

Oncology Surgery BCCA

Building on Strengths

Richard Finley, March 27, 2009

Thank You

- SON Yasmin
- Sam Bugis
- Noelle Davis, Dianne Miller, Susan O'Reilly, Garth Warnock, Larry Goldenberg, Bas Masri
- Robin McLeod and Jonathan Irish CCO
- Jonathan Meakins Oxford

Why is Surgical Oncology Important to BC Patients, BCCA and SON?

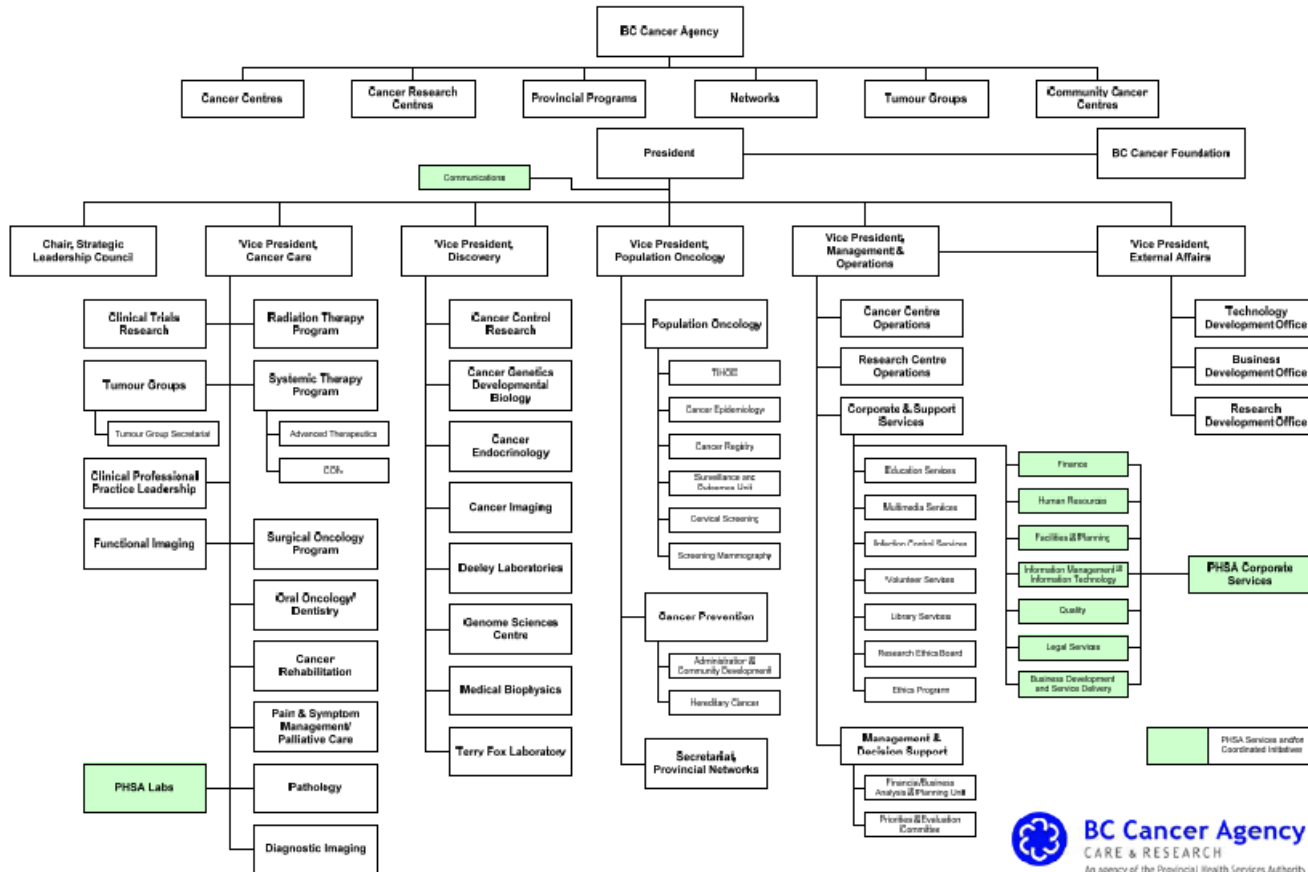
- Most effective therapy for most solid cancers
- Accounts for ~ 25 % of cancer care costs
- Most cancer surgery occurs outside the “cancer system”
- Surgical care is provided in regions where patients reside
- “General” surgeons provide a large amount of cancer care
- Some complex operations have better outcomes in high volume centres

BCCA Strategic Plan 2009

- To sustain and advance the BC Cancer Agency's system of cancer control.
- To establish the knowledge generation and application paradigm within the provincial cancer control platform.
- To support regional centres, regions and communities with the implementation of provincial cancer control programs and the integration of knowledge across the discovery -> clinical practice -> population application continuum.
- To ensure the provision and deployment of resources to achieve maximal organizational effectiveness.

BCCA Organization

BC Cancer Agency – Direct Reporting Structures (Operational & Resource Management Accountability)



Members of the BC Cancer Agency Executive Team 2009

- Brian Schmidt, Interim President
- Dr. Sam Abraham, Vice President Strategic Relationships
- Nicole Adams, Director, Communications & Public Affairs
- Fiona Bees, Chief Nursing Officer
- Dr. Charles Blanke, Provincial Program Leader Systemic Therapy
- Dr. Andy Coldman, Vice President of Population Oncology
- Dr. Connie Eaves, Vice President, Research
- Dr. Mark Elwood, Vice President Family & Community Oncology
- Karim Karmali, Vice President Management and Operations
- Dr. Ivo Olivotto, Provincial Program Leader, Radiation Oncology
- Dr. Susan O'Reilly, Vice President Cancer Care
- Dr. Clayton Smith, Leader Tumour Group Council
- **Who represents Surgical Oncology?**

Surgical Oncology Network

- The Surgical Oncology Network includes all providers of surgical oncology services from surgeons in remote areas to sub-specialists.
- Its purpose is to provide strong linkages with surgeons and hospitals across the province, including the BC Cancer Agency's five cancer centres and 17 clinics.
- The Network's goal is to establish a structure and a system to enable the integration of quality surgical oncology services into the formal cancer care system.

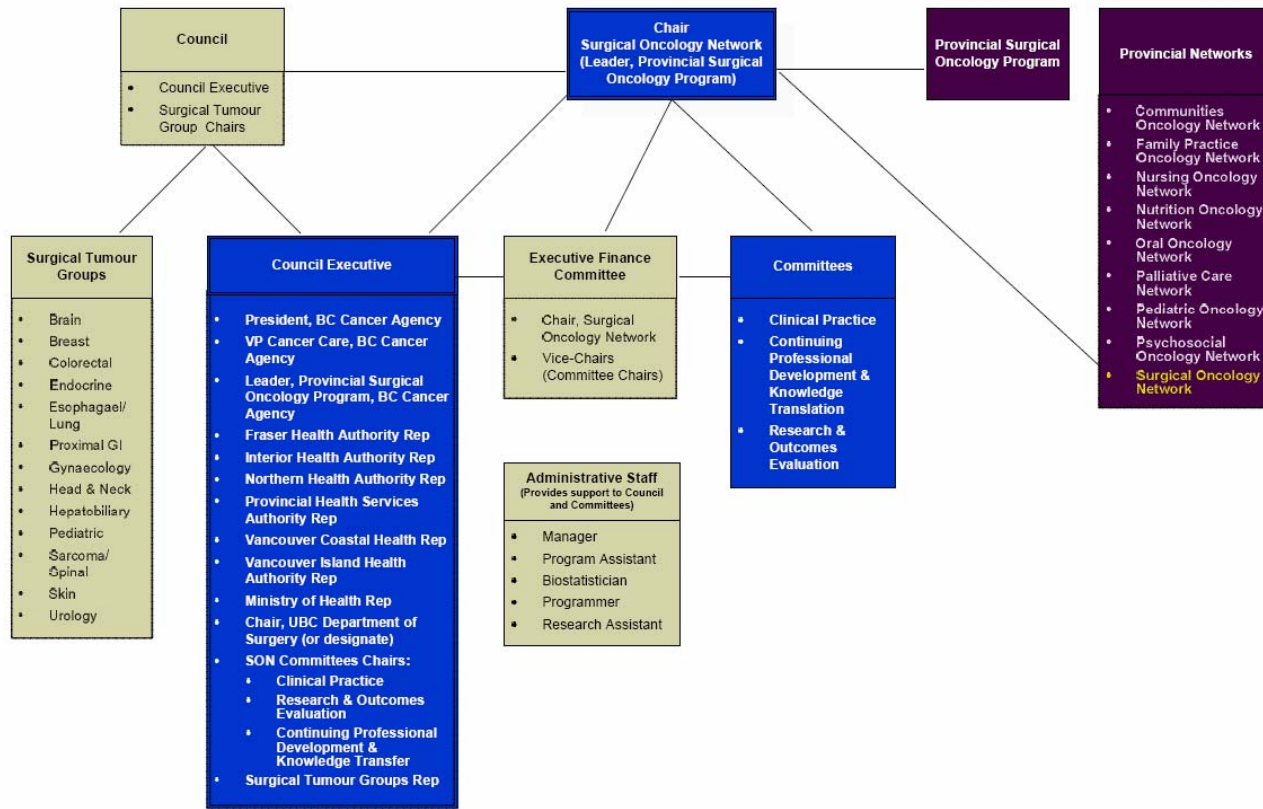
Surgical Oncology Network Functions

- Developing communications tools to enhance surgical decision making provincially;
- Participating in the identification and/or development of peer- reviewed, evidence-based guidelines based on 'best practice' principles;
- Developing a high quality continuing education program that meets standards of the Royal College of Physicians and Surgeons; and
- Conducting regionally based research and outcome analyses to provide vital information for Network initiatives.

SON Organization

Surgical Oncology Network

BC Cancer Agency



SON Council Executive

- Sets priorities for the Council and Network.
- Establish networks to facilitate the integration of community surgeons into the cancer treatment system.
- Perform annual performance review of the Council and Network.
- Provide and disseminate information about surgical oncology activities in a timely manner to surgeons, surgical oncologists and the Health Regions through the website, videoconferencing and newsletter.
- Liaise with the Ministry of Health (including the provision of regular reports).
- Appoint Surgical Oncology Tumour Group Chairs and recommend surgeons for membership on BCCA Tumour Groups.
- Establishes and oversees Surgical Oncology Network Council Committees, including the appointment of Committee Chairs.
- Liaise with Health Authorities (Fraser Health, Interior Health, Northern Health, Vancouver Coastal Health, and Vancouver Island Health Authorities).

SON Council

- Assists with the planning, implementation and promotion of activities for the Network.

Surgical Tumor Groups

- Advises the Surgical Oncology Council & Network on the issues and challenges in the surgical management of patients within each tumour grouping, to improve the surgical management of oncology patients.

SON Committees

- **Executive Finance Committee** Dianne Miller
 - Sets the financial plan for the Network's annual activity plan in accordance with the Network's annual operating budget.
- **Clinical Practice Committee** Noelle Davis
 - Develops and promotes surgical quality improvement endeavors, practice guidelines and standards in surgical oncology for the province.

SON Committees

Continuing Professional Development & Knowledge Transfer Committee -Rona Cheifetz

- Develops and implements professional development opportunities that will lead to improved surgical oncology practice and increased knowledge in the field of surgical oncology, as well as improve communication between the Council and the surgeons of BC.

- Research & Outcomes Evaluation Committee

- Carl Brown
- Supports research and evaluation activities of the Surgical Oncology Network by providing guidance and assistance to Network surgeons with research projects, feasibility studies and measurement of practice improvement.

SON Newsletter

Rona Cheifetz

Focus on Tumour Groups:2
Sarcoma Surgical Tumour
Group

Community Perspective4
on Soft Tissue Tumours

Malignant Bowel5/6
Obstruction

Update on SON Synoptic8
Operative Reporting
(WebSMR) Project

Hay Report 2000

BCCA Surgical Oncology

- An administrative framework that parallels radiation & systematic therapy
- Enhance cancer services regionally by developing a network of practicing community surgeons
- Develop best practice guidelines
- Surgical wait list & outcomes registry
- Develop education & research resources

Consequences of not providing a BCCA Surgical Oncology Program in which surgeons are not formally linked to the cancer care delivery system

- Variation in surgical practice & outcome
- Few guidelines
- No regional information on wait lists, appropriateness or outcomes
- No oncology education or quality improvement programs for all surgical specialties

BCCA Surgical Oncology Bell/Nason Report 2004

- Strong commitment to multidisciplinary surgical oncology practice by Dr. Davis.
- Great progress in SON particularly in education with Dr. Cheifetz & TEM project led by Dr. Phang
- Lack of programmatic attention to Surgical Oncology at the University level
- Excellent MSK, Gynecology, Urology Programs

BCCA Surgical Oncology Bell/Nason Report 2004

- General Surgery Oncology services suffered from a lack of comprehensive care organized around a patient centred focus and a commitment to develop subspecialized surgical oncology care
- Opportunity for PHSA, BCCA and UBC to organize the academic health science component of surgical oncology as a provincial resource.

Cancer Care Ontario Executive

- Dr. Carol Sawka, VP, Clinical Programs
- Dr. Melissa Brouwers, Director, Program in Evidence-based Care
- Dr. Deborah Dudgeon, Provincial Head, Palliative Care
- Audrey Friedman, Provincial Head, Patient Education
- Scott Gavura, Director, Provincial Drug Reimbursement Programs
- Esther Green, Provincial Head, Nursing and Psychosocial Oncology
- **Dr. Jonathan Irish, Provincial Head, Surgical Oncology**
- Dr. Anne Keller, Imaging Representative
- Dr. Verna Mai, Director, Screening
- John McLaughlin, PhD, VP, Population Health and Surveillance
- Dr. George Pasut, VP, Prevention and Screening
- Jillian Ross, Director, Clinical Programs
- Elham Roushani, Chief Financial Officer
- Michael Sherar, VP, Regional Programs
- Pamela Spencer, VP Corporate Affairs, General Counsel & Chief Privacy Officer
- Dr. John Srigley, Provincial Head, Laboratory Medicine/Pathology
- Dr. Terrence Sullivan, President and CEO
- Dr. Maureen Trudeau, Provincial Head, Systemic Therapy
- Dr. Tony Whitton, Provincial Head, Radiation Treatment

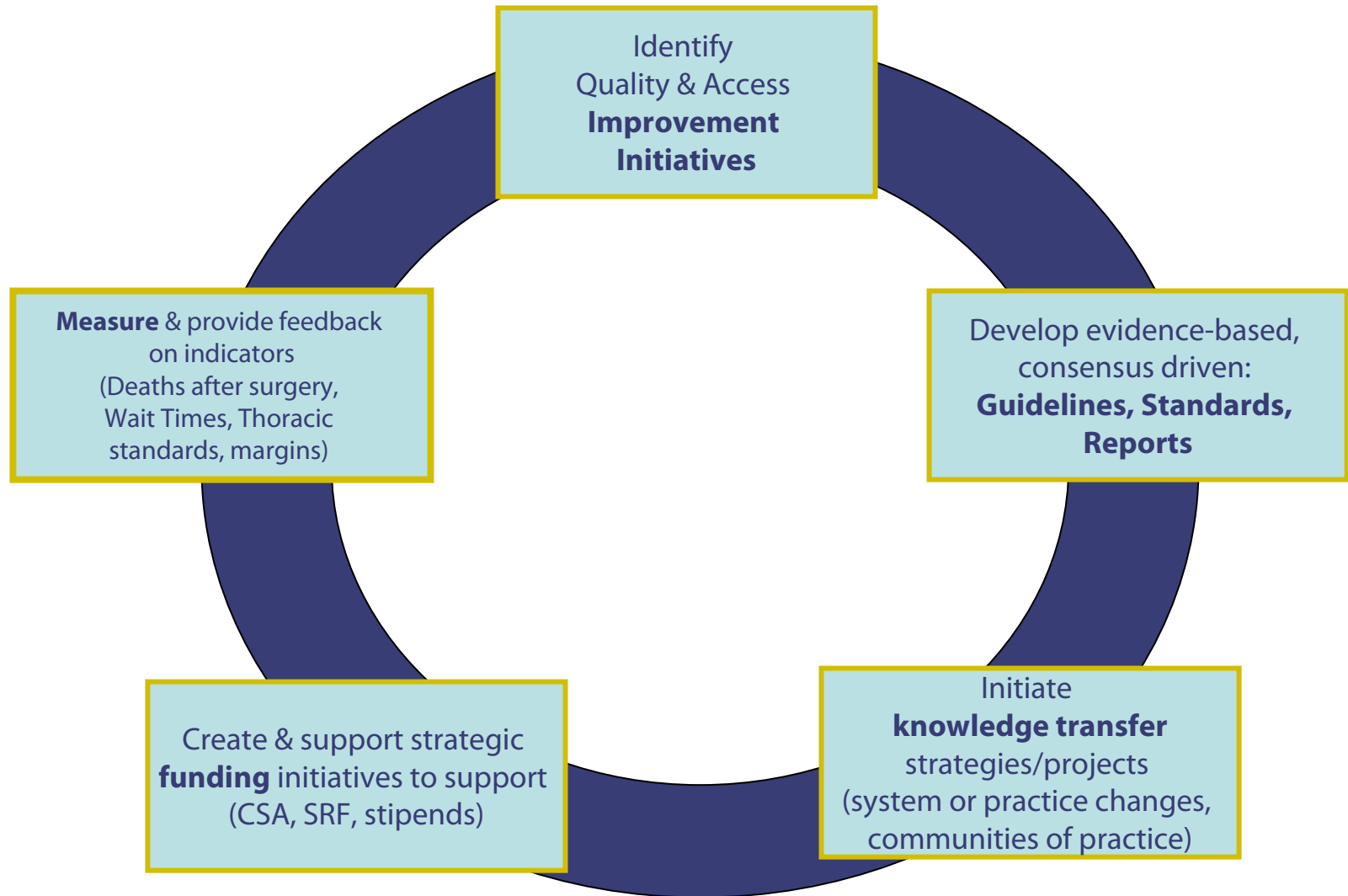
CCO Disease Group

- Jim Biagi, Gastrointestinal
- Andrea Eisen, Breast
- Bill Evans, Lung
- Neil Fleshner, Genitourinary
- Michael Fung Kee Fung, Gynecology
- Ralph Gilbert, Head and Neck
- Sebastian Hotte, Genitourinary
- Kevin Imrie, Hematology
- Tom Kouroukis, Hematology
- Normand Laperriere, Neuro-oncology
- Andrew Loblaw, Genitourinary
- James Perry, Neuro-oncology
- Teresa Petrella, Melanoma
- Yee Ung, Lung
- Shailendra Verma, Sarcoma
- Eric Winkvist, Genitourinary
- Rebecca Wong, Gastrointestinal

CCO Surgical Oncology Executive

- **Dr. Jonathan Irish**
Provincial Head, Surgical Oncology
Lead, Access to Care & Strategic Funding
- **Dr. Robin McLeod**
Lead, Quality Improvement & Knowledge Transfer
- **Amber Hunter**
Program Manager
- **Jennifer Mah**
Executive Secretary
- **Cindy Nhan**
Project Coordinator
- **Dr. Michael Fung Kee Fung**
Advisor, Knowledge Transfer
- **Dr. Andy Smith**
Lead, Colorectal Community of Practice
- **Dr. David Urbach**
Lead, Research
- **Dr. Frances Wright**
Lead, Multidisciplinary Cancer Conferences
- **LHIN Regional heads**

Surgical Oncology Program (CCO)



CCO Surgical Oncology Philosophy

- Care must be taken to ensure that “regionalization” or “centralization” does not disengage our community
- Must build quality in centres not move patients to “quality centres”

CCO Surgical Oncology Budget 2009

- Administrative
\$ 1.1 million
- Surgeon clinical remuneration fund
\$ 7 million
- Surgical wait list improvement fund
\$ 40 million
- MMC Coordinators
one FTE for each cancer centre

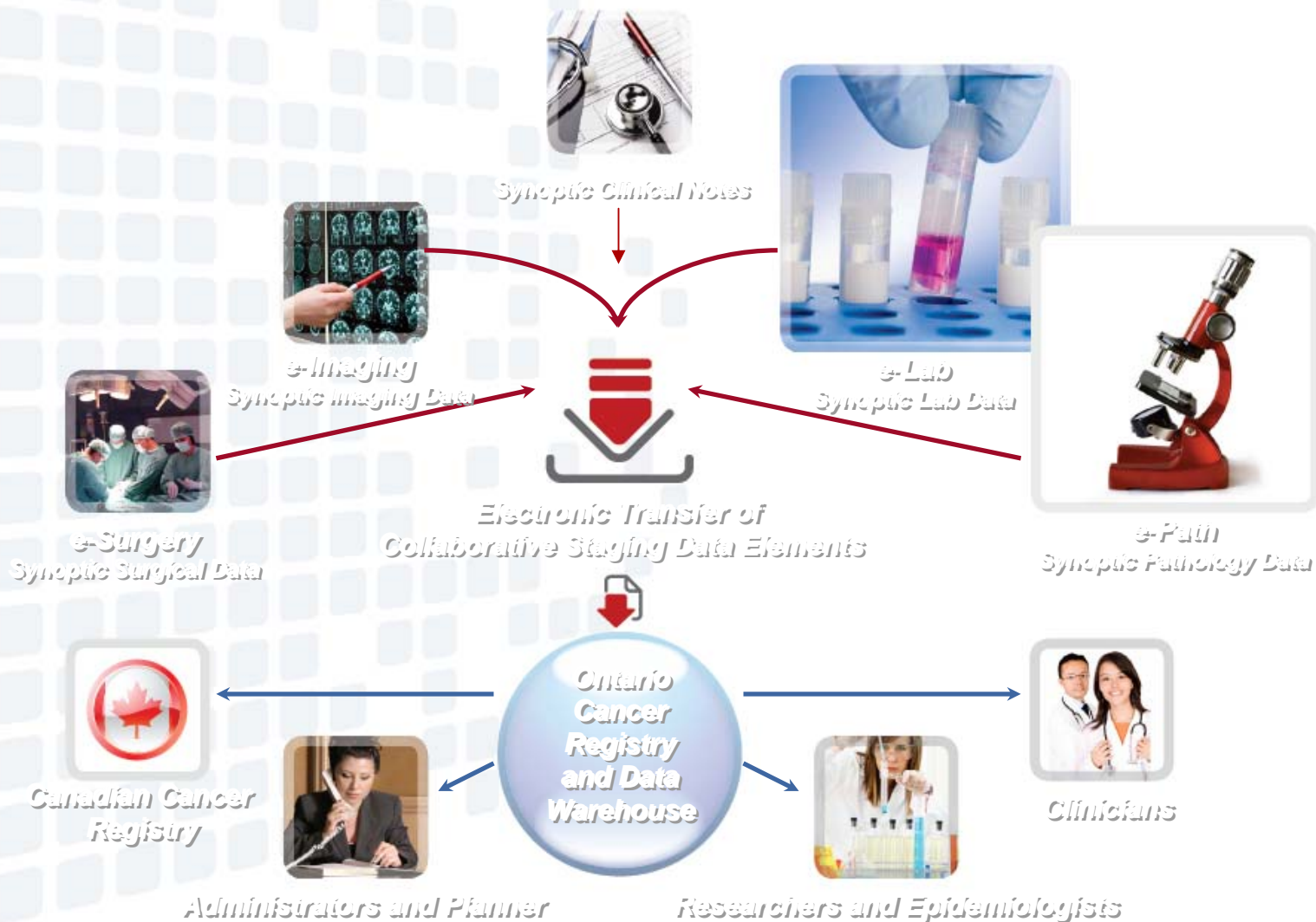
Surgical Oncology Program (CCO) Planning and Prediction

Priority 1

Data Management

- ICES
 - Ontario Centre for Cancer Related Health Services Research
- Cancer Surgery Atlas
- Short Term Goal:
 - To demonstrate regional variation in cancer surgery rates and cancer surgery outcomes
- Long Term Goals:
 - To identify service delivery gaps and initiate process improvements

Synoptic pathology reporting tools are central to Ontario's and CPAC's vision for stage capture



Priority 2

Quality Initiatives

- Continued development of surgical standards and guidelines through CCO's Surgical Oncology Program and the Program in Evidence-Based Care
- Continued implementation of Communities of Practice within and across Local Health Integration Networks

Quality Improvement Philosophy

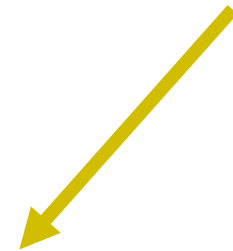
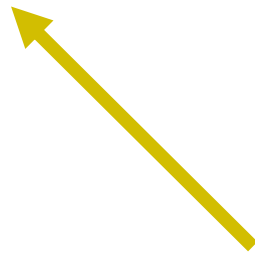
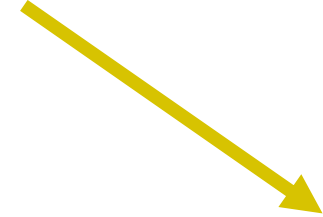
- Commitment that patient welfare is paramount
- Management should be based on best evidence
- Engagement of “community of practices”
 - experts in different subspecialties or disciplines
 - surgeons in one region
 - administrators
- SOP can facilitate change but implementation occurs locally in the regions

**Identify the
Problem**

**Develop Guideline
or Standard**

Evaluate Results

**Initiate Knowledge
Transfer Strategies**



Strategies

- Regionalization-complex surgery
 - HPB
 - Thoracic Surgery
- Other Strategies-surgery for other disease sites
 - approximately 70% breast, colorectal and prostate procedures are performed in community hospitals
 - education, quality improvement initiatives, development of community of practices etc.

CCO Surgery Standards and Evidence-based Series (EBS)

- **Optimization of Surgical and Pathological Quality Performance in Radical Surgery for Colon and Rectal Cancer: Margins and Lymph Nodes**
17-4 EBS: April 2008
 - [Practice Guideline](#)
 - [Evidence-Based Series](#)
- **Thoracic Surgical Oncology Standards**
Standards Report: September 2005
 - [Practice Guideline](#)
 - [Evidence-Based Series](#)
 - [Thoracic Standards Systematic Review](#) : "Reprinted from The Annals of Thoracic Surgery, Vol 84, Sundaresan S, Langer B, Oliver T, Schwartz F, Brouwers M, Stern H; Expert Panel on Thoracic Surgical Oncology. Standards for thoracic surgical oncology in a single-payer healthcare system. Pages No.: 693-701, Copyright 2007, with permission from The Society of Thoracic Surgeons. All rights reserved."
- **Laparoscopic Surgery for Cancer of the Colon**
2-20-2 EBS: September 2005
 - [Practice Guideline](#)
 - [Evidence-Based Series](#)

CCO Surgery Standards and Evidence-based Series (EBS)

The Surgery Standards and Evidence-based Series are produced by Expert Panels convened by Cancer Care Ontario that work together with the PEBC to gather and examine evidence on specific topics related to providing optimum surgical treatment for people affected by cancer in Ontario.

- **Hepatic, Pancreatic, and Biliary Tract (HPB) Surgical Oncology Standards**
17-2 Standards Special Report: June 2006
 - [Practice Guideline](#)
 - [Evidence-Based Series](#)
- **Guideline for Optimization of Surgical and Pathological Quality Performance in Radical Prostatectomy in Prostate Cancer Management**
17-3 EBS: September 2008
 - [Practice Guideline](#)
 - [Evidence-Based Series](#)
- **Optimization of Surgical and Pathological Quality Performance in Radical Surgery for Colon and Rectal Cancer: Margins and Lymph Nodes**

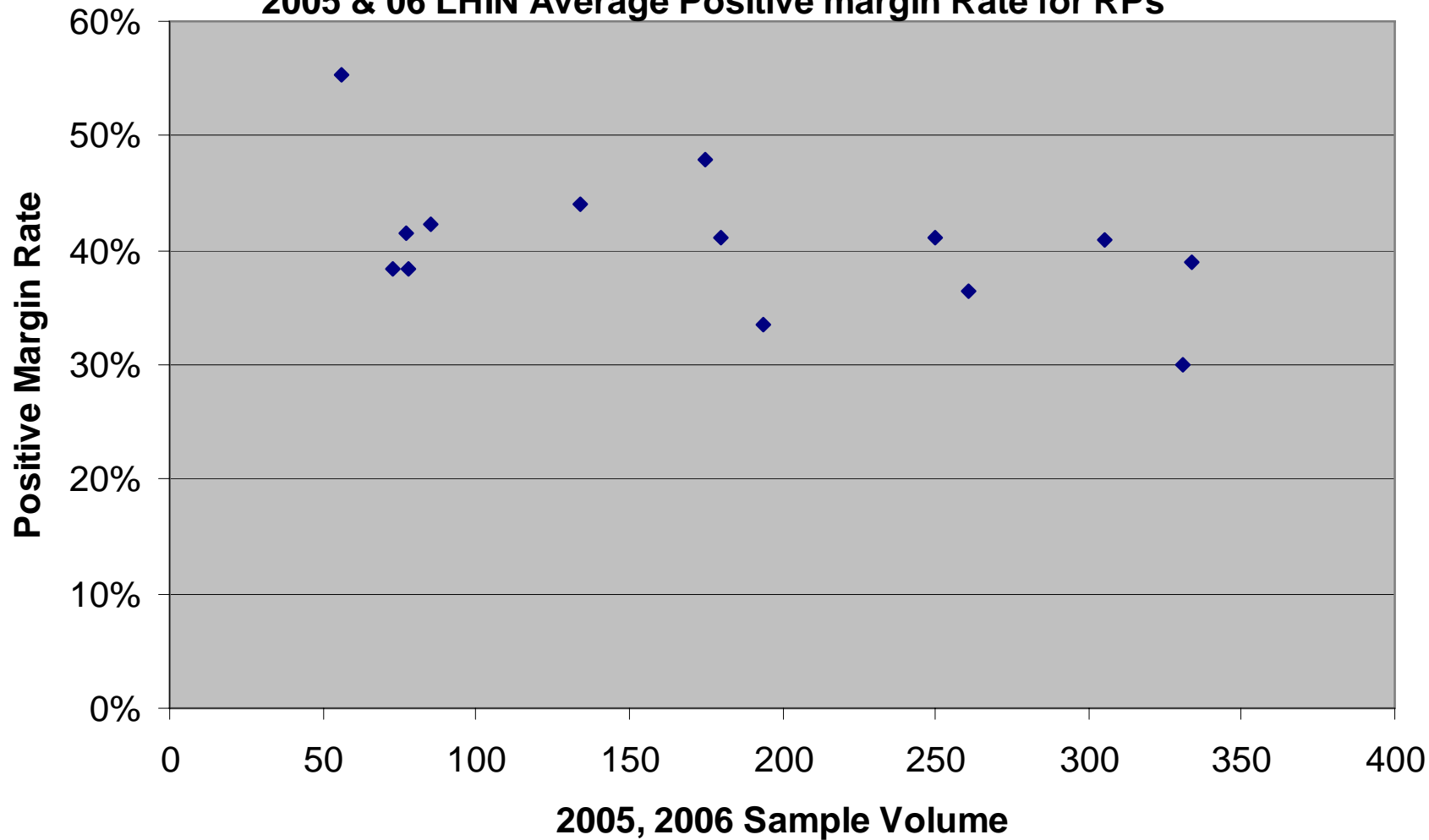
Quality Improvement Initiatives

- *Colorectal Cancer*
- *Prostate Cancer*
- *Sentinel Lymph Node
Biopsy*
- *Thoracic Surgery*
- *HPB Surgery*
- *MCCs*

Prostate Cancer Surgery Quality Improvement Initiatives

- *Prostate Margin Rate Audit*
- *LHIN and hospital level data have been distributed to:*
 - *RVPs,*
 - *Surgery and Pathology Leads*
 - *Chiefs of Surgery and Chiefs of Pathology/Laboratory Medicine*
- *Ontario data:*
 - *Overall positive margin rates*
 - *pT2, pT3 positive margin rates*

2005 & 06 LHIN Average Positive margin Rate for RPs



Prostate Cancer Surgery Quality Improvement Initiatives

- *Guideline has been released*
 - *Currently posted on the CCO website and awaiting publication*
- *Prostate Champion Workshop scheduled for December 1st, 2008*
 - *Urology Surgery and Pathology Champions from each LHIN as well as members of the Expert Panel have been invited*
 - *Joe Chin and Jose Gomez (Southwest)*
 - *Expenses paid by CCO*

Priority 3

Quality and Funding

- Strengthen the link between quality and funding
- Cancer surgery funding must be closely tied to increasing quality and performance expectations

Priority 4

Fund to Improve Access to Surgical Care

| Year | Incremental Cases | Incremental Funding | Hospitals |
|---------|-------------------|---------------------|-----------|
| 04-05Q4 | 1703 | 10 | 24 |
| 05-06 | 4817 | 26.7 | 37 |
| 06-07 | 5116 | 32.8 | 44 |
| 07-08 | 6199 | 39.1 | 46 |
| 08-09 | 5614 | 37.2 | 47 |

- “Schedule” deliverables:
 - Linked to CCO Quality Improvement initiatives
 - Catalyst to induce change
 - Empowers surgical and administrative leads

Volume Targets

| | Funded Volume | Actual Year-end Incremental Volume | % of Target | Funding (\$000) (after in-year adjustment) | Actual Year-end Funding | % of Target |
|--|----------------------|---|--------------------|---|--|--------------------|
| 2004/05 | 1,699 | 1,145 | 67% | \$10,000 | \$6,226 | 62% |
| 2005/06 | 4,909 (4,204) | 4,219* | 86% | \$26,700 (\$24,085) | \$20,094** | 75% |
| 2006/07 | 4,741 | 4,329 | 91% | \$26,700 | \$23,845 (after final reconcilliation Fall'07) | 85% |
| <p>* <i>Interim Data</i> ** <i>Method B to maximum of funded allocation</i></p> | | | | | | |

Priority 5

Subspecialty Training

- Support the expansion of subspecialty training in surgical oncology in Ontario.
- Includes funding support for post-residency surgical oncology fellowship positions.
- Goal: to populate the communities of practice with surgical oncology leaders

Priority 6

Funding Surgeons

- Transform the Sub-specialty Repair Funding for surgical oncology into an Alternate Funding Plan (AFP) for surgical oncology
- AFP should link funding to clear quality and performance accountabilities and deliverables
- OHIP fees to support Tumor Board activities for surgeons, pathologists and radiologists

Priority 7

Infrastructure Support

- Advocate for appropriate infrastructure support for major technological initiatives in surgical oncology
 - minimal access surgery
 - image guidance
 - Robotics, molecular guided surgery
- This support should be strongly linked to organizational performance standards

Priority 8

Multidisciplinary Cancer Conference

- MCC Workshop (November 24th, 2008)
 - Invitees represent different areas of expertise, disciplines and geographies
 - Goals & Objectives:
 - Review the current state of MCCs in Ontario
 - Understand technology enablers
 - Discuss MCC implementation strategy:
 - Develop guiding principles
 - Consider indicators for evaluation of MCCs
 - Set provincial goals for implementation

Current Status of MCCs

- Current Status Report
 - Captures the status of MCCs in each LHIN and across the province by cancer disease sites
 - Issues highlighted by LHINs include:
 - Access to administrative support;
 - Availability of proper technology and technological support
 - Attendance by appropriate disciplines
 - Compliance with all aspects of the MCC standards is low

Multidisciplinary Cancer Teams United Kingdom

- Mandated by law
- 1800 MDT teams(80 % of cancers)
- Breast, colorectal, gynecology, lung, prostate, esophageal ,brain
- Coordinators,surgeons,radiologists,pathologists,medical oncologists,nurse specialists,dietitians,palliative care
- Cost, loss of autonomy, effectiveness

KEY MDT OPERATIONAL FUNCTIONS

- MDT Co-ordinators.
- Diagnosis and treatment fax to GP's.
- MDT Operational Policies.
- Accurate Data collection.
- MDT at a time and day suitable for core members.
- Ensure appropriate documentation is present.
- Booking direct from MDT meeting.

MDT Cancer Teams

- [Do MDT meetings work?](#)
- [Does your MDT meeting have a suitable environment in which to meet?](#)
- [Does your MDT meeting have an operational policy in place, which is reviewed annually and distributed to all members of the team?](#)
- [Are you able to discuss all patients at your MDT meeting?](#)
- [How can you improve communication by using the MDT meeting?](#)
- [Are the key members of the team able to attend the meetings?](#)
- [Do you have protocols and proformas for recording discussions, decisions and treatment plans for each patient?](#)
- [**Why do you need an MDT meeting co-ordinator?**](#)
- [Should the MDT meeting be used to facilitate data collection and audit?](#)
- [Can the MDT meeting be used to facilitate entry into clinical trials?](#)
- [How does your MDT involve patients?](#)
- [How can we integrate Service Improvement?](#)

Why do you need an MDT meeting co-ordinator?

- Arranging the meeting.
- Obtains list of cases to be discussed.
- Co-ordinates imaging, case notes histology etc. (Acquiring films in hospitals without PACs is time consuming and additional support may be needed).
- Records attendance.
- Records discussion, diagnosis, decision and treatment plan.
- Collects data.
- Books or tracks appointments.
- Ensures co-ordination and communication between the team and its related teams in the network and with the referring Primary Care Organisation.
- Link administrator for the patient and the team.

MDT QI

- Single queues and pooled waiting lists for all referrals – streamlined referral process.
- Clear referral & discharge protocols in place.
- One-stop clinics – reducing and coordinating visits. Combined diagnostic tests/investigations.
- Review of follow-up protocols – reduce the number of Consultant led follow-ups.
- Scheduling and booking systems in place. Whole systems approach – no carve out of capacity.
- Reviewing skill mix and changing/developing new roles to match.
- The needs of the patient.
- Improve and streamlined the communication process with primary care.
- Process mapping at the level of MDT.
- Capacity and demand theory applied to practice

BCCA Surgical Oncology 2009 Strengths

- Excellent MSK, Gynecology, Urology Programs
- Excellent SON newsletter and education programs
- Commitment of community surgeons
- Rectal Cancer QI project
- Improved AFP support for academic surgery
- Regional administrative support started

BCCA Surgical Oncology 2009 Weaknesses

- Governance
- Budget has shrunk by 50% since 2004
- Poor buy-in by the non- General Surgery specialties
- Lack of programmatic attention to Surgical Oncology at the University level
- No control over the management of surgical wait lists or a budget to provide resources to decrease wait lists

BCCA Surgical Oncology 2009 Weak Governance

- Poor understanding of the roles and responsibilities of the Surgical Oncology Leader
 - BCCA versus Vancouver Cancer Centre
 - Surgical Oncology network
 - Other BCCA and regional leaders
 - Academic surgical specialties
- Surgical Oncology Leader not a member of the BC Cancer Agency Executive Team
- BCCA Governance does not favor multidisciplinary care

BCCA Surgical Oncology 2009 Opportunities

- New BCCA CEO
- Regionalization eg Thoracic surgery
- Wait list management CCOntario
- QI for all specialities
- Data management

BCCA Surgical Oncology 2009 Opportunities

- Multidiscipline **disease** Mx Clinics
eg UK
- Translational research eg tissue banking
- Telehealth for subspecialties
- Fellowship training
- Engagement of all Surgical Subspecialties

BCCA Surgical Oncology 2009 Threats

- Data and image management
- Complacency
- Regionalization
- Speciality Guilds
- Economy

***Phase 1* Recommendations**

Completed by April, 2009

1. Change name to Oncology Surgery to embrace all surgical specialities.
2. Appoint Provincial Program Leader of Oncology Surgery to be a member of the BC Cancer Agency Executive Team.
3. Clarify the role of Leader of Oncology Surgery at BCCA versus VCC and other Regional Centres.
4. Dr. Warnock to engage the Dean, CEOs of BCCA and Regions and the other academic surgical specialty leaders to finalize the roles and responsibilities, job description and support of new Provincial Program Leader of Oncology Surgery.

Phase 1 Recommendations

Completed by April, 2009

5. Regional Heads of Oncology Surgery should be appointed at each of the Cancer centres by the Centre director and the provincial program leader in Oncology Surgery. The Regional Heads should be appointed to the Centre executive team and, the Provincial Oncology Surgery Executive. The Regional Head should advance the mission and vision of BCCA by contributing to the development and implementation of the Oncologic Surgery Program initiatives and activities within their own health authorities
6. Ask for the PHSA Surgical Oncology wait list to be placed under the management of the Oncology Surgery program.

***Phase 2* Recommendations**

Completed by October, 2009

- 1. Initiate and conclude search for new Provincial Program Leader of Oncology Surgery.**
- 2. Appoint leaders of Oncology Surgery at each of the regional Cancer Centres.**
- 3. New leader to direct an in depth strategic planning session of all the key stakeholders including the Dean, CEOs of PHSA and the Regions, the members of SON executive and the academic leaders of the surgical specialities.**
- 4. Obtain a budget to execute the strategic plan.**

Phase 2 Recommendations

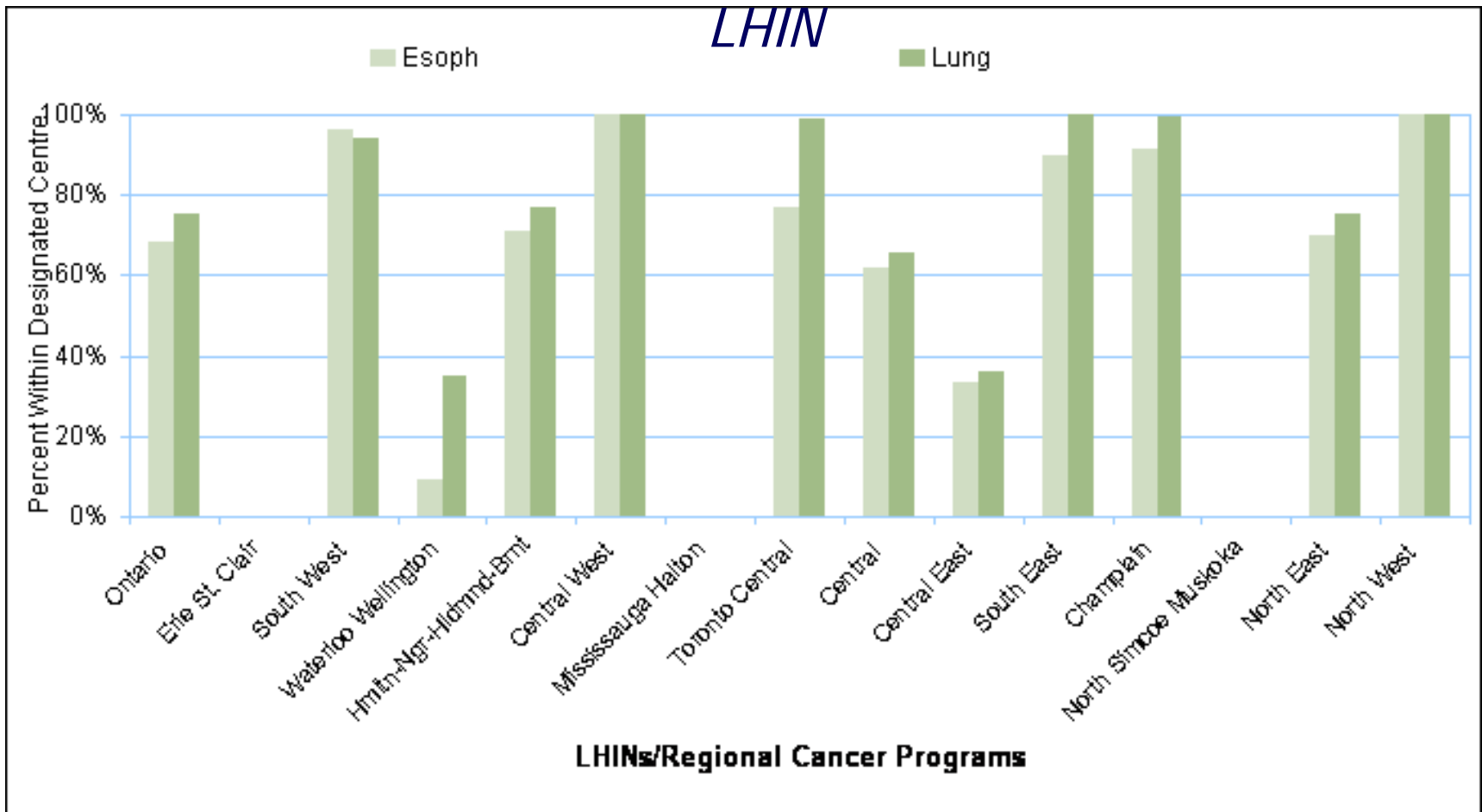
Completed by October, 2009

5. Realign SON committees to be more goal oriented and support the strategic plan
6. Implement QI projects in Hepatobiliary, Thoracic and Prostate
7. Improve communication with community surgeons including Telehealth consultation with surgical subspecialties.
8. Develop strategy for multidiscipline cancer teams.

Implementation of the Thoracic Surgery Standards

- *5 centers meet Level I volume requirements*
 - UHN, TOH, LHSC, SJH (Hamilton), Southlake*
- *7 centers have been designated as Level I centers but do not meet the volume requirements*
 - SMH, CV, William Osler, SJH (Toronto), TEGH, Lakeridge, Sudbury*
- *2 centers have been designated as Level II centers*
 - Thunder Bay, Kingston*
- *1 LHIN undesignated (Erie St Clair)*
- *1 LHIN (N Simcoe-Muskoka)-not doing TS*

Percent of thoracic (lung and esophageal) surgery patients treated in designated thoracic surgery centres, 2006/7, by



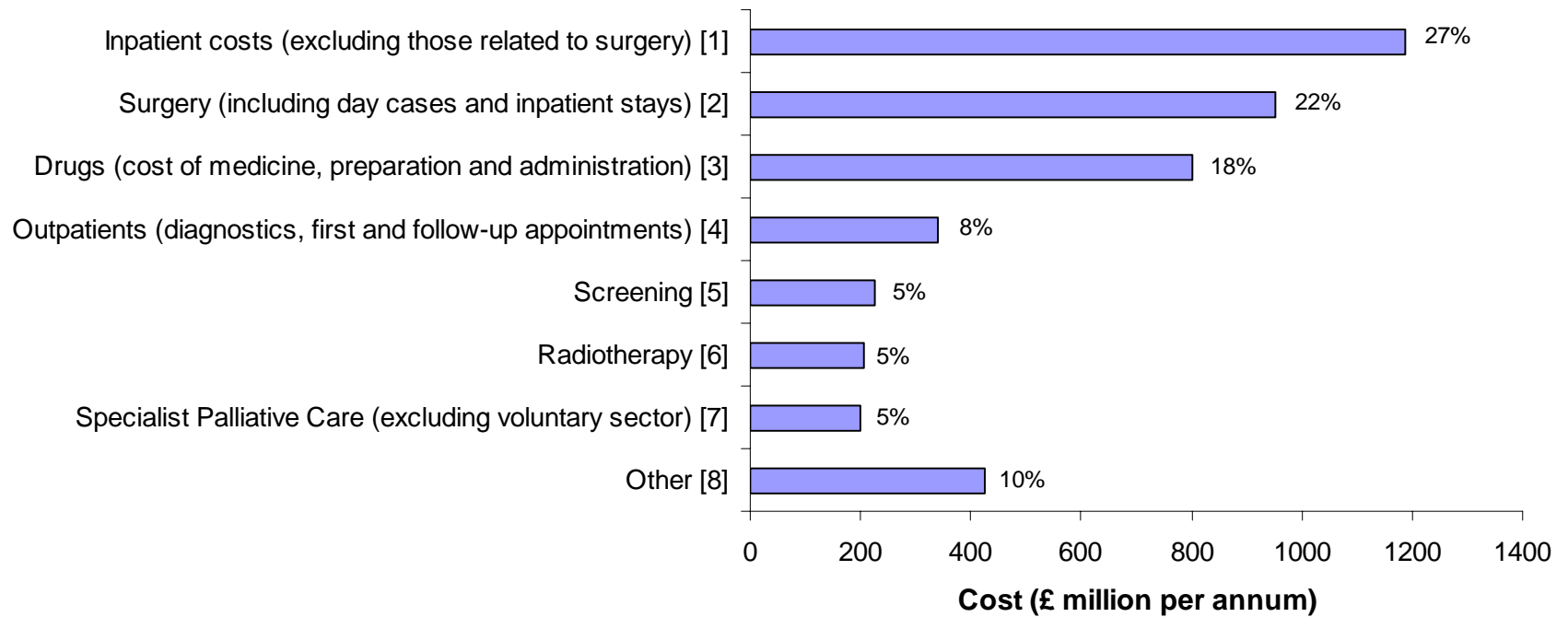
Source: Source – CIHI, Discharge Abstract Database, November, 2007

Note: Designated Centre is identified by the Regional Cancer Program as a centre that will move to achieving full compliance with Thoracic Surgical Oncology Standards for a level 1 centre (level 2 centre in the cases of Kingston and Thunder Bay only)

Thoracic Surgery-Quality Improvement Initiatives

- *Mediastinoscopy Guideline*
 - *scheduled to begin in winter of 2009*
 - *Gail Darling chosen as the lead*
 - *Preliminary questions have been drafted*
 - *To ascertain current practices, a survey will be distributed to the Thoracic CoP at the end of October*
- *Develop thoracic surgery indicators*

Estimated total NHS spend on cancer care 2006

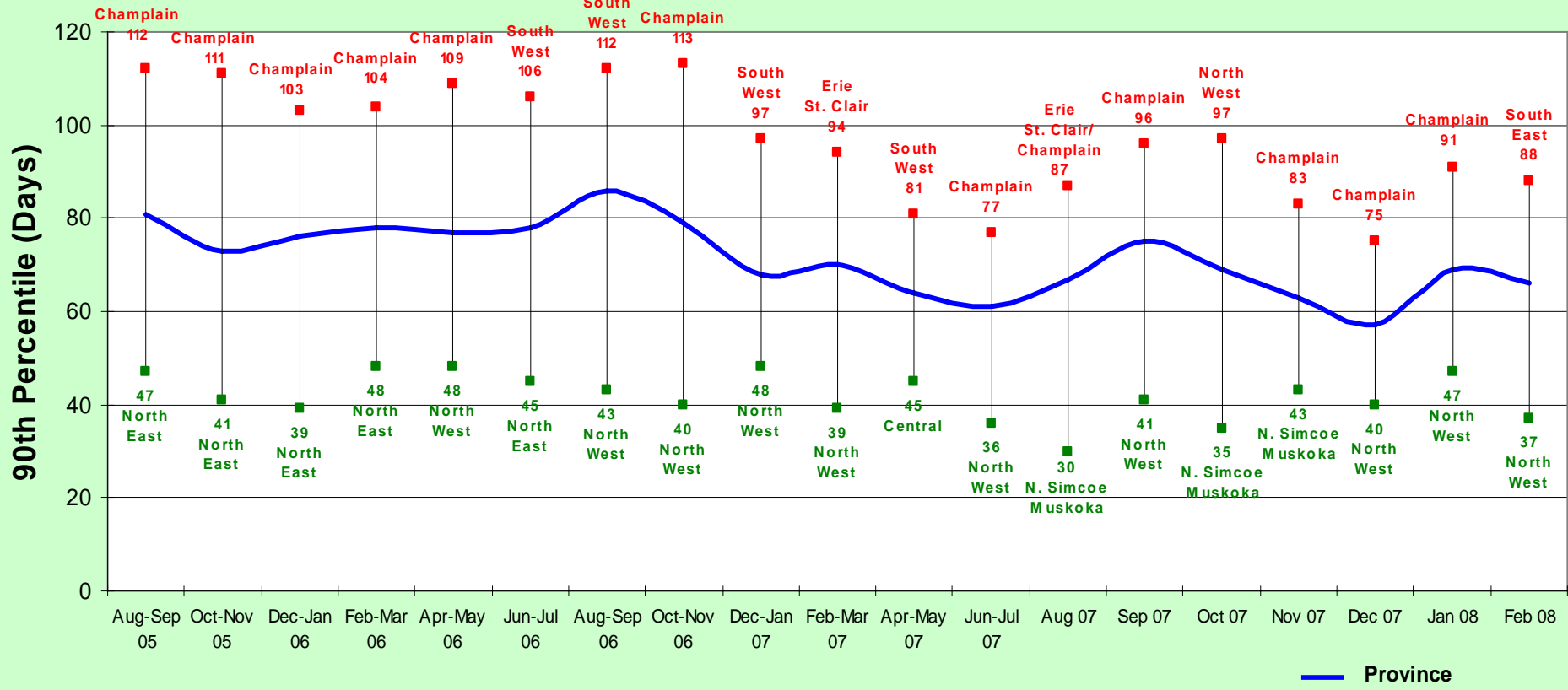


- **Figure 5: The expanding cancer workforce**
- **Headcount Projected**
- **Percentage percentage**
- **increase Projected increase**
- **2000 2006 2000-2006 2012 2006-12**
- **Consultants in Selected Specialties 9,681 13,137 36 17,852 36**
- **with a Major Role in Cancer Care**
- – General Surgery 1,331 1,756 32 2,387 36
- – Urology 382 510 34 700 37
- – Anaesthetics (inc. intensive care) 3,322 4,698 41 6,464 38
- – Respiratory medicine 439 583 33 815 40
- – Gastroenterology 481 639 33 985 54
- – Clinical Radiology 1,585 2,061 30 2,320 13
- – Histopathology 865 1,087 26 1,611 48
- – Clinical Oncology 307 482 57 636 32
- – Medical Oncology 133 233 75 395 70
- – Palliative Medicine 111 185 67 402 117
- – Haematology 527 663 26 804 21
- – Cardiothoracic Surgery 198 240 21 333 39
- **All radiographers 12,489 14,564 17 17,585 21**
- – Diagnostic Radiographers 11,036 12,535 14 14,605 17
- – Therapeutic Radiographers 1,453 2,029 40 2,980 47

Cancer Care Ontario(CCO)

- Provincial Leadership Council
- The Provincial Leadership Council provides advice on planning and coordinating cancer services in Ontario. The Council also reviews the performance of Ontario's cancer system, and provides advice on how to continually improve cancer services. Council members are CCO's regional vice presidents from across the province.

Cancer Surgery 90th Percentile Wait Times - LHIN variation



Province