



Queensland Health

Queensland Cancer Strategy

Consultation Survey Findings Report
April 2024



Queensland
Government

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Summary of key findings

More than 1,000 Queenslanders shared their ideas on solutions for improving cancer services across Queensland. All demographic questions were optional, and respondents could self-identify with more than one demographic group. A summary of who responded to the Queensland Cancer Strategy survey is detailed under 'Who we reached'.

Survey respondents were asked to consider the future of cancer care in Queensland. Based on the responses received, the following priorities were identified:

- Queenslanders in rural and remote areas want less waiting and less travel for diagnostic scans, tests and to see a doctor.**
- Enhanced care coordination and holistic support from diagnosis through to recovery.**
- Access to affordable early detection and screening especially for populations who experience barriers to access.**
- Increased use of specific models like mobile outreach services and telehealth.**
- More upskilling and training to develop workforce skills in person-centered care, communication and clinical care.**
- Consistent, quality information provided to consumers and carers throughout the cancer journey.**
- Increasing enrolment in clinical trials across the state and developing systems that allow research collaboration.**
- Prevention is critical and many respondents want to see more investment before people develop cancer.**
- Reducing out-of-pocket costs for treatment and travel costs associated with treatment.**

Acronyms and abbreviations

Acronym	Full description	What it means
ACCHO	Aboriginal and Torres Strait Islander Community Controlled Health Organisation	An ACCHO is a primary health care service initiated and operated by the local Aboriginal community to deliver holistic, comprehensive, and culturally appropriate health care to the community which controls it, through a locally elected Board of Management.
CALD	Culturally and linguistically diverse	People who identify with a culture or religion that is not predominantly represented in Australian society or who speak a language other than English at home.
GP	General Practitioner	Doctors who provide general healthcare for acute and chronic illness, usually in the community setting. GPs are usually the first point of contact with the health system and refer people with specific symptoms or conditions to specialist care.
HHS	Hospital and Health Service	Hospital and Health Services are providers of Queensland Health hospital services and other health services to specific geographic areas across the state. Each Hospital and Health Service is managed by its own Board.
MDT	Multidisciplinary team	Multidisciplinary team care is a treating team comprised of doctors, nurses and other allied health professionals that are all involved in treating one consumer. Cancer treatment is often complex and requires multiple different professionals with specialist experience and a MDT approach helps to coordinate care and make decisions about best treatment.
NDIS	National Disability Insurance Scheme	The National Disability Insurance Scheme is a scheme of the Australian Government that funds costs associated with disability.
NP	Nurse practitioner	A nurse practitioner is an advanced practice registered nurse with additional training to assess patient needs, order and interpret tests, and prescribe medications and treatment plans.
PREMS	Patient Reported Experience Measures	Patient Reported Experience Measures are once-off captures of the patient's view of their health care visit, used to support clinicians in partnering with patients to achieve safe, high quality care.
PROMS	Patient Reported Outcome Measures	Patient Reported Outcome Measures are numerous captures of the impact of an illness or health condition over time, used to support clinicians in partnering with patients to achieve safe, high quality care.

Introduction

Queensland Health is proud to offer high-quality cancer services throughout Queensland. Thanks to research, innovation, and our dedicated workforce, the face of cancer care is changing. More people are surviving cancer than ever before.

However, a cancer diagnosis still has a significant impact on the people affected and their loved ones. Cancer as a health issue remains one of the leading causes of death and the leading cause of reduced quality of life in Australia and Queensland.

The cancer service system is complex and faces several challenges. We recognise the need to take a whole-of-system approach and plan cancer services that are responsive to changing population health needs across Queensland.

To respond to current and future challenges, we are developing a Queensland Cancer Strategy to advance equitable, evidenced-based and innovative cancer services. The 10-year Strategy will build on work at the local, state and national levels like implementation of the Australian Cancer Plan, delivering the Queensland Cancer Centre, and improving cancer services for Aboriginal and Torres Strait Islander peoples across Queensland.

Through this Strategy, we want to grow a broad network of cancer services across the state that help people access high quality cancer care as close to their home as possible.

The first step in developing the Strategy was an online consultation survey open to all Queenslanders. This document is a summary of the key findings from the consultation survey.

Stakeholder feedback is included as stated and does not represent government policy. The document is intended to show what we have heard through this consultation process and does not draw conclusions.

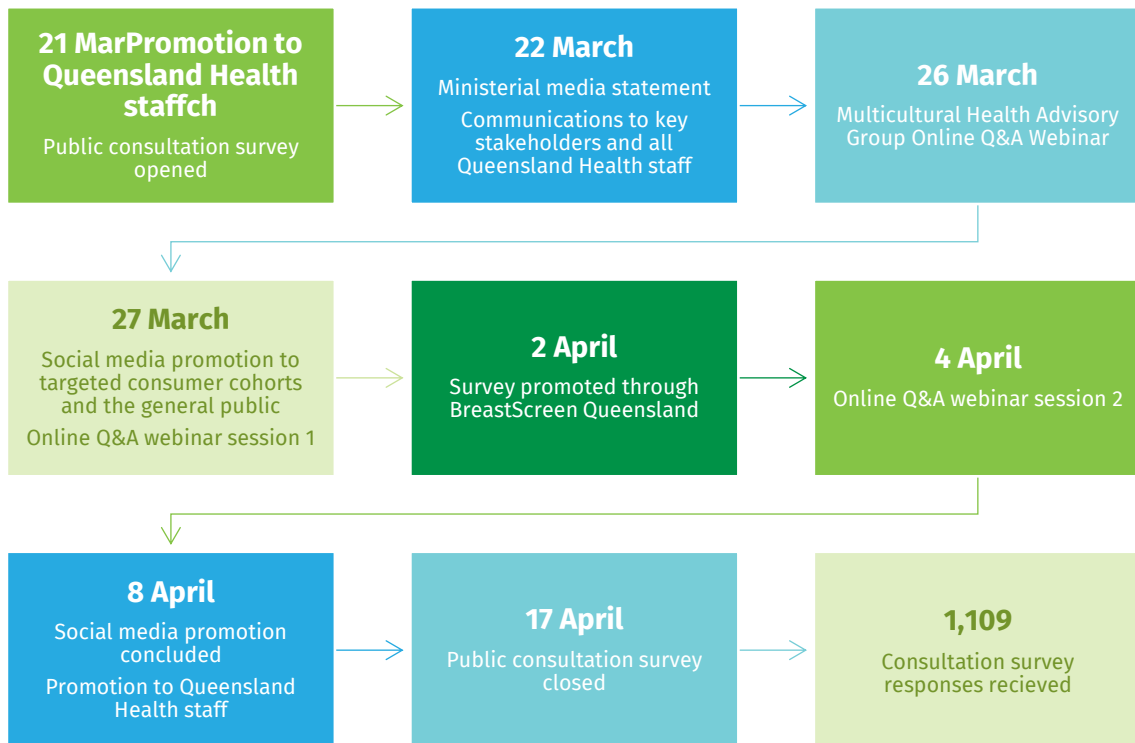
Queensland Health appreciates the contributions of all consultation participants. Your feedback and ideas will help shape the Queensland Cancer Strategy.

Consultation process

Collecting survey feedback

During public consultation from mid-March to mid-April 2024, we heard directly from 1,109 Queenslanders who shared their vision for future cancer services across Queensland through submissions to an online consultation survey. The consultation process is outlined in Figure 1.

Figure 1: Consultation survey process.



The consultation survey was widely shared across Queensland Health and externally to other stakeholders, including consumers. Approximately 186 individuals and organisations were contacted directly to participate and invited to share the opportunity through their networks.

Within Queensland Health, this included communications to:

- A clinical working group with 31 clinicians from across the Hospital and Health Services and across a broad range of cancer care professions, including nursing, allied health and different medical specialties.
- A consumer working group with 9 consumers from across the state with diverse experiences of cancer including childhood and adolescent and young adult cancer.
- Statewide clinical networks including the Queensland Cancer Clinical Network, the Rural and Remote Network, the Aboriginal and Torres Strait Islander Clinical Network, the General Medicine Clinical Network, the Palliative Care Clinical Network and the Respiratory and Sleep Clinical Network.

- Representatives from all sixteen Hospital and Health Services through multiple forums at the executive level and by direct engagement with health service planners and clinicians by the project team.
- All staff via multiple communication methods and platforms, at a state and local HHS level.

To reach the wider Queensland community, a targeted social media campaign was also undertaken on Facebook and Instagram. The campaign was seen by 103,310 accounts with 1,995 clicks. In the first four days of the campaign, advertisements were targeted to the following cohorts with specific experiences of cancer:

- Queenslanders in rural, remote and regional areas (outside Brisbane)
- Men
- Young people (aged 15 – 18)

Following this, the campaign was opened to the population of Queensland.

Throughout the engagement period, the Queensland Health webpage for the survey received 4,497 views.

To support engagement with the non-government sector, 38 organisations who support cancer survivors or provide cancer care were invited to participate. Two webinar sessions were held to support organisations to engage with their networks and complete the survey.

Analysis of survey responses

The online survey tool used for this consultation, has built in functionality that allows for qualitative data analysis including filtering tools, tagging, text-coding and cluster analysis.

A team of thematic analysts undertook a manual process of reviewing a subset of approximately 100 responses for each survey question. Through this process, they identified a series of key words or themes for responses to each question in the survey. These key words were compared with words and phrases uncovered by the Artificial Intelligence tools within the survey tool. Additional concepts or frequently used words found by the system were added to the manual process.

Thematic analysts grouped frequent words and phrases into 14 concepts for all responses:

- | | |
|-------------------------------------|---------------------------------------|
| 1. Access | 8. Rehabilitation and recovery |
| 2. Culturally appropriate care | 9. Research |
| 3. Data sharing | 10. Screening and diagnostics |
| 4. Demographic cohorts | 11. Cancer care service streams/types |
| 5. Information and involvement | 12. Support |
| 6. Out-of-pocket costs to consumers | 13. Treatment |
| 7. Prevention and health promotion | 14. Workforce |

Key words or phrases were identified as “tags” within concepts. For example, under the “Access” theme, tags included “care closer to home”, “flexible and better coordinated appointments”, “mobile outreach services”, “reduced wait times”, and “telehealth”. The tags were applied across all survey responses and the frequency in which they occurred enabled the analysts to ascertain the strength of concepts and themes.

The main themes for each question are presented in this report with related quotes from the survey responses and specific suggestions from the survey responses related to each theme. This report is intended to provide an overall summary of the survey feedback to facilitate discussion and development of the draft Queensland Cancer Strategy.

Limitations of data

This report represents the opinions and views of people who responded to the survey. Therefore, it reflects a small proportion of people affected by cancer and people who work in cancer.

More than half of the respondents reported they work for Queensland Health. Responses may be biased towards people who have higher health literacy than the general population.

The survey did not identify respondents' gender and therefore differences in response rates based on gender cannot be reported. However, we know from other surveys that women tend to participate at a higher rate than men which may contribute towards a gender bias in responses.

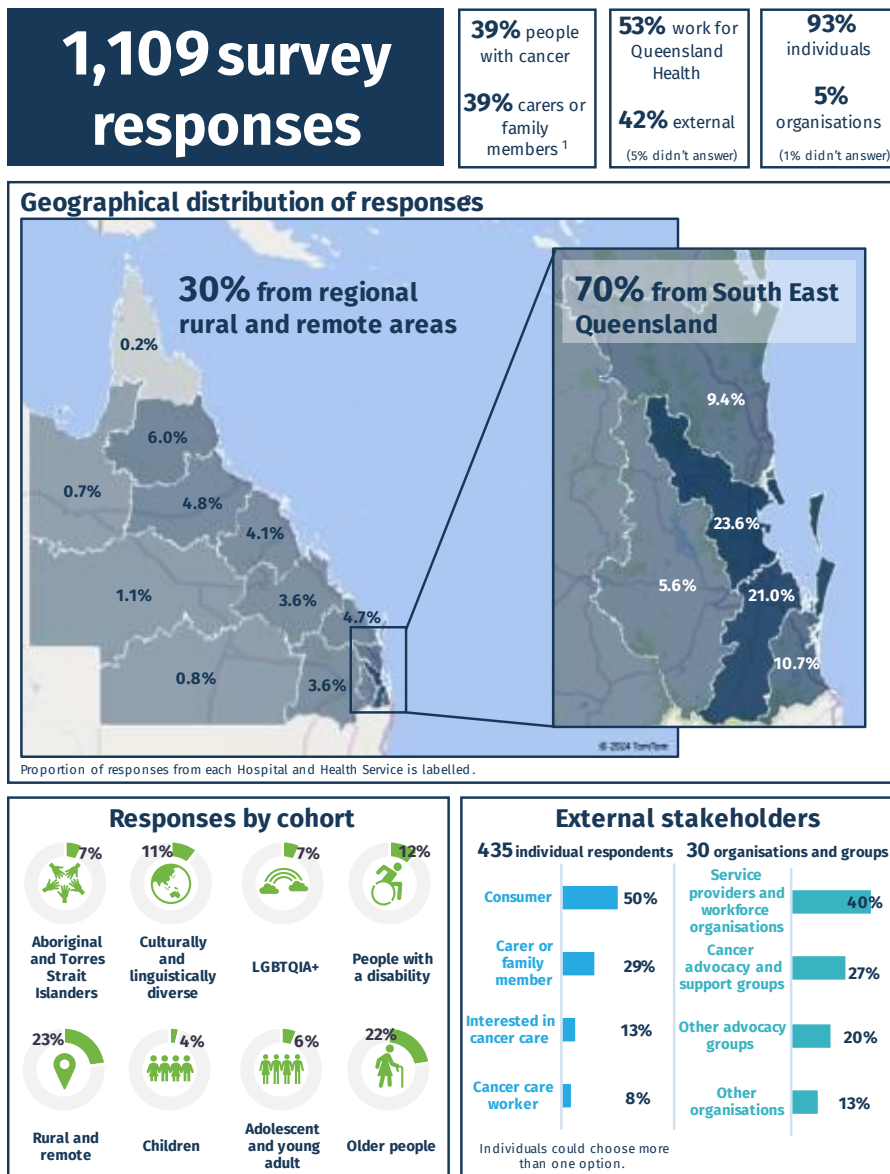
We did not include an option for respondents to identify as representing children under 15 years. This was highlighted as a limitation by groups or organisations representing children. For this report, we relied on child or children being mentioned by respondents, to identify the extent to which this demographic was represented.

A proportion of organisational or group responses may be limited to expressing only the views of the individual who completed the survey rather than reflective of the collective responses from members of the group. This may be due to time constraints in consulting group members or misinterpretation of the question.

Who we reached

The survey aimed to reach a broad range of people and groups across Queensland including priority community groups. Figure 22 outlines who and where we received feedback from in the survey responses.

Figure 2: Demographics of survey respondents.



¹ Individuals could choose more than one option. 67% of responses were from consumers and/or carers and family members. The additional 33% of responses were from people who work in cancer care or who are interested in cancer care based on self-identification across four categories: (1) consumer (2) carer or family member (3) person working in cancer care or (4) person interested in cancer care.

² 971 responses provided a valid Queensland postcode, 11 responses were from interstate. 127 responses did not provide a valid postcode. Postcodes were mapped to Hospital and Health Services (HHSs). South East Queensland HHSs include Metro North, Metro South, Sunshine Coast, Gold Coast and West Moreton. All other HHSs are categorised as regional, rural or remote.

Of the 1,109 responses, only 1,092 respondents read the privacy information and agreed to participate so analysis excluded 17 responses.

What we learned

The key themes in the survey responses were:

- **Rural and remote respondents experience long waits for diagnostic scans, tests and to see a doctor and often must travel long distances to access services.** We heard that your priorities are:
 - Increasing local availability of services using different service models/technology.
 - Reducing travel distance and the cost of travel.
- **Enhanced care coordination and holistic support**, especially for people receiving a new diagnosis. You told us this is also important during recovery from cancer to re-establish day-to-day life.
- **Access to affordable early detection and screening**, especially for priority populations who experience barriers to accessing cancer care or who experience poorer health outcomes when compared to the rest of the population.
- **Increased use of specific models like mobile outreach services and telehealth.**
- **Prevention is critical** and many respondents want to see more investment in prevention including:
 - Increasing diversity in the frontline cancer workforce and health promotion campaigns.
 - More campaigns raising awareness of lifestyle factors that influence cancer risk.
 - More integration of cancer prevention into other health services.
- **More upskilling and training to develop workforce skills** is important to build workforce capacity to provide person-centred care, communicate openly and honestly about a cancer diagnosis and build specialised skills (e.g. chemotherapy nursing, research workforce, building skills in management of specific cancer types.)
- **Consistent, quality information needs to be provided to consumers and carers throughout the cancer journey.** Information needs to be provided in an appropriate format for the individual – some people with cancer cannot access information online, and use of technology to improve information sharing needs to be inclusive.
- **Increasing enrolment in clinical trials across the state and developing systems that allow researchers to collaborate and share findings.**
- **Reducing out-of-pocket costs.** Survey respondents identified the cost of accessing general practice appointments, screening and follow up scans as limiting access, especially for vulnerable populations. Out-of-pocket costs also include the cost of lost income and time off work, travel, and accommodation. These costs are not fully subsidised and disproportionately impact Queenslanders from regional, rural and remote areas.

Preliminary focus areas

Focus area 1: Enhanced consumer and carer experiences through personalised and coordinated cancer care throughout the cancer journey.

What we asked

What solutions must be put in place to enhance consumer and carer experiences through personalised and coordinated cancer care throughout the cancer journey?

What we heard

Consumers and carers want access to a care coordinator and clearer information about options for care and treatment, particularly in the early stages of the cancer journey. In addition, many suggest increasing access to rehabilitation and palliative care.

The attitude of some medical professions can feel a bit like they are afraid to give you a map of the cancer 'national park' and all its different trails and hazards in case you ask too many questions (consume their time) or get overly distressed or confused. However, it can feel like being dropped off in the middle of a dark forest with no map of the area and a torch that is only big enough to illuminate your next immediate small step forwards which is disempowering and frightening/frustrating.
- Survey respondent

Themes in the responses

Theme	Respondent quote	Some of the specific solutions in survey responses
1a. Increase access to care coordinators and nurse navigators across the cancer care journey, focusing on holistic care.	<i>Treat the person not the cancer, treat a person holistically not in silos. Each person has a cancer care coordinator (one to few), to help them navigate their journey (appointments, access to financial and social support without needing to request information).</i>	<ul style="list-style-type: none"> Expand access to cancer nurse care coordinators across cancer types, regional areas and the public/private systems. Develop a care navigation framework to ensure statewide consistency. A body that provides statewide oversight for an integrated and coordinated cancer care system. 'One stop shop' phone support to assist in coordinating travel, accommodation, and financial supports.
1b. Increase access to rehabilitation and allied health, including exercise and social, emotional and economic support during treatment and recovery.	<p><i>After care does not really exist. They do scans but they don't give you physio or rehab or mental support when you are released after cancer surgery. I wish there was someone who came to you to point out your options.</i></p> <p><i>When cancer results in disability, rehabilitation needs to be available and responsive to optimise quality of life even when people's cancer is life limiting.</i></p>	<ul style="list-style-type: none"> Involve rehabilitation services in planning and coordinating support (e.g. NDIS) following diagnosis. Use a social prescribing approach for cancer care. Cancer survivors exercise programs (e.g. YMCA). Community-based rehabilitation services including outreach services for regional/rural areas. Peer support networks incorporating rehabilitation. Cancer care coordination and support centres which have health practitioners and allied health providers who can provide evidence-based services.

Theme	Respondent quote	Some of the specific solutions in survey responses
1c. Increase access to palliative care across all settings.	<i>My personal experience as the family member of two loved ones who have died with cancer is that palliative care was only very loosely suggested, within days of end-of-life, and in both instances, there was a lot of confusion for my family who believed the patients had significantly longer than they did. Both patients experienced more suffering and confusion than they would have if advance care planning and/or palliative care were introduced earlier.</i>	<ul style="list-style-type: none"> • Take an integrative approach to palliative care at all stages of the cancer journey including when cancer is being treated with curative intent or when consumers have metastatic cancer but aren't yet at the end-of-life. • Greater flexibility in eligibility criteria and protocols for palliative care. • Open and non-judgemental discussion about all palliative care options (including voluntary assisted dying) earlier in treatment. • Support for Aboriginal and Torres Strait Islander peoples to return to country to die.
1d. Improve the planning, coordination and communication of outpatient appointments, including reduced waiting times, greater flexibility with scheduling appointments and access to telehealth.	<i>There is a lengthy wait time between seeing your GP to hearing from anybody in the health service about an appointment. I had to follow back up with my GP and it turned out that my paperwork went missing, so I was not on the waiting list to be seen. If I hadn't followed up, I would still be waiting to hear from someone, and my condition could have significantly worsened.</i>	<ul style="list-style-type: none"> • Keep consumers informed of their progress through the system and reduce waiting times or increase predictability of wait times to allow consumers to plan around appointments. • Reduction of unnecessary in person appointments. • Use telehealth models to increase accessibility/convenience. • Provide more care in the home including a wider range of cancer treatments (e.g. chemotherapy). • Better use of electronic patient record for coordinating care.
1e. Increase support for families and carers and include in care plans.	<i>Include carers in patient care discussions - have a chair available for them in appointments, encourage people to bring a support person. Provide referral to community services for carers. Understand that the carer may not be the patient but they can be overlooked in the medical system and need support too.</i>	<ul style="list-style-type: none"> • Partnerships with community organisations to provide psychosocial support to patients and families. • Allied health led models for patient/family education. • Ensure the needs and rights of both patients and carers are recognised and supported. • Allow support people, including friends, family or support workers to accompany people with disabilities.
1f. Enhance workforce capability to have open, honest and respectful communication.	<i>[We need] clinicians and services [that] engage with consumers in honest appropriate language facilitating consumer understanding of the disease, prognosis, treatment options, treatment side effects immediate and delayed, and non-judgemental options, including palliative care when the consumer chooses not to undergo treatment. Therefore the solution is clinician education and support on how to communicate bad news and options.</i>	<ul style="list-style-type: none"> • Practice 'open disclosure' type conversations and models from the very first interactions with consumers and their families. • Coordinated and planned access to education for clinicians across the state. • Communication skills workshop for staff co-designed with consumers and families.
1g. Facilitate greater consumer involvement in decisions regarding cancer treatment planning and follow up.	<i>People diagnosed with cancer should be given treatment choices and time to consider them. I was told the MDT had decided what was best for me - they did not know me, they did not consider my background, and I wasn't allowed a choice. In the end after numerous surgeries and radiation 1 year later another cancer was found in the same area - my choice would have been the better choice. I wasn't even given the opportunity to seek a second opinion.</i>	<ul style="list-style-type: none"> • A clear 'road map' of what to expect at diagnosis and at different stages of the cancer journey. • Establish standardised feedback mechanisms to gather input from consumers and carers regularly. • Increase focus on bolstering consumer health literacy in cancer enabling more accessible and engaging information.

Focus area 2: Better access to cancer screening, prevention and early detection services.

What we asked

What solutions must be put in place to enable better access to cancer screening, prevention and early detection services?

What we heard

A strong theme is the accessibility and appropriateness of screening and prevention services. Survey respondents strongly recognise the importance of prevention, screening, and early detection and suggested services that are more culturally appropriate and convenient for consumers.

Living in a remote area, some cancer screening, prevention and early detection services are not available. Generally for people in my community we have a 1,400 km round trip to access some services. This is very costly in both time and travel/accommodation expenses, and as such some people won't or can't make the trip. There have been many improvements with access to some preventative services with the implementation of mobile screening, however more needs to be done in this arena otherwise people are unable to access potentially lifesaving services because of distance and cost.

- Survey respondent

Participants offered the following solutions for this focus area

Theme	Respondent quote	Some of the specific solutions in survey responses
2a. Greater public awareness and communication around screening including registries that alert individuals when screening is due.	<i>Had it not been for the 'Know your Lemons' poster, I would not have connected a dimple with breast cancer. Australia needs to do better - lumps are not the only sign of cancer.</i>	<ul style="list-style-type: none"> Public health campaigns using videos to improve awareness of self-examination techniques and what visual signs to look for that should prompt them seeking medical attention. Increase awareness of all the evidence-based cancer screening and detection programs available and create simple resources that explain how individual recommendations change based on family history. Partnerships to provide programs that raise public awareness (e.g. healthy ageing programs with local councils).
2b. Availability of tailored information, cultural support workers, and alternative models for screening for First Nations peoples and culturally and linguistically diverse communities.	<p><i>While we may see cervical cancer rates drop to the rate of 1 in 100,000 for all Australians thereby triggering that Cervical Cancer has been eliminated, if we do not see these same rates in First Nations and CALD communities, then we have to question this assertion.</i></p> <p><i>The Cancer Screening Unit used to have a dedicated First Nations project officer who was a point of contact for guidance on First Nations strategies and engagement at the statewide level. This position should be re-established.</i></p>	<ul style="list-style-type: none"> Make use of existing programs that engage First Nations people and culturally and linguistically diverse communities to promote awareness, screening, and culturally safe cancer care (e.g. maternity services to promote women's health screening.) Outreach and community engagement in partnership with community organisations and leaders. Partnerships with local councils for screening options that are not attached to government buildings / entities. Use of social media to better target hard to engage groups.

Theme	Respondent quote	Some of the specific solutions in survey responses
2c. Use mobile outreach services in rural communities e.g. visiting screening services.	<i>You have the BreastScreen mobile vans, servicing so many rural and remote areas, somehow team up with them, to bring Bowel Screening out to the remote areas as well.</i>	<ul style="list-style-type: none"> • Expansion of the Mobile Women's Health Service in regional areas. • Improved access to diagnostics and point-of-care testing in rural and remote areas, to reduce travel. • Mobile computed tomography (CT) services. • Combining screening activities (e.g. cervical screening and skin checks) • Partnerships with organisations like Royal Flying Doctor Service to reach rural communities.
2d. Increased access to screening services for the general population.	<i>Uptake of engagement with these screening programs could be boosted through better integration of health information systems across the continuum, enabling practitioners to identify and prompt eligible unscreened or under screened patients.</i>	<ul style="list-style-type: none"> • Lowering age thresholds for free screening. • After-hours access to screening services (e.g. BreastScreen.) • Consider eligibility for affordable screening as follow up post-treatment (e.g. mammograms post-breast cancer, positron emission tomography scans for monitoring for recurrence.)
2e. Reduce out-of-pocket costs of screening through bulk billing particularly screening that requires GP appointments. Consider the inequities for women who pay more for out-of-pocket screening.	<i>Better yet - lead a national first, by providing FREE breast cancer screening and diagnostic ultrasounds to asymptomatic and symptomatic young women - this small barrier prevents many early diagnoses due to the cost of getting this basic, low-invasive scan.</i>	<ul style="list-style-type: none"> • Access to free or low cost cervical screening for First Nations and culturally and linguistically diverse communities. • All imaging for the detection of cancer should be covered by Medicare or private health cover, including follow up screening post-diagnosis and treatment. (e.g. breast screening post-breast cancer.) • Bulk billed skin checks in general practices to enable everyone to access.
2f. More timely access to diagnostics and results.	<i>Availability. Consider using private facilities/agreements to assist manage demand to result in timely services.</i>	<ul style="list-style-type: none"> • Key performance indicators on waiting times to get diagnostic procedures, e.g. median time from positive screening test to diagnostic procedure. This should report differences for cohorts like Aboriginal and Torres Strait Islander peoples. • Use of Artificial Intelligence to improve scan reporting times.

Focus area 3: Improved health equity where people are not disadvantaged by who they are, where they live, or the resources they have.

What we asked

What solutions must be put in place to improve health equity so people are not disadvantaged by who they are, where they live, or the resources they have?

What we heard

Women, people residing in rural and remote communities, First Nations, culturally and linguistically diverse populations, people with disabilities and people on low incomes and in vulnerable housing are disproportionately affected by out-of-pocket costs in accessing care.

It is impossible to provide equitable care so financial support as well as accommodation and travel are necessary. It is also very daunting for a person from a rural community to navigate large city services; some sort of navigator or chauffeur would be marvellous.

- Survey respondent

Participants offered the following solutions for this focus area

Theme	Respondent quote	Some of the specific solutions in survey responses
3a. Out-of-pocket costs such as travel, accommodation, parking, private healthcare are a barrier to accessing cancer care for regional and rural consumers and people on low incomes.	<i>Reimbursement for patient travel subsidy takes around 4-6 weeks for funds to come through, we have had weeks where it is a choice between buying food or purchasing fuel for upcoming treatment. I had 15 appointments in February, the financial burden makes me feel useless and responsible for struggling.</i>	<ul style="list-style-type: none"> • Reduce out-of-pocket costs for travel and parking. • Access to low / no-cost accommodation for consumers, family or carers. • Quicker, more efficient processes and more adequate reimbursement for travel and accommodation with specific support for priority populations (e.g. children and families, Aboriginal and Torres Strait Islander consumers.)
3b. Care inclusive of social, emotional, cultural and financial impacts of a cancer diagnosis.	<i>As an Aboriginal woman, through my upbringing and experience working within Indigenous communities, it is that sharing personal information to anyone is very hard for an individual, we do not like to be judged, being made to feel like we have done something wrong, others knowing our business, or asking for help.</i>	<ul style="list-style-type: none"> • Consider the needs of whole family within the consumer's cultural context and increase support for families and carers. • Yarning circles to improve health literacy. • First Nations cancer care is co-designed, culturally appropriate. • Increase awareness and build capacity in trusted and embedded community health organisations. • Consider the 'cancer journey' in all strategies and policies for First Nations people. • Reduce stigma, discrimination, and improve the healthcare experience of the LGBTQI+ community.
3c. Increase workforce capability to deliver non-judgemental care/person-centred – choice, holistic care including physical, social, cultural and emotional needs.	<i>Training programs for healthcare providers [that include] understanding cultural nuances, beliefs, and practices related to cancer care among different ethnic communities. By doing so, healthcare professionals can provide more tailored and respectful care that aligns with the patients' cultural backgrounds.</i>	<ul style="list-style-type: none"> • A more diverse workforce with more identified positions. • Non-judgemental, person-centred care that provides choice and is holistic, inclusive of physical, social, emotional and cultural needs. • Increase workforce training in cultural awareness, unconscious bias and non-judgemental communication.

Theme	Respondent quote	Some of the specific solutions in survey responses
3d. Targeted and nuanced approach to specialist workforce positions and workforce training for priority populations.	<i>Adequately resource funding into key survivorship issues such as lymphoedema. Healthcare professionals have poor knowledge, resulting in access and care delays, cellulitis episodes and costs. No medical or other healthcare professional undergraduate degree sufficiently incorporates lymphoedema curricula; despite considerable advancements over the last several decades.</i>	<ul style="list-style-type: none"> • Women’s health and survivorship. • Increase specialist clinical roles through fellowships for child and/or adolescent cancer care or geriatric oncology. • Increase nurse navigator and nurse practitioner roles for priority populations including First Nations, people with disabilities, people from culturally and linguistically diverse communities, sexual health knowledge. • Educate general practitioners on basic oral cancer screening for high risk patients. Promote the adoption of this for people who do not see a dentist regularly. • Extend equitable access to expertise in regional and rural areas.
3e. Tailored outreach services for disadvantaged populations.	<i>Implementing targeted interventions and programs to address the specific needs of vulnerable populations, including racial and ethnic minorities, immigrants, refugees, LGBTQ+ individuals, people with disabilities, and those experiencing homelessness or incarceration. These interventions should be tailored to the unique challenges faced by each group and delivered in culturally appropriate ways.</i>	<ul style="list-style-type: none"> • Outreach services for cancer treatments and trials. • Home visits for older people or people facing difficulties accessing onsite appointments. • Establishing community visits, engagement with local ACCHOs and other local community stakeholders and partners • Expanding access to specialist staff, specialty care nurses, nurse navigators and nurse practitioners via telehealth models especially for rural and remote residents and for people who have reduced mobility.
3f. Co-designed health promotion campaigns that are engaging and accessible to diverse populations such as First Nations people, people with disabilities and culturally and linguistically diverse populations.	<i>Use more diverse actors in your ads, resources and promotions, visit people in their workplace, support services, cultural centres, train up locals in some of the early detection methods, and provision of support. Provide more treatment services closer to where people live.</i>	<ul style="list-style-type: none"> • Greater diversity representation of the Queensland population in health promotion campaigns. • Co-designed programs and support.
3g. More timely access to diagnostic tests and results in regional and rural areas and treatment and care closer to home.	<i>It is horrific for us to wait weeks for a test result on whether the cancer has recurred or not.</i>	<ul style="list-style-type: none"> • Increased nurse led and allied health clinics. • Satellite health clinics in regions with multidisciplinary teams. • Increase the number of public radiation therapy centres and improve access to specialised diagnostics, such as positron emission tomography scans, in regional areas.
3h. Expand existing services for consumer information and support.	<i>Queensland Cancer Council has a good phone line support but this is not as comprehensive and accessible as it could be.</i>	<ul style="list-style-type: none"> • A support telephone line that cancer patients could call rather than having to rely on online resources or Emergency Departments after hours. For example, 13HEALTH specifically for cancer, a contact phone number for cancer/cancer hotline. • Increased volunteer support including peer support, social support and drivers.
3i. Infrastructure and physical environments for care that supports people with diverse needs.	<i>Incorporate functional accessible design features like dimmable lighting, private waiting rooms and breakout spaces for quieter areas, adult continence change equipment, continence bins, ostomy cleaning facilities in accessible toilets, accessible equipment, hoists and hearing loops.</i>	<ul style="list-style-type: none"> • Consider accessibility and cultural appropriateness in the design of infrastructure for cancer care services, including digital tools. • If consumers need to present to emergency departments, provide a separate space to avoid public waiting areas while immunocompromised.

Focus area 4: Coordinated and statewide approach to research, innovation and education.

What we asked

What solutions must be put in place for a coordinated statewide approach to research, innovation and education?

What we heard

There is strong support for more opportunities for research, innovation and education across the state, including access to clinical trials, particularly in rural and regional areas.

The skill set of researchers are always concentrated in tertiary and metro centres. They have more skilled researchers at writing grant applications, more runs on the board to get ongoing funding, clinical trial resourcing from external companies. You need to once again increase funding for regional and remote researchers and allow for positions to conduct research as their role, not on top of their clinical role.
- Survey respondent

Participants offered the following solutions for this focus area

Theme	Respondent quote	Some suggested solutions
4a. Better coordination and oversight of research, education and innovation across Queensland.	<i>This is a challenge because much of the research, innovation and education relies on joint and coordinated efforts between the tertiary, private research, public health and private cancer organisations to identify, fund, staff and support research, innovation and education. Some of our employment conditions in Queensland Health restrict free movement of staff in and out of the Queensland Health system as well as resourcing. Perhaps there needs to be a separate entity that allows the researchers, innovators and educators to come together in a shared environment where they can take the time to explore their areas of interest and expertise.</i>	<ul style="list-style-type: none"> Establish a centralised body with representatives from academia, industry, government agencies, and community organisations to develop and oversee a statewide research and innovation strategy and take responsibility for ensuring a coordinated statewide approach to cancer research. This would streamline to reduce cost and duplication. Advocate for statewide policies and initiatives that support and prioritise cancer research, innovation and education. Encourage multi-site, cross-agency and cross-discipline collaboration and partnerships to foster innovation and knowledge exchange. Undertake a national and global approach to research, innovation and education, not just statewide.
4b. Fund research and support the workforce to engage in research, innovation and education activities.	<i>Queensland Health accreditation should be across all facilities to allow staff with expertise in an area and who are accredited at a Queensland Health facility to travel to other sites and share their expertise, to encourage multicentre research and to allow innovations to be shared quickly across facilities. There are too many bureaucratic hurdles to research and education outside of a clinician's main hospital.</i>	<ul style="list-style-type: none"> Provide more funding for research and clinical trials, share research funding across different cancers and distribute funding to both smaller research areas and larger corporates. Invest in the necessary resources including workforce and information technology systems. Allow protected time for clinicians to undertake research and educational activities. Support the retention of the cancer research workforce by providing grants and scholarships, appropriate remuneration and working conditions for researchers and recognition and reward programs.

Theme	Respondent quote	Some suggested solutions
4c. Increase consumer opportunities for participation in research, innovation and education.	<p><i>In the First Nations space, we need to hear the priorities of Communities in relation to cancer research. We need multiple First Nations Community Juries and Human Research Ethics Committees that provides Community approval for research being conducted with First Nations people. The priorities of Community should be the focus of innovation education and research.</i></p>	<ul style="list-style-type: none"> • Increase publicity about opportunities for cancer consumers to participate in research and clinical trials. Promote the benefits and importance of clinical trials to patients to increase participation. • Create a publicly accessible database to enable consumers and their treating health professionals to see the clinical trials conducted across the state. • Consult with First Nations communities to understand their priorities in relation to innovation, education, and research. • Public reporting on research outcomes and their translation into clinical care.
4d. Expand opportunities for regional, rural and remote consumers to participate in clinical trials.	<p><i>Improving access to clinical trials for patients in regional and rural centres is important. There are initiatives now that are looking into that. The aim would be for satellite centres so that patients can be treated close to home. If not possible then easier ability for patients to travel to participate in major trials. Some HHSs will not support travel for patients to be in a trial. For trial participation in regional centres to occur, this will require nurse and trial support groups within the HHS.</i></p>	<ul style="list-style-type: none"> • Enable rural and remote patients to access and participate in clinical trials via telehealth and home-based care. • Ensure sustainable funding for research and clinical trials in the regions. • Increase funding for regional and remote researchers and allow for positions to conduct research as part of their role.
4e. Translate research into clinical practice.	<p><i>Supporting translational research initiatives that bridge the gap between scientific discovery and clinical application, facilitating the translation of research findings into new treatments, diagnostics, and healthcare practices that benefit patients and communities. This may involve establishing translational research centres, providing funding for technology transfer and commercialization activities, and fostering partnerships with industry partners.</i></p>	<ul style="list-style-type: none"> • Ensure comprehensive cancer centres and networks prioritise research and research translation. • Support translational research initiatives e.g., the establishment of translational research centres. • Consult with existing translational research-to-clinic models to inform Queensland's translational research system.
4f. Enable systems that allow data sharing.	<p><i>Better data sharing. Currently difficult to get imaging reports/investigations from private providers for patients in the public system.</i></p>	<ul style="list-style-type: none"> • Support data linkage across different settings. • Establish a centralised repository of research, innovation and education initiatives and create platforms that facilitate data sharing and collaboration among researchers, innovators, and educators. • Promote data sharing and integration including developing standardised protocols for data collection, storage and sharing.

Partnership opportunities

What we asked

Partnerships will play a key role in strengthening cancer services. What are the opportunities for collaboration both within Queensland Health and/or with primary care, private providers, universities, non-government organisations and communities? Why are these partnerships important?

What we heard

The Queensland Cancer Strategy provides the opportunity for Queensland Health, partner organisations and Queensland's diverse communities to collaborate on a more efficient model of comprehensive cancer care that addresses health inequity. Strong partnerships are critical to achieve outcomes across all focus areas.

The sum is bigger than all the parts.
- Survey respondent

Participants offered the following solutions for this focus area

Theme	Respondent quote
5a. Strengthen partnerships to achieve the focus areas.	<i>Effective partnerships optimise delivery of clear, evidence informed, coordinated and responsive care approaches consistently for Queenslanders across the cancer care continuum. Quite simply better outcomes are delivered through collaboration rather than a siloed service delivery approach.</i>
5b. Partnerships for an efficient and comprehensive approach to cancer care.	<i>Partnerships allow us to pool resources, knowledge and expertise. They allow us to work collaboratively, leverage resources and maximise impact to improve health outcomes and address public health challenges. Partnerships [are required to] connect the various services to work as a whole instead of separately.</i>
5c. Partnerships are critical to design and deliver equitable cancer care services.	<i>Engage with representative bodies to understand their perspectives on the challenges and opportunities around cancer services. By fostering collaboration across these sectors, Queensland Health can leverage diverse expertise, resources, and networks to enhance cancer services, improve health outcomes, and address the unique needs of communities across the Queensland region.</i>

Other ideas

What we asked

Do you have additional ideas for improving cancer services in Queensland that are not covered in the focus areas?

What we heard

A truly connected system across Queensland with greater collaboration between metropolitan and regional and rural areas.
- Survey respondent

395 (41.7 per cent) respondents shared “other” ideas for improving cancer care. Many of the “other” ideas that were shared by these respondents are already highlighted in focus areas.

Other ideas that are not specifically mentioned in the focus area themes include:

Theme	Respondent quote	Some of the specific solutions in survey responses
Increased consumer involvement and co-design reflective of the diversity of people who are affected by cancer.	<i>Robust co-design where people with lived experience are truly engaged in the co-design of solutions to existing sub-optimal areas of cancer care as indicated by PREMS and PROMS and other measures.</i>	<ul style="list-style-type: none"> Collect and use patient reported measures for cancer care. Involve a greater diversity of consumers in co-designing all aspects of cancer care including health promotion, health literacy, service improvements, planning and designing services and research.
Therapies that support the mind, body and spirit integrated into cancer care.	<i>Holistic care with more therapies, massage, inclusion of music therapy in Queensland oncology services to support pain reduction, anxiety reduction, meaning making and legacy making in palliative care.</i>	<ul style="list-style-type: none"> Therapies that support this theme included art, music, pet therapy, massage therapy.
Complementary therapies and medicines.	<i>Decriminalising marijuana and further research into natural remedies, cures, etc. There is an untapped potential, no matter how controversial.</i>	<ul style="list-style-type: none"> Understanding elements of diet and exercise that can assist during treatment and survivorship. Access to medicinal cannabis.

Next steps

Queensland Health will consider all feedback received through the consultation survey when developing the draft Queensland Cancer Strategy. The draft strategy, aimed at building a more connected cancer care system for Queensland over the next 10 years will be available for further consultation in June 2024.