ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

Patron: H.R.H. The Prince of Wales

Queensland State Committee

6 December 2013

Dr Lizbeth Kenny
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Policy and Planning Branch
System Policy and Performance Division
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RE: Proposed cancer services state-wide health service strategy 2013

Dear Liz

Thank you for including the Queensland State Committee of the Royal Australasian College of Surgeons in your consultations regarding the state-wide cancer service strategy. We wish to commend you and your committee on the document which was discussed at the Queensland Regional Committee meeting of 6 November 2013.

The document is very comprehensive with important objectives and service directives. The Statewide Cancer Clinical Network and the Department of Health are to be congratulated. Our response relates specifically to the role of surgery in the planning and implementation of the broad policies outlined relating to Cancer management in Queensland.

Surgeons are commonly the first site of referral for solid organ cancers and for this group of patients they are likely to provide the definitive treatment as well. It is not clear from the document that that is the case. This will be because cancer treatment is a component of the case mix of most surgeons rather than their only focus. There are numerous references to "surgical oncologists" in the document. We understand why, but for those who are not medical who read this proposal may become confused with this terminology believing this is a co-ordinated group similar to medical and radiation oncology.

The labels Medical Oncology and Radiation Oncology are accepted and are well defined entities. Their workload is focussed on cancer treatments and can be well defined and in most cases reasonably straightforward to measure. There are defined clinics and centres in which these specialists work which are located in metropolitan and some regional centres. However, as you know, there is no specific surgical entity called a "Surgical Oncologist". Some surgeons may have trained in Cancer Centres and will call themselves "Surgical Oncologist" but the numbers are very small and this group will focus in one or two cancer streams and they will work in large metropolitan hospitals. The majority of the cancer surgery in regional areas and will be performed by general surgeons, or other subspecialty surgeons where the management of a particular type of cancer is part of their general training.

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Patients will be seen in the relevant specialty outpatients along with the case mix of benign conditions. Thus there are potential cases that will not be documented with the systems you have available at this time. You have tried to address the issue of cancer surgery in Queensland on page 26 but it does not measure the other aspects of the workload prior to an operation or those patients that may not have an operation. As well, not all cancer surgery patients need to see an oncologist (medical or radiation) or need to attend an MDT, so there is a patient group that will not be found in normal databases. As well it would be impossible to assess the issues of "evidence based care" and other outcomes that are seen to be important.

Our Committee supports the need for there to be a greater push to enable surgical cancer data, to be gathered and utilised for inclusion in health service strategy documents similar to this document. This is important when assessing services in rural, regional and metropolitan Queensland. Information systems are listed on page 6 of the document as one of a number of service directions. However we would like to be reassured that the cancer management / surgery performed by surgeons of all specialties will be captured as this will have important implications with respect to a number of the service directions outlined in the document. You state that the "Department of Health will monitor and evaluate progress towards achievement of service directions outlined in the strategy". With cancer surgery being so fragmented between surgical specialties and within each surgical speciality, it is difficult to accept this will capture the true workload of surgeons managing cancer.

One way to assist would be to provide assistance to centres for formal database support for documentation of cancer patients seen in hospitals and surgical units. With the recommendations that have been made in your document there are extra implications with respect to appropriate surgical and nursing staffing, development of formal networks (surgical), timely access to investigations and care, along with the issues of referrals between HHS for management that cannot be provided in a regional / rural centre.

In the Service Direction focussed on Networks (2), it is stated there will be formal links between services. At times these will need to cross HHS boundaries. You have outlined Adult Cancer Services on page 23 which implies strong links between various regional and rural units and three public cancer centres in Queensland. It is not stated clearly but it is presumed that this linkage relates to the co-ordination of medical and radiation oncology. As far as we are aware there are no formal linkages between surgery units in the State. In the present form the document maybe taken to imply that this includes surgical services but this is not correct. It needs to be made clear in the document that there are very few, if any, formal surgical linkages. However by specifying this is a deficiency it may lead to something being done. Thus with the more formal recommendation that this should happen; one would hope it would be financially supported at an appropriate level by the Government just as they have done when they have created the cancer centres / units.

We commend the principle for better networking but would be interested in how your group see this being developed in managing the Surgery for Cancer.

With respect to the resource implications the trend has been for the resources to go to creating Cancer Centres and providing medical and radiation oncology services, all of which has been appropriate. This appears to have been done without a vision of how the surgical services will fit into the model and how these services can be better co-ordinated and supported at the local regional level though to the larger metropolitan units.

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The RACS, Queensland State committee supports the principles of the document and wish you success in the implementation of the recommendations and actions.

Yours sincerely

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