NORTH TRENT CANCER NETWORK BOARD

Gynaecological Cancers - Improving Outcomes Guidance

1. Introduction

The North Trent Cancer Network originally submitted its action plan for meeting the Improving Outcomes Guidance in 1999/2000. This plan outlined the centralisation of all radical treatment in Sheffield with the exception of radical surgery for ovarian and endometrial cancers for Doncaster patients which would continue to be provided in Doncaster. A single specialist MDT would meet on a fortnightly basis in Sheffield and include clinicians from Doncaster. Clear guidelines and referral criteria were drawn up to ensure the appropriate flow of patients. Regular assessment of the arrangements by the Network proved to be satisfactory.

However at a meeting with the Director of the Cancer Action Team in September 2004 concerns were raised about the longer term sustainability of the plan. The main concerns related to sub-specialty specialised training; future recruitment of consultant staff with the appropriate sub specialty training; single handed consultants; and effective cross cover arrangements (rotas, EWTD etc). In this context the Network undertook to review the plan and submit a revised plan to the Cancer Action Team as soon as possible.

2. Process

Over the last year there have been a number of discussions about gynae-oncology services across the Network, involving both managers and clinicians.

There has also been consultation with all health communities on the proposed new service model. Responses were received from both PCTs and Trusts.

A draft proposed service model and the consultation responses were received by NORCOM at the meeting on 12 August. The service model was endorsed and it was agreed that a revised plan be submitted to the Cancer Action Team. It was agreed to establish an Implementation Group which would also address a number of operational issues identified during the consultation process.

3. Current Arrangements

The Guidance states that “women with gynaecological cancers which are less common or more difficult to treat ie ovarian cancers, later stage endometrial cancers, cancers of the cervix, vulva or vagina, should be managed by a specialist multiprofessional gynaecological oncology team based at the Cancer Centre”.

The gynaecology cancer services provided for Rotherham, Barnsley and North Derbyshire residents already comply with the centre/unit split outlined in the Guidance. There are however issues about: whether or not patients are travelling into Sheffield for follow up care which could be provided locally; links between the centre and units particularly in Rotherham, Barnsley and Chesterfield; and the overall continuity of care.

With regard to Doncaster and Bassetlaw patients, as previously stated, the Doncaster and Bassetlaw Trust has continued to provide surgery for all ovarian and endometrial cancer cases locally. The surgery for the other specialised work, for Doncaster patients, has already transferred to Sheffield.

The Tumour Site Specific Group has produced guidelines which clearly state in more detail the criteria for referrals to the specialist centre. These guidelines are particularly important in respect of ovarian and endometrial cancers where the treatment of early disease and less advanced disease stays at the DGH and more advanced disease and high risk cases are referred to the centre.

4. New Service Model

The new service model is a single site, single centre model with all radical treatment provided in Sheffield.

It was also agreed during the discussions that the revised plan should not just address the issues relating to the centralisation of radical surgery but also look to enhance local services. It was felt to be important to look at the needs of the service across the whole care pathway. The model therefore contains clear statements about the future levels of service to be provided locally.

A description of the future service model is attached at Appendix A.

All 5 Trusts have expressed general support for the model. All Trusts have identified some operational issues which will be addressed in the implementation process.

5. Next Steps

The model outlined has service capacity and revenue implications.

There will be a need for the Sheffield Teaching Hospitals Trust to :-

- Identify workforce implications
- Quantify service capacity implications (beds, theatres, critical care)

The outcome of this work will be considered by commissioners in the context of the Payment by Results financial regime.

Barnsley, Chesterfield, Doncaster and Rotherham will also be identifying any gaps between the current arrangements and the future service model.

The aim is to achieve the new specialist MDT arrangements and the transfer of activity from Doncaster to Sheffield by September 2006.

An Implementation Group will be established in October/November 2005 to co-ordinate the necessary actions to achieve a successful implementation.

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5 October 2005

APPENDIX A

NORTH TRENT CANCER NETWORK
GYNAE-ONCOLOGY

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-onco-surgical 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-onco-surgeons will be able to participate in the centre MDT to discuss specific cases.

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

d) Each unit will have a designated centre gynae-onco-surgeon who will visit on a regular basis.

e) The visiting centre surgeon will participate in local joint clinics with the local gynae-onco-surgical lead and the visiting oncologist.

f) The visiting centre surgeon 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 surgeon 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 <u>N.B. All locally treated patients with a definitive diagnosis need to be reviewed by the specialist MDT.</u>
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.

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