencement of each shift<br>At patient bedside at the commencement of each shift<br>T/L to T/L at the commencement of each shift<br>**Haematology and Med Onc Ouptatients:**<br>every morning with pharmacy<br>•Bedside handover following ISBAR<br>•At the beginning of the day before pts arrive: confirm the pts for treatment and any changes to treatment<br>•The team works as a team and not with individual allocation of pts which reduces the need for a inpt ward type of handover<br>•Work in progress= 3 core identifiers being used in handover<br>**L2 and Rad Onc:**<br>•Work being done in this space as practice is variable and needs to improve<br>•L2 handover from L4 does not occur and L2 will not communicate with L4 on incidents | | Monitoring of audit results re handover compliance |
| Explore if pts can communicate critical info and risks about their care to clinicians | **Nursing:**<br>Inpatients are allocated to a team who care for them each day. Critical information can be communicated at any time 24/7 and especially during bedside ward rounds and hourly rounding. Risks about care are generally discussed with the consultant when making a decision to have chemo or not. Other more general risks eg withholding a medication eg warfarin can be discussed on ward rounds, or at any time.<br>Outpatients are provided advice regarding symptoms which need investigation and who to approach for this. Alternately they can contact the CSN or speak with the nurses administering anticancer meds.<br>**Haematology Medical:**<br>Directly at consultation, via email, via phone<br>**Med Oncology:**<br>Nurse care coordinator. Rapid assessment Unit. Pts are advised to present to ED if acutely unwell | | |
| Analyse clinical communicaton policies for requirements in high risk situations | Emergency Management Plans - Code Blue<br>Goals of Care and Resuscitation Plan (Adult and Paediatric not neonate) Guideline<br>Patient and Family Escalation Process - Call and Respond Early (CARE) for Patient Safety<br>Vital Signs and Early Warning Scores<br>Neurological Observations - For Adults and Paediatrics | | |

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| Assess how info is received using fax machines, mail and email | **Medical Oncology and Haematology Inpatients**<br>They get a OK from a fax.<br>Generally e-mail re admission and chemo<br>Fax to CHI and NH<br>**Haematology and Med Onc Ouptatients:**<br>Information is provided through dual routes. This may be a fax to the GP and the patient also has a copy. For LINK – information is faxed and the pt also has a copy<br>•Email – response required<br>•Fax- RNs call after the document is faxed to ensure it is received<br>•Nurses do not use snail mail<br>**L2 and Rad Onc:**<br>•Improvements could occur in this area.<br>**Pharmacty**<br>Generally dont use fax. 99% of the time email and scanned material sent by email as this is clear. Faxes are not and errors are unacceptable from poor legibility. | | Review Fax policy for organisation. Review processes within the CAS division to determine where imporvements can be made | DON/ADON: due 30 September 2021 |
| Review policies for communicating critical information | Cancer Multidisciplinary Meeting Operational Procedure<br>Clinical Handover procedure | | | |
| Assess if formal survivorship plan is sent to GP when care handed over | Nursing<br>**Medical Oncology and Haematology Inpatients**<br>Discharge summery sent to GP<br>**Haematology and Med Onc Ouptatients:**<br>Yes – for some conditions eg breast care where once chemo finishes the ongoing hormonal treatment is prescribed by GPs and given out by community pharmacists.<br>As previously stated, GPs get a letter each time the pt is seen by a consultant.<br>Supportive meds – no this is managed between the GP and community pharmacy.<br>•Yes by medical officers<br>•Not by nurses<br>**Rad Onc and L2**<br>•Consultants send letters post consultations.<br>•Nil to community pharmacists<br>**Haematology Medical:**<br>For some groups yes. eg Leukaemia and lymphoma where care can be handed over. Other conditions stay with hte consultant as they have ongoing specialised needs and cannot be handed over.<br>**Medical Oncolgy**<br>All pts will have a letter to the GP generated from the final consultation visit. Survivorship plan is used in some disease type and in development eg in breast cancer . Care plan and med list also provided. | | | |
| Determine how community pharmacists are provided information | As above | | | |
| **Documentation of Information** | | | | |
| Explore CHARM for evidence based protocols + dose calculating tools | All due protocols are currently under review with Evidence base attached. Dose calculating is a feature of the program. Needs height and wt and BSA | | | |
| Assess if protocols are signed by a specialist + pharmacy reviewed | Protocols are signed by Clinical Director of Haematology or Medical Oncology or Director of CAS and are reviewed by Pharmacists. Only CHARM pharmacist can upload a protocol into CHARM and this is only done after being reviewed and agreed. Clinicians do NOT administer medications without the protocol beign present in CHARM. | | 3 year review cycle for those not aligning to the EVIQ schedule for RV. All others are to be reviewed aligning to EVIQ proposed schedule | |
| Determine if verbal orders are limited | **Haematoology Medical:**<br>Sometimes with oral chemotherapy only.<br>**Medical Oncology :**<br>No | | MedChart for supportive treatments allows medical officers to remotely access the system and order drugs rather than phone/ verbal orders. | |
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SENSITIVE - CABINET

**ACT Health Directorate**

**Tracking No.: GBC22/8**

| | |
|---|---|
| **To:** | Minister for Health |
| **CC:** | Rebecca Cross, Director-General |
| **From:** | Deborah Anton, Deputy Director-General |
| **Subject:** | Minister's Weekly Brief |
| **Critical Date:** | Friday, 14 January 2022 |
| **Critical Reason:** | To ensure you are briefed on current issues and events. |

**Recommendations**

That you note the:

- Information in the Minister's Weekly Brief for 3-7 January 2022;
- Media and Communication forecast at (Attachment A);
- Freedom of Information requests update (Attachment B); and
- Ministerial & Government Services Report (Attachment C).

**Noted / Please Discuss**

Rachel Stephen-Smith MLA ................................................................ 14/2/22

| Minister's Office Feedback |
|---|
| Out of Scope |

Out of Scope

**UPDATES ON KEY PROJECTS/PIECES OF WORK**

**Zita Mary Clinic – update**

11. On 5 January 2022 a meeting was held with Calvary Public Hospital Bruce (CPHB) and Canberra Health Services (CHS) stakeholders to consolidate advice on progress toward implementing the project to move chemotherapy administration from CPHB to the Canberra Region Cancer Centre (CRCC) at Canberra Hospital.
12. Part of this project involves transferring patients, who would otherwise receive transfusions other than chemotherapy at Canberra Hospital, to Zita Mary Clinic (ZMC) so that capacity is released at Canberra Hospital.

13. Approximately ten patients, mainly receiving ongoing immunoglobulin infusions, have initially been successfully referred from CRCC to ZMC. Senior clinical staff reported that they had contacted patients who were referred to ZMC and they were happy with the referral as access to services was faster and closer to their home.
14. Only patients living on the north side of Canberra are being transferred to ZMC from CRCC as part of the initial trial.
15. The next step in the project will be to transition new northside patients requiring chemotherapy transfusions to CRCC.
16. Specialist Oncology and Haematology clinics that are currently held at CPHB will transition to new CRCC clinic spaces between January and March 2022.
17. CPHB and CHS will review the project in May and September 2022 and again in March 2023 to ensure stakeholder satisfaction and to ensure processes continue to ensure patients are receiving timely care.
18. CPHB and CRCC senior staff continue to work collaboratively on this project to ensure patients are given timely care and close to their home.
19. A draft transition plan is currently being amended for distribution and review by stakeholders.

- Currently, public chemotherapy services in the ACT are provided from the Canberra Region Cancer Centre at Canberra Hospital and through the Zita Mary Clinic at Calvary Public Hospital Bruce.
- The Zita Mary Clinic opened in 2001, with nine chairs for the provision of chemotherapy. Prior to the change, that commenced in January 2022, approximately 15 patients a week received chemotherapy at the clinic. The Zita Mary clinic also provided a range of day treatment services including immunotherapy infusions.
- Recent changes were made in the 2020 Guidelines for Medication Management in Cancer Care by The Australian Commission on Safety and Quality in Health Care. A resultant review of service provision at the Zita Mary Clinic against the new Medication Management Guidelines highlighted difficulties that Calvary Public Hospital Bruce will face to comply with these standards.
- It is extremely important that health services comply with medication management guidelines and changes have been adopted following consultation with key stakeholders to provide a sustainable, multi-disciplinary service for cancer patients in the ACT.
- On 13 July 2021, a consultation process was launched to inform stakeholders of the proposed transition of chemotherapy and oncology consultation services, and to seek feedback and input on how this transition could best occur.
- The formal consultation process commenced 19 July 2021 and remained open until 30 August 2021, inclusive of community consultation.
- Following consultation, a decision was made to transition the delivery of oncology services from the Zita Mary Clinic to the Canberra Region Cancer Centre at Canberra Hospital in the short to medium term, to provide a consolidated and streamlined service in a single tertiary centre.
- The timing of the transfer of oncology patients  from ZMC to CRCC has be planned so  that patients could continue to receive their chemotherapy at Calvary Public Hospital Bruce until such time as their treatment was complete or until there was a natural break in their chemotherapy cycle.
- The future requirements for chemotherapy services will be considered in clinical services planning for the future Northside hospital.

- To ensure there is timely access to appointments at CRCC for the oncology patients being transferred from ZMC, a trial commenced in December 2021 CRCC to transfer suitable newly diagnosed patients requiring infusion therapies to ZMC for their treatments.
- Patients considered for referral could be receiving the following infusions, including but not limited to:
    - Neurology (Ocrelizumab/Natalizumab/Alemtuzumab/Immunoglobulin)
    - Gastroenterology (Infliximab/Vedolizumab/Ustekinumab)
    - Rheumatology (Abatacept/Tocilizumab)
    - Iron infusions; or
    - Therapeutic Venesection.

**Commented [WM(1]:** This is a transfusion

- All newly diagnosed patients requiring infusion therapies who have a northside address are being referred to ZMC for their treatments.
- There will be a phased approach of transitioning existing patients to ZMC from CRCC to allow for a smooth transition for both patients and staff.
- Patients identified as being able to receive their treatment at ZMC have been or will be supplied with a letter advising them of this change. If a patient advises that they would like to continue to receive their treatments at CRCC, their request will be assessed on a case-by-case basis.
- It is anticipated that all transition of patients between ZMC and CRCC will be completed by the end of July 2022.

**From:** Webb, Jaimilee (Health) on behalf of LHN Coord
**Sent:** Wednesday, 8 June 2022 10:58 AM
**To:** Robin Haberecht (Calvary)
**Cc:** Kanta Toraskar (Calvary); Pini, Sallyanne (Health); Grant, Karla (Health)
**Subject:** FYI - Minister for Health - Update - Transfer of Zita Mary oncology patients
**Attachments:** MIN22702 - Minister for Health - Update – transfer of Zita Mary oncology patients.DOCX

OFFICIAL

Dear Robin,

Please find attached a brief ACTHD have prepared for the Minister for Health.

Jacinta mentioned at the CNC we would share a copy with you for your information.

Thank you.

Kind regards

**Jaimilee Webb | Administrative Support Officer**
**Direct Email:** jaimilee.webb@act.gov.au
**Phone:** 02 512 43143
**Local Hospital Network Commissioning | Health System Planning and Evaluation | ACT Health Directorate**
Level 4, 6 Bowes Street Phillip ACT 2606
health.act.gov.au

ACT Government

OFFICIAL

MINISTERIAL BRIEF

**ACT Health Directorate**

| | | |
|---|---|---|
| **To:** | Minister for Health | **Tracking No.: MIN22/702** |
| **From:** | Rebecca Cross, Director General | |
| **CC:** | Kate Chambers, CFO<br>Margaret Stewart, EBM LHN Commissioning | |
| **Subject:** | Update – transfer of Zita Mary oncology patients | |
| **Critical Date:** | N/A | |
| **Critical Reason:** | N/A | |

- DG …/…/…

**Recommendations**

That you:

1. Note the update on progress of changes to oncology service arrangements at the Zita Mary Clinic, Calvary Public Hospital Bruce.

**Noted / Please Discuss**

Rachel Stephen-Smith MLA ………………..……………………….………………….. …../…../…..

| Minister's Office Feedback |
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**Background**

2. In 2020, Calvary Public Hospital Bruce (CPHB) following a review of Australian Commission on Safety and Quality standards, determined that it will not be able to meet accreditation standards for governance (medical support and comprehensive care) for oncology and haematology services (MIN20/1757).

3. CPHB identified that whilst many of the gaps against the standards were rectifiable, it would be resource intensive and would not be able to be fully resolved in the short to medium term.
4. In addition CPHB and Canberra Health Services (CHS) senior oncology and haematology clinicians have agreed the service at Zita Mary Clinic (ZMC) is not sustainable given several of the specialists have indicated they are not in a position to continue providing clinics at CPHB due to increasing clinical commitments elsewhere, predominately at CHS.
5. On 20 May 2021, you were briefed on the consultation about proposed changes to chemotherapy and oncology consultation service arrangements at the ZMC due to accreditation concerns (MIN21/632).
6. You agreed to the transfer of Chemotherapy and Oncology Consultation Services from the ZMC to the Canberra Region Cancer Centre (CRCC), subject to consultation with stakeholders.
7. This consultation occurred from 13 July 2021 to inform stakeholders of the decision to transition chemotherapy and oncology consultation services from the ZMC to the CRCC at CHS, and to seek feedback and input on how this transition could best occur.

**Issues**

8. Following the closure of consultation, ACT Health Directorate (ACTHD), CPHB and CHS stakeholders have been meeting regularly to progress the transition planning for the transfer of chemotherapy services from ZMC to CRCC at CHS for the short to medium term.
9. During transition planning it was agreed that no new oncology patients would be referred to the ZMC from 14 January 2022.
10. Patients who were still engaged with ZMC on or before 14 January 2022 have continued to receive their chemotherapy at CPHB until such time as their treatment is complete or until there is a natural break in their chemotherapy cycle. The transfer of these final patients is expected to be completed by the end of June 2022.
    - As of 2 June 2022, there are currently approximately 21 remaining patients receiving chemotherapy/oncology services at ZMC CPHB.
11. While the emphasis of the project was to transfer the high acuity oncology patients from ZMC to CRCC, the planning also sought to shift some of the lower acuity transfusion therapy patients from CRCC to ZMC, particularly those patients who live on the northside of Canberra to leverage capacity across both services.
12. In December 2021 CRCC commenced trialling the transfer of suitable patients requiring infusion therapies to treatment at ZMC. Patients considered for referral could be receiving the below infusions, including but not limited to the following:
    - Neurology (Ocrelizumab/Natalizumab/Alemtuzumab/Immunoglobulin)
    - Gastroenterology (Infliximab/Vedolizumab/Ustekinumab)
    - Rheumatology (Abatacept/Tocilizumab)
    - Iron infusions; or

- Therapeutic Venesection

13. It is anticipated that all oncology and transfusion therapy patients will be transitioned to CRCC or ZMC by the end of July 2022.
14. CRCC has also engaged a project manager to identify the existing CRCC patients requiring infusion therapies that live on the northside who could transfer their treatment to ZMC. All new patients requiring infusion therapies who have a northside address are also being referred to ZMC for their treatments.
15. Patients identified as being able to receive their treatment at ZMC have been or will be supplied with a letter advising them of this change. If a patient identifies that they would like to continue to receive their treatments at CRCC, their request will be assessed on a case by case basis.
16. To date the clinicians at both ZMC and CRCC advise that, anecdotally, the patients being transitioned have generally accepted the change (source: meeting with clinicians on 2 June 2022).

**Financial Implications**

17. Both the Chief Financial Officers have identified they will monitor the data once the transition of patients has occurred to determine if there are any financial adjustments that will be required.
18. Additional pharmacist and administration resources have been requested by CRCC, to both Chief Financial Officers for consideration.

**Consultation**

19. As part of preparing this brief ACTHD consulted closely with the project teams of both CPHB and CHS as well as the senior leadership at both organisations, including the Executive Director of Cancer and Ambulatory Care at CHS and the Medical Director of Clinical Services at CPHB.

**Work Health and Safety**

20. Nil.

**Benefits/Sensitivities**

21. The sensitivities around the patient transfers are being actively managed and addressed as they are identified, with both CHS and CPHB working closely with the patients.

**Communications, media and engagement implications**

22. An update on the transition of chemotherapy services will be communicated to stakeholders, staff, and the community once the final transitions are completed and all processes have been documented.

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|---|---|---|---|
| Signatory Name: | Jacinta George, Executive Group Manager, Health System Planning and Evaluation | Phone: | 5124 9699 |
| Action Officer: | Alexander Konovalov, Senior Director, Health System | Phone: | 5124 9699 |

| **Attachment** | **Title** |
|---|---|
| Attachment A | MIN20/1757 – Caveat Brief |
| Attachment B | MIN21/632 – Initiated brief - Chemotherapy Services offered at ZMC |

OFFICIAL MINISTERIAL BRIEF

ACT Government

**ACT Health Directorate**

| | | |
|---|---|---|
| **To:** | Minister for Health | Tracking No.: MIN22/702 |
| **CC:** | Rebecca Cross, Director General<br>Kate Chambers, Chief Finance Officer<br>Margaret Stewart, Executive Branch Manager, Local Hospital Network Commissioning | |
| **From:** | Jacinta George, Executive Group Manager, Health System Planning and Evaluation | |
| **Subject:** | Update – transfer of Zita Mary oncology patients | |
| **Critical Date:** | N/A | |
| **Critical Reason:** | N/A | |

**Recommendation**

That you:

1. Note the update on progress of changes to oncology service arrangements at the Zita Mary Clinic, Calvary Public Hospital Bruce.

**Noted** / **Please Discuss**

Rachel Stephen-Smith MLA .................................................. 18/7/22

Minister's Office Feedback

Thank you. Following final transition of patients it would be good to discuss the outcome of the ZMC taking on these infusions and whether there are any future opportunities for the clinic (or other clinic models elsewhere) to deliver care closer to home.

**Background**

1. In 2020, Calvary Public Hospital Bruce (CPHB) following a review of Australian Commission on Safety and Quality standards, determined that it will not be able to meet accreditation standards for governance (medical support and comprehensive care) for oncology and haematology services (Attachment A).

2. CPHB identified that whilst many of the gaps against the standards were rectifiable, it would be resource intensive and would not be able to be fully resolved in the short to medium term.

3. In addition, CPHB and Canberra Health Services (CHS) senior oncology and haematology clinicians have agreed the service at Zita Mary Clinic (ZMC) is not sustainable given several of the specialists have indicated they are not in a position to continue providing clinics at CPHB due to increasing clinical commitments elsewhere, predominately at CHS.

4. On 20 May 2021, you were briefed on the consultation about proposed changes to chemotherapy and oncology consultation service arrangements at the ZMC due to accreditation concerns (Attachment B).

5. You agreed to the transfer of Chemotherapy and Oncology Consultation Services from the ZMC to the Canberra Region Cancer Centre (CRCC), subject to consultation with stakeholders.

6. This consultation occurred from 13 July 2021 to inform stakeholders of the decision to transition chemotherapy and oncology consultation services from the ZMC to the CRCC at CHS, and to seek feedback and input on how this transition could best occur.

**Issues**

7. Following the closure of consultation, ACT Health Directorate (ACTHD), CPHB and CHS stakeholders have been meeting regularly to progress the transition planning for the transfer of chemotherapy services from ZMC to CRCC at CHS for the short to medium term.

8. During transition planning it was agreed that no new oncology patients would be referred to the ZMC from 14 January 2022.

9. Patients who were still engaged with ZMC on or before 14 January 2022 have continued to receive their chemotherapy at CPHB until such time as their treatment is complete or until there is a natural break in their chemotherapy cycle. The transfer of these final patients is expected to be completed by the end of June 2022.

10. As of 2 June 2022, there are currently approximately 21 remaining patients receiving chemotherapy/oncology services at ZMC CPHB.

11. While the emphasis of the project was to transfer the high acuity oncology patients from ZMC to CRCC, the planning also sought to shift some of the lower acuity transfusion therapy patients from CRCC to ZMC, particularly those patients who live on the northside of Canberra to leverage capacity across both services.

12. In December 2021, CRCC commenced trialling the transfer of suitable patients requiring infusion therapies to treatment at ZMC. Patients considered for referral could be receiving the below infusions, including but not limited to the following:

a. Neurology (Ocrelizumab/Natalizumab/Alemtuzumab/Immunoglobulin);

b. Gastroenterology (Infliximab/Vedolizumab/Ustekinumab);

c. Rheumatology (Abatacept/Tocilizumab);

d. Iron infusions; or

e. Therapeutic Venesection

13. It is anticipated that all oncology and transfusion therapy patients will be transitioned to CRCC or ZMC by the end of July 2022.

14. CRCC has also engaged a project manager to identify the existing CRCC patients requiring infusion therapies that live on the northside who could transfer their treatment to ZMC. All new patients requiring infusion therapies who have a northside address are also being referred to ZMC for their treatments.

15. Patients identified as being able to receive their treatment at ZMC have been or will be supplied with a letter advising them of this change. If a patient identifies that they would like to continue to receive their treatments at CRCC, their request will be assessed on a case by case basis.

16. To date the clinicians at both ZMC and CRCC advise that anecdotally, the patients being transitioned have generally accepted the change (source: meeting with clinicians on 2 June 2022).

**Financial Implications**

17. Both the Chief Financial Officers have identified they will monitor the data once the transition of patients has occurred to determine if there are any financial adjustments that will be required.

18. Additional pharmacist and administration resources have been requested by CRCC, to both Chief Financial Officers for consideration.

**Consultation**

19. As part of preparing this brief ACTHD consulted closely with the project teams of both CPHB and CHS as well as the senior leadership at both organisations, including the Executive Director of Cancer and Ambulatory Care at CHS and the Medical Director of Clinical Services at CPHB.

**Work Health and Safety**

20. Nil.

**Benefits/Sensitivities**

21. The sensitivities around the patient transfers are being actively managed and addressed as they are identified, with both CHS and CPHB working closely with the patients.

**Communications, media and engagement implications**

22. An update on the transition of chemotherapy services will be communicated to stakeholders, staff, and the community once the final transitions are completed and all processes have been documented.

| | | | |
|---|---|---|---|
| Signatory Name: | Jacinta George, Executive Group Manager, Health System Planning and Evaluation | Phone: | 5124 9699 |
| Action Officer: | Alexander Konovalov, Senior Director, Health Services Planning and Project Support | Phone: | 6205 2634 |

| **Attachment** | **Title** |
|---|---|
| Attachment A | MIN20/1757 – Caveat Brief |
| Attachment B | MIN21/632 – Initiated brief - Chemotherapy Services offered at ZMC |

**Consumer correspondence of note**

*Changes to the Zita Mary Clinic*

- In 2020, CPHB following a review of Australian Commission on Safety and Quality standards, determined that it will not be able to meet accreditation standards for governance (medical support and comprehensive care) for oncology and haematology services.
- CPHB identified that whilst many of the gaps against the standards were rectifiable, it would be resource intensive and would not be able to be fully resolved in the short to medium term.
- CPHB and Canberra Health Services (CHS) senior oncology and haematology clinicians agreed the service at Zita Mary Clinic (ZMC) were not sustainable given several of the specialists have indicated they were not in a position to continue providing clinics at CPHB due to increasing clinical commitments elsewhere, predominately at CHS.
- The Minister for Health agreed to the transfer of Chemotherapy and Oncology Consultation Services from the ZMC to the Canberra Region Cancer Centre (CRCC). Consultation with stakeholders ensued from 13 July 2021, seeking feedback and input on how this transition could best occur.
- ZMC has ceased taking new oncology patients and had transitioned or discharged the vast majority of existing patients by the end of July 2022.

SENSITIVE

SENSITIVE - CABINET

**MINISTERIAL BRIEF**

**ACT Health Directorate**

**Tracking No.: GBC22/501**

| | |
|---|---|
| **To:** | Minister for Health |
| **CC:** | A/g Deb Anton, Director-General |
| **From:** | A/g Stephen Miners, Deputy Director-General |
| **Subject:** | Minister's Weekly Brief |
| **Critical Date:** | Friday, 19 August 2022 |
| **Critical Reason:** | To ensure you are briefed on current issues and events. |

**Recommendations**

That you note the:

- Information in the Minister's Weekly Brief for 8-12 August 2022;
- Media and Communication forecast at (Attachment A);
- Freedom of Information requests update (Attachment B); and
- Ministerial & Government Services Report (Attachment C).

**Noted / Please Discuss**

Rachel Stephen-Smith MLA ........................................................ 28/9/22

Minister's Office Feedback

Re par 9, why is the Northside Clinical Services Plan being pre-empted? While a hub and spoke model may be practical, presumably it would require additional funding? It is unclear, given the very low numbers of patients previously supported, whether this is a cost-effective option compared with alternative uses of any funding.

Out of Scope

**UPDATES ON KEY PROJECTS/PIECES OF WORK**

**Zita Mary Clinic**

5. The transfer of oncology or cancer patients from Zita Mary Clinic (ZMC) to the Canberra Health services (CHS) Canberra Region Cancer Centre (CRCC), which started in January 2022 (with no new patients accepted at ZMC), has now completed.

6. There are no oncology or cancer treatments performed at ZMC. The final oncology patient receiving cytotoxic treatment at ZMC was 21 July 2022.

7. ZMC continues to receive patients from CHS CRCC for infusion therapies.

8. Calvary Public Hospital Bruce (CPHB) and CHS CRCC continue to work together to ensure patients requiring infusion therapies receive their treatment in a timely manner.

9. The Northside Clinical Services Plan, which is under development, will propose the re-instatement of same day cytotoxic treatments on the northside. This will be a Territory-wide model of service for chemotherapy management under CRCC governance (ie a hub and spoke model).

Out of Scope

<u>**Assembly Questions**</u>

| Record Number | Date due to Minister | Division | Title | Client | Current action |
|---|---|---|---|---|---|
| Out of Scope | | | | | |
| GBC22/485 | 26/8/22 | HSPE | QON 868 - Why was the oncology unit removed from Calvary Hospital | Ms Kikkert | 18/8/22 – HSPE drafted response with for Calvary review. |
| Out of Scope | | | | | |