INDEPENDENT EVALUATION OF THE CANADIAN PARTNERSHIP AGAINST CANCER

FINAL REPORT

April 22, 2009

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Executive Summary

a. Introduction

This report presents the findings, conclusions and recommendations of the Independent Evaluation of the Canadian Partnership Against Cancer Corporation ("the Partnership").

The Independent Evaluation was commissioned by the Partnership – its Board of Directors and Senior Executive – in order to assess progress to date as well as to meet terms of its Funding Agreement. Under its Funding Agreement with Health Canada, the Partnership was to "conduct an Independent Evaluation, using recognized evaluation standards, with respect to the achievement of the Strategy" and "make the …evaluation report available to the Minister no later than April 30, 2009." The Partnership was also required to make the evaluation report available to the public.

The scope of the evaluation was upon achievement of the Strategy as well as upon matters related to governance, accountability and design including the start-up of the organization and the initial implementation steps taken by the Partnership during the first 22 months of its mandate (from April 2007 to mid-February 2009).

The Partnership was announced in November 2006 by Prime Minister Stephen Harper as an independent organization, with a $250 million funding commitment over five years ending March 31, 2012, and charged with accelerating action on cancer control across Canada through the advancement of the Canadian Strategy for Cancer Control (CSCC)[1]. The CSCC was developed by more than 700 cancer groups, experts, patients and survivors over at least a decade.

Start-up funding for January to March 2007 was provided by Health Canada, and a provisional Board with Chair, Vice-Chair and a few members, and a transition team were put in place. The Partnership began operations as a not-for-profit corporation in April 2007. During this part of the transition phase, a permanent Board was established, the Funding Agreement approved, Action Groups brought into the Partnership (these existed under the CSCC to address priority areas), and a corporate structure established. The transition phase ended about October 2007 with the appointment of the Chief Executive Officer and the subsequent staffing of the senior executive team, and their divisions. During the last fifteen months, the Partnership has developed into a more and more fully operational organization.

[1] *The Canadian Strategy for Cancer Control: A Cancer Plan for Canada, Discussion Paper*, July 2006, http://www.partnershipagainstcancer.ca/inside.php?lang=EN&pID=38

b. Approach

The overall evaluation approach was based upon the collection and analysis of multiple lines of evidence. These lines of evidence were chosen to ensure that findings, conclusions and recommendations would be meaningful. The methodologies for data collection, analysis and presentation were designed to ensure reliable, valid and credible information were provided.

The evaluation team followed three main lines of evidence – document and literature review, key informant interviews and cases studies. Documents reviewed included the CSCC report, the Funding Agreement with Health Canada, the Partnership's Strategic Plan, other corporate planning and reporting documents, annual Funding Requests to Health Canada, terms of reference and minutes of governance and advisory bodies (i.e. Board of Directors, Advisory Council and Action Council), documents related to Partnership transition, Action Group and Core Framework charters, project plans, program and project status reports, and various consultants studies. Websites were also reviewed for organizations or agencies involved in cancer control internationally and in other countries.

Key informant interviews were conducted, either in-person or by telephone, with 79 key informants, inside and external to the Partnership. Key informants represented external organizational partners and funded project recipients, Health Canada, Public Health Agency of Canada, and internal networks such as the Advisory Council on Cancer Control, the Partnership's Board of Directors, Action Groups and the Partnership's senior management.

Case studies were prepared to provide more detail on specific areas of the Partnership's activities, including strategic initiatives, core frameworks and enablers.

c. Evaluation Conclusions and Recommendations

The remainder of this Executive Summary summarizes the more detailed discussion of evaluation findings, conclusions and recommendations presented in Section 4 of the main report.

c.1 Achievement of the Strategy

As outlined in the Partnership`s 2009-10 Funding Request to Health Canada and its February 2009 Progress Report to the public, many of the Partnership`s initiatives are at early stages with others already well underway. Key informants, both external and internal to the Partnership, noted that the stage of these initiatives was largely appropriate, and must be considered in the context of both the amount of time and effort

required to set up the Partnership as an operating entity in the first place, and the starting point for each initiative.

A number of key informants, for example, on the Board of Directors and Advisory Council, indicated that they had thought that progress might have been quicker, but, in hindsight, progress was reasonable given the start-up and transition challenges.

In developing its strategic plan, the Partnership selected six Key Areas of Focus and Strategic Initiatives within them, as areas where the Partnership could show results during its mandate up to 2012. These Strategic Initiatives that began in the Action Groups were chosen because of their potential for significant impact on cancer control outcomes.

Discussions with external key informants and senior management suggest confidence that the Strategic Initiatives will achieve the desired deliverables and have impacts during the next three years, that they are and will accelerate progress, and that they position the Partnership for overall impact.

Of note is that when asked about the "successes" of the Partnership to date, respondents pointed towards many of the Strategic Initiatives, especially:

- The Canadian Partnership for Tomorrow Project (the Cohort Study)
- Partnership Portal
- Staging
- Screening
- Synoptic reporting.

These were also considered as potential "legacy" projects given their size, scale and potential impact in the long-term on population health outcomes.

Both external and internal key informants think that the next year is crucial. The Partnership must really focus on "product" and "impact". This is both consistent with the Partnership's mandate, and with the reality that the current funding agreement is only for a five year term ending in 2012.

Regarding achievement of the Strategy, the evaluation therefore reaches the following conclusions.

- The Partnership has made significant gains since its inception in building its organization, in developing the partnerships and networks necessary for achieving the objectives of the CSCC while moving forward initiatives that promise to produce impacts consistent with the CSCC and Partnership's vision.
- There is, however, a continuing need to explain how these initiatives are consistent with the CSCC and the Partnership's vision and how these are

examples of success today and lay the foundation for achievement of the CSCC in the longer term.

- The Partnership has put in place a focused strategy appropriate for implementation. Through this strategy, the Partnership has accelerated progress on many initiatives, and has initiated others.
- The Partnership has managed a change process, moving the CSCC from a volunteer-led to an organization-led business model. This has inevitably led to tensions concerning issues such as decision-making, responsibilities and accountabilities, and the need for clarity that is discussed further below.
- In this change process, the Partnership needs to be careful to continue to foster partnerships, relationships and goodwill, that are more enduring and of a longer perspective, even when it may appear to delay results of deliverables in the shorter term.
- The Partnership must continue its work on cancer risk management models and cancer control system performance in order to:
    - Demonstrate the societal and economic benefits and impacts; and
    - Produce evidence that could influence equity of access to and quality of cancer care across Canada.

Based upon these conclusions, the following recommendations are made.

Recommendation 1: The Partnership is making progress and achieving results through its refined Partnership strategy, and appears well positioned to continue to do so. These achievements are endorsed by the majority of stakeholders. Therefore, the Partnership should continue to implement its strategy, with adjustments made when necessary to deal with new opportunities or performance gaps.

Recommendation 2: Impacts and benefits for the cancer control domain and its stakeholders will need to be shown to maintain support. Therefore, work on cancer risk management and cancer control system performance needs to continue so that information about benefits / impacts can be gathered, analyzed and disseminated.

Recommendation 3: The Partnership needs to continue to work with and through partners and collaboration for maximum longer-term impact even when there may be alternative approaches that might speed up the achievement of short term results that demonstrate quick successes.

c.2 Building the Organization

The findings concerning building of the Partnership as an organization lead to the following conclusions.

- The Partnership – its Board of Directors, senior management team and staff – have put in place the building blocks for a long term sustainable organization that has become a part of the cancer control landscape, with awareness and increasing acceptance of its ongoing role. This has involved and continues to be a significant change management process.
- Even during the building process, the Partnership and its Action Groups continued to advance the strategy on many fronts.
- With the building blocks in place, the focus has shifted and needs to continue to be upon initiative/project execution, with a keen eye on benefits and impacts achieved and the communication of these impacts across the stakeholder community.
- The roles/activities of the Action Groups and the Advisory Council need to be clarified with consideration of other advisory mechanisms that have been put into place for many specific priorities and initiatives – e.g., Cancer Risk Management Advisory Committee, Canadian Colorectal Screening Network, National Forum on First Nations/Inuit/Métis Cancer Control Planning Committee.

Based upon these conclusions, the following recommendations are made.

Recommendation 4: The Partnership needs to keep its eyes firmly on the target, and at this time work with and through its current corporate and advisory structures, and delivery approaches, except when barriers present significant risk. With this in mind, it is recommended that the role of the Advisory Council be clarified in relation to the other advisory mechanisms that have been put into place for specific priorities and initiatives (e.g., Cancer Risk Management Advisory Committee, Canadian Colorectal Screening Network).

Recommendation 5: When there are new initiatives, priorities and opportunities in pursuit of the achievement of the CSCC objectives, it would be appropriate for the Partnership to put in place new advisory and delivery approaches if the existing ones are inadequate.

c.3 Overall Governance and Accountability Mechanisms

The findings related to overall governance and accountability mechanisms lead to the following conclusions.

- Overall governance and accountability mechanisms within the Partnership are in place and working well.
- The Partnership should benefit from the increased flexibilities in its revised Funding Agreement, approved March 13, 2009.

No recommendations are made in this area.

c.4 Refinement and Focusing of the Strategy for Cancer Control

The evaluation concludes that the refinement and focusing of the CSCC as described in the Partnership's Strategic Plan, refined in February 2008, is largely supported by stakeholders. No recommendations are made in this area.

c.5 Core Frameworks and Corporate Enablers

The four core frameworks outlined in the Partnership's Strategy are:

- Knowledge Management;
- Cancer Control System Performance;
- Enterprise Performance and Risk Management; and
- Communications and Stakeholder Relations.

The evaluation also examined the Project Management Office (PMO) as a corporate enabler.

The evaluation findings lead to conclusions regarding performance measurement and project management.

- It is an appropriate time to settle upon one comprehensive performance measurement framework (outcomes, outputs and activities, with performance indicators). Such a framework is an integral part of planning, monitoring and reporting, and communications. One reporting view of this framework needs to continue to be the eight priorities in the original Partnership strategy.
- The Enterprise Performance and Risk Management scorecard is of great use for operational decision-making, but does not fully support reporting against outcomes. This gap needs to be filled.

- The project management approach will continue to need to be refined (e.g. stabilize the approach and associated tools and templates) and the benefits / value-added of its use be explained and understood by project participants.

Based upon these conclusions, the following recommendation is made.

Recommendation 6: The Partnership should develop a comprehensive performance measurement framework based upon a logic model (i.e., outcomes, outputs, activities) such as the one developed for this evaluation.

Current initiatives - the Enterprise Performance and Risk Management scorecard, cancer risk management model, cancer control system performance - would feed into this performance measurement framework.

Any additional gaps in the ability to tell the full performance story should be identified and filled, as appropriate.

c.6 Implementation Activities

Implementation activities included the work of the Action Groups and stakeholder engagement.

The findings related to Action Groups lead to the following conclusions.

- Action Groups serve a number of functions
  - Formulation and delivery of work plans in the priority areas
  - Stakeholder engagement
  - Good will built over time.
- Given the investment made to date in Action Groups, and the fact that each is indeed quite different, it is preferable to continue to look at the performance of each individually, rather than collectively.
- When alternatives to existing Action Groups are used (e.g., standards priority area) or projects are identified as strategic initiatives, it will be important to ensure that the variety of stakeholders, including patient voice, represented in Action Groups, continues to be heard.
- The roles of the Action Group Chairs and the Vice Presidents, and the reporting relationship of the Program Directors to each, needs to be clarified.

Based upon these conclusions about Action Groups, the following recommendation is made.

Recommendation 7: The Partnership should periodically review the roles, composition and activities of Action Groups and Pan-Canadian networks to ensure that they continue to provide net benefits. However, as noted in Recommendation 4, the priority should be to work with and through current structures and delivery approaches, except when barriers present significant risk.

When conducting a review, the best role, composition and activities for Action Groups and Pan-Canadian networks need to be looked at on a case by case basis.

The findings concerning stakeholder engagement lead to the following conclusions.

- The Partnership needs to bring a stronger focus upon its stakeholder engagement, especially now that it is starting to have a stronger performance story around results to tell.
- A stakeholder engagement strategy that would include what partners/stakeholders are now / should be engaged, for what reasons, to what extent, the roles of each party (e.g., communications in and out) and the value gained by each party, would help to focus stakeholder engagement. Embedded in such a strategy and in its implementation would be the notion of an engagement continuum, with different levels of engagement for different stakeholders at different times, depending upon issues or initiatives at hand, the roles that the stakeholders play and the impacts that they can bring to realization of the change agenda the Partnership is implementing. Hence, not every stakeholder could or should expect to be engaged identically on the continuum.

The following recommendation is made.

Recommendation 8: It is an appropriate time for the Partnership to put in place a stakeholder engagement strategy. The strategy should include the notion of an engagement continuum, with stakeholders being engaged in a manner appropriate to their roles and the impact that they can bring to the change agenda. The strategy should consider stakeholders that have not been engaged significantly over the last almost two years. This includes the public, aboriginal groups and other potential stakeholder/partners. The strategy should also promote the use by stakeholders of their own networks for communications out to broader audiences.

The Partnership is progressing well. The refinement of the strategy and identification of initiatives is well supported and appears to position for success in achieving the mandate of the organization in implementing the CSCC. Areas for improvement are noted in structures, functions, performance measurement, and stakeholder engagement.

1. Introduction

This report presents the findings, conclusions and recommendations of the Independent Evaluation of the Canadian Partnership Against Cancer Corporation ("the Partnership"[2]).

The Independent Evaluation was commissioned by the Partnership – its Board of Directors and Senior Executive – in order to assess progress to date as well as to meet terms of its Funding Agreement. Under its Funding Agreement with Health Canada for $250 million of funding over five years ending March 31, 2012, the Partnership was to "conduct an Independent Evaluation, using recognized evaluation standards, with respect to the achievement of the Strategy" and "make the …evaluation report available to the Minister no later than April 30, 2009." The Partnership was also required to make the evaluation report available to the public.

The focus of this Independent Evaluation was upon achievement of the Strategy as well as upon matters related to governance, accountability and design including the start-up of the organization and the initial implementation steps taken by the Partnership during the first 22 months of its mandate (from April 2007 to mid-February 2009).

The evaluation was conducted in accordance with recognized evaluation standards, as set by the Treasury Board Secretariat, Health Canada and the professional evaluation community.

A separate Minister's Evaluation will assess whether the Partnership has advanced the public health objective for cancer control, focusing mainly upon whether the Partnership is an effective instrument or model for implementing public policy. Based upon information from Health Canada, the schedule for this evaluation falls in 2009-10.

An overview of the framework for the evaluation is provided in the next section of this report. A profile of the Partnership is given in Section 3. Evaluation findings, conclusions and recommendations are presented in Section 4. Recommendations are summarized in Section 5.

Management of the Partnership has provided its response in Section 6.

[2] Please note that we have tried to the greatest extent possible to refer to the Canadian Partnership against Cancer Corporation as the Partnership. Acronyms are also used in various documents. The most common are CPAC and CPACC.

2. Evaluation Framework

2.1 Objective and Scope

The overriding objective of the Independent Evaluation was to assess the results the Partnership has accomplished and activities undertaken with respect to achievement of the Strategy or, as stated in the Funding Agreement, "conduct an Independent Evaluation, using recognized evaluation standards, with respect to the achievement of the Strategy".

The other objective of the evaluation was to address evaluation issues in the following areas:

- Implementation activities related to the CSCC (and its eight strategic priorities and two supporting activities) undertaken to date including work of the Partnership's Action Groups and work undertaken to achieve stakeholder engagement.
- Overall governance and accountability mechanisms established by the Partnership;
- Core frameworks established to guide the organization including knowledge management, communications, cancer system performance and enterprise performance and risk management;
- Activities undertaken to refine and focus the strategy for cancer control – the Canadian Strategy for Cancer Control (CSCC);
- Start-up activities undertaken by the Partnership including Board governance, policies and procedures, operating model and organizational structure;

The evaluation covered the period from the inception of the Partnership with the Prime Minister's announcement in November 2006 to mid-February 2009 when the information collection and fieldwork for this evaluation was completed.

2.2 Approach and Methodology

The Independent Evaluation was conducted in four phases. In Phase I, a logic model and detailed evaluation plan were developed, and documented in the report, *Evaluation Framework and Plan, Final*, dated November 19, 2008. In the remaining phases, the evaluation plan was implemented through interviews, information collection and analysis (Phase II), preparation of a preliminary report (Phase III), and preparation of the draft and final reports (Phase IV).

The overall evaluation strategy was based upon the collection and analysis of multiple lines of evidence. These lines of evidence were chosen to ensure that findings, conclusions and recommendations would be meaningful. The methodologies for data

collection, analysis and presentation were designed to ensure reliable, valid and credible information were provided.

The lines of evidence were document and literature review, key informant interviews and cases studies.

Documents reviewed included the CSCC report, the Funding Agreement with Health Canada, the Partnership's Strategic Plan, other corporate planning and reporting documents, annual Funding Requests to Health Canada, terms of reference and minutes of governance and advisory bodies (i.e. Board of Directors, Advisory Council and Action Council), documents related to Partnership Transition, Action Group and Core Framework Charters, Project Plans, Program and Project Status Reports, and various consultants studies. Websites were also reviewed for organizations or agencies involved in cancer control internationally and in other countries.

Key informant interviews were conducted, either in-person or by telephone, with stakeholders inside and external to the Partnership[3]. The interviews were a key source of information for all the issues included in the evaluation. The numbers in brackets give the number of respondents in each key informant group.

a. External organizations that partner with the Partnership and funded project recipients (21)
b. Other external individuals (4)
c. Government of Canada – Health Canada and Public Health Agency of Canada (2)
d. Members of Advisory Council on Cancer Control (8)
e. Members of the Partnership's Board of Directors (14)
f. Partnership's Corporate Management – Senior executives, and Directors (16)
g. Partnership's Action Groups – Chairs and Program Directors (14)

A listing of the names of key informants is given in Annex B.

Case studies were prepared to provide more detail on specific areas and impacts / results of the Partnership's activities and investments. They are shown in Annex C.

2.3 Limitations of the Study

The study design and methodology had the following limitations.

First, from the design point of view, the evaluation issues/questions related to success/results were focused upon establishing whether or not the Partnership appears to be moving in the right direction, establishing the conditions for success and identifying signs of success, rather than a more rigorous impact analysis of the Partnership's desired

[3] A total of 79 key informant interviews were completed.

outcomes. These limitations in the study design recognized the current level of maturity of the Partnership, as well as data and performance information availability.

Second, from the methodological point of view, the stakeholder consultation line of inquiry was designed to gather information from a number of respondents in a range of stakeholder segments. The respondents were chosen, for the most part, because they had had significant interaction with the Partnership. They were not chosen on a statistical sampling basis. This limits extrapolation of findings across the full universe of stakeholders.

Third, stakeholder consultations focused upon individuals representing organizations involved in cancer control. The evaluation team did not survey individuals specifically as individual practitioners or survivors, although many of the individuals representing organizations also wore the practitioner or survivor hat. Therefore, the Partnership's "touch points" at the individual level were not explored. For example, questions were not pursued concerning awareness of the Partnership in the broad public, or concerning practitioners' awareness of the Partnership and their adoption of the products of the Partnership's initiatives. Such surveys might be appropriate to consider in a later evaluation of the Partnership, more focused upon impacts and benefits.

These limitations were considered to be relatively minor in nature and do not compromise the findings, conclusions and recommendations presented in this report.

3. Profile of the Partnership

This section of the evaluation report is intended to provide key information about the Partnership to provide context for understanding the evaluation findings, conclusions and recommendations. Additional more detailed information about the Partnership is available at its website www.partnershipagainstcancer.ca and in the plans and reports listed there.

The profile begins with some general information about key events for the Partnership from its announcement in November 2006 through to February 2009. The Partnership was formed to advance the Canadian Strategy for Cancer Control (CSCC) which is described in section 3.2. The CSCC outlined priority areas for action and high level action plans, as well as a proposed structure/organization for moving forward. This proposed structure/organization had important differences from the way in which the federal government actually chose to establish the Partnership. Both the level of detail in the CSCC (and hence its readiness for implementation) and the differences between the actual structure/organization of the Partnership and expectations of some participants in the CSCC are important backdrops for understanding how the Partnership has evolved and some stakeholders' reactions to it.

During the first year of operations, the Board of Directors with senior management established a vision and mission for the Partnership. They also developed a strategy for the Partnership which was subsequently refined in February 2008. The refinement was significant in narrowing down the quite broad scope of the eight priorities in the CSCC through identifying six cross cutting Key Areas of Focus in which the Partnership would commit to achieving results during its first five year mandate. To move forward in these Key Areas of Focus, a number of Strategic Initiatives and Core Frameworks were then chosen. The Strategic Initiatives are multi-stakeholder, multi-year, larger, higher impact projects. They were the result of a deliberate scanning and selection process, especially looking at work already taking place in the Action Groups. The Core Frameworks were chosen as being fundamental platforms that are core to the Partnership's mandate. The vision, mission and components of the Partnership's strategy are outlined in section 3.3.

The Partnership's project portfolio, made up of Strategic Initiatives, Core Frameworks and work within the Action Groups, and how these correlate to the eight priorities, is described more completely in section 3.4.

The Partnership's activities, outputs and outcomes are then presented in a logic model in section 3.5. The logic model outlines how the Partnership's activities and outputs (e.g., its project portfolio) contribute to the achievement of direct, shared and final outcomes (i.e., impacts, benefits, consequences).

The governance and organization of the Partnership is described in section 3.6. The Board of Directors, senior management team and organization, Action Groups and advisory bodies such as the Advisory Council and Action Council are all introduced.

The Partnership operates within a complex landscape of stakeholders and partners, much of which pre-existed the Partnership. The landscape and a number of key stakeholders / partners are outlined in section 3.7.

The Partnership's Funding Agreement with Health Canada is the source of its funds. The agreement has terms and conditions attached to the flow of funds. For example, a detailed Annual Funding Request needs to be made. Another example is that funding was set at $50 million each year, even in the Partnership's ramp-up period, without the ability to carry forward unexpended funds. The inability to have flexible multi-year funding also impacts the funding requirements for larger multi-year projects being executed by external partners. More information about the Funding Agreement is given in section 3.8.

Finally, the Partnership has developed a set of management processes and tools, at the corporate, portfolio and project levels, in order to support its governance, planning, monitoring and reporting. These are described briefly in section 3.9 with more detail provided in Annex A.

3.1 Background

The Partnership was announced in November 2006 by Prime Minister Stephen Harper as an independent organization, funded by the federal government, and charged with accelerating action on cancer control across Canada through the advancement of the Canadian Strategy for Cancer Control[4]. This Strategy was built by more than 700 cancer groups, experts, patients and survivors.

Start-up funding for January to March 2007 was provided by Health Canada, and a provisional Board with Chair, Vice-Chair and a few members, and a

Excerpts from the Prime Minister's Announcement Speech:

This Pan-Canadian body will serve as a clearing house for state-of-the-art information about preventing, diagnosing and treating cancer.

Recognizing that health care falls within provincial jurisdiction, the new national agency will play no role in the administration of health policy or programs.

Its job is simply to make sure that the best cancer care practices in any single part of Canada are known and available to health care providers in every part of Canada.

This initiative marks the first coordinated and comprehensive approach to cancer control in our country.

[4] *The Canadian Strategy for Cancer Control: A Cancer Plan for Canada, Discussion Paper*, July 2006, http://www.partnershipagainstcancer.ca/inside.php?lang=EN&pID=38

transition team were put in place. The Partnership began operations as a not-for-profit corporation in April 2007. During this part of the transition phase, a permanent Board was established, the Funding Agreement approved, Action Groups brought into the Partnership and a corporate structure established. The transition phase ended about October 2007 with the appointment of the Chief Executive Officer and the subsequent staffing of the senior executive team, and their organizations. During the last fifteen months, the Partnership has developed into a more and more fully operational organization.

> Cancer control aims to reduce the incidence, morbidity and mortality of cancer and to improve the quality of life of cancer patients in a defined population, through the systematic implementation of evidence-based interventions for prevention, early detection, diagnosis, treatment and palliative care. Comprehensive cancer control addresses the whole population, while seeking to respond to the needs of the different subgroups at risk.
>
> *Cancer Control: Knowledge into Action, WHO Guide for Effective Programs, Planning*, World Health Organization, 2006

3.2 The Canadian Strategy for Cancer Control

The Canadian Strategy for Cancer Control (CSCC) was published, as a discussion paper, subtitled "A Cancer Plan for Canada" in July 2006. It set the stage for the creation of the Partnership, and influenced many of the "going in" expectations of stakeholders and conditions on the Partnership. As such, some detail about the CSCC is important to understanding the evaluation findings, especially coming from a number of the key informant interviews.

The CSCC was designed to address the cancer crisis in Canada. Its rationale was both social and economic, with significant benefits to be delivered to individual Canadians, the economy and governments. As examples of the social benefits, the CSCC report[5] states, when speaking of the cancer crisis that it is estimated that over the next 30 years:

- Almost six million Canadians will develop cancer;
- Approximately three million will die from the disease; and
- Over 38 million potential life years will be lost due to premature death.

It goes on to say that with the adoption of the CSCC, it is estimated that decisive action and better alignment of cancer resources could, over the next 30 years:

- Prevent over 1.24 million Canadians from developing cancer;

[5] Ibid, Page 2 and 3. Estimates come from econometric modelling done by RiskAnalytica, *Life at Cancer Risk 2005.*

- Save the lives of over 423,000 Canadians; and
- Prevent over 7.3 million potential years of Canadian life being lost.

As examples of economic benefits, the report further states that over the next 30 years, it is estimated that:

- Cancer will cost the health care system $177.5 billion in direct health care costs;
- 2.4 million Canadian workers will get cancer;
- 872,000 workers will die from the disease;
- Cancer will reduce taxation revenues by $250 billion; and
- Cancer will cost the Canadian economy $543 billion in lost wages.

With the implementation of the CSCC, over the next 30 years, it is estimated that these improved health outcomes will:

- Save over $39 billion in direct health care costs;
- Prevent the loss of over $34 billion in total government tax revenues; and
- Prevent the loss of over $101 billion in wage-based productivity.

The CSCC takes "an inclusive, integrated and comprehensive approach to health care management, covering the full cancer control continuum".[6] As well, other key aspects of the CSCC are:

- It is a knowledge-based strategy. It will maximize the development, translation and transfer of knowledge and expertise across Canada. New research will be developed across the cancer control spectrum. Existing knowledge will be consistently and effectively applied…
- The CSCC encourages, supports and facilitates collaborative initiatives with the cancer care community…
- The CSCC supports and respects provincial and territorial jurisdiction over health…
- The CSCC approach also permits a national perspective by enabling comparability, transparency, consistency and portability of knowledge across Canada...

The CSCC business plan identified strategic priorities for investments in the period 2006-2010. The initial five priorities and the Action and Working Groups that would manage the investments through their work plans were[7]:

- Cancer Prevention and Early Detection
    - Primary Prevention Action Group
    - Screening and Early Detection Action Group

[6] Ibid, page 2
[7] Ibid, pages 8-14

- Support the Cancer Patient's Journey
  - Standards Action Group
  - Clinical Practice Guidelines Action Group
  - Rebalance Focus Action Group
- Supporting the Cancer Workforce
  - Human Resources Action Group
- Encouraging Cancer Research
  - Research Action Group
- Improving Cancer Information and Access
  - Surveillance Action Group
  - Knowledge Translation Working Group
  - Quality and Performance Assurance Working Group

In terms of governance, the CSCC was envisioned as a standalone legal entity, with a Board of Directors (Governing Council) and Executive Team in place to coordinate the investments managed by the Action Groups. They would be supported by a Secretariat coordinating activities across the Action Groups. It also proposed a Cancer Control Advisory Council, composed of cancer control experts, cancer stakeholders and cancer survivors, as well as the Chairs of the Action Groups and Working Groups, that would provide advice to the Board of Directors.[8]

The federal government chose to accelerate the implementation of the CSCC through the creation of the Canadian Partnership against Cancer. The not-for-profit corporate model established by the federal government for this Partnership is different than that proposed in the CSCC.

Key aspects of the Partnership are outlined in the following sections.

3.3 The Partnership's Vision, Mission and Strategy

The Partnership's vision is *to achieve improvements in cancer control in Canada by being a catalyst for a coordinated approach that will:*

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

The first three bullets in this vision statement are embedded in the goal statement for the CSCC. The last bullet was added by the Board to reflect the importance of having impact upon the cancer system to advance cancer control.

[8] Ibid, page 15

Aligned with the vision, the Partnership identified the following 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 across Canada.*

The Partnership's strategy was developed by its Board of Directors and Executive Team and is outlined in the *Partnership Strategic Plan, 2007/08 to 2011/12*[9], later refined in February 2008. The strategy is included in the annually updated Funding Requests from the Partnership to Health Canada.

The refined strategy reflects an evolution of the original CSCC primarily through focusing it upon those areas where the Board decided that the Partnership would have the greatest impact. Such evolution and refinement, directed by the Board, are expected to continue in order to deal with future changes in priorities in the cancer control domain and actual impacts being achieved.

The refined strategy lays out the following objectives for the Partnership:

- Reduce gaps in knowledge to enhance cancer control
- Facilitate and accelerate implementation of best available knowledge
- Optimize quality and access
- Improve the cancer experience for Canadians.

It was decided that these objectives for the Partnership are ones for which it could be accountable, within the broad cancer control domain.

The refined strategy includes:

- Eight Strategic Priority Areas each with its own Action Plan and Expected Outcomes for 2008-2012 – these correspond to the breakout of the five initial priorities in the CSCC into the eight Action Groups in the CSCC:
    - Primary Prevention
    - Screening/Early Detection
    - Standards
    - Cancer Guidelines
    - Rebalance Focus, renamed Cancer Journey
    - Human Resources, renamed Health Human Resources
    - Research
    - Surveillance

[9] *Partnership Strategic Plan, 2007/08 to 2011/12,* http://www.partnershipagainstcancer.ca/inside.php?lang=EN&pID=42

- Six Key Areas of Focus, each with Strategic Initiatives – the Key Areas are presented as a refinement of the CSCC to pinpoint areas that are "key to the Partnership delivering against its objectives within the next four years…cut across all priorities and require an integrated approach…offer significant opportunity for impact and outcomes…will continue to be refined over the next four years as the initiatives take shape and activities are underway"[10]. The Key Areas are[11]:

    - Content areas in cancer with a potential to generate tangible and sustainable advancements
        - Environmental exposures to cancer risk factors
        - Population-based screening and prevention
        - Focus on patients and equitable access
    - Foundation areas that strengthen and support the Partnership's ability to influence change – these cut across the cancer control continuum and can be leveraged through the Partnership and its partners
        - Accurate and complete information on the cancer profile
        - Reporting on the performance of the cancer control domain
        - Coherent implementation plan for a cancer control strategy.

- Four Core Frameworks, that reflect fundamental platforms for the Partnership's role in the cancer control domain:

    - Knowledge management (KM)
        - Knowledge broker and strategy
        - Development of core KM infrastructure – the Portal
        - Analytical capacity and cancer risk management
    - Cancer control system performance
    - Enterprise performance and risk management
    - Communications

[10] Ibid, page 13
[11] Ibid, page 14

3.4 The Partnership's Project Portfolio

The Partnership's project portfolio for 2009-10, as shown in Table 3.4.1, is to be made up of Strategic Initiatives, and work being carried out by Action Groups and through Central Activities. The focus is increasingly upon Strategic Initiatives, reflecting the movement towards investment in fewer, higher impact initiatives. The 2009-10 Funding Request notes that:

> Our strategic initiatives now represent 59% of the 2009/10 funding request. This increase is a reflection of new initiatives (including CLASP and CAPTURE ...). By focusing on strategic initiatives that are multi-year in scope, bring value to ongoing efforts of others, and have the potential to integrate across the cancer control continuum, we are seeing clear traction from our work this year and building momentum leading into 2009/10.[12]

In comparison, in the 2008-09 Funding Request Strategic Initiatives represented 24% of the total budget. There were only six Strategic Initiatives compared to seventeen in the 2009-10 Funding Request.

Table 3.4.1 Nominal Distribution of Funding in the 2009-10 Funding Request, January 28, 2009

Funding Request 2009-10 – Nominal funding amounts are 5 year totals in millions of Dollars					
Strategic Initiatives	**$M**	**Action Groups**	**$M**	**Central Activities**	**$M**
Translational Research Initiative	10.0	Primary Prevention	6.2	Knowledge Management	20.5
Canadian Cohort Study	42.1	Cancer Screening	3.8	Communication & Public Engagement	12.0
CAREX	4.1	Standards	1.2	Cancer Control/System Performance	7.6
Synoptic Reporting	5.9	Cancer Control Guidelines	5.2	Board and Advisory Committee	4.7
Capacity Enhancement	4.6	Cancer Journey	4.9	Corporate Services	21.2
Guideline Adaption Project	2.0	Health Human Resources	4.2	One-time set up costs	3.8
Staging	17.4	Research	4.2		
Surveillance &Epidemiology Networks	4.5	Surveillance	6.8		
Colorectal Screening	3.3				
Aboriginal Strategy	4.0				
Strategic Innovation Fund	1.8				
CLASP	15.7				
HPV/Cervical Screening	1.7				
CAPTURE	4.8				
Integrated Person-Centred Care	4.8				
Survivorship	3.1				
Quality Initiatives	4.5				
Totals	134.3		36.5		69.7
Reserves and Adjustments	(0.1)				
Total	**240.4**				

The mapping of the components of the 2009-10 Funding Request to the eight Strategic Priorities in the Funding Agreement is shown in Table 3.4.2. The intention of the

[12] Funding Request 2009/10

mapping is to indicate the potential to do work in these areas. It can be seen that there are Strategic Initiatives, and work by the Action Groups and on Central Activities, attached to each of the Strategic Priorities.

Notably, the 2009-10 Funding Request introduced specific targets for 2012 for each of the Strategic Initiatives.[13]

Table 3.4.2 Mapping of Components of the 2009-10 Funding Request to Eight Strategic Priorities

Funding Request 2009-10	Eight Strategic Priorities in Partnership Strategic Plan 2008-2012							
	Primary Prevention	Screening	Standards	Cancer Guidelines	Cancer Journey	Health Human Resources	Research	Surveillance
Strategic Initiatives								
Translational Research Initiative	X	X	X	X	X	X	X	X
Canadian Cohort Study	X						X	
CAREX	X						X	
Synoptic Reporting				X				X
Capacity Enhancement	X	X	X	X	X	X	X	X
Guideline Adaption Project	X	X	X	X	X	X	X	X
Staging				X				X
Surveillance and Epidemiology Networks				X				X
Colorectal Screening	X	X						
Aboriginal Strategy	X	X	X	X	X	X	X	X
Strategic Innovation Fund	X	X	X	X	X	X	X	X
CLASP	X	X						
HPV/Cervical Screening	X	X						
CAPTURE	X	X						
Integrated Person-Centred Care					X			
Survivorship					X			
Quality Initiatives	X	X	X	X	X	X	X	X
Action Groups								
Primary Prevention	X							
Cancer Screening		X						
Standards			X					
Cancer Control Guidelines				X				
Cancer Journey					X			
Health Human Resources						X		
Research							X	
Surveillance								X
Central Activities								
Knowledge Management	X	X	X	X	X	X	X	X
Communication and Public Engagement	X	X	X	X	X	X	X	X
Cancer Control/System Performance	X	X	X	X	X	X	X	X
Board and Advisory Committee								
Corporate Services								
One-time set up costs								

[13] Ibid. Appendix 4, page 106.

3.5 The Partnership's Activities, Outputs and Outcomes

The logic model provides an overview of the outcomes to be achieved (immediate outcomes) or influenced (intermediate and final outcomes) by the Partnership, and how outputs and supporting activities contribute to these outcomes. The questions asked in this evaluation, were very strongly linked to the logic model.

It should be noted that this is the logic model for Partnership as the leader in the implementation of the Canadian Strategy for Cancer Control, as opposed to the logic model for the strategy itself. Many other players in Canada contribute and play central roles in the achievement of the CSCC including cancer agencies, clinicians, Health Canada, Public Health Agency of Canada, Statistics Canada, Canadian Cancer Society, Canadian Cancer Action Network, and many other organizations and individuals.

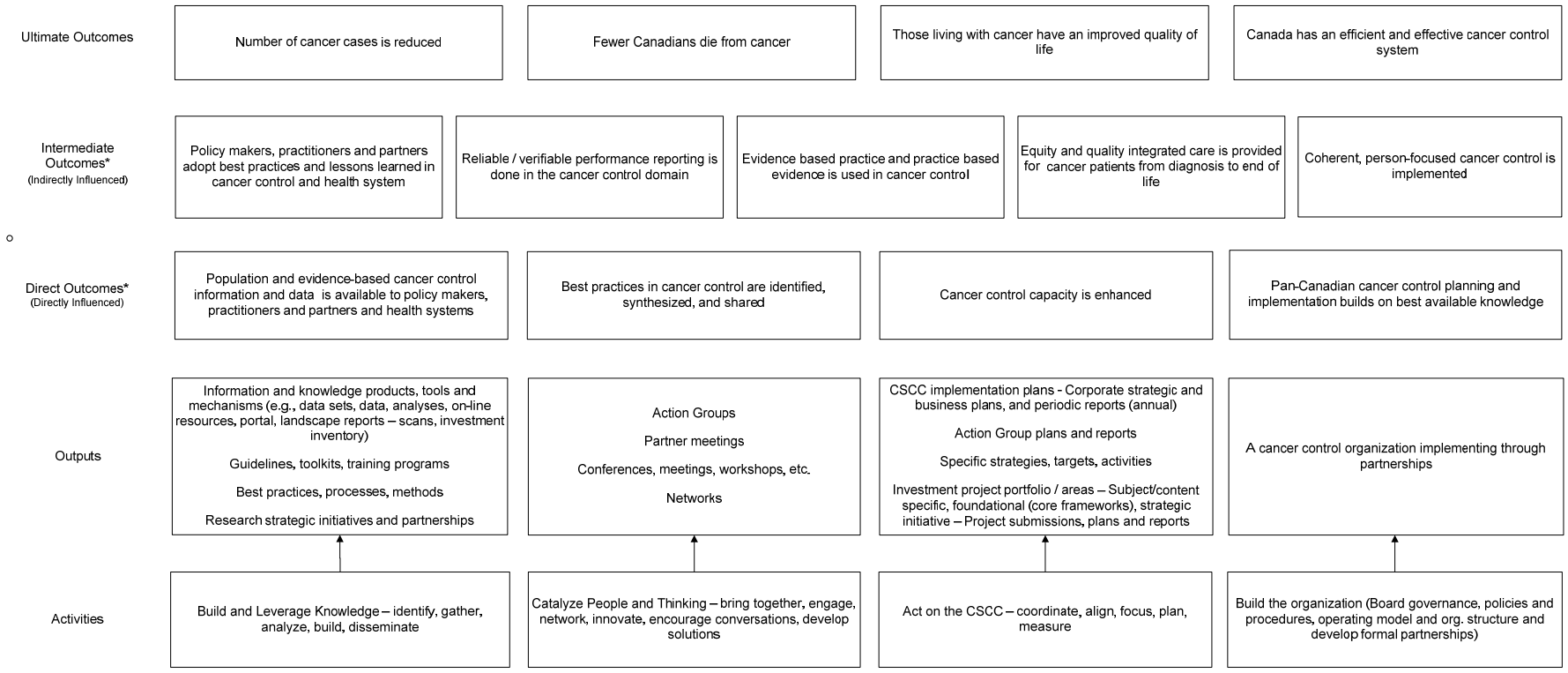
The activities and related outputs in the Partnerships are described as clustering into four main groups:

- Build and Leverage Knowledge
- Catalyze People and Thinking
- Act on the CSCC
- Build the Organization.

These activities and related outputs lead to a number of Direct Outcomes over which the Partnership has a high degree of influence and control. These, in turn, contribute to the achievement of Intermediate (Shared) Outcomes which are shared with other stakeholders, and Ultimate Outcomes which are the high level benefits. The Ultimate Outcomes correspond to the goals embedded in the Partnership's vision and the CSCC's goal statement. The Direct and Intermediate Outcomes correspond more closely to the objectives in the Partnership's strategy.

Canadian Partnership Against Cancer Corporation Draft Logic Model

Draft, October 20, 2008



* N.B. Outcomes have two key dimensions – degree of influence and time. In this logic model, the outcome levels reflect degree of influence rather than time frames, and the outcome statements themselves describe "end states" rather than directional statements. Directionality and time frames are captured through the indicators and targets set for each outcome, rather than in the outcome statements themselves.

Direct outcomes are ones over which CPAC has a high degree of influence. The achievement of these is directly tied to the outputs produced by CPAC. Intermediate outcomes are shared by CPAC, policy makers, practitioners, partners and health systems. CPAC is one of the contributors to the achievement of the intermediate outcomes. Progress towards the intermediate outcomes is a result of progress on the direct outcomes. Therefore, there is likely to be a time lag seen on progress towards the intermediate outcomes. The case is similar for the relationship between intermediate and ultimate outcomes.

3.6 The Partnership's Governance and Organization

Board of Directors

The Partnership's Board of Directors (the Board) represents key stakeholders in Canadian cancer control as reflected in its membership. The Board is comprised of eighteen Directors[14].

As per the Partnership's *Delegations of Authority Framework* (April 11, 2008), the Board has delegated responsibilities in oversight for the Partnership's resourcing and expenditures. In terms of human resources (HR), the Board oversaw the hiring of the Chief Executive Officer and is responsible for ongoing assessment of performance. Furthermore, the Board reviews overall HR compensation and annually approves compensation of the senior executive team. Board accountabilities related to expenditure includes approval of annual business plan and budget, financial statements, funding submissions to Health Canada, individual contract projects and commitments over one million dollars and all banking resolutions and investment policies. The Partnership's strategic plan, and stakeholder/ partner affiliation arrangements and significant public announcements also require Board approval.

Meetings of the Board occur five to eight times per year and since its inception, the Board has engaged in two strategic retreats. Board agendas include reports of the various components of the Partnership including the Chair, Advisory Council, CEO, Board sub-committees, Action Groups and core framework and strategic initiative activity. Meetings are held on a rotational basis in different geographical locations across Canada to reflective the pan-Canadian perspective and afford the opportunity to connect with cancer control leaders at the provincial/territorial level to better understand their environment and also what the Partnership is advancing.

Board committees are either standing, or permanent and special committees established by resolution to carry out specific tasks and make recommendations to the Board on certain issues. There are standing committees; namely, the Executive committee, the

[14] The Partnership's Board of Directors is composed of 18 members and reflects the Partnership's *Bylaw 3*, June 2008, stipulating the requirements of appointment as follows:

(i) One Director, appointed by the Federal Minister of Health;
(ii) Ten Directors elected provided that each Region shall be represented by two Directors:
  (a) Five Directors, who may be affiliated with a Cancer Agency
  (b) Five Directors, who are knowledgeable about cancer and cancer control, drawn from the non-government sector
(iii) Two Directors who are cancer patients or their family members;
(iv) Two Directors, one of whom is affiliated with the Canadian Association of Provincial Cancer Agencies and the other of whom is affiliated with the Canadian Cancer Society – National Cancer Institute of Canada;
(v) One Director at large, who is an Aboriginal person; and
(vi) Two Directors at large, being unrestricted as to either government or non-government.

Finance and Audit Committee, the Governance and Nominating Committee and the Performance Committee. There is also a Portal oversight committee providing direction on the Partnership Portal project.

Advisory Council

The Advisory Council on Cancer Control (the Advisory Council) was initially established as an advisory body accountable to the Board of Directors for the provision of advice. Since the inception of the Partnership, the terms of reference for the Advisory Council have been revised. It is now more focused upon providing advice to senior management of the Partnership.

The Advisory Council is co-Chaired by the Vice-Chair of the Board and the Chief Executive Officer. The Advisory Council is comprised of Action Group Chairs and experts from across the cancer care continuum and Canadian cancer control universe. Appointments of either two or three years are made by the Board. Members meet twice per year with additional meetings as necessary as determined by the Co-Chairs.

Corporate Structure

The Partnership's corporate structure is led by the Chief Executive Officer. The CEO is charged with the overall implementation of the Partnership. Specifically, the CEO recommends the annual budget to the Board for approval and approves project and commitments and budget transfers between divisions and within the overall Strategy. The CEO provides overall leadership and vision for the Partnership and drives the organization to achieve results.

Reporting to the CEO are three Vice Presidents, each managing a portfolio, and a Chief Financial and Administration Officer (CFAO) directing the Finance and Administration functional area. The three portfolios are Strategy, Performance Measures and Communications; Cancer Control; and, Knowledge Management (KM).

VPs have a number of accountabilities related to the Partnership. They are responsible for final approvals on the hiring and termination of all divisional staff, that is, within their portfolio of activity. Further, the VPs approve annual performance reviews, salary increases and attendance / leaves for their direct reports within Board-approved policy directions. VPs also have delegated authority for expenditure commitments within the overall Board-approved plan and budget.
The Strategy, Performance Measures and Communication portfolio is designed to support three key activities as follows[15]:

[15] Source: KPMG (October 2007). Canadian Partnership Against Cancer: Detailed Operational Design. Draft Report. Page 18

- To facilitate the process of reviewing and refining the 5-year strategy, to align the business plans with the strategy and to generate partnership opportunities;
- To develop and monitor performance measures that support the evaluation of the Corporation relative to its mandates; and,
- To establish and maintain a pan-Canadian focus through relationships, communication and stakeholder engagement and consolidate and analyze cancer control activities in order to inform local stakeholders and public of the work of the Partnership and Action Groups.

The VP, Strategy, Performance Measures and Communications, also oversees the work of the Cancer Journey Action Group and the Integrated Person-Centred Cancer Care and Survivorship strategic initiatives.

The Cancer Control portfolio mandate[16] is to:

- Provide expert cancer control advice;
- Research, analysis, development and dissemination of new cancer control initiatives; and
- Report on cancer control progress and emerging issues across the Action Groups.

The VP, Cancer Control, is also the Chair of the Action Council and supports the ongoing work of the Primary Prevention, Screening and Research Action Groups as well as the Standards Working Group, quality initiatives, and the strategic initiatives of Cancer System Performance, National Nutrition Mobilization, CLASP, CAPTURE, Colorectal Screening Initiative, HPV Screening, Translational Cancer Initiative (Terry Fox Research Institute Initiative) and the Canadian Partnership for Tomorrow Project (Cohort).

The Knowledge Management portfolio supports the Partnership as a knowledge-based organization that manages the 'collection, analysis, development and dissemination of knowledge capital'[17]. In general, the KM portfolio is mandated to:

- Align KM with the overall priorities of the Corporation;
- Identify the key KM initiatives which meet the Corporations priorities;
- Determine accountabilities and responsibilities for the development and delivery of KM initiatives;
- Monitor and achievement of KM activities;
- Facilitate the building of KM information management capacity in cancer control; and,
- Ensure the provision of modeling and forecasting.

The VP, Knowledge Management oversees the work of the Cancer Guidelines, Health Human Resources and Surveillance Action Groups and the Portal, Cancer Risk

[16] Ibid. Page 4
[17] Ibid. Page 34

Management, Surveillance and Epidemiology Networks, National Cancer Staging, Capacity Enhancement, Guideline Adaptation, and Synoptic Reporting strategic initiatives.

The CFAO ensures that the Partnership is supported by effective and efficient solid corporate services and strong financial management principles. Specifically, the Financial and Administrative function encompasses human resources, finance, information technology, legal, project management office, and support services.

Action Groups

Action Groups are composed of cancer experts from across the cancer control spectrum and represent collaborative networks of experts aligned to the Partnership's priorities. Action Groups became part of the Partnership in April 2007.

The Partnership's *Strategic Plan 2008-2012* indicates that Action Groups "have primary responsibility within CPAC for knowledge formation and direct action"[18].

With the transition of the Standards Action Group into the Working Group, there are currently seven Action Groups. Basic information about each of the Action Groups is summarized in Table 3.5.1. This includes mandates, memberships and resourcing, as well as how they have evolved. In many cases, Action Groups were formed as working/ thematic groups and directly contributed to the development of the CSCC.

The interface between the Partnership's corporate staff and the Action Groups is facilitated by an Action Group Chair. Action Group Chairs allocate a percentage of their time from their ongoing employment to contribute towards Action Group efforts. Each Action Group is supported by a full–time Program Director. Specific projects and initiatives are led by Project Leads.

Action Groups are accountable to the executive through the Action Group Chair. Action Group Program Directors report to a VP and are accountable to their Action Group Chair. Action Group Chairs also are members of the Advisory Council and the Action Council.

[18] Strategic Plan 2008-2012. Page 24

Table 3.6.1 Profile of Action Groups

Action Group	Start Date	End Date	Mandate	No. of Members	Type of Positions	Location of Chairs and PD
Standards Action Group	Late 2002, the priority area "Standards and Guidelines" was split into two priority areas. The Standards Action Group was established to correspond to the Standards priority area.	Final Minutes May 23, 2008 and transitioned to the Standards Working Group	To establish, through national collaboration, a cross-Canada approach to promote, stimulate, and facilitate the development, dissemination, uptake and evaluation of evidence-based Pan Canadian standards and indicators in key aspects of cancer control.	N/A	N/A	N/A
Screening Action Group	Emerged from research theme working group (Under Standards) in development of CSCC 1998 Original TOR Dated: July 2006.	Ongoing	The Screening Action Group (SNAG) will address: 1. Cancer site- specific screening issues, complementing the efforts of the sister action groups and national committees already in existence; and, 2. Broader cancer screening issues	10	Program Director: Full Time Chair: Part time	Chair: Toronto Program Program Director: CPAC, Toronto
Rebalance Focus/ Cancer Journey Action Group	Emerged from Supportive/Palliative cancer care thematic working groups 1998. Late 2002 the working group renamed as action group and was split from standards	Ongoing	Provide leadership to achieve a permanent change in the cancer system so that individuals diagnosed with cancer and their families receive care, throughout their cancer experience, that is responsive to the full range of their needs, compassionate, and evidence-based. No TOR to date - work is proceeding to draft TOR	14	Program Director: Full Time Chair: Part time	Chair: Toronto Program Director: CPAC, Toronto
Primary Prevention Action Group	1998 prevention topic working group in 2003 formally. Late 2002 the working group renamed as action group	Ongoing	Mandate: a) Reduce the incidence of preventable cancers in Canada, and ultimately reduce morbidity and mortality from this disease; and, b) Play a leadership role in promoting major change in the cancer control and health care paradigms, whereby primary prevention/health promotion obtains the appropriate increased priority and resource allocation, and this increase is sustained in the future.(Source 2007-08 work plan) Note: unchanged for 08-09 work plan	25	Program Director: Full Time Chair: Full-time. 50% of time allocated to role as Chair; 50% Senior Scientific Advisor to Cancer Control and Knowledge Management	Chair: CPAC, Toronto Program Director: CPAC, Toronto

Action Group	Start Date	End Date	Mandate	No. of Members	Type of Positions	Location of Chairs and PD
Guidelines Action Group	Emerged from research theme working group (Under Standards) in development of CSCC 1998. Late 2002 the working group renamed as action group and split from standards)	Ongoing	The mandate is to champion pan-Canadian collaboration through innovative social network approaches that will design, evaluate and disseminate tools for the optimal use of evidence in cancer control through guidelines across the disease continuum and levels of decision making (Source: 2008-09 Work plan).	19	Program Director: Full Time Chair: Part time	Chair: British Columbia Program Director: Ottawa
Surveillance Action Group	In 2003, the Canadian Cancer Surveillance Alliance (CCSA) and the Canadian Strategy for Cancer Control (CSCC) Governing Council agreed the CCSA should become the Surveillance Action Group (Surveillance AG) of the CSCC.	Ongoing	To establish an enhanced national cancer surveillance system that improves cancer control by leading the coordinated planning, development and implementation of Canadian cancer surveillance initiatives in information collection, analysis, communication and application of results.	18	Program Director: Full Time Chair: Part time	Chair: Regina, Saskatchewan Program Director: Ottawa
Research Action Group	Emerged from research theme working group in development of CSCC 1998. Late 2002 the working group renamed as action group. The Action Group is the same as the Canadian Cancer Research Alliance. In the future, the Alliance may act beyond the mandate of the Action Group.	Ongoing	The mandate is to inform the Partnership and the Advisory Council on Cancer Control on all matter pertaining to cancer research, and to deliver on the research strategic priorities of the Canadian Strategy on Cancer Control.	24	Program Director: Full Time Chair: Part time	Chair: Kingston, Ontario Program Director: CPAC Toronto
Health Human Resources Action Group	Emerged from research theme working group in development of CSCC 1998. Late 2002 the working group renamed as action group	Ongoing	The mandate is to develop, implement, and evaluate a Pan-Canadian integrated cancer workforce strategy to meet the needs of Canadians living with or at risk of cancer. This strategy is predicated upon quality services being delivered to Canadians in a timely fashion by the most appropriate health systems and team of care-givers across the cancer continuum (from prevention to palliation).	47	Program Director: Part Time on contract (will reconsider to permanently fill position) Chair: Part time	Chair: Ottawa, Ontario Program Director: Kingston

Action Council

The Action Council is comprised of all Action Group Chairs, the VP Knowledge Management, the VP Strategy, Performance Measures and Communications, the CFAO and the Chair of the Cancer Risk Management Advisory Committee.

The Action Council was formed to help in the execution of the refined Partnership strategy. The roles[19] of the Action Council focus upon integration of the work of the Action Groups, both across the Action Groups themselves and with the key areas of focus, strategic directions and frameworks, and the general work of the Partnership. It is a "forum for discussion of means to ensure consistency, transparency, and fairness in the implementation of Action Group plans". It also provides "advice on optimal implementation strategies, including those related to inter-sectoral and interdisciplinary collaboration, the integration of science and medicine, and potential sources for resource 'leveraging'".

The Action Council holds between eight and ten meetings annually.

3.7 The Partnership's Stakeholders and Partners

The Partnership operates within a complex landscape of organizations and individuals representing a broad range of interests:

- Federal departments;
- Provincial and territorial ministries / departments of health, and often cancer control agencies with varying degrees of autonomy, through to organizations with more local spheres of interest and influence;
- All points in the cancer control continuum, from prevention through to treatment and palliative care;
- Specific cancers through to cancer in general;
- Cancer focus through to chronic disease focus;
- Advocacy through to implementation; and
- Patient and survivor voice through to health care providers and to suppliers to the health care system.

Each of these organizations and individuals has a specific footprint in the cancer control landscape, based upon factors such as mandate and roles and also upon where they see value in going it alone, partnering with other players or partnering with a pan-Canadian organization such as the Partnership.

[19] CPAC (June 2008) *Action Council Terms of Reference*

A partial list of stakeholders follows:

- Health Canada - as funder and partner
  - First Nations Inuit Health Branch

- Other Federal Government Departments and Agencies
  - Public Health Agency of Canada – public health issue
  - Statistics Canada
  - Canadian Institutes of Health Research (CIHR)

- Provincial / Territorial Cancer Control Agencies

- Health Ministries/Departments
  - Organizations in each province or territory – various configurations, with some major changes occurring (e.g., winding down the Alberta Cancer Board and embedding cancer control into different organizations within the new Ministry of Health Services)
  - Canadian Association of Provincial Cancer Agencies (CAPCA)

- Non-governmental Organizations, such as:
  - Canadian Cancer Society
  - Patient organizations / associations – Canadian Cancer Action Network (CCAN), Cancer Advocacy Coalition of Canada (CACC), Campaign to Control Cancer (C2CC)
  - Disease site and cancer site specific organizations / associations
  - Professional groups – e.g., Canadian Association of Psychosocial Oncology (CAPO), Canadian Association of Nurses in Oncology (CANO)

- Individuals
  - Patients, survivors, and people living / looking after them
  - Practitioners
  - Researchers

- Organizations representing specific target, at risk, groups, such as:
  - Aboriginal
  - Youth

- Other organizations
  - Canadian Institute of Health Information (CIHI), Canada Health Infoway and similar pan-Canadian organizations
  - Canadian Agency for Drugs and Technologies in Health (CADTH)
  - Universities
  - Research institutes
  - Hospitals and other health treatment centres

3.8 The Partnership's Funding Agreement and Annual Funding Requests

A funding agreement[20] with Health Canada was entered into on April 1st 2007, for a period of five (5) years, expiring on March 31, 2012. The agreement provides for an amount of up to fifty million dollars ($50,000,000) for each Fiscal Year.

The funding requirements are laid out in the funding agreement and require that each Fiscal Year, the Partnership's funding request include, but not be limited to:

- intended short and medium term activities and outcomes for the upcoming Fiscal Year, consistent with and in furtherance of the Strategic Plan;
- reference to the Recipient's Funding Request for the previous Fiscal Year with a focus on its successes and remaining challenges;
- the Recipient's budgeted expenditures for the upcoming Fiscal Year and any anticipated revenues from other sources;
- the Cash Flow Statement for the first quarter of the Fiscal Year;
- planned activities for the Fiscal Year;
- risk assessments and mitigation strategies; and
- ongoing performance monitoring strategies.

One of the specific terms of the original funding agreement is that the Partnership shall not use any portion of the Grant Funding for the purpose of accumulating surplus funds, but the Partnership may retain funds with respect to expenditures incurred, but not actually disbursed, during the Fiscal Year[21]. It is with respect to this condition of the Funding Agreement where there are existing issues dealing with the annual funding process and the allocation of approved funding to individual projects, funded by the Partnership. Projects that are multi-year and multi-stakeholder do not lend themselves to single year allocations of funds.

A result of the funding agreement was the lapse of funds in Year 1, when the Partnership spent much less than allocated and requested that Health Canada re-profile the overall funding envelope accordingly. The re-profiling of the fiscal envelope was approved by Health Canada in October 2007. The total funding request for 2008-09 was consistent with the re-profiled amount.

In the fall of 2008, the Partnership made submissions to Health Canada requesting greater flexibility in its use of the funding commitment. Negotiations were ongoing during most of the period of this evaluation.

[20] Funding Agreement Canadian Strategy For Cancer Control
[21] Ibid

In its Funding Request for 2009-10[22], the Partnership notes that for 2008/09, actual spending is projected to be less than the profiled amount above. Based upon the assumption of successful negotiations regarding flexibilities, this underspending is allocated to future years. The Funding Request states that the flexibility to reallocate funds ensures the preservation of the funds remaining from the original grant.

A revised funding agreement with increased flexibilities was approved on March 13, 2009.

3.9 The Partnership's Management Processes and Tools

The Partnership employs a full range of management processes and tools, for its planning, monitoring and reporting at the corporate, portfolio (Action Groups and Core Frameworks) and project levels.

At the corporate level of the Partnership key planning, monitoring and reporting documents are:

- Strategic Planning
  - Partnership Strategic Plan 2007/08 to 2011/12, dated May 15, 2007
  - Partnership Strategic Plan 2008-2012, Updated February 2008 and January 2009
- Business Planning
  - Business Plan 2009-2010
  - Annual Funding Requests to Health Canada – portion on plans for coming year
- Reporting
  - Quarterly internal financial and performance reporting
  - Annual Report
  - Annual Funding Requests to Health Canada – portion on accomplishments for the past year
  - Communications products – e.g., Progress Report, Winter 2009, released February 4, 2009; newsletters; e-bulletins

The Project Management Office (PMO) has developed a toolkit for the portfolio and project levels. The tools and templates included in the toolkit to support portfolio and project execution, planning and initiating, and reporting are illustrated in Annex A.

[22] Funding Request 09/10, January 28, 2009

4. Evaluation Findings, Conclusions and Recommendations

This section provides the evaluation findings, conclusions and recommendations and is organized by the objectives of the evaluation as outlined in section 2.1.

The next section presents the Partnership's results and successes in "achievement of the Strategy" as stated in the Funding Agreement. It outlines progress as reported in key planning, reporting and accountability documents produced by the Partnership, as well as noted by key informants. It describes how key informants view the Partnership's prospects for success going forward. It also comments upon expectations around measuring societal and economic impacts.

An important area of results has been the building of the Partnership as an organization. As such, Section 4.2 focuses on "Building the organization", that is, the start-up and later activities undertaken by the Partnership. This includes Board governance, policies and procedures, the operating model and organizational structure that were put in place over the last 22 months. More specific details are then presented in section 4.3, 4.4, 4.5 and 4.6.

Section 4.3 concerns the overall governance and accountability mechanisms established by the Partnership and how they are operating today. Here, issues related to the funding agreement are also discussed.

Section 4.4 outlines findings and conclusions regarding the activities undertaken to refine and focus the CSCC.

Section 4.5 focuses on the core frameworks established to guide the Partnership, including knowledge management, communications, cancer system performance, and enterprise performance and risk management. It also includes the Project Management Office as a corporate enabler.

Section 4.6 presents the implementation activities related to the CSCC undertaken to date by the Partnership. This includes the work of the Partnership's Action Groups and work undertaken to achieve stakeholder engagement.

The recommendations are summarized in section 5 of this report.

4.1 Achievement of the Strategy

Results / Successes to Date

The Partnership's results and successes to date have been summarized by the majority of external and internal key informants, as well as in reporting documents produced by the Partnership, in the following terms:

- Putting the Partnership organization in place so that it is a solid foundation for delivering results;
- Transitioning the CSCC from a planning and advocacy phase aimed to a large part at obtaining funding from the federal government, to an implementation/execution phase aimed at changing the cancer control system; and
- Moving forward on the implementation phase, with specific activities being carried out, outputs being produced or in process, and some early stage outcomes/impacts being seen.

As outlined in section 3 where the Partnership is profiled, a significant organization is considered to have been built, moving from initial start-up to an increasingly mature organization. More about the findings and conclusions related to building the Partnership and its governance bodies is presented in sections 4.2 and 4.3 respectively.

Also, in general, the Partnership is viewed as having successfully transitioned the CSCC to implementation and execution, through its work on focusing the strategy (more in section 4.4) and associated planning and reporting processes, and project approval and management practices (more in section 4.5).

The remainder of this sub-section focuses only upon the third bullet. The Partnership's 2009-10 Funding Request describes progress made during 2008-09 on Strategic Initiatives and work of the Action Groups and on central activities. It provides plans for 2009-10, as well as 2012 targets for the Strategic Initiatives. The Partnership also released, on February 4, 2009, a Progress Report to the public. These documents follow a number of performance reports and annual reports, as well as progress reports embedded in documents such as funding requests.

As outlined in the Funding Request and Progress Report, many of the initiatives are at early stages with others already underway. Key informants, both external and internal to the Partnership, noted that the stage of these initiatives was largely appropriate, and must be considered in the context of both the amount of time and effort required to set up the Partnership as an operating entity in the first place, and the starting point for each initiative. As one respondent commented, in those cases when you are starting with essentially nothing and you are working in the complex cancer environment, then even putting the process in place to get moving forward can be considered to be an achievement. In other cases, where work preceded the Partnership, then more advanced

progress is a reasonable expectation. In fact, the Partnership is attributed with accelerating the progress of such initiatives.

A number of key informants, for example, on the Board of Directors and Advisory Council, indicated that they had thought that progress might have been quicker, but, in hindsight, progress was reasonable given the start-up and transition challenges. (See section 4.2)

Of note is that when asked about the "successes" of the Partnership to date, respondents pointed towards many of the strategic initiatives, especially:

- The Canadian Partnership for Tomorrow Project (the Cohort Study)
- Partnership Portal
- Staging
- Screening
- Synoptic reporting.

These were also considered as potential "legacy" projects given their size, scale and potential impact.

Interestingly, a small number of external respondents mentioned that the Cohort Study, albeit an important success story, might fall outside of the intent of the CSCC because it focuses on new research rather than knowledge translation. This suggests a need for the Partnership to continue to explain its mandate, strategy and rationale for investments.

Looking Ahead

In developing its Partnership strategic plan, the Partnership selected its six Key Areas of Focus and Strategic Initiatives within them, as areas where the Partnership could show results during its mandate up to 2012. These Strategic Initiatives that began in the Action Groups were chosen because of their potential for significant impact.

Discussions with the external key informants and senior management suggest confidence that the Strategic Initiatives will achieve the desired deliverables and impacts during the next three years, that they are and will accelerate progress, and that they position the Partnership for overall impact.

Both external and internal key informants think that the next year is crucial. The Partnership must really focus on "product" and "impact". This is both consistent with the Partnership's raison d'être, and with the reality that the current funding agreement is only for a five year term ending in 2012.

Many external key informants noted that, even with this imperative on results, continued improvement and relevance of the Partnership means that it will need to:

- Continue to address system issues recognizing that longer timeframes are required for results; and
- Continue to work with/through partners and harness new partnership opportunities.

Measuring Long Terms Results / Successes / Impacts

Initial expectations concerning the impacts of the CSCC were set in the strategy discussion paper (see section 3.2). Significant benefits, both societal and economic, were attributed to the implementation of the CSCC. Over the next 30 years, the CSCC was estimated to reduce the severity of the cancer crisis across a number of factors by 10-20%. Dollar savings alone were estimated to be in the billions. These modelling estimates were an important selling point to the federal government for funding the Partnership.

The estimates were provided by a company which used a proprietary econometric modelling tool. Based upon interviews with a number of key informants involved at the time, there were concerns about the transparency of the methodology used to derive the estimates.

Recognizing this issue and the gap it creates in the ability to forecast long term impacts and report on this important part of its performance story, the Partnership is leading an initiative to develop a transparent methodology that will provide estimates of economic and societal impact. Advice is being provided by the multi-stakeholder Cancer Risk Management Advisory Group comprised of senior leaders and decision-makers, cancer control experts, and modelling and economic experts.

Support was also expressed by key informants for the cancer control system performance work being done by the Partnership. A set of well structured indicators around attributes such as access and quality, good data to support these, and appropriate reporting, is seen as being able to, for example, influence the provincial and territorial cancer care deliverers to seek out best practices to close performance gaps and make the necessary investments.

Conclusions and Recommendations

The findings in this section lead to the following conclusions.

- The Partnership has made significant gains since its inception in building its organization, in developing the partnerships and networks necessary for achieving the objectives of the CSCC while moving forward initiatives that promise to produce impacts consistent with the CSCC and Partnership's vision.
- There is, however, a continuing need to explain how these initiatives are consistent with the CSCC and the Partnership's vision and how these are

examples of success today and lay the foundation for achievement of the CSCC in the longer term.

- The Partnership has put in place a focused strategy appropriate for implementation. Through this strategy, the Partnership has accelerated progress on many initiatives, and has initiated others.
- The Partnership has managed a change process, moving the CSCC from a volunteer-led to an organization-led business model. This has inevitably led to tensions concerning issues such as decision-making, responsibilities and accountabilities, and the need for clarity that is discussed further in the following sections of the report.
- In this change process, the Partnership needs to be careful to continue to foster partnerships, relationships and goodwill, that are more enduring and of a longer perspective, even when it may appear to delay results of deliverables in the shorter term.
- The Partnership must continue its work on cancer risk management models and cancer control system performance in order to:
  - Demonstrate the societal and economic benefits and impacts
  - Produce evidence that could influence equity of access to and quality of cancer care across Canada

Based upon these conclusions, the following recommendations are made.

Recommendation 1: The Partnership is making progress and achieving results through its refined Partnership strategy, and appears well positioned to continue to do so. These achievements are endorsed by the majority of stakeholders. Therefore, the Partnership should continue to implement its strategy, with adjustments made when necessary to deal with new opportunities or performance gaps.

Recommendation 2: Impacts and benefits for the cancer control domain and its stakeholders will need to be shown to maintain support. Therefore, work on cancer risk management and cancer control system performance needs to continue so that information about benefits / impacts can be gathered, analyzed and disseminated.

Recommendation 3: The Partnership needs to continue to work with and through partners and collaboration for maximum longer-term impact even when there may be alternative approaches that might speed up the achievement of short term results that demonstrate quick successes.

4.2 Building the Organization

The Blueprint for the Partnership

The Partnership officially began its operations in April 2007, after being announced in November 2006. However, ideas and expectations about the appropriate Partnership organization and business model were sown over many years, during and perhaps even before the CSCC. This is an important backdrop to understanding the evaluation findings related to building the Partnership's organization.

From expectations and opinions that the evaluation team heard during key informant interviews or that are embedded in key documents, there was considerable consensus around the idea that the Partnership would be a long term sustainable organization that is an integral part of the cancer control landscape and hence has an ongoing catalytic role for change, coordination and improvement across the country.

However, there is a degree of tension around the Partnership's decision-making and operational models. It appears that the initial expectation of many people who were involved in the development of the CSCC was that all initiative and project delivery would continue to be through the Action Groups, and bodies such as the Advisory Council would be more involved in decision-making. This seems to remain the "lens" through which some continue to view the Partnership, even when they say that the Partnership needed to take the path it has taken in order to accelerate action.

Early Start-up (2006-07)

Early start-up and transition covered the period from late 2006 until roughly the end of March 2007. Key informants who were involved during this period noted that the focus was necessarily upon putting in place what was absolutely necessary for the Partnership to start operating on April 1, 2007. This meant getting the Board and an initial corporate organization operational, developing and negotiating the funding agreement with Health Canada that had to be in place for April 1, 2007, and finalizing a strategic plan that had to be part of the funding agreement. Key milestones during this period included[23]:

- On November 24, 2006, the Prime Minister's announcement of the creation of the Corporation and committed $260 million over five years to implement the strategy. He named the Chair and the Vice-Chair.
- A Provisional Board being put in place to oversee the start-up.
- An eight-person Transition Team being established to support the Board in its activities, as well as establish and conduct basic corporate function.

More specifically, matters that were dealt with by the Provisional Board included:

[23] Annual Performance Report, Start-up, 2006-07, as of March 31, 2007

- Adoption of By-Law #1 that dealt with such matters as the process for appointing the Board, its processes and responsibilities, required Board Committees, the responsibilities of the Advisory Council including the establishment of Action and Working Groups, Membership, appointment of officers, banking arrangements, fiscal year, location of head office, appointment of auditors, and conflict of interest.
- Review and approval of terms of the Contribution Agreement with the federal government dealing with start-up funding from January 15 to March 31, 2007.
- Review and approval of terms of the Funding Agreement with the federal government that set the funding framework for the five-year period starting April 1, 2007 and enabled the first year's funding to flow in 2006-07. This included the initial Strategic Plan and work plan with funding requirements for incorporation in the Funding Agreement and for use by the new Board.
- Review of other corporate start-up activities – e.g., leases, insurance, and remuneration.

One result of the focus of the Provisional Board and Transition Team on becoming operational as soon as possible and meeting the April 2007 deadline imposed for having a Funding Agreement, with a five year strategic plan attached, was that the Partnership's first strategic plan was basically the same as the CSCC plan. There was only very limited time available to consider any refinements or adjustments that would be relevant for the context of the Partnership.

It was also observed by many key informants, both inside and external to the Partnership, that the strategy itself was more of a list of activities to be done, rather than a focused and detailed plan, ready to be implemented. This situation was considered to be understandable, given the intent of the CSCC exercise. However, it meant that, even at this early stage, considerable work was seen as being needed to be done to translate it into a focused and detailed plan.

Later Start-up and Transition (2007-08) [24]

Later start-up and transition covered the period from April 2007 to March 2008. During this period, there were many significant milestones and accomplishments[25]:

On May 15, 2007, the inaugural Board of Directors assumed its governance role from the provisional Board which had been put in place to direct the beginnings of an organizational framework. The Board and its committees (Executive, Finance and Audit, Performance, and Governance and Nominating) have met regularly since then.

[24] "Start-up" of the Partnership as an organization and corporate entity, and "transition" from the CSCC and its planning/advocacy focus to the Partnership with its implementation/execution focus.
[25] Many of these bullets extracted and summarized from the Partnership's Funding Request 2008/09, dated March 7, 2008

During the next few months, the Board developed key governance policies. The Board also focused on the creation of an initial business plan and operations in the period preceding the establishment of the executive team, but later shifted to its governance role.

The Transition Team continued to support the Board and play a corporate management role, ending in late 2007.

The network of Action Groups that were established under the CSCC became part of the Partnership in April 2007 in accordance with its agreement. During the following months, the Action Groups became embedded within the organization and developed plans to operationalize and implement the strategy. They transitioned from being independent volunteer groups to operating within a corporate accountability structure. This required formalizing contracts with leaders from the community to become Chairs of the Action Groups. In addition, Program Directors were hired to coordinate the activities identified by the Action Group members, and ensure projects were on track to achieve their deliverables. Many of the Program Directors came on board in 2008.

Each Action Group created initial work plans, project charters and budgets for 2007/08. Thirty-nine projects were initiated over the year. Some were short term projects to address specific opportunities in cancer control, and others were multiyear initiatives that achieved milestones during the year.

To support the work of the Partnership, the Advisory Council was formed in October 2007 in accordance with the government-approved by-laws.

The Board undertook a search in the summer of 2007 for a permanent chief executive officer. The new CEO began her work with the Partnership on October 1, 2007. The hand-off from the Transition Team to a new permanent management team started at this time. Joining the Partnership during the next few months as members of the executive team were the three Vice-Presidents and Chief Financial and Administrative Officer. They began to staff up their respective areas.

A strategy refinement process was undertaken to review and assess the direction for the organization. The overall objective was to bring more focus to the strategy to achieve significant impact in cancer control, while maintaining the broader strategic direction established by the CSCC. The Board of Directors held a retreat in November 2007 and was clear in its direction to create focus and impact, while exploring the potential for greater collaboration among Action Groups. An updated Strategic Plan 2008-2012 was released in February 2008.

The Action Council was formed to steward the implementation of the strategy and to ensure activities are leveraged across Action Groups, with meetings started in February 2008. The Action Group Chairs and senior management comprised the Action Council, chaired by the VP, Cancer Control.

As can be seen by the milestones and achievements listed above, much work during this period continued to focus upon building the basics of the Partnership. Key components of governance – the Board of Directors and the senior management team – were put into place. The operating model - corporate part of the Partnership, Action Groups, Advisory Council, and Action Council – was established and began to operate. The corporate organization was established and staffing was done. Policies and procedures for corporate functions were introduced and refined.

Key informant interviews with people involved with the Partnership during its first year revealed the following additional findings about the topics in the previous paragraph.

- There was a sense of excitement among stakeholders about taking full advantage of the opportunity presented by the Partnership, coupled with a sense of urgency about achieving "results during the mandate" while "bringing everyone along".
- There was general understanding that the Partnership's challenge of implementation is quite different than the CSCC's challenge of advocacy, and that moving already existing Action Groups and stakeholders to the implementation mode can require interventions that would not please everyone.
- The time taken to set up the Partnership as an organization was seen by some Action Group members, who felt ready to move ahead on their plans from day one, as a barrier causing frustration.
- The time taken in explaining plans and reformulating them with a transitional organization that was seen as being good administratively but weak in terms of cancer subject matter expertise was again frustrating to some Action Groups. In addition, there was a degree of frustration with the planning and reporting requirements required by the Partnership for due diligence and project management purposes, compared to the previous experience of many recipients for their research grant monies.

Further it was reported that:

- Putting in place the executive team is seen to have been a critical milestone for the Partnership, bringing a sense of permanency to the organization, allowing the Board of Directors to be less hands-on operationally and assume its more appropriate governance role, and leading to staffing up the organization. The addition of a Vice President who is a nationally recognized cancer expert is considered to have been an important step in terms of advancing the organization and increasing credibility in the cancer community.
- Staffing up the organization during this time allowed a more appropriate stratification of work to develop – earlier, the VP's were being "pulled" to do the work of Directors, and the CEO was doing the work of the VPs. However, this staffing has taken time, due to staffing processes and finding the right people. For example, Program Director positions continue to be filled into early 2009.
- There was lack of clarity around the roles of the Action Groups and their Chairs, relative to those of the new Vice-Presidents and their corporate staff, and the

Program Directors in between. If fact, this extended to questions about what parts of the Action Groups, if any, are within the Partnership as a corporation.
- There was also lack of clarity around the role of the Advisory Council, or at least, consensus among members about the role being set for them compared to their expectations coming out of the CSCC.

The findings that relate to the Partnership's update to its five-year strategy are discussed further in section 4.4. Policies and procedures related to work planning and reporting for Action Groups and at the project / initiative level are discussed in section. 4.5. The implementation of projects and initiatives is discussed in section 4.6.

This Year (2008-09, up to Feb. 2009)

During the past ten months, work continued on putting the organization in place, as well as advancing and accelerating the work on the strategy itself. Achievements against the strategy have already been discussed in section 4.1. With regard to the organization itself, the shift could be described as the Partnership now being up and running, with a Board of Directors in place and providing overall direction and governance, a senior management team and staff in place and up to speed, and a focused strategy as to how the CSCC should be implemented for maximum impact in the short, medium and long terms.

The Partnership continued to look at its own management capability. Management Matters, an organizational design consulting firm, was engaged to conduct an organizational effectiveness assessment. The purpose of this assessment was to assess the design and alignment of corporate structure, roles and accountabilities to effectively deliver on the strategic direction set by the Partnership and commitments made in the funding agreement.

Increasingly, as evidenced by a strategy session in October 2008, with both external participants and Partnership staff, the focus was upon actions that would drive forward the overall strategy of eight priorities and strategic initiatives in six key areas (see section 3.3). Similar strategy sessions were being held in many of the eight priorities areas.

Indeed, during key informant interviews that were held in the December 2008-February 2009 period, the overwhelming opinions, both internally and externally, were that:

- The Partnership has done a good job in building its capacity to deliver results;
- The Partnership has already used this capacity to launch important initiatives that would deliver results both within its 5-year mandate and in the longer term;
- The pace may have been slower than many had originally expected. However, in hindsight, the Partnership is about where "you would expect it to be"; and
- The capacity built within the Partnership, if used well, provides it the opportunity to continue to improve its performance and impact.

At the same time, it was noted by a cross-section of external and internal respondents that there remains a gulf between many of those who were involved during the development of the original CSCC and those setting the course for the Partnership today. The nature of the gulf concerns the extent of the former's influence on what is implemented, how it is done and who does it, and was most often expressed in terms of the roles of the Advisory Council and of the Action Groups.

Conclusions and Recommendations

The findings in this section lead to the following conclusions.

- The Partnership – its Board of Directors, senior management team and staff – have put in place the building blocks for a long term sustainable organization that has become a part of the cancer control landscape, with awareness and increasing acceptance of its ongoing role. This has involved and continues to be a significant change management process.
- Even during the building process, the Partnership and its Action Groups continued to advance the strategy on many fronts.
- With the building blocks in place, the focus has shifted and needs to continue to be upon initiative/project execution, with a keen eye on benefits and impacts achieved and the communication of these impacts across the stakeholder community.
- The roles/activities of the Action Groups and the Advisory Council need to be clarified with consideration of other advisory mechanisms that have been put into place for many specific priorities and initiatives – e.g., Cancer Risk Management Advisory Committee, Canadian Colorectal Screening Network, National Forum on First Nations/Inuit/Métis Cancer Control Planning Committee.

Based upon these conclusions, the following recommendations are made.

Recommendation 4: The Partnership needs to keep its eyes firmly on the target, and at this time work with and through its current corporate and advisory structures, and delivery approaches, except when barriers present significant risk. With this in mind, it is recommended that the role of the Advisory Council be clarified in relation to the other advisory mechanisms that have been put into place for specific priorities and initiatives (e.g., Cancer Risk Management Advisory Committee, Canadian Colorectal Screening Network).

Recommendation 5: When there are new initiatives, priorities and opportunities in pursuit of the achievement of the CSCC objectives, it would be appropriate for the Partnership to put in place new advisory and delivery approaches if the existing ones are inadequate.

4.3 Overall Governance and Accountability Mechanisms

The Partnership's governance and accountability mechanisms are described in section 3.6 and their evolution in section 4.2. This section focuses upon additional findings and resulting conclusions, particularly from key informant interviews.

Board of Directors

Generally, key informants viewed positively the Board of Directors and its work and contribution. Some more specific observations from key informants, including Board members, follow:

- The leadership of the Board has been effective;
- The Board is considered to provide a good cross-section of expertise and representation of key stakeholder groups , within the parameters set out for Board composition;
- The Board has transitioned successfully to a more normal governance role from its more "hands-on" role in the early days;
- Some Board members expressed a preference that a more strategic level of discussion take place, while others suggested that they would like to see some issues discussed at more length; and
- Generally, Board members felt they were being provided with the right type of information from senior management.

Key informants also noted that as the Board membership changes over time, it will be important to maintain continuity and momentum. This appears to be well understood by the Board.

Senior Executive Team

Generally, key respondents felt that the Senior Executive Team – CEO, VPs, Program Directors, and Directors – is strong and looking after business well, and that there is now a good mix of cancer content and management expertise and experience.

Some specific comments from key informants were that:

- The management team is relatively small and working very hard – care needs to be taken to avoid burnout; and
- The team obviously needs to focus on results, but at the same time, ensure it continues to engage existing and new potential partners.

Advisory Council

As was noted in section 3.6, the terms of reference for the Advisory Council was revised in September 2008 to be more advisory to senior management of the Partnership rather than to the Board of Directors.

From the key informant interviews, a number of points emerged:

- Key informants from the Partnership's Board of Directors generally felt that the Advisory Council's appropriate role was advisory to senior management and through senior management to the Board. This was consistent with the accountabilities of the Board. It was also noted that, despite the Vice Chair of the Board being co-Chair of the Advisory Council, very little of the results from the Advisory Council meetings was actually presented to the Board.
- Key informants from the Partnership's management team thought that the Advisory Council meeting in the Fall 2008 was quite effective and well received, with its focus on discussing a particular issue, getting "information in" from the members rather than pushing a lot of information out to them. The sense was that this would be an effective model going forward.
- Some key informants on the Advisory Council, especially those involved in the CSCC, stated that the Advisory Council as being run was not "what they had signed on to". They expressed a desire that the Advisory Council be more proactive in terms of setting its "advice" agenda.

Action Council

The Action Council is considered to be a useful forum to ensure internal communication and partnerships. Similarly, monthly meetings of Program Directors are considered to be beneficial first, in creating a greater awareness between Action Groups of ongoing activities, and second, in facilitating Action Group interactivity.

Funding Agreement

The Partnership's funding agreement with Health Canada was briefly described in section 3.8. Issues related to the need to reprofile funds during the "ramp-up" of the Partnership and to the difficulties in funding multi-year projects delivered by multiple stakeholders when funds cannot be carried forward across fiscal years were described.

In our key informant interviews, the following points were raised:

- With regard to the flow of funds:
    - Allocating $50 million per year starting year 1 did not recognize the ramp up period for the organization and for many projects, and led to funds being lapsed;

  - A five year timeframe for funding was probably too short – 7-8 years would have been more appropriate given ramp-up and the time period required to develop and execute some projects;
  - There is an ongoing need for multi-year funding and carry forward, so that funds can be expended as projects become ready, rather than lapsing funds. In other words, the funding model does not match the way projects work and as a result, people tend to start thinking in terms of operational budgets as opposed to project budgets;
  - The Partnership made submissions to Health Canada to obtain more flexibility in its funding agreement, and these were under consideration and discussion during much of the time period of this evaluation.

- With regard to reporting against the funding agreement:
  - Health Canada requires that the Partnership continue to report results and forward plan against the eight priorities that were in the original Partnership strategy, rather than only against its refined strategic plan. At the same time, Health Canada recognizes that the Partnership has flexibility to adjust what is implemented within each of the eight priorities;
  - The Partnership's senior management felt that this ties the federal government's assessment of the success of the Partnership back to an older strategic framework. However, it has continued to comply with the Health Canada requirement, including in the detailed progress reporting section of its February 2009 progress report.

A revised funding agreement providing the requested flexibilities was approved on March 13, 2009.

Conclusions and Recommendations

The findings above lead to the following conclusions.

- Overall governance and accountability mechanisms within the Partnership are in place and working well.
- The Partnership should benefit from the increased flexibilities in its revised Funding Agreement, approved March 13, 2009.

No recommendations are made in this area.

4.4 Refinement and Focusing of the Strategy for Cancer Control

As was noted in section 4.2, during 2007 and early 2008, a strategy refinement process was undertaken to review and assess the direction for the organization. The overall objective was to bring more focus to the strategy to achieve significant impact in cancer control, while maintaining the broader strategic direction established by the CSCC. The Board of Directors held a retreat in November 2007 and was clear in its direction to create focus and impact, while exploring the potential for greater collaboration among Action Groups. An updated Strategic Plan 2008-2012 was released in February 2008.

The updated Strategic Plan, still guiding the Partnership, retains the original eight priority areas of the Partnership's first strategic plan, but brought into prominence six key areas of focus and associated strategic initiatives. These areas are ones in which the Partnership feels it will achieve significant impact during its mandate.

One way of putting this work into perspective is against the cycle of:

- Concept – design – development – implementation – monitor/review/evaluate

The original CSCC basically outlined Concept, Design and high-level Development of a strategy. As described earlier, the first Partnership strategic plan was essentially the same as the CSCC, because the funding agreement needed to be put in place so quickly. This meant that there was a jump to Implementation, without detailed Development of the strategy being done. The refinement of the Strategy described above basically was an opportunity to reflect on the Concept and Design, and then fill in the detailed Development piece.

Interviews with key informants across the spectrum suggest that it was important that the Partnership refine and focus the CSCC. As noted in section 4.1, the strategic initiatives chosen correspond to areas that many key informants felt to be important.

Increasingly, as evidenced by a strategy session in October 2008, with both external participants and Partnership staff, the focus is upon actions that would drive forward the refined strategy. Similar strategy sessions have been held in many of the eight priorities areas to create ownership across the country.

Conclusions and Recommendations

We conclude that the refinement and focusing of the CSCC as described in the Partnership's Strategic Plan, refined in February 2008, is largely supported by stakeholders. No recommendations are made in this area.

4.5 Core Frameworks and Corporate Enablers

In this section, findings and conclusions are presented for core frameworks and corporate enablers.

Knowledge Management

Knowledge management (KM) includes three areas:

- Knowledge broker and strategy
- Development of core KM infrastructure – the Portal[26]
- Analytical capacity and cancer risk management

External key informants view the knowledge management core framework primarily in the context of the Partnership Portal, and in some cases, the cancer risk management modelling. As noted in section 4.1, they also see the portal project as being a very important initiative in terms of organizing and disseminating knowledge, as well as supporting work and collaborations across the Partnership, including external networks, organizations and individuals, and reaching various publics. However, there is also a bit of a "wait and see" attitude about the impact that the portal will have – that it is not just "another portal" dotting the cancer landscape.

Internal key informants noted that the KM framework is critical to extending the benefits of the Partnership and engaging more stakeholders and partners (i.e. "a new larger tent altogether"). It is seen as the interactive and communicative foundation of the organization that is vital in bringing the community together. It will be the unifying theme for web-based tools, information and data bases across all priorities in the strategy.

In terms of processes being used for the portal development, internal key informants also said that:

- The iterative approach being taken is more beneficial than a more traditional systems development approach;
- Good communications tools are in place for the portal development and to support project accountability (e.g., monthly meetings with the portal advisory group; monthly updates to senior executive; updates to the Portal committee of the Board of Directors; Program Directors receive regular updates); and
- Ongoing engagement with Program Directors around the portal project provides an opportunity to develop a common understanding of what it means to work in a collaborative environment – at the same time, there is little interaction with the Action Group Chairs.

[26] A case study is being prepared for the Partnership Portal initiative.

As well, a repository has been built as a KM tool to support Action Group work.

Regarding the cancer risk management model/tool, as was noted in section 4.1, this is an important initiative to be able to estimate the societal and economic impacts of the Partnership's interventions and actively model different cancer control programs and their potential outcomes. There is also the potential for provinces and territories to use the model for their own initiatives.

Cancer Control System Performance[27]

This core framework will provide a scorecard on how provinces and territories are doing on cancer control across the continuum. Its benefits include:

- Use in projecting needs and enabling planning;
- International comparative analysis (UK, France, Germany, Australia)
- Tool for policy development and decision-making

The scorecard will consist of a refined set of indicators on incidence, prevalence and survival rates, i.e., population impacts, developed in consultation process with stakeholder group and steering committee. The objective is to bring the current 800 or so indicators down to 60-80. Indicator selection criteria have been developed. The next challenge is to get buy-in from provinces, although the desire is presumed to be there.

The initiative is seen to be cutting across the Partnership. There is reported to be good alignment and integration with Knowledge Management. As well, there is integration with Surveillance Action Group for surveillance enhancements i.e. enhanced analytic capacity to enable rapid use of information and addition of core elements to add to the explanatory power.

The initiative is reported to be on-track for all deliverables with the indicator scorecard to be presented in April 2009.

In terms of actual use of the scorecard, a challenge will be to get the data consistently from across the country. There could also potentially be issues regarding data sharing by provinces who do not want to be compared or disagree with the indicator set in the scorecard. These are issues that will require some strategic thinking.

Enterprise Performance and Risk Management

The Enterprise Performance and Risk Management scorecard is built upon a modified Balanced Scorecard approach with four performance views:

- Finance and Portfolio Management

[27] This is a potential case study topic.

- Delivery Mechanisms
- Stakeholders
- Organizational Excellence

as well as risk assessments tied to each view.

For each view, there are Board level and Management level performance indicators, each with current and previous values and targets being provided. The Delivery Mechanism view drills down to results by Action Group and Strategic Initiative. The scorecard for the Board contains the Board level indicators and targets.

Based upon the evaluation team's experience in performance and risk management, this core framework provides a robust enterprise-wide picture of performance and risks, primarily at the activity and output levels.

When considering reporting performance against the outcomes in the logic model (see section 3.4), there appear to be some gaps that will not be filled, even considering information coming from the cancer risk management tool and the cancer control system performance tool. To some extent the expected results and targets set for 2012 for the Strategic Initiatives in the 2009-10 Funding Request will help fill the gaps. However, these again are not outcome-level targets.

Communications and Stakeholder Relations

Communications has both internal and external dimensions. Regarding internal communications, key informants within the Partnership noted that:

- There is a need to do more internal communications across all areas of the Partnership. For example, strategic direction and priorities should be communicated to Action Groups through the Program Directors more effectively – these messages would be the "global" Partnership narrative as opposed to numerous local Action Group narratives.
- Because many key personnel have recently joined the Partnership, there is a need for clearly communicating how the Partnership works, for example, the work of the Action Groups and how this fits into the overall strategy and aligns with new strategic commitments.

Regarding external communications, key informants within the Partnership stated that the message needs to evolve, and indeed has, from a starting point of "Here's who we are" to "Here's what we are doing" to "Here's what we are achieving and the impacts we are having". They also felt that the Partnership's value-added needs to be systematically communicated. However, this does require quantitative performance information to provide a credible message.

Comments made by external key informants provide additional insights:

- The Partnership is not taking full advantage of the opportunity to leverage its partners in its communications approach;
- A question as to whether the communications strategy is geared towards informing others of the work of the Partnership or creating a national dialogue on cancer control.

Finally, an observation is provided from the evaluation team based upon its own review of Partnership documents. Tracing and therefore communicating the Partnership's performance story is fairly complicated. The basic framework or "table of contents" has changed over time from its roots in the original five priorities (and 8 Action Groups) in the CSCC documents, to eight priorities (same areas as the 8 Action Groups) in the original Partnership strategic plan, and to eight priorities and six key areas of focus in the refined Partnership strategic plan. This does present challenges in communicating a straightforward story to various audiences. For example, the February 2009 Progress Report was organized around three themes that overlaid the Strategic Initiatives. Since the strategy appears to have stabilized, there should be an opportunity to settle on one "table of contents" for communications purposes.

Project Management Office (PMO)

The following observations are based upon document review and comments from key informants associated with the PMO and users of the project management system such as Program Directors.

The review of PMO documentation led to the observation that there is a lack of alignment between project plan objectives, the Partnership's goals and expected outcomes. For example, the project plan template requests the identification of measures of success for each of the project objectives and the project objectives articulate and advance the Partnership's key areas of focus; however, these are not aligned with the Partnership's goals nor the expected outcomes related to the strategic priorities.

Continuous improvement is evidenced by ongoing adjustment and iterations of project management tools and templates, the provision of training for Program Directors and other staff and the development of guidance documents. In the initial years of the Partnership, work planning templates were adjusted to meet the demands of the funding agreement reporting requirements. Some respondents indicated that the change from cycle to cycle was frustrating.

The PMO has developed a common set of project management tools that is readily available to Project Directors and Managers through a shared drive. This PMO "tool kit" provides project management tools for the initiation, planning and execution of projects. Findings derived from the key informant interviews indicate that the PMO has provided useful support to accommodate the steep project management learning curve. Informants also indicated that while they acknowledge the importance of project management,

monitoring and reporting, ongoing and applied training is necessary. Further, many respondents identified a need for improved communication about the value-added of the PMO tools and related implementation challenges between Project Directors / Managers and the PMO to improve buy-in in support of the Partnership's overall project management approach.

A solid and comprehensive risk management approach to project planning and reporting has been established. This regime includes the identification, assessment and analysis of risk conducted on a project-by–project and Action Group–by-Action Group basis. Risk is considered. In addition, there is a strong alignment of risk assessment and monitoring from project to portfolio and enterprise-wide (EPRM).

Conclusions and Recommendations

The findings related to core frameworks and enablers lead to the following conclusions.

- It is an appropriate time to settle upon one comprehensive performance measurement framework (outcomes, outputs and activities, with performance indicators). Such a framework is an integral part of planning, monitoring and reporting, and communications. One reporting view of this framework needs to continue to be the eight priorities in the original Partnership strategy
- The Enterprise Performance and Risk Management scorecard is of great use for operational decision-making, but does not fully support reporting against outcomes. This gap needs to be filled.
- The project management approach will continue to need to be refined (e.g. stabilize the approach and associated tools and templates) and the benefits / value-added of its use be explained and understood by project participants.

Based upon these conclusions, the following recommendation is made.

Recommendation 6: The Partnership should develop a comprehensive performance measurement framework based upon a logic model (i.e., outcomes, outputs, activities) such as the one developed for this evaluation.

Current initiatives - the Enterprise Performance and Risk Management scorecard, cancer risk management model, cancer control system performance - would feed into this performance measurement framework.

Any additional gaps in the ability to tell the full performance story should be identified and filled, as appropriate.

4.6 Implementation Activities

Action Groups

As previously described in section 3.5, the Action Groups, for the most part, evolved from the CSCC. Also, as explained in section 4.2, there was an expectation at the time that the Action Groups would be an integral part of the ongoing strategy as the points of delivery of Partnership initiatives and that Action Group Chairs would play significant governance roles. Action Groups would involve membership representing different stakeholders, including the patient voice, and be channels for information and consultations into and out of the Partnership. They also would be the way to continue to harness volunteer time from Action Group members involved in various initiatives.

On the point regarding the role of Action Groups within the Partnership's strategy, the majority of key informants, inside of and outside of the Partnership, viewed the eight priorities rather than the original eight Action Groups themselves as being at the heart of the achievement of the Strategy. The Action Groups themselves are seen as an option as to how work is done.

Also based upon review of work plans and from key informant interviews, clearly the Action Groups coming into the Partnership in April 2007 were at different points – based upon their history, the area they were working in, the readiness of their work plans, and their leadership and membership. This, together with factors such as staffing of the Program Director positions, affected how quickly they "got off the mark", aligning with the Partnership's refined strategy, moving forward on projects, and incorporating new planning and reporting processes.

As a result of progress made and prospects looking ahead, the Partnership transitioned the Standards Action Group in late 2008 into the Working Group that is aligned to the core framework of System Performance[28]. It refocused the work plan for the Health Human Resources Action Group. It brought on board a new Program Director and Chair to accelerate and focus the work of the Primary Prevention Action Group, as well as a new Chair for the Research Action Group. While most key informants felt that such actions are a necessary prerogative of management, key informants involved in Action Groups also thought that it sent strong messages to all Action Group members as to the value of their work to date.

Additional comments from those involved in Action Groups are also instructive.

- Are Action Groups inside of or outside of the Partnership? For example, at the time of our interviews, they were not shown on the Partnership's organization chart.

[28] This will be the subject of a case study.

- There should not be "one model fits all" for Action Groups. In some cases, when there are active existing networks in a priority area, then the associated Action Group can be primarily advisory. In other cases, the Action Group needs to be much more involved in the actual work.
- Program Directors spend a significant portion of their time (50% was cited) dealing with administrative matters and planning and reporting requirements from the centre, rather than on the initiative portfolios in their priority areas.
- There is lack of clarity concerning the roles of the Action Group Chairs and the Vice Presidents, and the reporting relationship of the Program Directors to each.
- There is a view that projects identified as strategic initiatives have been taken over by the central organization, leaving the Action Groups with the smaller, lower impact projects. It also raised questions as to how views, such as patient voice, now embedded in the Action Groups would continue to be brought to bear on these strategic initiatives.

Stakeholder Engagement

Stakeholders are engaged by and in the Partnership in a variety of ways. Some are involved in the Partnership's governance bodies – the Board of Directors, more in advisory bodies – the Advisory Council, and many more in Action Groups, various networks/alliances and initiatives related to the priorities in the strategic plan. Advisory groups have been formed, such as:

- Cancer Risk Management Advisory Committee;
- Portal Content and Design Committee;
- System Performance Steering Committee;
- Canadian Colorectal Screening Network;
- Canadian Cancer Research Alliance (in which the Research Action Group is embedded); and
- National Forum on First Nations/Inuit/Métis Cancer Control Planning Committee;

Stakeholders have also been engaged in a broad variety of specific events such as Knowledge Management Forum Oct/08.

Key informants added the following points.

- To date, much of the stakeholder engagement effort has focused upon multi-stakeholder groups, as well as Health Canada and the Public Health Agency of Canada.
- There have been challenges in establishing a clear relationship with the Public Health Agency of Canada, given that there are many areas with shared responsibilities. However, there are relationships at the Action Group level.
- Progress was slower than might have been expected in developing a strong relationship with Statistics Canada. However, there is now a Memorandum of

Understanding in place, and Statistics Canada is involved in the projects such as cancer risk management.
- It is important that the Partnership formalize its relationships with provincial ministries and cancer agencies in order to ensure buy-in.
- Important new partnerships have been developing with organizations such as Canada Health Infoway (e.g., synoptic reporting initiative) and the Canadian Institute for Health Information, that also have pan-Canadian mandates.
- There is a need to engage more with the public.
- There is a need to engage better on the aboriginal front.
- There is a need to engage to ensure that requirements of diversity are heard. The Partnership cannot assume that this is brought to the table by some of its key partners sitting on governance and advisory bodies.
- The Partnership cannot assume that people engaged from, for example, one of the Atlantic provinces, represent the regional view and communicate back out to the region.
- Stakeholders engaged in the Advisory Council, Action Groups and other advisory and working bodies need to leverage their own networks in communicating out key messages from the Partnership.
- The Partnership needs to develop an engagement strategy that includes critical thinking about who the "right" partners are and for what reasons. This is essential to the achievement of shared outcomes. It is our understanding that the Director, Strategy, hired in October 2008, will play a lead role in such stakeholder outreach and engagement.
- The Partnership needs to avoid overly centralizing and controlling partnerships, but work with and through organizations already in place.

Also, of great importance is that the Partnership appears to be having an impact on other organizations with which it has engaged. For example, it is our understanding from key informant interviews, that:

- CAPCA, the Canadian Association of Provincial Cancer Agencies, is reviewing its own strategy, and considering lining up some of its own priorities more closely with the Partnership as a lead organization; and
- CIHI, the Canadian Institute for Health Information is interested in pursuing more active partnership.

Conclusions and Recommendations

The findings related to Action Groups lead to the following conclusions:

- Action Groups serve a number of functions
    - Formulation and delivery of work plans in the priority areas
    - Stakeholder engagement
    - Good will built over time.

- Given the investment made to date in Action Groups, and the fact that each is indeed quite different, it is preferable to continue to look at the performance of each individually, rather than collectively.
- When alternatives to existing Action Groups are used (e.g., standards priority area) or projects are identified as strategic initiatives, it will be important to ensure that the variety of stakeholders, including patient voice, represented in Action Groups, continues to be heard.
- The roles of the Action Group Chairs and the Vice Presidents, and the reporting relationship of the Program Directors to each, needs to be clarified.

Based upon these conclusions about Action Groups, the following recommendation is made.

Recommendation 7: The Partnership should periodically review the roles, composition and activities of Action Groups and Pan-Canadian networks to ensure that they continue to provide net benefits. However, as noted in Recommendation 4, the priority should be to work with and through current structures and delivery approaches, except when barriers present significant risk.

When conducting a review, the best role, composition and activities for Action Groups and Pan-Canadian networks need to be looked at on a case by case basis.

The findings concerning stakeholder engagement lead to the following conclusions.

- The Partnership needs to bring a stronger focus upon its stakeholder engagement, especially now that it is starting to have a stronger performance story around results to tell.
- A stakeholder engagement strategy that would include what partners/stakeholders are now / should be engaged, for what reasons, to what extent, the roles of each party (e.g., communications in and out) and the value gained by each party, would help to focus stakeholder engagement. Embedded in such a strategy and in its implementation would be the notion of an engagement continuum, with different levels of engagement for different stakeholders at different times, depending upon issues or initiatives at hand, the roles that the stakeholders play and the impacts that they can bring to realization of the change agenda the Partnership is implementing. Hence, not every stakeholder could or should expect to be engaged identically on the continuum.

The following recommendation is made.

Recommendation 8: It is an appropriate time for the Partnership to put in place a stakeholder engagement strategy. The strategy should include the notion of an engagement continuum, with stakeholders being

engaged in a manner appropriate to their roles and the impact that they can bring to the change agenda. The strategy should consider stakeholders that have not been engaged significantly over the last almost two years. This includes the public, aboriginal groups and other potential stakeholder/partners. The strategy should also promote the use by stakeholders of their own networks for communications out to broader audiences.

5. Summary of Recommendations

Recommendation 1: The Partnership is making progress and achieving results through its refined Partnership strategy, and appears well positioned to continue to do so. These achievements are endorsed by the majority of stakeholders. Therefore, the Partnership should continue to implement its strategy, with adjustments made when necessary to deal with new opportunities or performance gaps.

Recommendation 2: Impacts and benefits for the cancer control domain and its stakeholders will need to be shown to maintain support. Therefore, work on cancer risk management and cancer control system performance needs to continue so that information about benefits / impacts can be gathered, analyzed and disseminated.

Recommendation 3: The Partnership needs to continue to work with and through partners and collaboration for maximum longer-term impact even when there may be alternative approaches that might speed up the achievement of short term results that demonstrate quick successes.

Recommendation 4: The Partnership needs to keep its eyes firmly on the target, and at this time work with and through its current corporate and advisory structures, and delivery approaches, except when barriers present significant risk. With this in mind, it is recommended that the role of the Advisory Council be clarified in relation to the other advisory mechanisms that have been put into place for specific priorities and initiatives (e.g., Cancer Risk Management Advisory Committee, Canadian Colorectal Screening Network).

Recommendation 5: When there are new initiatives, priorities and opportunities in pursuit of the achievement of the CSCC objectives, it would be appropriate for the Partnership to put in place new advisory and delivery approaches if the existing ones are inadequate.

Recommendation 6: The Partnership should develop a comprehensive performance measurement framework based upon a logic model (i.e., outcomes, outputs, activities) such as the one developed for this evaluation.

Current initiatives - the Enterprise Performance and Risk Management scorecard, cancer risk management model, cancer control system performance - would feed into this performance measurement framework.

Any additional gaps in the ability to tell the full performance story should be identified and filled, as appropriate.

Recommendation 7: The Partnership should periodically review the roles, composition and activities of Action Groups and Pan-Canadian networks to ensure that they continue to provide net benefits. However, as noted in Recommendation 4, the priority should be to work with and through current structures and delivery approaches, except when barriers present significant risk.

When conducting a review, the best role, composition and activities for Action Groups and Pan-Canadian networks need to be looked at on a case by case basis.

Recommendation 8: It is an appropriate time for the Partnership to put in place a stakeholder engagement strategy. The strategy should include the notion of an engagement continuum, with stakeholders being engaged in a manner appropriate to their roles and the impact that they can bring to the change agenda. The strategy should consider stakeholders that have not been engaged significantly over the last almost two years. This includes the public, aboriginal groups and other potential stakeholder/partners. The strategy should also promote the use by stakeholders of their own networks for communications out to broader audiences.

6. Management Response and Action Plan

Recommendation 1: The Partnership is making progress and achieving results through its refined Partnership strategy, and appears well positioned to continue to do so. These achievements are endorsed by the majority of stakeholders. Therefore, the Partnership should continue to implement its strategy, with adjustments made when necessary to deal with new opportunities or performance gaps.

An initial refinement of the national strategy for cancer control was undertaken between November 2007 and February 2008 to bring focus to what could be realistically implemented in the initial five year mandate. Initiatives were identified across each of the priority areas where there was momentum and an opportunity for the Partnership to accelerate action. The initiatives are high impact and the results will have long-term impact on cancer control. These initiatives have all been defined and are currently being implemented. Once implementation was underway, a strategy workshop with key stakeholders occurred in October 2008 to advise on the ongoing implementation and how best to ensure sustainable change in cancer control. It was highlighted at the workshop, and further by the advisory structures within the Partnership, that targets for the initiatives were required to ensure we could track performance and measure outcomes. Targets to 2012 have now been established for each initiative and were approved by the Board in February 2009. Work is underway to incorporate the targets into a logic model that will become the overall performance framework.

While we are implementing, we are mindful of gaps and opportunities that emerge. There will be many opportunities to explore and validate new initiatives with our partners. We must ensure that they can help advance the existing strategy for cancer control.

Recommendation 2: Impacts and benefits for the cancer control domain and its stakeholders will need to be shown to maintain support. Therefore, work on cancer risk management and cancer control system performance needs to continue so that information about benefits / impacts can be gathered, analyzed and disseminated.

It is important to continue to develop work in cancer risk management in order to demonstrate the potential benefits and impacts of investing in cancer control. We have identified Statistics Canada as the partner/vendor to develop the cancer risk management modeling and technology platform. This platform will be available on the Partnership portal to be used by policymakers to assist them in measuring the long-term impact of investments in cancer control. The first priorities identified by the advisory committee (composed of health system leaders, leaders from the Canadian Institute for Health Information and cancer agencies, methodologists, economists, cancer control experts, and a member from the financial sector focused on risk) were in the areas of prevention and screening. The first phase of work in our contract with Statistics Canada will look at both of these issues in the areas of colorectal cancer and lung cancer. Phase 1 will have

capabilities for both disease and economic modeling, and will be completed this fall. At the same, a plan for the next phases and focused topics is in development. The result will be a platform that we can continually add to and make accessible.

A cancer system performance advisory committee (made up of senior practitioners, operations officers and measurement/evaluation experts across Canada) is identifying a set of pan-Canadian indicators that will be tracked year-over-year to measure progress. The Partnership has established the baseline measures for the first report, and is working directly with provinces and territories to ensure that what is being measured is reported in a way that is relevant to these groups and will enhance quality and access. Reporting against performance is an important way to address quality improvements, and the Partnership will work closely with its provincial/ territorial partners and cancer agencies to ensure the appropriate means for tracking and measuring progress of the cancer control system.

By combining these two initiatives, we will have a system to monitor what is occurring on specific indicators through system performance and then project the potential impact we could have by making progress on these indicators using the cancer risk management platform capabilities both through current and future investments.

Recommendation 3: The Partnership needs to continue to work with and through partners and collaboration for maximum longer-term impact even when there may be alternative approaches that might speed up the achievement of short term results that demonstrate quick successes.

Implementing the national cancer control strategy depends on collaboration and partnerships. The Partnership is conscious of the need to engage its partners in the realization of long-term benefits in cancer control. We recognize the tension that a five year mandate creates on the implementation of initiatives, and while it may be expedient to seek short-term wins, we are committed to keeping a focus on the long-term outcomes required to advance cancer control, and be consistent with our partners' priorities. The initiatives currently being implemented depend on partners to advance the work. Outcomes will be realized by 2012 but the broader population health outcomes may not be realized for decades.

Beyond advisory and planning mechanisms, we have entered into formal and contractual arrangements to support multi-year strategic initiatives. An example would be that we have formal agreements with cancer agencies/programs to implement our staging initiative. We have also entered into formal partnerships with five provinces/regions, including both universities and cancer agencies, to implement the Canadian Partnership for Tomorrow cohort research project – a legacy project that will involve 300,000 healthy Canadians. Another example is that the Partnership is chairing the national colorectal screening network which consists of both screening program representation and ministries of health representation across the country. By working together we are able to support implementation of programs by provinces/territories, including the

development of quality determinants, and the development of a national survey and awareness initiative.

Recommendation 4: The Partnership needs to keep its eyes firmly on the target, and at this time work with and through its current corporate and advisory structures, and delivery approaches, except when barriers present significant risk. With this in mind, it is recommended that the role of the Advisory Council is clarified in relation to the other advisory mechanisms that have been put into place for specific priorities and initiatives (e.g., Cancer Risk Management Advisory Committee, Canadian Colorectal Screening Network).

The organization is now fully established and the focus has moved from one of initiation to implementation. All key initiatives are identified and work is underway lead by various delivery structures. The Partnership acknowledges that the role of the Advisory Council on Cancer Control requires clarification as we have created many advisory mechanisms to guide and advance the implementation of initiatives within our current mandate.

Recommendation 5: When there are new initiatives, priorities and opportunities in pursuit of the achievement of the CSCC objectives, it would be appropriate for the Partnership to put in place new advisory and delivery approaches if the existing ones are inadequate.

The Partnership management agrees that advisory mechanisms and delivery approaches need to be designed to support implementation of work and sustainability of the initiatives. Currently, all of our strategic initiatives have advisory structures guiding the work. The Partnership is conducting an annual review of structures to ensure that the best framework, including advisory groups, is in place to execute the CSCC. As a result of these evaluations, advisory mechanisms are being tailored to meet the needs of each initiative. A variety of delivery and advisory mechanisms are necessary to advance the work of the Partnership and it is important to ensure that those who are implementing and embedding initiatives are part of these advisory structures. The Partnership has acknowledged this through the development of new advisory committees such as the cancer risk management advisory committee (composed of health system leaders, leaders from the Canadian Institute for Health Information and cancer agencies, methodologists, economists, cancer control experts, and a member from the financial sector focused on risk) which was established to guide the work of the Cancer Risk Management initiative. Similarly, the Action Council (composed of the Chairs of each of the Action Groups) was established to guide the work of the Action Groups and to support more effective collaboration across the priority areas.

Recommendation 6: The Partnership should develop a comprehensive performance measurement framework based upon a logic model (i.e., outcomes, outputs, activities) such as the one developed for this evaluation.

Current initiatives - the Enterprise Performance and Risk Management scorecard, cancer risk management model, cancer control system performance - would feed into this performance measurement framework.

Any additional gaps in the ability to tell the full performance story should be identified and filled, as appropriate

The Partnership management agrees with this recommendation, and as noted by the evaluators, a number of performance measurement tools are currently in place. To measure initiative-specific performance, 2012 targets have been set, and project management tools are in use to track achievement of milestones, deliverables and assess risk as initiatives are being implemented. To measure its performance as an organization, the Partnership uses an enterprise performance risk management tool (a balanced scorecard), risk status assessment, and develops a concrete deliverables chart for Health Canada through the submission of its annual funding request. The balanced scorecard is updated and reviewed quarterly by the Board. To measure the performance of the cancer system, the Partnership is working with provinces and territories to develop a set of pan-Canadian cancer system performance indicators. Finally, cancer risk management tools are being developed to measure the long-term impact of cancer control interventions. The initial performance framework was linked to the strategy, and involved the identification and implementation of initiatives, and the development of targets and performance measurement tools. It is now time to link this framework to outcomes. As recommended by the evaluators, the Partnership will develop a logic model to show one comprehensive performance picture and pull all of the existing measurement tools together. This will include mapping measures, and identifying and filling any gaps in performance. It is the Partnership's goal to be able to easily communicate a well-rounded performance measurement model that speaks comprehensively to the impact of the CSCC on the priority areas. Additionally the performance framework should be able to show synergies and impact between initiatives, between partnerships, and across provinces and territories.

Finally, we need to ensure our partners agree with the broad performance measurement framework because they are directly responsible for the delivery of programs and services in cancer control.

Recommendation 7: The Partnership should periodically review the roles, composition and activities of Action Groups and Pan-Canadian networks to ensure that they continue to provide net benefits. However, as noted in Recommendation 4, the priority should be to work with and through current structures and delivery approaches, except when barriers present significant risk.

When conducting a review, the best role, composition and activities for Action Groups and Pan-Canadian networks need to be looked at on a case by case basis.

Although the model of using pan-Canadian networks of experts under the form of an Action Group is currently functioning well, the Partnership acknowledges that there will

be multiple ways to work with stakeholders in the future as the initiatives mature and new ones are identified. Each Action Group has a unique function and the form it takes is defined by the work it is implementing, the partners it is engaging and how the work needs to be supported and sustained. The Partnership has already adjusted some structures to reflect initiatives. For example, the Standards Action Group was instrumental in setting the foundation for the pan-Canadian indicators work, but now that this work is well underway, the Standards Action Group has evolved into a Standards Working Group that is incorporated within the Cancer Control division to drive specific work related to standards development. This will be linked to the systems performance and quality initiatives in areas of focus. To ensure Action Groups are working effectively, terms of reference and membership will be reviewed annually; this process has already been initiated.

Recommendation 8: It is an appropriate time for the Partnership to put in place a stakeholder engagement strategy. The strategy should include the notion of an engagement continuum, with stakeholders being engaged in a manner appropriate to their roles and the impact that they can bring to the change agenda. The strategy should consider stakeholders that have not been engaged significantly over the last almost two years. This includes the public, aboriginal groups and other potential stakeholder/partners. The strategy should also promote the use by stakeholders of their own networks for communications out to broader audiences.

Now in year two, the Partnership is working to broaden its stakeholder reach and communicate progress against its initiatives. Particular emphasis has been placed on communicating and engaging stakeholders so that they will continue to be informed and supportive of the execution of the national cancer control strategy. This has included increasing outreach through numerous vehicles including bi-weekly and monthly updates, newsletters, priority area content on the Partnership website and developing content for the launch of the portal. A Progress Report was launched on February 4, 2009 and sent directly to stakeholders, through our networks, and also made available publicly on the website.

The Partnership has numerous stakeholders and multiple venues to reach them, and engage them in the implementation of the strategy. These include our pan-Canadian networks, consultations, convening expert panels and working with patients, survivors and families through the Canadian Cancer Action Network. The Partnership is working to broaden its stakeholder reach and work is underway to create stakeholder maps to strategically identify and stratify stakeholders in terms of their importance to how initiatives are implemented, embedded locally and sustained to ensure the outcomes defined by the national strategy are achieved.

The Partnership is working on a First Nations/Inuit/Métis action plan that is being informed by these communities. A recent forum has identified gaps and opportunities in First Nations, Inuit and Métis communities with direction provided on initiatives that can be accelerated by the Partnership. The intention will be to work with each community through an ongoing advisory mechanism that can advise on implementation.

A further effort to reach the public is part of the stakeholder engagement focus. The launch of the portal will provide a platform to explore public dialogue and interest in cancer control.

Finally, it will be important to ensure that all the networks within the Partnership provide both advice to the implementation and also engage directly with their membership to ensure transfer of knowledge in their communities. One example of this knowledge translation with partners and stakeholders is our upcoming forum in July 2009. Ongoing and active stakeholder engagement will continue to be a key focus for the remaining three years of the current mandate.

Annex A: Management Tools – Planning and Reporting

The following table summarizes tools that the Partnership employs for its planning, monitoring and reporting at the corporate, portfolio and project levels. The Project Management Office (PMO) has developed a toolkit for project and portfolio planning and reporting. The tools and templates included in the toolkit to support portfolio and project execution, planning and initiating, and reporting are illustrated in the last two columns of the table.

	Cancer Control System	**Corporate Management**	**Portfolio Management (Action Groups and Core Frameworks)**	**Project Management**
Planning				
Strategic Plans	Canadian Strategy for Cancer Control	Partnership Strategic Plan 2007/08 to 2011/12, May 15, 2007 Partnership Strategic Plan 2008-2012, Updated February 2008		
Business Plans		Business Plan 2009-2010 Annual Funding Requests to Health Canada		
Work Plans				Project plan template Planning Process Training Project Plan Training Deck Project Plan: Environment Section Documents (incl. Common Assumptions, Common Constraints; Common Readiness; Common Risks and Common Stakeholders) Budget Tool Template and Training Deck MS Project Training Deck (Part I and II) Budget Tool Template and Training
Monitoring / Reporting				
Monthly reporting		Budget performance financial statements	Budget performance financial statements	Budget performance financial statements
Quarterly Reporting		Project quarterly financial data Board financial status report	Status Report Template Status review meeting Summary Template Status Reporting Process Summary Template for communication of	Status Report Template Status review meeting Summary Template Data Collection Tool (Status reporting template for small projects only)

	Cancer Control System	Corporate Management	Portfolio Management (Action Groups and Core Frameworks)	Project Management
			requests to Senior Management Committee Board status report	Status Reporting Process Board status report
Annual Reporting	Cancer System Performance	Annual Report Annual Funding Requests to Health Canada		
Other		Progress Report, Winter 2009, released Feb. 4, 2009	Portal Evaluation Plan (in development)	Project Plan PMO Evaluation Guide
Project Approval				
		Protocols: Annual Project Budget Size Approval Body Less than $250,000 Vice President $250,000 or more and less than $1 million Senior Management Committee $1 million or more Board	Change Request Process and Template Approval Process Project Approval Process Map Change Request Process and Template Change Request Process Map Glossary	Change Request Process and Template Approval Process Project Approval Process Map Change Request Process and Template Change Request Process Map Glossary
Risk Management				
	Cancer Risk Management: Forecast/ impact modeling in four priority areas incl. cancer prevention, cancer screening, new cancer treatments, palliative care (in progress) Cancer Risk Management Plan	Enterprise Risk Monitoring Scorecard (in draft form)		Risk Planning Training
Supporting Frameworks/ Policies				
		Compensation Framework Performance Management Template		
		Finance Vision and Strategy Document		
		Procurement Policy		
		Travel Policy		

Annex B: List of Key Informants

Bob Allen	Chair, Surveillance Action Group, Canadian Partnership Against Cancer CEO, Saskatchewan Cancer Agency
Richard Alvarez	Chief Executive Officer, Canada Health Infoway
	Vice President, Research & Analysis Canadian Institute for Health Information
Harley J. Ast	Member, Advisory Council on Cancer Control, Canadian Partnership Against Cancer Campaign to Control Cancer
	Executive Director, Canadian Hospice Palliative Care Association
Kathy Bouey	CPAC Transition Team Lead
Carrie Bourassa	Member, Advisory Council on Cancer Control, Canadian Partnership Against Cancer First Nations University
Dr. George Browman	Chair, Cancer Guidelines Action Group, Canadian Partnership Against Cancer Department of Medical Oncology, BC Cancer Agency
Tabitha Brown	Human Resources, Office Services and Procurement Lead, Canadian Partnership Against Cancer
Adalsteinn Brown	Advisory Group for Cancer Risk Management Assistant Deputy Minister, Health System Strategy Division, Ministry of Health and Long-Term Care, Government of Ontario
Heather Bryant	Vice President, Cancer Control Programs, Canadian Partnership Against Cancer

Jack Butt	Canadian Cancer Action Network
John Callum	Chief Financial and Administrative Officer Canadian Partnership Against Cancer
Chris Clark	Member, Board of Directors, Canadian Partnership Against Cancer Chief Executive Officer and Canadian Senior Partner of PricewaterhouseCoopers LLP
Dr. Catherine Cook	Member, Board of Directors, Canadian Partnership Against Cancer Executive Director of Aboriginal Health Programs at the Winnipeg Regional Health Authority
	Program Manager, Patient Navigation & Surgical Oncology, Cancer Care Nova Scotia
Christine da Prat	Program Director, Health Human Resources Action Group, Canadian Partnership Against Cancer
	Canadian Cancer Action Network Representative to Surveillance Action Group
Dr. Elizabeth Eisenhauer	Chair, Research Action Group, Canadian Partnership Against Cancer Director, Investigational New Drug Program, NCIC
Kim Elmslie	Director General, Centre for Chronic Disease Prevention and Control, Public Health Agency of Canada
Dr. Mark Elwood	Member, Advisory Council on Cancer Control, Canadian Partnership Against Cancer BC Cancer Research Centre
	President, Juravinski Cancer Centre at Hamilton Health Sciences, Regional Vice President, Cancer Care Ontario
Mario Fabrizio	Controller, Canadian Partnership Against Cancer
Lee Fairclough	Vice President, Knowledge Management Canadian Partnership Against Cancer

Cindy Fedell	Director, Project Management Office, Canadian Partnership Against Cancer
Susan Fekete	Program Director, Screening Action Group Canadian Partnership Against Cancer
	Vice President, Medical Affairs & Community Oncology, Alberta Cancer Board
Dr. Margaret Fitch	Chair, Rebalance Focus / Cancer Journey Action Group, Canadian Partnership Against Cancer Head, Oncology Nursing and Supportive Care, Odette Cancer Centre
Rene Gallant	Member, Board of Directors, Canadian Partnership Against Cancer Past national president of the Canadian Cancer Society
Hank Gosar	Corporate Secretary, Canadian Partnership Against Cancer
Anna Greenberg	Director, Knowledge Management, Canadian Partnership Against Cancer
Leslie Greenberg	Director, Stakeholder Relations, Canadian Partnership Against Cancer
Dr. Eva Grunfeld	Member, Advisory Council on Cancer Control, Canadian Partnership Against Cancer Director, Knowledge Translation Research, Family Healthcare, University of Toronto
	Project lead for Can-Adapte Community Health and Epidemiology, Director, Queen's Joanna Briggs Collaboration, Senior Scientist Practice and Research in Nursing (PRN) Group, Queen's University
Carolyn Heick	Director, Health Information Standards Canadian Institute for Health Information
Sarah Hicks	Director, Communications, Canadian Partnership Against Cancer
Jessica Hill	Chief Executive Officer, Canadian Partnership Against Cancer

Barbara Kaminsky	Member, Advisory Council on Cancer Control, Canadian Partnership Against Cancer CEO, Canadian Cancer Society, BC and Yukon Division
Morley Katz	Organizational Design Consultant
Deb Keen	Program Director, Primary Prevention Action Group, Canadian Partnership Against Cancer
Dr. Jon Kerner	Chair, Primary Prevention Action Group, Also, Senior Scientific Advisor for Cancer Control and Knowledge Translation, Canadian Partnership Against Cancer
Leanne Kitchen-Clarke	Vice President, Strategy, Performance Measures and Communications Canadian Partnership Against Cancer
Dr. Eshwar Kumar	Head, Department of Oncology for the Atlantic Health Sciences Corporation
Nancy Lefebre	Saint Elizabeth Health Care
Dr. Antoine Loutfi	Quebec Observer, Board of Directors, Canadian Partnership Against Cancer
Jeffrey C. Lozon	Chair, Board of Directors, Canadian Partnership Against Cancer President and Chief Executive Officer of Toronto's St. Michael's Hospital
Dr. Verna Mai	Chair, Screening Action Group, Canadian Partnership Against Cancer Cancer Care Ontario
	Chair, Canadian Cancer Statistics Steering Committee, Sr. Scientist and Director, Surveillance Unit, Division of Preventive Oncology, Cancer Care Ontario
	Executive Director, Canadian Cancer Society, Manitoba Division
	Deputy Chief, London Health Sciences Center

Paddy Meade	Member, Board of Directors, Canadian Partnership Against Cancer Deputy Minister of Alberta Health and Wellness
Dr. Anthony Miller	Co-Chair, Cancer Risk Management Advisory Group, Canadian Partnership Against Cancer Professor, Department of Public Health, University of Toronto
Nancy Milroy Swainson	Director, Chronic and Continuing Care Division, Health Canada
	Manager, Colorectal Cancer Prevention Program, Cancer Care Nova Scotia
Irene Nicoll	Program Director, Rebalance Focus / Cancer Journey Action Group, Canadian Partnership Against Cancer
Dr. Andrew Padmos	Chair, Health Human Resources Action Group, Canadian Partnership Against Cancer CEO, Royal College of Physicians and Surgeons of Canada
	Preventions Coordinator, Cancer Care Nova Scotia
Renee Reddick	Human Resources Lead, Canadian Partnership Against Cancer
Wayne Roberts	Project Director, Information Management / Knowledge Management, Canadian Partnership Against Cancer
Paula Robson	Project Coordinator, Alberta Health Services – COHORT
Dr. Paul Rogers	Member, Advisory Council on Cancer Control, Canadian Partnership Against Cancer Head, Pediatric Hematology/ Oncology, BMT, UBC
Dr. Brent Schacter	Chair, ex-Standards Action Group, Canadian Partnership Against Cancer CEO, Canadian Association of Provincial Cancer Agencies (CAPCA)
Dr. L. John Schreiner	Department of Medical Physics, Cancer Centre of Southeastern Ontario
Dr. Marla Shapiro	Member, Board of Directors, Canadian Partnership Against Cancer Health and medical contributor for CTV's Canada AM and medical consultant for CTV National News

Jack Shapiro	Member, Advisory Council on Cancer Control, Canadian Partnership Against Cancer Chair, Canadian Cancer Action Network
Salah Sharieh	Chief Architect, Canadian Partnership Against Cancer
Dr. Isaac Sobol	Member, Advisory Council on Cancer Control, Canadian Partnership Against Cancer CMO, Nunavut
Mary Spayne	Program Associate, Knowledge Management, Canadian Partnership Against Cancer
Terry Sullivan	Member, Board of Directors, Canadian Partnership Against Cancer President and CEO of Cancer Care Ontario
Dr. Simon Sutcliffe	Vice Chair, Board of Directors and Chair of Advisory Council on Cancer Control, Canadian Partnership Against Cancer President of the BC Cancer Agency
Laura M. Talbot	Member, Board of Directors, Canadian Partnership Against Cancer President and Senior Partner Talbot-Allan Consulting
Dr. Walley Temple	Chief of the Division of Surgical Oncology and Professor with the Departments of Oncology and Surgery with the Faculty of Medicine at the University of Calgary
Sally Thorne	Member, Board of Directors, Canadian Partnership Against Cancer Professor and Director of the School of Nursing at the University of British Columbia
Theresa Marie Underhill, M.Ed., MHSA	Chief Operating Officer, Cancer Care Nova Scotia
Elizabeth Whamond	Member, Board of Directors, Canadian Partnership Against Cancer Vice-Chair, Canadian Cancer Action Network
Dr. Barbara Whylie	Member, Board of Directors, Canadian Partnership Against Cancer CEO of the Canadian Cancer Society

Arlene Wilgosh	Member, Board of Directors, Canadian Partnership Against Cancer Deputy Minister of Health and Healthy Living for the Province of Manitoba
	Director, Screening Programs & Medical Lead, Alberta Colorectal Cancer Screening Program, Alberta Cancer Board
Louise Zitzelsberger	Program Director, Cancer Guidelines Action Group, Canadian Partnership Against Cancer

Annex C: Case Studies

This annex presents six case studies. The purpose of these case studies is to describe, in more detail than possible in the body of the main report, initiatives and activities that have been undertaken by the Partnership. In each case, there is a brief description and rationale, an outline of progress to date and planned tasks/activities, and results achieved or expected.

The six cases cover selected content, foundational and management aspects.

- C.1 The Canadian Partnership for Tomorrow Project (CPTP, also known as the Cohort Study)
    - Chosen as an important research investment by the Partnership in a potential legacy project promising long term benefits related to cancer and other chronic diseases. Also an example of a pan-Canadian initiative, with several participating provinces.

- C.2 The Synoptic Reporting Initiative (Pathological and Surgical)
    - Chosen as a potential legacy project, illustrating a partnership with Canada Health Infoway.

- C.3 Cancer View Canada, The Portal Project
    - Chosen as a potential legacy project showing how the Partnership is implementing a knowledge management core framework for use across the cancer control domain.

- C.4 Cancer Control System Performance Core Framework
    - Chosen to show a potential legacy project showing how the Partnership is implementing a cancer control system performance core framework for use across the cancer control domain.

- C.5 The Standards Action Group (SAG)
    - Chosen to illustrate how, based upon progress made and requirements moving forward, the Partnership transformed an existing Action Group to a more appropriate Working Group approach.

- C.6 The Project Management Office (PMO)
    - Chosen to illustrate how the Partnership has introduced project management principles and a toolkit in order to ensure rigour in project planning, execution and reporting, and to execute its own accountabilities and responsibilities.

The information in the case studies was drawn from the Partnership's internal files, available through the PMO, and supplemented by key informant interviews.

C.1 The Canadian Partnership for Tomorrow Project (CPTP, also known as the Cohort Study)

The Canadian Partnership for Tomorrow project (also referred to as the Cohort study) is a long-term longitudinal Canadian study that investigates and quantifies cancer risk associated with genetics, lifestyle, and the environment.[29] The study involves up to 300,000 Canadians between the ages of 35 and 69 and is being conducted in collaboration with provincial cancer cohorts. The overall study includes a biomarker component that enables the collection and storing of blood and urine samples that will provide an opportunity to test hypotheses.[30]

A Canadian Institutes of Health Research (CIHR) report identifies four key benefits of a Canadian-focused cohort as follows:

- Enable us to address uniquely Canadian research questions in a Canadian context;
- Encourage a strong and robust population research community;
- Provide a population "laboratory" or "research platform" that would facilitate studies by population, basic and translational researchers; and
- Create a resource and legacy for future generations of Canadians that will continue to yield valuable information and potentially provide answers to questions that we haven't even thought of as yet.[31]

In the short term, the study is intended to provide a “snap shot picture of risk factors exposure of the Canadian populations”. Over the longer term, the study will contribute to the ability to determine “when in a person’s life the exposure to the risk factor increases the chances of developing cancer”[32] and other chronic diseases. The project supports evidence-based cancer prevention intervention strategies through identification of the sequence of events that lead to a cancer diagnosis.[33]

Participating provinces include Alberta, Ontario and Quebec, where the Partnership is supporting ongoing existing studies and British Columbia and Atlantic Canada, where the Partnership is consolidating new initiatives. The Partnership will guide the study to ensure regional linkages in support of a national scope. Costs are shared between the Partnership and provincial/ territorial jurisdictions.[34]

[29] CPAC Research Action Group 2007-08 Workplan. April 2007. Pg. 4
[30] CPAC 2008-09 Funding Request. Pg. 16
[31] CIHR. Cancer Prevention: The Case for a Canadian Cancer Cohort. Available at: http://www.cihr-irsc.gc.ca/e/36658.html. Last viewed on 2009/03/12.
[32] CPAC Research Action Group 2007-08 Workplan. April 2007. Pg. 6
[33] CPAC Progress Report. Winter 2009. Pg. 22
[34] CPAC Research Action Group 2008-09 Workplan. April 2007. Pg. 11

In the 2007-08 fiscal year, the Partnership developed protocols and supported pilot studies to test the feasibility of many project components.[35] During the 2008-09 fiscal year, a number of activities have been undertaken including the establishment of a governing council and location for the national coordination centre (Alberta).

Currently, the participating provinces are actively recruiting participants for their cohorts within the larger Cohort study. In some jurisdictions, data collection is already underway. Harmonization guidelines / standards have been developed to ensure that all jurisdictions are collecting and will collect data in the same way so that data analysis can be done across all of the 300,000 participants. Further, specialized software is being developed to compile data on physical measures and to ensure that information from different cohorts can be combined to form a sample that is large enough to further existing knowledge on the causes of cancer.[36]

The expected outcome of the Cohort study is to provide policy-makers with information on how to target chronic disease prevention efforts and to provide a legacy project for future research worldwide. Over the long term, the data gathered will be made available for the study of other chronic diseases.[37] Other anticipated results include the development of an environmental exposures map that can be tied to population-based data.[38]

Key informants, within and outside of the Partnership, frequently pointed to this initiative as an example of an excellent investment decision by the Partnership. Results they attributed to the Partnership included acceleration of the implementation of the Cohort study as well as increasing its scope to a larger number of provinces.

[35] CPAC Research Action Group 2007-08 Workplan. April 2007. Pg. 4
[36] CPAC. Canadian Partnership for Tomorrow Project Update. November 6, 2008. Available at: http://www.partnershipagainstcancer.ca/tomorrow_update. Last viewed on 2009/03/12.
[37] CPAC Progress Report. Winter 2009. Pg. 22
[38] Ibid.

C.2 The Synoptic Reporting Initiative (Pathological and Surgical)

The Synoptic Reporting Initiative is an example of the Partnership extending the reach and scope of initial work done in a few provinces, as well as its development of a collaborative relationship with Canada Health Infoway.

Synoptic reporting refers to "a systematized method for structuring healthcare reports to include important information that has been demonstrated to influence health outcomes through decision-making".[39]

The project is developing standards for both surgical and pathology synoptic reporting. Common to both is taking a checklist approach to what elements should be included in a report.

Synoptic reports have been shown to "better capture essential information for evidence-informed cancer care downstream".[40] The synoptic reporting tool is aligned with key dimensions of quality for cancer pathology reporting. These are as follows:

- Completeness i.e. the extent to which important clinical content is included in the report;
- Usability (format) i.e. the ease with which the data can be understood and used;[41] and
- Timeliness i.e. the degree to which the currency of the information meets the need for currency.

Pathology

The project builds on the College of American Pathologist Cancer (CAP) checklists. In 1998, CAP published the first standardized cancer reporting checklist. The CAP checklist was developed by multidisciplinary teams, literature and expert opinion and was field tested with pathologists. Following this, in 2002 CAP established a process and infrastructure for updating the checklists. The Commission on Cancer endorsed the checklists in 2004 as a requirement for cancer hospital accreditation in the United States.[42] Since 2004, the checklists have been reviewed and expanded as a result of ongoing expert panels to ensure uniformity of data elements across all checklists and to support collaborative staging.[43]

[39] CPAC. Cancer Guidelines Action Group Work plan and Funding Requirements. May 2008. Pg. 16
[40] CPAC. Cancer Guidelines Action Group Workplan and Funding Requirements. April 2007. Pg. 5
[41] CPAC. Improving Quality through Standardized Cancer Pathology Reporting. Power point presentation to the Council of Canadian Association of Pathologies. July 13, 2008. Pg. 13
[42] Ibid. Pg. 16
[43] Ibid. Pg. 17

The Partnership is working with the Canadian Association of Pathologists to endorse the synoptic pathology approach and use of the CAP checklist as the standard for content.[44] Looking ahead, the intent is that the Canadian Association of Pathologists, the Partnership, and its partners is to work together to initiate implementation in two to three provinces.[45] Ontario has led the way and the Partnership has engaged the lead pathologist from Ontario to work on the national initiative.

Surgery

In 2008, the Synoptic Reporting (Surgery) project became a strategic initiative of the organisation and the Cancer Guidelines Action Group continued to provide leadership.[46]

Proposals were received in 2008 from provinces for the adoption of synoptic reporting for colorectal, breast, head, and neck, and ovarian cancer were built on the experience of Alberta, work that was funded initially by Canada Health Infoway. The Alberta physician lead has been engaged by the Partnership as the national lead for this initiative. After proposals were received, pilot projects were started in Alberta, Nova Scotia, Quebec, Ontario and Manitoba. The work includes active collaboration with Canada Health Infoway on incorporating technical standards.

More specifically, during 2008-09, five (5) key deliverables were developed in support of the project as follows:

- Project plans for each Synoptic Reporting Tool project (September 2008);
- Report from an IT National workshop held in May 2008 (May 2008);
- Finalized templates for four (4) tumors (March 2009)
- Installation and functionality of the Alberta WebSMR software; and,
- Live Alberta WebSMR tool including training of users and roll-out.[47]

The project is now expanding to include a national process to endorse standard content for reporting through wide engagement of the surgical community.

In summary, the value-added of the synoptic reporting tool is the provision of consistent and complete data, improvement of communication between providers, facilitation of decision-making for treatment, enablement of analysis of practice and the standardization of data elements to enable secondary usage.[48]

[44] CPAC. Improving Quality through Standardized Cancer Pathology Reporting. Power point presentation to the Council of Canadian Association of Pathologies. July 13, 2008
[45] Ibid. Pg. 11
[46] CPAC. Cancer Guidelines Action Group Workplan and Funding Requirements. May 2008. Pg. 16
[47] Ibid. Pg. 16-17
[48] Examples of secondary uses of data are tumor registries, quality reporting, storage capture, quality management and evaluation, patterns of care and outcomes analysis, system planning and population research. CPAC. Improving Quality through Standardized Cancer Pathology Reporting. Power point presentation to the Council of Canadian Association of Pathologies. July 13, 2008. Pg. 15

C.3 Cancer View Canada, The Portal Project

The Partnership's Cancer View Canada (Vue sur le Cancer Canada) project, also known as the Portal project, is the core knowledge management platform that "supports a wide range of knowledge management activities across the organization".[49] The core principle of the portal is that it is "integrative, avoids duplication and leverages, where possible, existing technology and information of partners".[50]

The Portal is a "springboard into the Canadian cancer community, where users can find, develop and exchange the information that they need in their journey or role in cancer control".[51,52] The Portal is further described as follows:

1. A platform for Knowledge management to support our partners in cancer control;
2. A technology to support connecting, collecting, collaborating and sharing; and,
3. A tool to leverage, showcase, expand access to the investments of partner organizations.[53]

The development of the Portal was informed by the analysis of existing cancer control knowledge management gaps in Canada. The Partnership identified six gaps as follows:

1. Common interactive tools to collaborate, and to network virtually;
2. Search capability to target high-quality services offered the Canadian cancer community;
3. Clear comparison and compilations of online cancer control information from across Canada;
4. User profiles and tailored content to offer the most relevant information;
5. Notification technology to enable users to request updates as they become available on specific topics; and,
6. Accessibility of information to support multiple audiences.[54]

The Portal is intended to meet the needs through the provision of a set of tools for three key stakeholder groups including people affected by cancer, people working in cancer control and people who treat people with cancer.[55] Tools available through the Portal include a content management system, user profile management system, federated search engine, social networking tools, survey/ polls/ e-form tools, contact relationship

[49] CPAC 2008/09 Funding Request. February 5th Board Meeting Power Point Presentation p. 33
[50] CPAC 2008-2012 Strategic Plan. Pg. 19
[51] Ibid.
[52] CPAC Newsletter.
[53] The Partnership's Portal Initiative: Cancer View Canada. Available at: http://www.partnershipagainstcancer.ca/portal_overview. Last viewed on March 02, 2009. Pg. 3-5
[54] The Partnership's Portal Initiative: Cancer View Canada. Available at: http://www.partnershipagainstcancer.ca/portal_overview. Last viewed on March 02, 2009. P. 9
[55] Ibid., pg. 6

management system, and user analytics.[56] In addition, the Portal will provide a repository of evidence-driven information to share experience across the country, options for accessing online patient and family support groups and access to a comprehensive listing of clinical trials in Canada.[57]

Spanning across all areas of CPAC activity, the Portal is also an integrative tool for the Partnership. In its initial development, it will support the following Action Group project initiatives:

- Standards and Guidelines Evidence (SAGE) Repository and Adaptation Process (Guidelines Action Group)
- Cancer Prevention Policies and Legislation for Food, Physical Activity, Alcohol and Public Education Repository (Primary Prevention Action Group)
- Community Services Database (CSD) and online Support Networks (Cancer Journey Action Group
- Human Resources Service Delivery Model Repository (Human Resources Action Group)
- Research Project Repository (Research Action Group)
- Collaborative communities to support the Surveillance Analytic Networks (Surveillance Action Group)
- CLASP (Coalitions Linking Action and Science for Prevention) cooperative workspace (Primary Prevention Action Group)

Activities undertaken by the Partnership in 2007 were the development of detailed business requirements, engagement of partners and the completion of a Request for Proposal process to identify a third party vendor to provide the portal solution.[58]

In 2008, a multi-year finding request was made to the Board of Directors. In this request, the Partnership identified key partners for Release I of the portal. Partners were identified based on a number of criteria including the following:

- Strategic alignment to priority areas and partnership strategy;
- Alignment to target audiences;
- Assists in providing coverage of cancer disease site topics;
- Coverage across the cancer continuum;
- Quality of information; and,
- Well-established organization with a sustainable budget.[59]

A total of 23 partners were identified. Of these, thirteen (13) are provincial partners, and ten (10) are federal and national partners.

[56] Ibid., pg. 11
[57] CPAC Newsletter (nd).
[58] Briefing note to the CPAC Board of Directors, October 7, 2008.
[59] Ibid., pg. 4

The Partnership has established a comprehensive project management regime for the Portal. First, in terms of evaluation of the Portal, the Partnership is developing metrics that will enable the tracking of traffic and activity on the portal and metrics that will demonstrate the benefits that the Partnership relationship represents for partners. This latter metric development is occurring in consultation and negotiation with partners. In addition, the Partnership is developing an evaluation framework to assess the effectiveness and impact of the Portal as a knowledge management platform for the cancer control community.

Second, a risk management approach to the Portal project underpins all activity. The risk management plan is founded upon a five-pronged (5) approach and is described as follows:

- Team: Development of an experienced team that includes a senior consultant in the role of Project Director who has been involved in the implementation of several portals in a health care setting and a chief architect with experience in the private sector. Contractors have been sourced that have extensive expertise in knowledge management.
- Approach: The Partnership has adopted a "30-day incremental approach" that enables "test drives" by partners of the portal to assess functionality. User acceptance and usability is built into this approach.
- Contract Structure: The Partnership contracts solely with Deloitte and all sub-contractors are managed by Deloitte. The contract has a flexible ceiling price for Release I and II and payments are made on deliverable milestones.
- Quality Assurance: A Quality Assurance Plan has been developed. Deloitte has assigned a partner to oversee all matters relating to quality assurance.
- Project Reporting and Tracking: Project monitoring and reporting occurs as per the requirements of the PMO. In addition, written updates are provided to the Board of Directors at each meeting.[60]

An extensive risk log has been established that identifies categories of risk, a description of each risk, the impact of each risk, risk rating, risk approach and response, potential risk triggers and responsibility for monitoring each risk.[61]

Portal project accountability is conducted through three key governance bodies. The Board of Directors has established an oversight committee. Two other governance mechanisms were established to facilitate the success of ongoing work include the content and design committee and the technical working group.

Release I of the Portal is to be launched in Spring 2009. This release will provide a platform that supports the creation of searchable repositories of information that are easily accessible (COLLECT), that supports the linking of networks and experts to foster the creation of new ideas for cancer control (CONNECT) and that enables the creation of

[60] Ibid., pg. 13
[61] CPAC Portal Risk Log (nd)

collaborative environments to develop new information (COLLABORATE) and share the information publicly (TRANSFER). This reflects a 3CT (i.e. Collect-Connect-Collaborate-Transfer) service model that brings together core Portal components into a cohesive business solution that is replicable and can be applied to all areas of cancer control.

Services leveraged through Release I include the National Clinical Trials Website and Repository, Canadian Cancer Society 1-800 Client Support Service and the Canadian Cancer Society Community Services Directory. Websites leveraged include the Canadian Virtual Hospice, Canadian Cancer Control P.L.A.N.E.T. Canada, Canadian Cancer Research Alliance (CCRA) and the Cervical Cancer Prevention and Control Network (CCPCN).[62]

October 2009 will mark Release II of the Portal with expanded functionality.[63]

[62] Partnership Portal Project Plan FY 09/10. Knowledge Management Division, CPAC (November 2008).
[63] Briefing note to the CPAC Board of Directors, October 7, 2008. Pg. 2

C.4 System Performance in Cancer Control

The Cancer Control System Performance core framework contributes to achievement of the goal, "Increase effectiveness and efficiency of the cancer control domain" and to the Partnership's objectives.[64] The rationale for this framework is, according the 2009 Progress Report, "central to cancer control planning in being able to use, over many years, data and information to increase the quality and efficiency of the system".[65]

The Cancer Control System Performance core framework addresses gaps in Canadian surveillance in terms of providing a view of what happens between diagnosis of cancer and recovery or death from cancer. Working in collaboration with a number of partners, the system performance efforts of the Partnership are geared towards first, enhancing cancer surveillance through the addition of core elements to improve the explanatory strength of existing and newly developed indicators, and second developing the analytic capacity to enable expedited application of the performance information.

Ongoing application and supplementation of surveillance data is the foundational rationale of key activities related to this core framework; more specifically, to monitor key trends in population experience of cancer and to measure the population impact in support of planning and forecasting of future needs in the cancer control domain. Further, ongoing monitoring and reporting of cancer control data "at provincial, territorial and national levels, will identify both areas of strength in cancer control and issues to be addressed".[66]

The central activity of the Cancer Control System Performance core framework is the "System Performance Indicator Project" that was established to create a national cancer control scorecard.[67] Building on existing Canadian data to measure indicators across the cancer control continuum "is an essential component of the cancer control system".[68] Analytic support for the execution of the indicator project is integrated with the work of the Knowledge Management (KM) Strategy Division. Province-specific reports will be prepared for individual jurisdictions with the completion of the first year's Scorecard.[69]

[64] The four Partnership objectives are: Reduce gaps in knowledge to enhance cancer control; facilitate and accelerate implementation of best available knowledge; optimize quality and access; and, improve the cancer experience for Canadians.
[65] CPAC Progress Report. Winter 2009 p. 9
[66] Ibid.
[67] While the scorecard will enable international comparative analysis on cancer control, the CPAC VP of Cancer control indicated that nationally, the scorecard is not a report card per se that would assess data on an interprovincial level. If this were the case, provinces and territories might be reticent to provide data that might be used to compare national activities.
[68] Memo to the System Performance Steering Committee submitted by Mary Spayne, Director –System Performance Cancer Control Division, CPAC.
[69] CPAC 2008-09 Funding Request. Pg. 45

The System Performance Indicator Project builds on work that began in 1999, prior to the creation of the Partnership, through the Canadian Strategy for Cancer Control. In 2003, an indicator subgroup was formed and in early 2008 a national conference took place, resulting in an evaluation of approximately 600 indicators. Drawing from this effort, CPAC's System Performance Steering Committee, comprised of scientists, analysts, cancer policy makers and health care practitioners from across the country, worked to narrow down and identify a core set of high-level, pan-Canadian indicators to begin to report on the status of cancer control in Canada. The process resulted in 17 indicators which span the cancer control continuum.[70]

The development strategy of the scorecard is set out in six steps. These steps are defined as follows:

- Stakeholder Engagement: CPAC has met with many government and /or cancer agency representatives to discuss the initiative, collect information on current processes and receive advice;
- Indicator Identification: The Standards Action group conducted an indicator conference in February 2008;
- Development of criteria for indicator selection: Experts from across the country representing expertise in measurement, clinical care, population health and leadership/ policy formed the key information group (Steering Committee) guiding the development of criteria;
- Development of a consensus roundtable to select key indicators: A Steering Committee workshop was conducted in the Fall of 2008. The purpose of the workshop was to arrive at consensus on the indicator criteria and to develop a short-list of the first set of indicators;
- Reporting and feedback; and,
- Refinement and iteration.

The latter two steps in the strategy are ongoing. In March/April 2009, four webinars have been be held with provincial and territorial partners to discuss appropriate presentation of indicator data, and "plan for uptake and dissemination of information." Feedback from these webinars will be incorporated into the Scorecard. [71]

In June/July 2009, four regional System Performance Indicator conferences will take place across the country to present the first pan-Canadian Scorecard.

[70] RFP For System Performance in Cancer Control. CPAC, July 2008
[71] Memo to the System Performance Steering Committee submitted by Mary Spayne, Director –System Performance Cancer Control Division, CPAC.

C.5 The Standards Action Group

The Standards Action Group (SAG), initially one of the eight Action Groups under the Council of the Canadian Strategy for Cancer Control (CSCC), was created to "gather and critically analyze cancer information and knowledge across the cancer control continuum, provide cancer expertise and management advice in specified priority areas, and coordinate and drive action across Canada. The SAG feeds information into the Council's risk management and knowledge platform, make recommendations to the Council regarding priority setting, and manage and implement cancer control activities in their areas of expertise, ensuring that action is taken across the continuum of care."[72]

The business goals (2006-2010) of the SAG, as described in the CSCC, were to[73]:

- Establish an inter-provincial mechanism to promote and facilitate the development, dissemination, uptake and evaluation of evidence-based, pan-Canadian standards and performance indicators for cancer diagnosis, treatment and care;
- Develop common data and technology system for storing and accessing performance indicators and best-practice standards information; and
- Improve access to standards and performance indicator information by professionals, patients and the community at large.

With the creation of the Partnership, existing Action Groups under the CSCC migrated to become part of the Partnership's organizational structure. The initial meeting of the Chairman of the Board of CPAC and Action Group chairs was held on February 16, 2007. Discussions were then held with each Action Group Chair concerning their work plans, budgets and support requirements. This helped to inform the development of the CPAC Strategic Plan and the First Year Funding Requirements submission to Health Canada.[74]

Under the Partnership's umbrella, the main focus of the Standards Action Group was the development of pan-Canadian standards and performance indicators for cancer diagnosis, treatment and care and improved access to standards and performance indicator information by professionals, patients and the community at large. In 2007-2008, the following progress was reported[75]:

- An analysis of gaps in cancer control standards was completed.

[72] The Canadian Strategy for Cancer Control: A Cancer Plan for Canada, Discussion Paper, July, 2006
[73] Ibid.
[74] CPAC Annual Performance Report, Start-up, 2006-07, March 31, 2007
[75] CPAC Annual report 2007-2008

- 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.

As early as March 2008[76], it was noted that the work of the Standards Action Group had connections and linkages with the work of other Action Groups (indicators and guidelines). At the April meeting[77] of the Standards Working Group, there was confusion noted among the members as to the definition of a "standard" versus a "guideline".

In August 2008, the alignment of the Action Groups to CPAC Vice Presidents was altered with the Standards Action Group working closely with the Vice President, Cancer Control[78].

During 2008, specific projects and initiatives under the auspices of the Standards Action Group were subsumed into the Partnership as strategic initiatives (e.g. Cancer System Performance Indicators) eliminating the requirement for the indicator sub-committee of the SAG. Other projects were also subsumed by other Action Groups (e.g. SAGE in Guidelines) and the role of the Standards Action group was put into question as a separate entity.

The Standards Action Group was transitioned into the Standards Working Group and the work of the SAG was absorbed into existing projects within the Partnership or within other Action Groups (e.g. Guidelines).

There continues to be a "Standards Working Group" that is currently funded by the Partnership to hold a conference in May 2009 of Cancer Standards experts to identify gaps in existing standards within Canada. It may also, based on the results of the conference, work towards development of standards in one or two areas of high need.

[76] Action Council/Program Director's Meeting Minutes, March 26, 2008
[77] Action Council/Program Director's Meeting Minutes, April 28, 2008
[78] Action Council/Program Director's Meeting Minutes, August 22, 2008

C.6 The Project Management Office (PMO)

The Project Management Office (PMO) is viewed as a key corporate enabler that provides project and portfolio project management support and analytical capacity. In doing so, the PMO supports the Partnership's staff to ensure that project activities are aligned with the Partnership's Strategy and are planned, monitored and reported based on the objectives of the strategy.

The PMO engages and supports The Partnership's staff through the lifecycle of projects from project planning to approval, initialization, execution, change approval process and closure. Finance and project management analysts work in collaboration to ensure that project and portfolio level performance is related to the achievement of results and is resource based.

The PMO also assists the Partnership at the Portfolio and Corporate level to conduct cost-benefit analysis, feasibility assessment and high-level planning.

The approach taken in the establishment of the PMO was based on four principles of development as follows:

- Cultural Fit: Ensure that the PMO approach "fits" the organization. A decentralized model was adopted.
- Focus: Develop project management tools to address performance gaps or "pain points" and drivers of success.
- Organizational Project Management governance through:
    - Consideration of roles, responsibilities and accountabilities,
    - Relationships and services provided,
    - Tools and supports required,
    - A maturity model, and
    - Appropriate measures that align with enterprise wide performance and risk management; and,
- Communication of success.[79]

In support of its role, the PMO has developed a comprehensive toolkit for Program Directors, Directors, and Managers to facilitate project management processes. The toolkit includes a number of tools that align with the stages of project management as follows:

- Project planning
- Project initializing

[79] CPAC. Project Management Office. Power Point Presentation to Senior Management Team. July 8, 2008.

- Project executing
- Project closing

Annex A presents the various portfolio and project level tools and supports of the PMO.

In its first complete year of operation (i.e. 2008-09), the annual activities of the PMO were organized to align with the rollout of the Partnership's strategic and work planning and reporting cycle and supported the building of capacity associated with these activities.

In the first quarter (Q1) of 2008, the PMO updated the quarterly project status reporting template and developed a project status data collection tool. Status reporting occurs quarterly on a project-by-project basis and project status is aggregated at the portfolio level on an Action Group-by-Action Group basis. Core framework and strategic initiative status is reported quarterly. Performance status is assessed in terms of, first, whether the project is on track regarding work and budget and second, the extent to which project is having an impact. Formal quarterly project status meetings are held that facilitate the reporting process. The CFAO, Program Directors, Directors, PMO and Finance analysts, communications staff and the associated VP attend. Projects that are identified in these quarterly meeting to be in a high-risk or "red" category are elevated to the Senior Management Team to be reviewed.

In Q2, the PMO developed a project approval and change approval process and supporting tools such as the approvals process map and change request form. Two training sessions were conducted with Program Directors, Directors, and Managers to familiarize them with the approvals process and key concepts of and tools for ongoing project management. The PMO created glossary guidance documents for each project management cycle in order to ensure a common project management language and understanding across the organization.

A risk management plan was developed in Q2. Risk planning was integrated into the project planning process and associated templates for 2009-10 and training was provided to build the capacity of Program Directors, Directors, and Managers to integrate risk assessment and analysis into project planning. Training also took place.

Risk is regularly assessed in each quarter in terms of work/ effort progress, budgeting, and objectives and is aligned with the Partnership's Enterprise Performance and Risk Management (EPRM) Scorecard. This scorecard is in a final draft stage and assesses enterprise performance and risk through the following categories: finance and portfolio management, stakeholders, organizational excellence and delivery mechanisms. Each of these performance areas is assigned key performance indicators and targets, and responsibility.

Activities in Q3 and Q4 were geared towards project and Partnership-wide planning and supported the development of the 2009-10 Funding Request to Health Canada. Project planning templates were finalized that included key considerations such as an

environment scan, readiness, risk management, constraints management, resource management, and communications management. Project budget and associated software tools training was also provided. Further, a matrix of roles and responsibilities and a communication plan templates were created.

In order to assist in the PMO's role in evaluating project plans, two tools have been developed. First, a project plan assessment tool assesses projects through a set of questions in three categories including: objectives and scope, risk and workplan. This tool guides project evaluation. A second tool supports project and portfolio assessment and includes a set of questions for the Partnership's Senior Management Team.

Continuous improvement is evidenced by the identification and analysis of lessons learned and best practices in each stage of the project management cycle, and their use in ongoing development and refinement of project management practices.