Doncaster and Bassetlaw Hospitals NHS
NHS Foundation Trust

Cancer Improving Outcomes Guidance (IOGs)

Proposals Relating to Gynaecology

Summary

The proposed centralisation of complex gynaecology cancer in Sheffield will result in changes to how this Trust provides gynaecology services to local women. This paper sets out the implications that will result from this proposal from NORCOM and the North Trent Cancer Network in response to the Improving Outcomes Guidance in gynaecological cancers.

The loss of local access for local women, loss of activity associated with ovarian and some endometrial cancer, the necessary and resulting changes to clinical and operational practice and the loss of income are all important factors.

This paper sets out the detail of these factors and proposes a response to the limited consultation that seeks to ensure guarantees about the current level of service.

The Board of Directors is asked to:

- Receive and note the contents of this paper.
- Agree the draft consultation response to NORCOM.

Ian Greenwood
Director of Strategic and Service Development

July 2005

1 Introduction

The Board of Directors has been briefed previously on the North Trent Cancer Network and NORCOM led process to implement the Department of Health's Improving Outcomes Guidance (IOG) for cancer. This paper updates the Board of Directors on the progress to date within the specialty of gynaecology, sets out the proposals from NORCOM and the implications for women's services, and offers a framework on which this Trust should respond.

2 Proposals

NORCOM have chaired or hosted a series of discussions that have resulted in the proposals to centralise radical surgery at the Cancer Centre, with the aim of improving outcomes for women with gynaecological cancers. This is despite the Trust's continued opposition to the centralisation of these services. The Trust has been represented by a combination of Mr Alloub, Consultant in Obstetrics and Gynaecology, Dr Ramakrishnan, Cancer Lead Clinician, the Chief Executive and the Director of Strategic and Service Development.

Surgery for women with cervical, vulval and some endometrial cancer is already undertaken at the Cancer Centre in Sheffield.

The Action Plan that resulted from this process sets out the proposed future service model (Appendix A) as described by NORCOM. The implementation of the suggested service model would result in a number of significant changes for local women and for the Foundation Trust, which will have implications for service delivery, funding and working arrangements for staff.

The key changes would be:

- Surgery for women with suspected ovarian cancer [risk of malignancy Index > 250] will move to Sheffield (the proposed cancer centre for gynaecology).

- The unit will have a designated centre gynae-onco-surgeon who will participate in local joint clinics and attend local Multi Disciplinary Teams.

These are based on the following underlying principles:

- Equal priority is given to enhancing and sustaining local services, and centralising radical surgery.

- There will be a designated gynae-onco-surgical lead in each cancer unit.

- There will be stronger links between the local services and the centre service through either "outreach" or "inreach" activities.

The lead role will ensure there is a strong focus on and commitment to robust local diagnostic, assessment and follow-up services. This role will also facilitate continuity of patient care.

3 Implications

The Board of Directors recognises that Commissioners are required to procure services which meet national accreditation standards, such as those set out in the IOG, and which will be reviewed in March 2006, during the first cancer accreditation peer review visit to this Trust. In principle, the Board of Directors recognises that some elements of centralisation of services now appears inevitable, but the Board is seeking guarantees from NORCOM and the North Trent Cancer Network about the nature and extent of future services.

There are a number of implications of centralising radical gynaecological surgery at the Cancer Centre. This change, however, relates primarily to ovarian cancer as cervical and vulval cancers, as well as some endometrial cancers, are already treated at the centre. Some endometrial and ovarian cancers will essentially continue to be treated in the unit. However, low grade or early disease gynaecological cancer cases will be treated in the cancer unit by surgical intervention where indicated.

3.1 Clinical Implications

Women's Services has a number of issues relating to Consultant staffing caused by:

- The review of the Royal College of Obstetricians and Gynaecologists resulting recommendations.
- The current allocations of existing Consultant Pas.
- Shortfall at Bassetlaw DGH due to the locum post and Mr Alloub's cancer work.
- A number of Consultant retirements in the next few years.

The cancer unit at Doncaster Royal Infirmary has a successful history. Women are offered a local service, access times are low, clinical outcomes are good and the unit does very well against the peer review criteria. Nevertheless, NORCOM are proposing to centralise. An important factor in responding to these proposals is to ensure that the current level of service is improved. The consultation response needs to seek guarantees of many factors including dedicated and regular support from the centre, improving the current access times and improved clinical outcomes.

There are implications with the two Consultant Gynaecologists who currently undertake the cancer surgery and on our future ability to maintain high grade surgical skill.

3.2 Business Implications

The ovarian cancer cases which would be transferred to the Cancer Centre would be those with a risk of malignancy above an RMI score of 250. For Doncaster and Bassetlaw this is estimated by the Lead Gynae-onco-surgeon to be approximately 35-40 cases per annum. Taking the upper limit to calculate potential lost income and activity this equates to:

HRG	**2005/06**	**Potential lost income**
M08 – Upper Genital Tract Complex Major Procedures	£3,480	£139,200

Bed days: 208 per year

Theatre lists: 26 list per year

There is also the likelihood that part of this income gap will be met by the unit lead's four sessions working in Sheffield. Women's Services is in the process of working up a retraction business case in order to fully understand these implications and how these can be addressed. It is inevitable, however, that there will be loss of income associated with the loss of activity.

3.3 Implications on Patients and Consultation

The intention within these proposals from NORCOM is to ensure improvements. This Trust needs to seek guarantees about the current level of service with the local commissioners in Bassetlaw and Doncaster. There will be, however, a loss of local access for the surgical element of the women's pathway as this will be provided in Sheffield.

NORCOM and the PCTs are not currently planning to publicly consult on this service change.

4 Development of the Cancer Unit

The proposals produced by the Network explicitly state that there will be an emphasis on developing local services, while centralising radical surgery. There will also be a focus on creating much stronger links between the Unit and the Centre to support the new model. This is welcomed by the Foundation Trust and the Gynae-oncology Team. The aim will be to develop the service positively to achieve sustained and continuing improvements to patient care. The current service provided by the unit benefits from a highly experienced, skilled and committed Multidisciplinary Team, and existing well defined links with the Cancer Centre.

A Gynaecological Oncology Clinical Nurse Specialist has recently been appointed, and her role will be crucial to the success of the new service model as she will be committed to the creation of a seamless patient pathway between Unit and Centre, alongside her medical colleagues. The Unit must also achieve the 31 day and 62 day targets for patients receiving treatment here and contribute to the achievement of those targets for patients transferred for treatment at the Centre. Work is ongoing to identify and address potential delays and bottlenecks in the system. Improved two way communication with the MDT at the Cancer Centre will be essential to ensure that this is achieved for all patients.

The Unit has extensive experience of working with the Cancer Centre. In line with IOGs, vulval cancers, cervical cancers and appropriate endometrial cancers are already transferred to the Centre for treatment. The Doncaster and Bassetlaw MDT core members attend the Centre MDT meetings on a regular basis, and discuss all confirmed cases there. At present, Doncaster and Bassetlaw is the only Unit in North Trent to do this. The Unit also benefits from weekly attendance by an Oncologist from the Centre at Doncaster Rapid Access Clinics, and his regular attendance at the local MDT. The Unit has also been involved in annual review meetings with the Centre to discuss the gynae-oncology service, and the Unit has presented comprehensive outcome data at these meetings.

In adopting the proposed future service model put forward by the Network, the Trust will plan to:

a) Comply with IOGs as required by national guidance and the National Cancer Action Team.

b) Build on existing good practice by seeking sustained and continuing improvements to patient care.

c) Strengthen existing links with the Centre through the Lead Gynae-onco-surgeon working at the Centre, and having a designated visiting Centre Gynae-onco-surgeon; also through MDT attendance at both Unit and Centre, and through nurse specialist links.

d) Achieve 31 day and 62 day targets at the Unit and contribute to achievement at the Centre.

e) Minimise the loss of activity from the Unit by appropriate scoring of cases against the Risk Malignancy Index.

f) Make cost savings where possible to offset the loss of income.

g) Explore the possibilities for reuse of capacity to offset the loss of income e.g. other elements of gynaecology.

5. Conclusion

The proposal to centralise radical cancer surgery for gynaecology in Sheffield is clearly described here. This paper has set out the issues and implications that will arise as a result of this change in service delivery that cause some difficulties. However, the immediate future needs to concentrate on:

- Responding to the request for consultation from NORCOM.
- Ensuring that the financial and business implications are minimised.
- Supporting Women's Services to ensure a positive and robust cancer unit service.
- Consult with those individual members of staff once the decision has been made.

The Trust remains committed to provide a rapid and effective gynaecology cancer service for local women, working as closely as possible with the Sheffield Centre, but we are determined to ensure that the consequences of the implementation of national policies such as the Improving Outcomes Guidance for cancer services are fully understood and worked though at all levels in the Heath Service.

6. Recommendations

The Board of Directors is asked to:

- Receive and note the contents of this paper.

- Agree the draft consultation response to NORCOM

Ian Greenwood
Director of Strategic and Service Development

July 2005

APPENDIX A
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NORTH TRENT CANCER NETWORK
GYNAE-ONCOLOGY

POSSIBLE FUTURE SERVICE MODEL

1 Underpinning Principles

a) Equal priority is given to enhancing and sustaining local services, and centralising radical surgery.

b) There will be a designated gynae-oncologist lead in each cancer unit.

The lead role will ensure there is a strong focus on and commitment to robust local diagnostic, assessment and follow-up services. This role will also facilitate continuity of patient care.

c) There will be stronger links between the local services and the centre service through either "outreach" or "inreach" activities.

2 Working Assumptions

a) MDTs will continue to be held locally.

b) There will be a specialist MDT meeting in the centre held weekly.

c) All the designated unit gynae-oncologists will be able to participate in the specialist MDT to discuss specific cases.

(N.B. Not core members. This could be by videoconferencing).

d) Each unit will have a designated centre clinician who will visit on a regular basis.

e) The visiting centre clinician will participate in local joint clinics with the local gynae-oncology lead and the visiting oncologist.

f) The visiting centre clinician and the visiting oncologist will also participate in local MDTs (could be held just before the joint clinic).

g) During the time on site locally the visiting centre clinician will respond to ward referrals.

h) During the time on site locally the visiting oncologist will initiate/review chemotherapy.

N.B. The frequency and timing of visits will need to ensure cancer waiting time standards are met.

3 Centre/Unit Activities

All the activities below are described and defined in detail in the North Trent Gynae-Oncology Group clinical guidelines.

	Centre	Unit
a)	<u>Vulval Cancer</u>	
	• Pathology of <u>all</u> cases reviewed • Radical surgery • Chemotherapy (rare) • Radiotherapy	• Investigations i.e. biopsy • Treatment of very early disease i.e. surgery • Follow up
b)	<u>Cervical Cancer</u>	
	• Pathology of <u>all</u> cases reviewed • Radical surgery • Chemotherapy • Radiotherapy	• Investigations i.e. biopsy, MRI • Treatment of early disease i.e. surgery • Follow up
c)	<u>Ovarian Cancer</u>	
	• Pathology of <u>all</u> unusual tumours reviewed • Treatment of all young patients with suspected malignancy i.e. surgery • Treatment of all cases with an RMI* greater than 250 i.e. surgery • Chemotherapy (local where possible, regimen specific)	• Investigations i.e. ultrasound tumour markers • Calculation of RMI* • Treatment of cases with an RMI* of less than 250 i.e. surgery • Follow up N.B. All locally treated patients with a definitive diagnosis need to be reviewed by the specialist MDT.
d)	<u>Endometrial Cancer</u>	
	• Treatment of grade 3 tumours and unusual cases i.e. surgery	• Investigations i.e. ultrasound biopsy hysteroscopy • Treatment of grade 1 and 2 tumours i.e. surgery • Follow up (a few exceptions)

* RMI = Risk of Malignancy Index.

This is the index of probability or possibility of malignancy calculated from the results of investigations. This approach/methodology is included in the Royal College guidelines.