

WORK IN PARTNERSHIP INCREASE
UNDERSTANDING OF CANCER RISKS
HELP PREVENT CANCER PROMOTE
SCREENING AND EARLY DETECTION
ENHANCE EQUITABLE ACCESS FOR
PATIENTS AND FAMILIES PROPEL
KNOWLEDGE TO ACTION

ANNUAL REPORT 2007-2008

CANADIAN PARTNERSHIP
AGAINST CANCER



PARTENARIAT CANADIEN
CONTRE LE CANCER



THE CANADIAN PARTNERSHIP AGAINST CANCER: A VISION BECOMES REALITY

In April 2007, the Canadian Partnership Against Cancer Corporation (the Partnership) began operations as an independent, non-profit organization with a \$250-million, five-year commitment from the Government of Canada.

The Partnership evolved from the Canadian Strategy for Cancer Control – a volunteer-driven coalition of cancer groups, experts, patients and survivors working to counteract the growing burden of cancer on Canadian society. The coalition drafted Canada's first national cancer control plan and advocated successfully for its funding. The Partnership was established to accelerate implementation of the strategy.

In our initial five-year mandate, the Partnership is enabling cancer control efforts across the country by bringing together cancer survivors, patients and families, as well as clinical experts and government representatives. Central to our mandate is knowledge translation – helping to move what is known about cancer control into action across the country and helping to fill key knowledge gaps.

OUR VISION

We strive to improve cancer control in Canada by being a catalyst for a coordinated approach that will:

- Reduce the expected number of cancer cases
- Enhance the quality of life for those affected by cancer
- Lessen the likelihood of Canadians dying from cancer
- Increase effectiveness and efficiency of the cancer control domain

WHY A NATIONAL STRATEGY?

With 10 provinces, three territories and many organizations working toward the same goals, the Partnership represents an unprecedented opportunity to share the best available knowledge and to enhance the unique strengths of diverse stakeholders through support and collaboration.

To achieve our vision, we work with partners across the cancer control continuum. Some of our partners provide care to patients. Others advocate for change. Some raise money and fund research programs. Some are policy-makers. These are not our roles and we do not duplicate their efforts.

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HOW CANCER CONTROL DIFFERS FROM CANCER CARE

Cancer control spans prevention, screening, surveillance, guidelines, education and research, as well as treatment and supportive care.

Cancer control is broader than cancer care in that it involves the entire population – not only those who have been diagnosed with cancer and are being treated within the cancer care system.

“A well-conceived, well-managed national cancer control programme lowers cancer incidence and improves the life of cancer patients, no matter what resource constraints a country faces.”

World Health Organization

“The Partnership plays an important role in knitting together the efforts of many so we can understand as a nation how we can advance cancer control.”

Jeff Lozon, Chair of the Canadian Partnership Against Cancer

MESSAGE FROM THE CHAIR AND CHIEF EXECUTIVE OFFICER



Jeffrey C. Lozon
Chair

This annual report speaks to the milestones of our first year building the Canadian Partnership Against Cancer. It reports on strong governance and accountability, strategic focus and impact, and the crucial role of partnerships and collaboration in all our initiatives. These are cornerstone achievements for the Partnership's success. But, we must all remember they are simply the means to a greater goal.

That goal is a coordinated, effective and efficient cancer control domain that serves all of us as Canadians – a system that helps prevent cancer, enhances quality of life through survival or end-of-life care and makes it so that fewer members of our families, friends, co-workers and neighbours will die from cancer.



Jessica Hill
Chief Executive Officer

This year 73,800 Canadians are expected to die from cancer*. Each of us will probably know at least one of them personally. Another 166,400 will be told they have cancer – that is more than the combined populations of Fredericton, N.B., Medicine Hat, Alta., and Granby, Que. That is too many people we know and care about.

As the Partnership moves decisively toward implementing sustainable and measurable outcomes, there is no doubt about the breadth and complexity of the challenge. Nonetheless, we are confident that with the growing momentum that has propelled us in our first year, we are solidly on track as a catalyst for positive change in cancer control – a change that will make a difference in the lives of Canadians.

*Canadian Cancer Society/National Cancer Institute of Canada: Canadian Cancer Statistics 2008, Toronto, Canada, 2008

Our belief in the power of partnerships is the springboard for our achievements. These include launching CAREX Canada, which focuses on exposures to cancer causing agents, and the Canadian Partnership for Tomorrow Project, a long-term study of 300,000 people to identify the causes of cancer and other chronic diseases. All the initiatives presented in this report highlight the value of collaboration and the growing momentum in cancer control.

Our strategic plan remains true to our roots in the Canadian Strategy for Cancer Control. The priorities have not changed. Six Key Areas of Focus have been defined – areas where we know important outcomes can be achieved within our initial five-year mandate. Knowledge translation across all areas remains central to our work.

Our Board of Directors, Advisory Council on Cancer Control and senior management team are now in place. A professional staff supports the team and the Partnership's initiatives. Diverse networks of experts form Action Groups dedicated to implementing our priorities. These partnerships are essential to our success.

We continue to work closely with provincial cancer agencies, government departments and charitable and non-governmental organizations. Many of these groups were advocates for the original strategy, and we thank them and the federal government for their vision and commitment. We are excited by the energy they, and all of our partners, bring to our common purpose.

Jeffrey C. Lozon, Chair

Jessica Hill, Chief Executive Officer

OUR MISSION

We are a partnership of cancer experts, charitable organizations, governments, patients and survivors, determined to bring change to the cancer control domain.

We work together to stimulate generation of new knowledge and accelerate the implementation of existing knowledge about cancer control across Canada.

OUR VALUES

Building on the principles defined in the Canadian Strategy for Cancer Control, the Partnership pursues its mission guided by core values. We are:

- Transparent to the public, our partners and stakeholders
- Accountable to Canadians
- Collaborative with experts in Canada and around the world
- Innovative in our approach to accelerating cancer control
- Respectful of federal, provincial and territorial boundaries
- Integrative and inclusive to ensure we represent a pan-Canadian approach
- Evidence-driven in decision-making

INAUGURAL BOARD OF DIRECTORS 2007-2008

A key step in building our foundation was the establishment of the Board of Directors in May 2007. This very talented and experienced group – with representatives from cancer organizations, the provinces/territories, patient, family and survivor groups, the Aboriginal community and the federal government – is ensuring strong governance and accountability.

Jeffrey C. Lozon, Chair

President and Chief Executive Officer of St. Michael's Hospital, Toronto

Simon Sutcliffe, MD, Vice-Chair

President and Chief Executive Officer of the BC Cancer Agency, Vancouver

Chris Clark

Chief Executive Officer and Canadian Senior Partner of PricewaterhouseCoopers LLP, Toronto

Peter Crossgrove

Past Chair of the Canadian Association of Provincial Cancer Agencies, Sudbury

Lindsay Crowshoe, MD

Assistant Professor at the University of Calgary, member of the Piikani Nation of Alberta, primary health-care provider, Calgary

Louis Dionne, MD

Cancer surgeon and pioneer in palliative care and founder of the Maison Michel Sarrazin, Quebec City

René Gallant

Past National President of the Canadian Cancer Society, Halifax

Perry Kendall, MD

Provincial Health Officer for British Columbia, Victoria

Joy Maddigan

Assistant Deputy Minister for the Department of Health and Community Services for Newfoundland and Labrador, St. John's

Paddy Meade

Deputy Minister of Alberta Health and Wellness, Calgary

Gary Semenchuck

Past Chair of the Saskatchewan Cancer Agency, Regina

Marla Shapiro, MD

Associate Professor in the Department of Family and Community Medicine at the University of Toronto, medical consultant/contributor for the CTV Broadcasting Network, cancer survivor, Toronto

Terrence Sullivan, PhD

President and Chief Executive Officer of Cancer Care Ontario, Toronto

Laura M. Talbot

President and Senior Partner TalbotAllan Consulting, Kingston, Ont.

Sally Thorne, PhD

Professor and Director of the School of Nursing at the University of British Columbia, Vancouver

Elizabeth Whamond

Co-founder Breast Cancer Survivors Fredericton, First President of the New Brunswick Breast Cancer Network, First President of the Canadian Breast Cancer Network, Vice-Chair of the Canadian Cancer Action Network and Chair of the Cochrane Collaboration Consumer Network, Fredericton

Barbara Whyllie, MB BCh BAO

Chief Executive Officer of the Canadian Cancer Society, Toronto

Arlene Wilgosh

Deputy Minister of Health and Healthy Living for Manitoba, Winnipeg

Observer: Antoine Loutfi, MD

Director of Cancer Control for the Quebec Ministry of Health and Social Services, Quebec City

“By combining our strengths, pooling resources, and sharing best practices, collaboration within the cancer control community will enable us to advance towards our shared goals of eradicating cancer and enhancing quality of life for Canadians living with cancer.”

Dr. Barbara Whyllie, Partnership Board member and Chief Executive Officer of the Canadian Cancer Society.

ADVISORY COUNCIL

ADVISORY COUNCIL ON CANCER CONTROL 2007-2008

Simon Sutcliffe, MD, Chair

President and Chief Executive Officer of the BC Cancer Agency and Vice-Chair of the Canadian Partnership Against Cancer, Vancouver

Heather Bryant, MD, PhD, Vice-Chair*

Vice-President and Chief Information Officer and Director of the Division of Population Health and Information, Alberta Cancer Board, Calgary
**Dr. Bryant was the first Vice-Chair of the Council, but stepped down when she was appointed Vice-President Cancer Control for the Partnership in January 2008.*

Bob Allen

Surveillance Action Group Chair
Chief Executive Officer of the Saskatchewan Cancer Agency, Regina

Harley J. Ast

Board member of the Canadian Prostate Cancer Network (Regina), President and CEO of the Campaign to Control Cancer, member of Health Canada's Scientific Advisory Committee on Oncology Therapies, Regina

Carrie Bourassa, PhD

Assistant Professor in the Department of Science at the First Nations University of Canada, Regina

Philip E. Branton, PhD

Research Action Group Chair
Scientific Director, CIHR Institute of Cancer Research, Montreal

George P. Browman, MD

Cancer Guidelines Action Group Chair
Medical Oncologist at BC Cancer Agency and Clinical Professor in the Department of Healthcare and Epidemiology at the University of British Columbia, Victoria

Mark Elwood, MD

Vice-President of Family and Community Oncology for the BC Cancer Agency, Vancouver

Margaret I. Fitch, PhD

Rebalance Focus/Cancer Journey Action Group Chair
Head of Oncology Nursing and Supportive Care and Director of the Psychosocial and Behavioral Research Unit at the Odette Cancer Centre, Sunnybrook Health Science Centre, Toronto

Eva Grunfeld, MD, DPhil

Director of Cancer Outcomes Research Program at Cancer Care Nova Scotia and Professor in the Division of Medical Oncology at the Department of Medicine, Dalhousie University, Halifax

Jessica Hill

Chief Executive Officer of the Canadian Partnership Against Cancer, Toronto

Barbara Kaminsky

Chief Executive Officer of the Canadian Cancer Society, BC and Yukon Division, Vancouver

Alan Katz, MBChB

Primary Prevention Action Group Chair
Associate Professor in the Departments of Family Medicine and Community Health Sciences, University of Manitoba and Associate Director of the Manitoba Centre for Health Policy, Winnipeg

Elisa Levi

Public Health Research and Policy Analyst at the Assembly of First Nations, Toronto

Verna Mai, MD

Screening Action Group Chair
Director of Screening for Cancer Care Ontario, Toronto

Anthony Miller, MD

Quality and Performance Assurance Action Group Chair
Professor Emeritus at in the Department of Public Health Sciences, University of Toronto, Toronto

Ellen Murphy

Director of Prevention for the Division of Population Health, Alberta Cancer Board, Calgary

Andrew Padmos, MD

Health Human Resources Action Group Chair
Chief Executive Officer of the Royal College of Physicians and Surgeons of Canada, Ottawa

Michael Richards, MD

National Cancer Director for England, National Health Service, London, UK

Paul Rogers, MBChB

Clinical Professor and Head Pediatric Oncologist at BC Children's Hospital and University of British Columbia, Vancouver

Jack Siemiatycki, PhD

Professor and Canada Research Chair in Environmental Epidemiology and Population Health and Guzzo Chair in Environment and Cancer at the University of Montreal, Montreal

Brent Schacter, MD

Standards Action Group Chair
Chief Executive Officer of the Canadian Association of Provincial Cancer Agencies (CAPCA), Winnipeg

Jack Shapiro

Chair of the Canadian Cancer Action Network, Toronto

Isaac Sobol, MD

Chief Medical Health Officer for Nunavut, Iqaluit

Sylvie Stachenko, MD

Deputy Chief Public Health Officer of the Public Health Agency of Canada, Ottawa

Observer: Jean Latreille, MD

Hemato-Oncologist at Charles LeMoigne Hospital, Longueuil, Que.



PARTNERSHIPS

The Canadian Cancer Action Network

The Canadian Cancer Action Network (CCAN) is a volunteer-led, incorporated organization, mandated to ensure patient interests are key to the national cancer agenda. Uniting cancer patient support organizations and other groups from across Canada, CCAN brings a collective patient voice to support and inform our work. CCAN – one of the driving forces behind the initial pan-Canadian strategy – is now an affiliate of the Partnership. It will receive funding in 2008-2009 to enable it to deliver on patient-focused projects and initiatives. “The core of our cancer system is patients, survivors and their families,” says Jack Shapiro, Chair of CCAN. “We must ensure that their voices are instrumental in reshaping and improving the cancer landscape across Canada.”

Our strength is drawn from the knowledge, energy and dedication of hundreds of groups and individuals, and our impact is through collaboration and partnership.

We value our relationships with federal, provincial and territorial governments, and our collaborative work with cancer agencies and the Canadian Cancer Society is central to our success as a catalyst for a coordinated national approach to cancer control. These organizations play an instrumental role in implementing the strategy as they plan and deliver cancer programs and services, and provide information to patients and their families. Consistent with our knowledge translation mandate, they are critical to developing and sharing best practices in a pan-Canadian way to achieve tangible outcomes in cancer control.

Provincial, national and international groups, such as the International Union Against Cancer (UICC), the Campaign to Control Cancer and the Cancer Advocacy Coalition of Canada are also key partners.

Our Advisory Council on Cancer Control draws on expertise from across the cancer community. Numerous individuals and groups contribute time and expertise with Action Groups and make it possible to transform ideas into action.

CCAN MEMBER ORGANIZATIONS:

Assembly of First Nations
Brain Tumour Foundation of Canada
Canadian Breast Cancer Network
Canadian Cancer Society
Canadian Liver Foundation
Canadian Lung Association
Canadian Prostate Cancer Network

Canadian Skin Patient Alliance
Canadian Thyroid Cancer Support Group
Cancer Advocacy Coalition of Canada
Carcinoid-NeuroEndocrine Tumour Society Canada
Childhood Cancer Foundation Candlelighters
Canada
Coalition Priorité Cancer au Québec

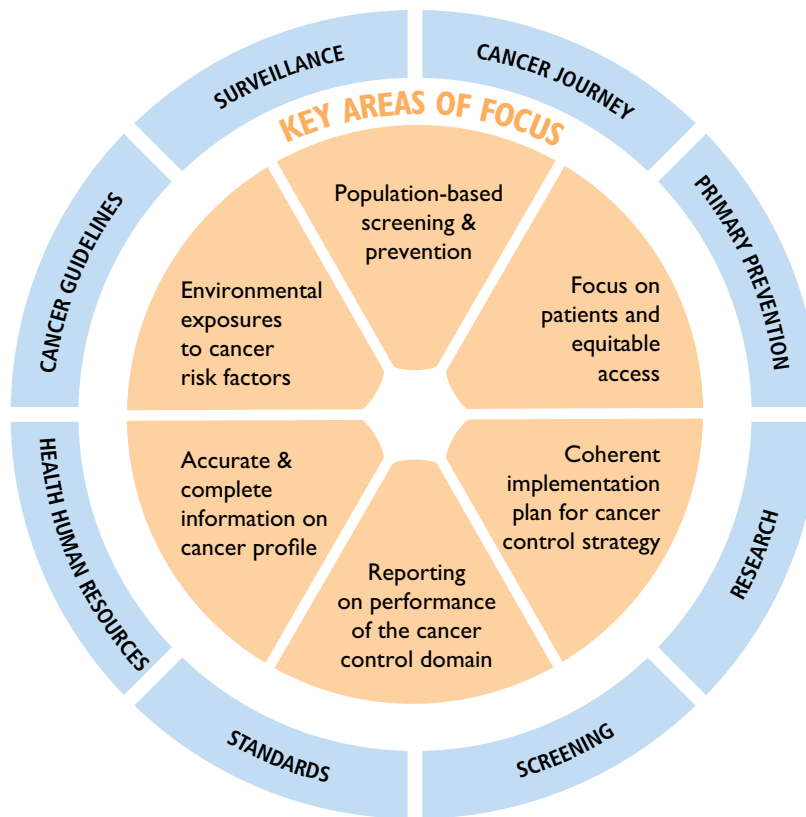
Colorectal Cancer Association of Canada
Inuit Tapiriit Kanatami
Kidney Cancer Canada
Leukemia & Lymphoma Society of Canada
Lung Cancer Canada
Lymphoma Foundation Canada
Ovarian Cancer Canada

STRATEGIC DIRECTION

A SHARPENED FOCUS ON SHARED GOALS

Cancer control priorities are shared by organizations worldwide: enhancing prevention, screening and early detection, person-centred care, clinical practice guidelines and standards, research, surveillance (the gathering and analysis of data related to cancer) and supporting the cancer workforce.

Over the past year, the Partnership has identified areas within these priorities where we know we can work with partners to have impact on the cancer control landscape. Some address very specific areas of cancer control, such as population-based screening, while others target the broader cancer control domain.



“It is exciting to see the potential for measurable and sustainable advancements that exists in each of these Key Areas of Focus. With the support of clearly defined strategic initiatives that reflect important priorities, they will surely strengthen the Partnership’s ability to effect positive change in the cancer control domain.”

Dr. Simon Sutcliffe, Vice-Chair of the Partnership, Chair of the Advisory Council on Cancer Control and President of the BC Cancer Agency.

WHAT MORE CAN BE DONE TO HELP CANADIANS AVOID CANCER



Prevention is considered a cornerstone of cancer control worldwide and it is crucial to the Partnership's overall strategy.

Certain cancer-causing agents occur in the environment where we live, while others are tied to lifestyle choices we make or other factors. The Partnership's activities that raise awareness of risks will support prevention efforts for individuals, researchers and policy-makers.

Prevention takes place on many levels. Our work includes helping to build a stronger evidence base to support prevention initiatives as well as enhancing research, surveillance, public awareness and training capacity across the country.

As well, there is recognition of the role of common causes with other diseases. Diabetes and heart disease, for example, are tied to cancer risk factors such as poor nutrition, smoking and lack of physical activity. Working relationships and partnerships with other disease groups will maximize the impact of our work on the overall health of Canadians.

“An estimated 50 per cent of cancers can be prevented. While the rewards of concerted efforts to prevent cancer will not be immediate, primary prevention efforts can substantially reduce the number of deaths and the amount of suffering experienced as a result of cancer.”

Dr. Alan Katz, Chair of the Primary Prevention Action Group and Manitoba Medical Service Foundation Clinical Research Professor in Population Medicine at the University of Manitoba.

In 2007-2008

- CAREX Canada, a national system of carcinogen surveillance, was launched to provide an in-depth examination of environmental and occupational exposures to cancer-causing agents.
- Information was compiled and disseminated on several aspects of prevention, such as sun safety, in order to build knowledge and raise awareness of cancer risk factors.
- A survey of family physicians served as the basis for key initiatives, such as the development of e-learning tools, to support family doctors in the goal of primary prevention.

Looking Ahead

- The relationship between sun exposure, Vitamin D and skin cancer risk will be examined through a national consultation in 2008.
- A survey of public perceptions of cancer risks and prevention will form the basis of targeted public education messages.
- Development will continue on a Canadian program that builds on research by the World Cancer Research Fund connecting cancer risk to nutritional factors and physical activity.
- Initiatives will focus on infectious agents, such as the human papilloma virus, and their role in causing cancer.

CAREX Canada

PROJECT HIGHLIGHT

- PARTNERS:** Based at the University of British Columbia, CAREX Canada is led by the School of Environmental Health's Paul Demers, PhD, and will encompass work by partners within and beyond the cancer community. The project is based on a system developed by the Finnish Institute for Occupational Health.
- OBJECTIVE:** To develop estimates of the number of Canadians exposed to cancer-causing agents (carcinogens) in their workplaces and communities and, if possible, identify how and where people are exposed and determine their level of exposure.
- HOW:** Estimates will be generated from existing data sources in combination with census population estimates, using the best available exposure estimation procedures. The project will draw on data from regulatory agencies and research, government and private sources across Canada.

The principal uses of information generated by this project will be primary prevention, exposure and disease surveillance, and research. Initiatives based on the data will include:

- setting priorities for prevention-related activities
- assessing the impact of policy, regulations, and interventions
- assisting with the identification of the causes of specific cancers
- investigating why large geographic differences in cancer rates exist in Canada
- monitoring trends in carcinogen exposure and cancer prevalence over time

See also: www.carexcanada.ca

Screening



HOW CAN SCREENING PROGRAMS BE SUPPORTED AND ENHANCED ?

In 2007-2008

- A National Colorectal Cancer Screening Network was established.
- As part of the Partnership’s overall cancer risk modelling project, a multi-year project was launched to create a mathematical model for cancer screening in the Canadian population.
- A national screening conference brought together 70 key players, representing a wide range of cancer screening program planners and stakeholders.
- The characteristics of different types of fecal occult blood tests were examined in a literature review.
- Initial work was completed to develop education tools that will help Canadians make informed decisions about screening.

Looking Ahead

- Collaboration will be facilitated among the numerous players in the field of cervical cancer screening in order to promote consistent action and messaging about screening and prevention. Much of this work will focus on the opportunities for prevention presented by the human papilloma virus (HPV) vaccine and HPV testing.
- Ongoing work by the Partnership to develop common quality assurance indicators and other related initiatives will support the work of provinces and territories in initiating colorectal screening programs.

Catching cancers early can have significant impact on treatment and survival. With effective tests available for the early detection of breast, cervical and colorectal cancer, championing the use of screening in these areas is vital.

The Partnership supports organized delivery of screening through population-based programs, which offer high-quality tests to everyone in a demographic group. Screening programs will be supported through the development of performance indicators, the sharing of effective strategies to improve access and participation, and fostering collaborative work across jurisdictions.

The Partnership’s approach has a special focus on colorectal cancer – a cancer that is expected to kill 4,800 men and 4,100 women in Canada this year*. It is also a cancer that is easily treated when detected in its early stages. The Partnership supports use of simple home fecal tests as the first step in population-based screening for colorectal cancer.

“Effective cancer screening will save lives. We have a tremendous opportunity through the Partnership to maximize the positive impacts of early detection across Canada for those populations for whom it is recommended.”

Dr. Verna Mai, Chair of the Screening Action Group and Director of Screening for Cancer Care Ontario.

*Canadian Cancer Society/National Cancer Institute of Canada: Canadian Cancer Statistics 2008, Toronto, Canada, 2008

Focus on colorectal screening

The biggest barriers to colorectal cancer screening may be inadequate information and lack of awareness. “Inconsistent recommendations about colorectal cancer screening make it difficult for primary care practitioners to decide which tests to offer,” says Dr. Heather Bryant, Vice-President of Cancer Control for the Partnership. For example, some family doctors lack awareness of the evidence in favour of fecal occult blood test (FOBT) screening. As well, resources and the ability to plan for follow-up colonoscopies can be a challenge.

Some physicians may believe their patients will be reluctant to take the test, but evidence from other types of screening tests and other jurisdictions contradicts this. “We might be overprotecting our patients’ sensibilities,” notes Dr. Bryant.

Simple and effective – Fecal Occult Blood Test (FOBT)

There is clear evidence supporting the Fecal Occult Blood Test as a baseline for colorectal screening – annual or every-second-year testing reduces mortality. The FOBT is used to detect blood in the stool that is not visible to the naked eye. Stool samples collected at home are sent to a laboratory for testing. While the presence of blood may not mean cancer is present – blood can arise from non-cancerous sources – it does signal the need for

Toward a national strategy: National Colorectal Cancer Screening Network

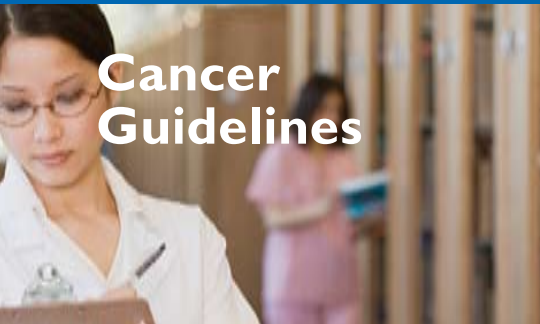
Coordinated efforts to share information and build awareness are vital to boosting population-based programs and improving screening rates across the country. With that ultimate goal, the National Colorectal Cancer Screening Network was established in December 2007.

The Network includes representatives from all the provinces, the Canadian Cancer Society, the Canadian Cancer Action Network, the Colorectal Cancer Association of Canada, the Canadian Association of Gastroenterology, and the Public Health Agency of Canada. Representatives of Canada’s territories are also involved.

The Network draws on the work of the Partnership in various areas, including Guidelines and Knowledge Management, to give policy-makers a national perspective from which to review and discuss matters and, most importantly, to take action on colorectal screening. With three provinces – Alberta, Manitoba, Ontario – already implementing population-based colorectal screening programs, the Network is working to hasten the development of high-quality programs across the country.



further testing. This is usually a colonoscopy where a doctor examines the inside of the colon and rectum with a flexible, lighted tube that sends images back to a video screen. The FOBT is recommended for men and women aged 50-74. People with special risk factors such as a family history should speak to their doctors about whether additional testing is required.



Cancer Guidelines

HOW CAN EVIDENCE-DRIVEN PRACTICES BE ENCOURAGED



In 2007-2008

- Established an agreement with an international collaboration group to use the ADAPTE process for guideline development.
- Five pilot projects were launched as part of the Synoptic Reporting project (see page 13).
- Two clinical practice guidelines were developed: comprehensive management of pain when cancer has spread to the bone and, with experts in gynecologic cancer, treatment of advanced ovarian cancer.

Looking Ahead

- The new guideline for managing bone pain in cancer will proceed to review, finalization and dissemination.
- A Cancer Knowledge Resource (CKR) will house guidelines, standards and tools for evidence development, adaptation, appraisal and implementation and will be integrated into the Partnership's web portal.
- Education materials and workshops on evidence-based principles, methods and knowledge translation will be developed and delivered.
- A casebook will be compiled of best practices in applying evidence.
- An inventory of resource allocation tools and the role of guidelines in decision making will be produced.
- The first annual Status Report on Canadian Cancer Guidelines will be published.

Guidelines are statements, based on evidence, that steer clinical practice and policy decisions. High-quality guidelines are powerful tools that promote appropriate practice, inform investment in new technologies and enhance quality improvement programs. In patient care, for example, guidelines provide a basis for quality, consistent care developed from the best available knowledge.

The Partnership's support for the development and implementation of high-quality guidelines includes advancement of an adaptation methodology that uses the framework of existing guidelines to help cancer groups efficiently develop guidelines in their own areas of focus, and applicable to their context.

Our strategy is aimed at building capacity for evidence-informed decision making, using social networks and technology platforms to transfer knowledge and skills across provincial/territorial jurisdictions.

PROJECT HIGHLIGHT

Guideline Adaptation Manual and Toolkit

OBJECTIVE:

To provide methodology support to groups seeking to develop new guidelines by adapting existing guidelines to their areas of work.

HOW:

Five development groups will apply the guideline adaptation process and build knowledge around the importance of evidence-based guidelines that respond to proven needs. Importantly, guidelines are being developed in key areas, such as diagnostic and treatment areas, and in the psychosocial area, where few guidelines currently exist. Some work will lay the foundation for extended national work in particular areas, such as pediatrics. Other applications, such as tele-health patient support, will move quickly to local implementation.

High-quality reports facilitate knowledge transfer

Using synoptic reporting templates is expected to make surgical record-keeping more efficient – saving time and money. The template-based approach also offers unique opportunities to capture information – such as clinical stage and even the rationale for one type of surgery over another – that previously was rarely recorded and would otherwise be very difficult to get at, says Cancer Surgery Alberta’s Dr. Walley Temple. The result is an unprecedented ability for coordination and new research. “We could measure outcomes that never before could be measured, or were measured from inadequate information,” he says.

Synoptic reporting also spurs quality improvements, with templates providing links to national and international guidelines, and checklists that allow surgeons to measure their work against operative standards. “It’s one of the most amazing tools for knowledge transfer in cancer surgery,” says Dr. Temple, who maintains a keen focus on the project’s ultimate goal. “Our dream is to have standardized data that we collect to help guide treatment in a national focus.”

What’s more, the pioneering work of the team – Canada leads the world in the work to develop and implement broadly based synoptic surgical reporting – has implications far beyond cancer surgery, according to Dr. Temple. “I believe it will sweep all medical systems in the next 10 years. This work will make it happen faster in Canada.”

Synoptic Reporting Tools Project: Supporting best practices to improve outcomes

Traditional surgery reports tell the story of the operation in the surgeon’s own words – a narrative report. But sometimes they don’t tell the whole story. “We realized the surgeon knows a lot about all the things that are very important for overall care – the critical stage of the patient, which tests were used, the history of the patient, and why they’re doing an operation,” says Dr. Walley Temple, Clinical Director of Cancer Surgery Alberta.

However, this knowledge tends to be retained by the individual surgeon or, when information is recorded using the traditional method of dictation, its value can be undermined by subjectivity and incompleteness. By contrast, the “synoptic reports” being developed are template-driven, electronic records created by surgeons before, during and after cancer surgery, using standardized, user-friendly electronic forms. This format requires consistent, comprehensive information about the patient and process to be recorded. Then it can be shared almost instantly using a web-based tool.

As the national synoptic surgical reporting project leader, Dr. Temple heads a development and implementation team piloting five projects – in Nova Scotia, Quebec, British Columbia, Manitoba and Ontario – to adapt the Alberta-based model of synoptic reporting and expand it to more tumour sites: breast, ovarian, colorectal and head and neck.

“This work continues to build momentum generated by a Canada Health Infoway-funded innovation project,” says Lee Fairclough, the Vice-President for Knowledge Management at the Partnership. “This project is a powerful example of how we can develop solutions in one part of the country and grow them using resources from across the country – to improve quality for the benefit of individual patients and the system overall.”

“The beauty of synoptic reporting is that it prompts practitioners to use evidence in decision making in a way that does not depend on them being aware of guidelines. It’s a seamless, effective way of bringing research evidence into practice.”

Dr. George Browman, Chair of the Cancer Guidelines Action Group and medical oncologist with the BC Cancer Agency.



HOW CAN WE PROMOTE HIGH-QUALITY SERVICE ACROSS CANCER CONTROL?

What do we mean by standards and indicators?

STANDARDS:

A standard defines the performance expectations and/or structure and processes that must be in place in order for an organization to provide safe, high-quality services across the continuum of cancer control. Standards are characteristically organizational based documents that address service provider education and roles, organizational behaviour, and health system requirements.

INDICATORS:

Indicators are measures of the quality of performance of cancer treatment/care service delivery, reflected by the patient/family experience as related to: the prevention, screening/early detection, diagnosis, treatment, supportive care, rehabilitation, survivorship, and the palliative/end-of-life segments of the cancer care trajectory.

Quality improvements in cancer control are driven by high standards and quality patient-centred service. The Partnership is helping establish, through national collaboration, a cross-Canada approach to standards and indicators.

A repository of Canadian standards and indicators that span cancer prevention, screening, diagnosis, treatment and care will also facilitate their uptake across the country. Common data and technology systems will improve access to best-practice information and support the use of consistent, quantifiable tools in assessing standards development.

In 2007-2008

- An analysis of gaps in cancer control standards was completed.
- A national forum made notable progress in selecting a core set of service delivery indicators, reducing a compilation of 650 indicators to approximately 50.
- Work began on a web-based resource centre.

Looking Ahead

- A pilot project, shaped by the most immediate needs of key partners and stakeholders, will facilitate the development and review of new and existing standards.
- A web-based resource centre will be created for the development, collection and dissemination of standards and indicators.
- Work will continue to develop a set of core indicators for cancer service delivery and plan for their integration into practice.

“A key area in which the Partnership can make an important contribution to improving the quality of cancer care in Canada is in the facilitation of the development, dissemination, uptake and evaluation of cancer service and cancer control standards and performance indicators.”

Dr. Brent Schacter, Chair of the Standards Action Group and Chief Executive Officer of the Canadian Association of Provincial Cancer Agencies.

Health Human Resources

WHAT CAN BE DONE TO ADDRESS WORKFORCE SHORTAGES



PROJECT HIGHLIGHT

Cancer Workforce Scoping Study

OBJECTIVE:

To complete a pan-Canadian situational analysis of the cancer workforce, in order to provide recommendations to an overall human resources strategy.

HOW:

Cancer control human resources challenges and trends are being identified for the immediate, medium, and longer term.

The project is also developing a comprehensive bibliography of literature related to the cancer workforce that will be accessible through a public website.

This information complements the knowledge of provincial and territorial system planners, researchers and educators, and fulfills the Partnership's broader objective of closing gaps in knowledge to enhance cancer control and accelerate action on what we know.

It is well established that many factors, including a growing and aging population, are making demands on health human resources that the system struggles to keep up with. The cancer workforce is no exception.

The Partnership is working to increase understanding of the challenges posed by these shortages and helping to develop and share innovative solutions.

In 2007-2008

- With contributions from more than 40 key informants, a study of the cancer workforce climate was completed, in order to identify issues affecting cancer control and the implications for health human resources.
- An inventory was created to identify stakeholders who contribute to supply, research and planning in the cancer control workforce.

Looking Ahead

- A compilation of successful modes of service delivery will provide a starting point to inform future strategies to overcome existing challenges. Patient navigators, for example, offer a potential strategy for maximizing available resources.
- We will forge partnerships with stakeholders involved in planning to bring cancer perspectives to human resource planning arenas.

“Cancer care, from prevention to palliation, is about people caring for people. But we have serious health human resource shortages in Canada that are straining cancer care. The Partnership's Health Human Resources Action Group is looking for solutions that build on innovations in cancer care delivery so we can make the best of today's workforce and better prepare for tomorrow.”

Dr. Andrew Padmos, Chair of the Health Human Resources Action Group and Chief Executive Officer of the Royal College of Physicians and Surgeons of Canada.

Rebalance Focus/Cancer Journey



HOW CAN THE SYSTEM BETTER SERVE PATIENTS AND FAMILIES



A cancer diagnosis brings emotional, social, spiritual and practical consequences for patients and families that can reach well beyond the time spent in treatment.

For many people, lack of access to information and supportive care services makes the cancer experience much more difficult. There is also growing evidence that survivors may continue to have special needs after their cancer has been treated. For others, improvements are needed in end-of-life care.

The Partnership strives to provide and foster leadership to promote integrated, person-centred care throughout the cancer journey.

The Rebalance Focus Action Group (now known as the Cancer Journey Action Group) has been spearheading this work.

In 2007-2008

- Cross-country consultations on a vision for a person-centred system were completed.
- Regional workshops on patient navigation were held in Fredericton, Winnipeg and Edmonton. (For more on patient navigation, see page 18)
- Consensus was reached, through a stakeholder workshop, on the need to develop and implement a Canadian strategy for screening for distress.
- A pan-Canadian workshop examined issues of survivorship.
- A national forum on vulnerable and underserved populations brought together stakeholders from across the country to share knowledge.

Looking Ahead

- The Partnership will boost initiatives that promote the uptake of screening for distress and facilitate the expansion of patient navigation programs.
- Work will continue on projects investigating and evaluating initiatives in survivorship, including the use of technology to provide professional and peer-led support and to reach underserved populations.
- Priorities in palliative care will be identified.
- Development and adaptation work will continue on guidelines and standards for adult psychosocial and supportive care.
- Resources promoting person-centred care will be developed and made available to health-care providers and those affected by cancer.

Psychosocial Oncology Education

PROJECT HIGHLIGHT

OBJECTIVE: To establish and promote psychosocial oncology education among health-care providers.

HOW: As part of a commitment to shift cancer care away from a tumour-centred approach to a person-centred one, the following initiatives aim to create a better understanding of the role of psychosocial education in delivering quality care:

- The Canadian Association of Psychosocial Oncology is working with community-based organizations to develop a community of practice website. It will connect providers of supportive psychosocial cancer care with stakeholders such as Wellspring, RealTime Cancer, Brain Tumour Foundation of Canada and Lung Cancer Canada.
- Creation of a web-based course, Families in Oncology and Palliative Care, developed by Halifax's Capital District Health Authority and the Canadian Association of Psychosocial Oncology, as part of the Interprofessional Psychosocial Oncology Distance Education Project (IPODE).
- Expansion of a professional development workshop for health professionals and clinical administrators working across the continuum of care in the Montérégie region of Quebec is underway through the Hôpital Charles Lemoyne, Centre intégré de lutte contre le cancer de la Montérégie.
- Development of an online training module for teachers, counselors, nurses and administrators, by the Canadian Association of Psychosocial Oncology, aimed at supporting school-aged children experiencing cancer in their families.
- Work by the Centre for Education and Research on Aging and Health at Lakehead University in Thunder Bay, Ont., to advance the implementation of social work competencies in palliative care education through a national consultation.

“When I was diagnosed, I was terrified. My immediate response was to learn everything I could. But not all patients have that instinct to advocate for themselves. When you don't know what to expect or who to ask for help, you can start feeling overwhelmed and frustrated. Patients shouldn't have to navigate the system on their own.”

Linda Jalbert, cancer survivor, Quebec City

Rebalance Focus/Cancer Journey

More than one way to lend a hand

There is no single model across Canada for delivering the range of services that comprise comprehensive cancer care. “We know what the functions of navigation are – where and how to make them available depends on the situation,” says Sandra Cook. She recently co-chaired workshops in Winnipeg, Fredericton and Edmonton for the Rebalance Focus Action Group. By fostering collaboration in planning, including identifying success factors and sharing challenges, the Partnership is helping Canadian jurisdictions implement cancer patient navigation programs.

“Cancer is life-altering. One’s perspective is irrevocably changed and coloured by a diagnosis of cancer. Life is never exactly the same ever again. The goal is to have a cancer system that pays attention to the individual person through compassionate and coordinated care, throughout treatment and beyond.”

Dr. Margaret Fitch, Chair of the Rebalance Focus/Cancer Journey Action Group and Head of Oncology Nursing, Sunnybrook Health Sciences Centre, Toronto.

Patient navigation

Joe VanBuskirk’s first encounter with a patient navigator took place in 2004 when he was in hospital recuperating from cancer surgery.



Joe VanBuskirk and Joanne Cummingner

“At that time, I’d never heard of patient navigation and didn’t know what it was.”

Since then, Mr. VanBuskirk, 64, has grown to value the service. His patient navigator, Joanne Cummingner of the Pictou County Health Authority in central Nova Scotia, keeps him informed about his condition, explains treatments, and makes sure he gets referrals as needs arise for other services.

“If I have any questions, Joanne is the one to answer them,” says the lay pastor and former pulp mill employee. The service makes it easier to deal with the cancer and is the reason why he is “doing well,” says Mr. VanBuskirk. “I credit the response of the team, and Joanne is the key member who keeps things going.”

A comprehensive approach

The original meaning of “navigation” is the process of planning and guiding something from one point to another safely and efficiently, says Sandra Cook, project manager for patient navigation at Cancer Care Nova Scotia since 2001.

“If you apply that to the cancer journey, the navigation challenges become the components of the health-care system including providers, the myriad of tests, treatment options, services, the need for education, dealing with the practical things like ‘how do I get to a cancer centre?’ and the various transition points along the different stages of care. Navigators have the ability to systematically assess the patient and proactively identify supportive care needs.”

Sharing experiences to catalyze action

Building on a March 2008 workshop – Screening for Distress Workshop: 5th and 6th Vital Signs – we are working with partners to facilitate a national screening for distress strategy.

The workshop looked at existing screening for distress programs across Canada, documenting differences in process (who was screened and when), tools used for assessment and the domains of distress assessed. As well, regional programs were reviewed in terms of test results, resource implications, and challenges and opportunities posed by the process. Importantly, despite differences in definitions, tools and approaches, all programs support cancer patients by improving access to services and widening the range of assistance.

“The goals are to simplify the process, encourage the use of standardized measures and empower patients to use the data,” says organizer Dr. Barry Bultz, a psychologist at Calgary’s Tom Baker Cancer Centre. Overall objectives include raising awareness of the importance of addressing emotional distress, and emphasizing the need to monitor distress and consider distress screening a point of entry for providing better care.

Screening for distress

Emotional distress in cancer patients often goes beyond anxiety and depression – sometimes manifesting in fatigue, nutrition problems, pain and other physical symptoms. Yet while heart rate, breathing rate, temperature and blood pressure – the four standard vital signs – are routinely measured, emotional distress is often not recorded.

There is widespread recognition that cancer patients are at high risk to experience emotional distress and that there need to be standardized ways of identifying those who would benefit from additional assistance.

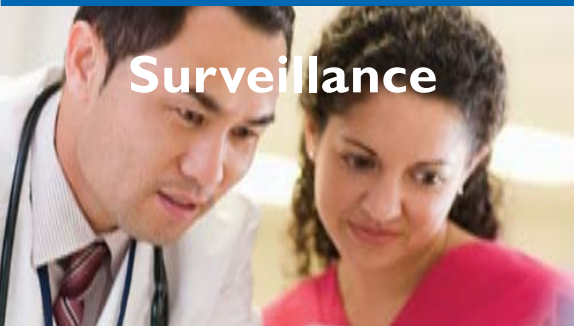
Distress screening tools are used in some cancer care settings across Canada, but there is no consistency in their application. Guidelines and standards for distress screening and for the management and care of those with emotional distress need to be implemented. Standing in the way of distress screening are limited human resources and practitioners’ inexperience in psychosocial oncology – a patient-centred approach that takes into account the needs of the whole person during clinical care and treatment.

The 6th vital sign

In 2004, the Canadian Strategy for Cancer Control fully endorsed the concept of screening for emotional distress, the 6th vital sign. (Pain, a counterpart to distress, is considered the 5th vital sign.) The Partnership is supporting work to adopt a systemic approach to screening, monitoring and responding to emotional distress.

The Canadian Council on Health Services Accreditation recommended in 2008 that the 6th vital sign be recognized as a significant step toward wider screening. Canada is a leader in taking this step. Relationships built through the Partnership and provincial cancer agencies offer the ability to move forward and implement a cross-Canada program to screen for emotional distress in cancer patients.

Surveillance



HOW CAN CANCER DATA AND INFORMATION BE IMPROVED



PROJECT HIGHLIGHT

Cancer Control P.L.A.N.E.T. Canada

OBJECTIVE:

To provide improved access to cancer resources and surveillance data in Canada, in order to support evidence-based cancer control strategies.

HOW:

The Canadian Cancer Control P.L.A.N.E.T. (Plan, Link, Act, Network with Evidence-based Tools) is a web portal designed to bridge the gap between planning and informed decision making.

Through a partnership with the National Cancer Institute in the U.S., the Partnership's Surveillance Action Group is working to adapt the NCI's web interface.

Cancer Control P.L.A.N.E.T. Canada will broaden access to Canadian Cancer Registry data. In turn, better access to cancer surveillance data and research-tested resources provides support for the development of evidence-based cancer control strategies for Canada.

Surveillance is the collection and analysis of data to monitor changes in cancer patterns, such as the number of new cases, prevalence and survival rates. Establishing a coordinated cancer surveillance system, including connecting the many areas where information resides, will facilitate comparisons and enable accurate conclusions.

Collaboration with the provinces and territories, and other national organizations, is bringing together nationwide cancer data and information. A key area is enhancing the collection of staging data, an indicator of the severity of a patient's disease at diagnosis. This data will be used to help partners plan cohesive action in prevention, screening, health-care delivery and policy.

In 2007-2008

- In conjunction with the U.S. National Cancer Institute, work began on a website – Cancer Control P.L.A.N.E.T. Canada – that will offer access to comprehensive Canadian surveillance information.
- Preliminary work was completed to create surveillance and epidemiology networks, and to document and assess the current quality of cancer surveillance data in Canada.

Looking Ahead

- The collection of staging data will be improved with an emphasis on national, population-based Collaborative Stage data for colorectal, breast and lung cancer cases. New technology will be employed to capture data electronically.
- Networks and information products will be created in surveillance and epidemiology to support collaboration across regions and disciplines.

“Surveillance is a cornerstone for cancer control. By coordinating efforts with partner organizations, we are strengthening this foundation through complementary initiatives that help monitor and plan cancer control programs.”

Bob Allen, Chair of the Surveillance Action Group and Chief Executive Officer of the Saskatchewan Cancer Agency.

In 2007-2008

- The Canadian Partnership for Tomorrow Project was launched. This landmark 300,000 person “cohort” study of people who don’t have cancer links the work of several regional partners to explore the connections between environment, lifestyle and cancer risk (see page 22).
- A partnership was formed with the newly created Terry Fox Research Institute to enable a biomarker initiative that fosters the transfer of knowledge among the scientific community, health professionals, policy-makers and the community at large.
- The first CCRA cancer research survey, Cancer Research Investment in Canada, 2005, was published in September 2007.

Looking Ahead

- Information about the Canadian Partnership for Tomorrow Project will be widely communicated, participants will be enrolled and its governance and coordination structures will be further developed.
- Development will continue on the biomarker initiative with the Terry Fox Research Institute.
- The second edition of the cancer research survey will be published in mid-2008. Participation has expanded from 19 participants in the first edition to 34 for the second edition. The survey is based on comprehensive and systematic collection of information from organizations that fund cancer research.

“Support of CCRA has given Canada an ability – unique from most other countries – to develop, optimize and coordinate a national cancer research strategy.”

Dr. Philip Branton, Chair of the Research Action Group and Scientific Director, CIHR Institute of Cancer Research.

MEMBERS OF THE CCRA:

Alberta Cancer Board

Alberta Heritage Foundation for Medical Research

BC Cancer Agency

Canadian Association of Provincial Cancer Agencies

Canadian Breast Cancer Foundation

Canadian Breast Cancer Research Alliance

Canadian Cancer Society

Canadian Institutes of Health Research

Canadian Partnership Against Cancer

CancerCare Manitoba

Cancer Care Nova Scotia

Cancer Care Ontario

(The) Cancer Research Society

Fonds de la recherche en santé du Québec

Genome Canada

Michael Smith Foundation for Health Research

National Cancer Institute of Canada

National Research Council Canada

New Brunswick Cancer Network

Ontario Institute for Cancer Research

Prostate Cancer Research Foundation of Canada

Public Health Agency of Canada

Saskatchewan Cancer Agency

The Terry Fox Foundation

Research



An enduring legacy

The project’s study design is considered to be the gold standard in population research. Because it unfolds in real time, a prospective study such as this generates much more accurate data than do retrospective studies that rely on participants’ memory and recall.

In the short term, researchers will be able to gauge how Canadians are responding to public health and prevention programs. With time, the data will illuminate how environmental, health, and lifestyle characteristics that change over the years relate to the onset of cancer in some individuals and not in others.

The rich repository of high-quality data and the associated specimen bank will be a resource for cancer researchers around the world. They will also be available for study of other chronic diseases such as diabetes and cardiovascular disease.

The Canadian Partnership for Tomorrow Project is being driven forward by partner organizations in five regions: the BC Cancer Agency, the Alberta Cancer Board, Cancer Care Ontario with the Ontario Institute for Cancer Research, Quebec’s CARTaGENE project, and Cancer Care Nova Scotia with Dalhousie University collaborating for work in the Atlantic Provinces. In addition to funds committed by the partners, the Canadian Partnership Against Cancer is providing \$42 million.

THE CANADIAN PARTNERSHIP FOR TOMORROW PROJECT

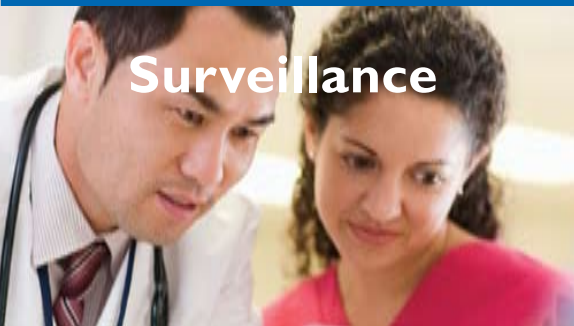
Researchers have long known that a complex association of factors contributes to the development of cancer. How to untangle the knot of genetics, behaviour, lifestyle, and environmental factors that may lead to cancer is one of the most important questions in cancer today.

The Canadian Partnership for Tomorrow Project responds to this challenge with a scope and breadth of research that immediately make it a landmark study. It will track 300,000 Canadian adults over at least two to three decades, tracing the effects of cancer risks and preventive factors over time.

In the largest Canadian study of its kind, participants (ages 35-69) are being randomly selected. Blood, urine and other samples will be collected from the participants. Data will also be gathered through regular surveys about their health status, lifestyle factors, disease occurrence, environmental risks, and occupational exposures to potential cancer risks.

The findings will support the development of more effective prevention and public health programs in cancer, and also will generate unique data about other chronic diseases in Canada.

Surveillance



HOW CAN CANCER DATA AND INFORMATION BE IMPROVED



PROJECT HIGHLIGHT

Cancer Control P.L.A.N.E.T. Canada

OBJECTIVE:

To provide improved access to cancer resources and surveillance data in Canada, in order to support evidence-based cancer control strategies.

HOW:

The Canadian Cancer Control P.L.A.N.E.T. (Plan, Link, Act, Network with Evidence-based Tools) is a web portal designed to bridge the gap between planning and informed decision making.

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Collaboration with the provinces and territories, and other national organizations, is bringing together nationwide cancer data and information. A key area is enhancing the collection of staging data, an indicator of the severity of a patient's disease at diagnosis. This data will be used to help partners plan cohesive action in prevention, screening, health-care delivery and policy.

In 2007-2008

- In conjunction with the U.S. National Cancer Institute, work began on a website – Cancer Control P.L.A.N.E.T. Canada – that will offer access to comprehensive Canadian surveillance information.
- Preliminary work was completed to create surveillance and epidemiology networks, and to document and assess the current quality of cancer surveillance data in Canada.

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- The collection of staging data will be improved with an emphasis on national, population-based Collaborative Stage data for colorectal, breast and lung cancer cases. New technology will be employed to capture data electronically.
- Networks and information products will be created in surveillance and epidemiology to support collaboration across regions and disciplines.

“Surveillance is a cornerstone for cancer control. By coordinating efforts with partner organizations, we are strengthening this foundation through complementary initiatives that help monitor and plan cancer control programs.”

Bob Allen, Chair of the Surveillance Action Group and Chief Executive Officer of the Saskatchewan Cancer Agency.



Knowledge Management

HOW CAN THE SHARING OF KNOWLEDGE BE IMPROVED



In 2007-2008

- Environmental scans and stakeholder consultations identified gaps in knowledge sharing, best practices in cancer control and created an inventory of key national and provincial knowledge management projects.
- Planning for a web portal began, including consultations with a variety of stakeholders.
- The Quality and Performance Assurance Action Group organized an international workshop focused on forecasting the cancer burden. The delivery of this group's activities has been restructured as part of the Partnership's Knowledge Management Framework and will be guided by an advisory committee of experts.

Looking Ahead

- The Partnership portal will be launched to serve as a core knowledge management platform.
- Development and implementation of multiple strategies for the exchange and uptake of new evidence will continue.
- An advisory committee will be formed to help create a methodology for cancer risk management and develop a risk management platform – including assessment of economic impact.
- Analytic capacity will be expanded to maximize the use of existing cancer information and apply new data sets.

The Partnership is committed to a multi-faceted knowledge management strategy that will accelerate 'knowledge to action' across the cancer control system in Canada. Initially, this strategy will focus in three main areas.

The implementation of a core knowledge management platform, the Partnership Portal, will provide a springboard into the Canadian cancer community. Users will be able to find, develop and exchange the information they need to support their journey or role in cancer control. The portal will provide the tools and mechanisms for knowledge exchange and collaboration, connecting networks and individuals across the country. It will also be a source of up-to-date evidence and compilations of best practices.

Enhanced analytic capacity will increase the use of cancer data sets and develop new knowledge products to support the management of the cancer control system. A component of this will be the development of the cancer risk management platform, which will enable stakeholders to evaluate programs and strategies in cancer control and assess future impact in reducing risks to the population from cancer from both economic and disease perspectives.

Finally, a series of core resources and a Knowledge Translation Toolkit will support the organization in developing appropriate, innovative and effective implementation strategies to enable the uptake of new evidence and proven practices.

International Workshop on Methods of Forecasting the Cancer Burden

PROJECT HIGHLIGHT

OBJECTIVE: To consider approaches to forecasting each of 20 cancer types and the related resource requirements.

HOW: A workshop held in October 2007 brought together 44 experts from seven countries to help formulate recommendations for a standardized method of forecasting.

The workshop took an innovative approach to assessing the validity of a number of forecasting methods by using a common dataset. Specific group sessions allowed for presentation and detailed discussion of individual models, and one session demonstrated the variety of software that may be used in forecasting.

Many cancer control interventions are being evaluated using models that take into account the role of various factors in chronic diseases. These elements include tobacco control policies, physical activity, screening and treatment.

These models require an understanding of both the natural history of specific cancers and the impact of the various interventions throughout each and every stage of their histories—from initiation of the disease through progression to death or cure.

Importantly, the workshop confirmed that modelling solutions will vary according to specific circumstances. Models must be adapted according to cancer sites and in terms of intervention circumstances, such as prevention, screening and treatment. It also became clear, however, that models are important in determining past and potential future successes in cancer control. Those findings will help set outcome targets for the Partnership, and allow monitoring and forecasting of progress in achieving these targets.

“This was the first time that people working around the world to forecast the cancer burden had been brought together in one meeting. Canada will benefit greatly from the expertise that was shared with us.”

Dr. Anthony Miller, Chair of the Quality and Performance Action Group and Professor Emeritus, University of Toronto.

LOOKING AHEAD

“Born from collaboration and urgency, the Partnership continues to listen to many voices and that is an encouraging signal of ultimate success. Now the challenge is to move forward expeditiously.”

Dr. James D. Gowing, Chair, Cancer Advocacy Coalition of Canada

“The Partnership is all about reaching out to generate ideas and design innovative solutions for change. It is exciting to be engaged in a process that brings First Nations communities together to identify complex challenges and to invest in action benefiting First Nations and all of Canada.”

Elisa Levi, member of the Advisory Council on Cancer Control and policy analyst for the Assembly of First Nations.

The year ahead will be significant for the Canadian Partnership Against Cancer, as we move forward on implementing the strategy and building on the foundation established in 2007.

In the immediate future, the Partnership will continue to develop strategic initiatives and alliances where we are uniquely positioned to drive knowledge into action across our priorities. Some of these initiatives – the CAREX Canada project, our work in colorectal screening, the Canadian Partnership for Tomorrow Project, synoptic reporting, to name just a few – are well underway. Others will be put in place over the next year.

In 2008-2009

In the year ahead we will achieve significant program milestones across all priority areas – as outlined in earlier sections of this report. In collaboration with our provincial and territorial partners and cancer agencies, we will be developing targets and a common set of indicators to improve system performance. We will expand our analytics capacity and risk management platform. These will enable the assessment of the burden of cancer on both the individual and the economy, and assist in the evaluation of current and future investments in cancer control.

With knowledge translation central to our mandate, we eagerly anticipate the launch of the first phase of the Partnership’s cancer web portal in Spring 2009. The portal will provide an important mechanism for knowledge exchange and dissemination in the cancer community.

With the Partnership's commitment to identifying opportunities to minimize gaps in the areas of screening, surveillance, prevention, access to care and culturally appropriate services, we are developing partnerships with organizations, such as the Assembly of First Nations and Inuit Tapiriit Kanatami, and with individuals and organizations working within First Nations, Inuit and Métis communities. Our goal is to establish priority initiatives where we can achieve meaningful outcomes together.

Finally, as we move forward in implementing the national cancer control strategy, we will undergo regular evaluations to measure the impact of our work. The Partnership will coordinate an independent evaluation in the year ahead, which will be followed in the third year of our mandate by a more comprehensive review by Health Canada. We welcome this important process as it will confirm that the mission entrusted to us on behalf of all Canadians is being pursued with vision, innovation, passion and accountability.

The next four years will be instrumental in reshaping the cancer landscape. Nonetheless, because of the complex nature of this disease, we know that even with rapid implementation of high-quality, well-executed interventions it will take many years to significantly reduce the burden of cancer on our society. But this burden will be reduced. That is the reason we are here.

“Canada has a plan to change incidence, mortality, suffering, experience and the expectations of cancer. But the plan is only as good as its execution. For this reason, the C2CC is actively working with the Partnership – which represents a conceptual shift from concentrating on the individual cancer patient to a concern for the whole population – to fully engage Canadians in our national 21st century plan to apply everything we know and learn to control cancer. It is time to overcome differences and marshal our collective will and passion. Millions of Canadians are counting on us.”

Pat Kelly, Program Director, the Campaign to Control Cancer (C2CC)



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Auditors' Report

To the Board of Directors of
Canadian Partnership Against Cancer Corporation

We have audited the statement of financial position of the Canadian Partnership Against Cancer Corporation as at March 31, 2008 and the statements of operations and net assets and cash flows for the year then ended. These financial statements are the responsibility of the Partnership's management. Our responsibility is to express an opinion on these financial statements based on our audit.

We conducted our audit in accordance with Canadian generally accepted auditing standards. Those standards require that we plan and perform an audit to obtain reasonable assurance whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation.

In our opinion, these financial statements present fairly, in all material respects, the financial position of the Partnership as at March 31, 2008 and the results of its operations and its cash flows for the year then ended in accordance with Canadian generally accepted accounting principles. As required by Canada Corporations Act, we report that, in our opinion, these principles have been applied on a basis consistent with that of the preceding year, except for the changes in accounting policies as explained in Note 2 to the financial statements.

Chartered Accountants
Licensed Public Accountants
May 23, 2008 except for Note 10 which is at June 16, 2008

Member of
Del i

Canadian Partnership Against Cancer Corporation

STATEMENT OF FINANCIAL POSITION

as at March 31, 2008

(with comparative figures as at March 31, 2007)

	2008	2007
	\$	\$
ASSETS		
Current		
Cash and cash equivalents	1,695,795	1,994,259
Short-term investments	8,238,979	-
Accounts receivable	308,604	34,023
Projects in process and advances (Note 5)	6,189,512	-
Prepaid expenses	152,863	50,746
	16,585,753	2,079,028
Capital assets (Note 6)	1,720,153	8,829
	18,305,906	2,087,857
LIABILITIES		
Current		
Accounts payable and accrued liabilities	3,158,734	288,935
Due to Health Canada (Note 7)	5,136,312	1,739,347
Deferred contributions - operating (Note 7)	4,890,707	50,746
	13,185,753	2,079,028
Deferred capital contributions (Note 7)	1,720,153	8,829
	14,905,906	2,087,857
NET ASSETS		
Reserve Fund (Note 10)	3,400,000	-
General Fund	-	-
	3,400,000	-
	18,305,906	2,087,857

Approved by the Board



Jeffrey C. Lozon
Chair of the Board



Peter Crossgrove
Chair of the Finance and Audit Committee

Canadian Partnership Against Cancer Corporation

STATEMENT OF OPERATIONS AND CHANGES IN NET ASSETS

year ended March 31, 2008

(with comparative figures for the three months ended March 31, 2007)

			2008	2007
	General Fund	Reserve Fund (Note 10)	Total	Total
	\$	\$	\$	\$
EXPENSES				
Programs				
Primary prevention	1,254,398	-	1,254,398	-
Screening	467,118	-	467,118	-
Cancer guidelines	1,162,797	-	1,162,797	-
Standards	209,887	-	209,887	-
Rebalance focus	1,403,198	-	1,403,198	-
Research	1,128,574	-	1,128,574	-
Surveillance	200,867	-	200,867	-
Health human resources	394,534	-	394,534	-
Knowledge management	1,011,985	-	1,011,985	-
	7,233,358	-	7,233,358	-
Operating expenses	3,456,094	-	3,456,094	-
Startup expenses	3,753,170	-	3,753,170	676,348
	14,442,622	-	14,442,622	676,348
REVENUE				
Health Canada contributions (Note 7)	14,233,854	3,400,000	17,633,854	674,582
Amortization of deferred capital contributions	208,768	-	208,768	1,766
	14,442,622	3,400,000	17,842,622	676,348
Excess of revenue over expenses	-	3,400,000	3,400,000	-
Net assets, beginning of the year	-	-	-	-
Net assets, end of the year	-	3,400,000	3,400,000	-

Canadian Partnership Against Cancer Corporation

STATEMENT OF CASH FLOWS

year ended March 31, 2008

(with comparative figures for the three months ended March 31, 2007)

	2008	2007
	\$	\$
OPERATING ACTIVITIES		
Health Canada contributions received (net) (Note 7)	27,086,204	2,457,908
Interest received on short-term investments	465,689	-
Cash paid for programs, operating and start-up expenses	(17,930,265)	(453,054)
	9,621,628	2,004,854
INVESTING AND FINANCING ACTIVITIES		
Purchase of capital assets	(1,920,092)	(10,595)
Purchase of short-term investments	(8,000,000)	-
	(9,920,092)	(10,595)
Net (outflow) inflow of cash and cash equivalents	(298,464)	1,994,259
Cash and cash equivalents, beginning of year	1,994,259	-
Cash and cash equivalents, end of year	1,695,795	1,994,259

Canadian Partnership Against Cancer Corporation

NOTES TO THE FINANCIAL STATEMENTS

March 31, 2008

I. DESCRIPTION OF THE BUSINESS

Canadian Partnership Against Cancer Corporation (the "Partnership") was incorporated on October 24, 2006 under the *Canada Corporations Act* and commenced start-up operations on January 1, 2007. The Partnership's mandate is to maximize the research, development, translation and transfer of knowledge, expertise and best practices concerning cancer control across Canada with policy-makers, health-care providers, patients and the community at large and in doing so help:

- a) reduce the number of Canadians diagnosed with cancer;
- b) enhance the quality of life of those affected by cancer;
- c) lessen the likelihood of Canadians dying from cancer; and
- d) increase the effectiveness and efficiency of the cancer control domain.

The Partnership is registered as a not-for-profit Corporation under the *Income Tax Act* and, accordingly, is exempt from income taxes. The Partnership is funded through a Funding Agreement dated March 27, 2007 with Health Canada which calls for \$250 million of contributions over the five years ended March 31, 2012. The contributions are subject to terms and conditions set out in the Funding Agreement.

2. CHANGE IN ACCOUNTING POLICIES

a) *Adoption of new accounting standards- Financial Instruments*

In 2006, the Canadian Institute of Chartered Accountants ("CICA") issued new accounting standards concerning financial instruments: Financial Instruments - Recognition and Measurement ("Section 3855") and Financial Instruments – Disclosure and Presentation ("Section 3861"). The standards require prospective applications and that the Partnership applies the new accounting standards at the beginning of its current fiscal year.

In accordance with these revised standards, the Partnership has classified each of its financial instruments into accounting categories effective April 1, 2007. The category for an item determines its subsequent accounting under the revised standards. Effective April 1, 2007, the Partnership has classified its financial instruments as follows:

- Cash and cash equivalents and short-term investments as "held-for-trading". Held-for-trading items are carried at fair value, with changes in their fair value recognized in the statement of operations in the current period.
- All accounts receivable as "loans and receivables". Loans and receivables are carried at amortized cost, using the effective interest method.
- All financial liabilities as "Other Liabilities". Other Liabilities are carried at amortized cost, using the effective interest method.

As required by the transitional provisions of Section 3855, the accounting policy change from cost to fair value was adopted retrospectively, without restatement of the prior year's financial statements.

As a result of adopting these revised standards as at April 1, 2007, the carrying value of all the Partnership's financial instruments have remained the same as the carrying value recorded as at March 31, 2007. These new standards did not result in any opening or year end adjustments.

The Partnership selected January 1, 2007 as its transition date for accounting for embedded derivatives. The Partnership has determined that there are no embedded derivatives that are required to be accounted for separately as derivatives.

Canadian Partnership Against Cancer Corporation

NOTES TO THE FINANCIAL STATEMENTS

March 31, 2008

2. CHANGE IN ACCOUNTING POLICIES (CONTINUED)

b) *Revenue recognition*

The Partnership changed the method of recording revenue from the deferral method to the restricted fund method of recording restricted contributions. This change in accounting policy did not result in any change in previously reported amounts for the period ended March 31, 2007. There is no effect of this change in accounting policy on the current year's financial statements.

3. SIGNIFICANT ACCOUNTING POLICIES

a) *Financial statement presentation*

These financial statements have been prepared in accordance with Canadian generally accepted accounting principles.

b) *Revenue recognition*

The Partnership follows the restricted fund method of accounting for contributions.

Capital contributions for the purchase of capital assets are deferred and amortized into revenue on a straight-line basis at a rate corresponding with the amortization rate of the related capital assets.

c) *Deferred contributions – operating*

Deferred contributions – operating represents amounts received from Health Canada which have been expended on prepaid expenses and projects in process and which are expected to be expensed in the subsequent fiscal year.

d) *Cash and cash equivalents*

Cash and cash equivalents consist of unrestricted cash and short-term deposits with a maturity at acquisition of less than 90 days.

e) *Short-term investments*

Short-term investments consist of deposits with a maturity at acquisition of more than 90 days and less than 1 year. Investment income which consists entirely of interest is recorded on the statement of operations and net assets on an accrual basis.

f) *Description of funds*

General Fund – records the ongoing operations of the Partnership.

Reserve Fund – The Reserve Fund is an externally restricted fund and may only be used for purposes approved by the Board of Directors and the federal Minister of Health.

g) *Capital assets*

Capital assets are recorded at cost and are amortized over their estimated useful life on a straight-line basis using the following rates:

Information technology and telecommunication	3 years
Furniture and equipment	5 years
Leasehold improvements	Over the term of the lease (5 years)

In the year of acquisition, 50% of the annual amortization rate is used.

h) *Use of estimates*

The preparation of financial statements in accordance with Canadian generally accepted accounting principles requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenue and expenses during the year.

Canadian Partnership Against Cancer Corporation

NOTES TO THE FINANCIAL STATEMENTS

March 31, 2008

4. FUTURE ACCOUNTING POLICY CHANGES

The CICA has issued two new accounting standards, Section 3862, Financial Instruments – Disclosures, and Section 3863 Financial Instruments – Presentation. Both Sections will be applicable to financial statements relating to fiscal years beginning on or after October 1, 2007. Section 3862 on financial instruments disclosures, requires the disclosure of information about: (a) the significance of financial instruments for the Partnership's financial position and performance and (b) the nature and extent of risks arising from financial instruments to which the Partnership is exposed during the period and at the balance sheet date, and how the Partnership manages those risks. Section 3863 on the presentation for financial instruments establishes standards for presentation of financial instruments and non-financial derivatives. Section 3863 is unchanged from the presentation requirements included in Section 3861.

These changes in accounting policies, which will be adopted effective April 1, 2008, will only require additional disclosures in the financial statements.

5. PROJECTS IN PROCESS AND ADVANCES

At March 31, 2008 the Partnership had advanced \$6,189,512 of which \$4,737,844 is related to research projects where project milestones were in process of completion and funds had not been expended and \$1,451,668 is related to advances to third parties for future research activities. Health Canada's contributions of \$4,737,884 related to the research projects in process have been deferred as Deferred contributions-operating.

6. CAPITAL ASSETS

Capital assets at March 31 consist of:

			2008	2007
	Cost	Accumulated amortization	Net book value	Net book value
	\$	\$	\$	\$
Information technology and telecommunication	208,997	38,365	170,632	8,829
Furniture and equipment	857,709	85,770	771,939	-
Leasehold improvements	863,980	86,398	777,582	-
Total	1,930,686	210,533	1,720,153	8,829

Canadian Partnership Against Cancer Corporation

NOTES TO THE FINANCIAL STATEMENTS

March 31, 2008

7. DUE TO HEALTH CANADA – DEFERRED CONTRIBUTIONS

The continuity of amounts owing to Health Canada and deferred contributions is as follows:

	Due to Health Canada – Deferred contributions	Deferred contributions operating	Deferred capital contributions
	\$	\$	\$
Balance, beginning of the year	1,739,347	50,746	8,829
Health Canada contributions received	28,825,551	-	-
Repaid to Health Canada	(1,739,347)	-	-
	27,086,204	-	-
Interest earned	704,668	-	-
Transfer to deferred contributions- operating	(4,839,961)	4,839,961	-
Transfer to deferred capital contributions	(1,920,092)	-	1,920,092
Transfer to Reserve Fund	(3,400,000)	-	-
Amounts recognized as revenue	(14,233,854)	-	(208,768)
	(23,689,239)	4,839,961	1,711,324
Balance, end of the year	5,136,312	4,890,707	1,720,153

8. COMMITMENTS

a) Contractual research commitments

In accordance with its mandate, the Partnership has approved project funding for future years amounting to approximately \$65 million. As of March 31, 2008, the Partnership has contractual commitments related to these projects amounting to \$14.4 million as follows:

	\$
2009	4,693,367
2010	3,889,769
2011	3,399,658
2012	2,428,098
2013	-
	14,410,892

Canadian Partnership Against Cancer Corporation

NOTES TO THE FINANCIAL STATEMENTS

March 31, 2008

8. COMMITMENTS (CONTINUED)

b) *Operating lease commitments*

The Partnership rents premises under operating leases which expire, in 2013. Minimum annual rental payments to the end of the lease terms are as follows:

	\$
2009	861,244
2010	861,075
2011	864,470
2012	864,113
2013	526,470
	3,977,372

c) *Contractual commitments*

Additionally, the Partnership has entered into other commitments, including contracts for professional services with various expiry dates to December 2010. The annual payments are as follows:

	\$
2009	1,370,543
2010	196,097
2011	60,000
	1,626,640

9. GUARANTEES

In the normal course of operations, the Partnership enters into agreements that meet the definition of a guarantee.

The Partnership's primary guarantees subject to the disclosure requirements of Accounting Guideline 14 are as follows:

- (a) The Partnership has provided indemnities under a lease agreement for the use of operating facilities. Under the terms of this agreement the Partnership agrees to indemnify the counterparties for various items including, but not limited to, all liabilities, loss, suits, and damages arising during, on or after the term of the agreement. The maximum amount of any potential future payment cannot be reasonably estimated.
- (b) The Partnership has indemnified its present and future directors, officers and employees against expenses, judgments and any amount actually or reasonably incurred by them in connection with any action, suit or proceeding in which the directors are sued as a result of their service, if they acted honestly and in good faith with a view to serving the best interest of the Partnership. The nature of the indemnity prevents the Partnership from reasonably estimating the maximum exposure. The Partnership has purchased directors' and officers' liability insurance with respect to this indemnification.

Canadian Partnership Against Cancer Corporation

NOTES TO THE FINANCIAL STATEMENTS

March 31, 2008

10. SUBSEQUENT EVENT - RESERVE FUND

On March 4, 2008, the Board of Directors approved the creation of a Reserve Fund. Under the Funding Agreement with Health Canada, the establishment of a Reserve Fund requires the approval of the federal Minister of Health. On June 16, 2008 the federal Minister of Health approved a Reserve Fund in the amount of \$3.4 million.

11. REMUNERATION OF DIRECTORS AND SENIOR MANAGEMENT

For the year ended March 31, 2008, remuneration paid to the Partnership's directors amounted to \$205,666 and remuneration paid to the Partnership's five highest paid staff amounted to \$424,519.

12. COMPARATIVE FIGURES

Certain of the prior year figures have been reclassified to conform to the current year's presentation.

Partnership materials completed April 1, 2007 – March 31, 2008

The following materials were completed by the Partnership for external audiences in 2007-2008. Note that some of the workshops and conferences noted below have reports or other publications in process for 2008 distribution, in addition to materials developed for the event itself.

PRIMARY PREVENTION

- Report on Attributable Risk Factors in Canada
- Canadian Family Physician Cancer and Chronic Disease Prevention Survey Report, November 2007
- Primary Prevention Action Group Newsletter, June 2007 and February 2008

SCREENING

- Assessment of Fecal Occult Blood Tests for Colorectal Cancer Screening: A Systematic Review – Executive Summary

QUALITY & PERFORMANCE ASSURANCE

- Materials, Methods of Forecasting Cancer Burden, International workshop hosted by QPAAG, October 2007, Toronto

CANCER GUIDELINES

- Synoptic Reporting Tools for Cancer Surgery and Pathology: Results of a National Workshop, May 2007

STANDARDS

- Materials, Indicators Workshop, February 2008, Winnipeg
- Literature Review and Environmental Scan for Cancer Performance Indicators 2007

Several of these projects are foundational reports undertaken during the interim period when the Canadian Strategy for Cancer Control was evolving into the Canadian Partnership Against Cancer. The Partnership gratefully acknowledges the work of the Canadian Strategy for Cancer Control as well as funding provided by the Public Health Agency of Canada.

REBALANCE FOCUS/CANCER JOURNEY

- Proceedings, A National Forum on Cancer Care for All Canadians: Improving Access & Minimizing Disparities for Vulnerable Populations, November 1-3 2007, Vancouver, in cooperation with the BC Cancer Agency and the University of British Columbia Interprofessional Continuing Education
- Materials, Cancer Patient Navigation Workshops, Winnipeg, December 2007, Fredericton, January 2008, Edmonton, February 2008, in cooperation with Public Health Agency of Canada and the Canadian Association of Provincial Cancer Agencies
- Materials, Building Inter-Provincial Capacity for Achieving Best Practices in Psychosocial and Supportive Care Standards and Guidelines, March 17 -18, 2008, Toronto
- Materials, Survivorship Workshop, March 25-26, 2008, Toronto
- Report, National Psychosocial Oncology Education Framework; developed by the Canadian Strategy for Cancer Control, Public Health Agency of Canada.

The Annual Report 2007-2008, and the programs described within it, have been made possible through a financial contribution from Health Canada.

The views expressed herein represent the views of the Canadian Partnership Against Cancer.

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