Executive Summary

Proposal for the Implementation of Gynaecological Improving Outcomes Guidance

Purpose of the paper:

To inform the committee of the proposal to change hospital site for specialist gynaecological cancer surgery from Shrewsbury and Telford NHS Hospital (SaTH) to a nationally compliant hospital; University Hospital of North Staffordshire (UHNS) or Royal Wolverhampton Hospital (RWH). Initial referral, diagnosis, chemotherapy, radiotherapy and follow up will remain at SaTH.

Background:

In 1999 the NHS Improving Outcomes Guidance (IOG) for gynaecological cancers was published by the Department of Health.

The evidence and guidance suggests that centralising expertise and resources for complex surgery can improve long term outcomes and survival rates for women with advanced, rare and complex gynaecological cancers and it is the only way to ensure compliance with the widely acknowledged best practice contained in the IOG. Implementing the proposed model of care outlined in this document will help us reach our aspiration to match the highest survival rates and best standards of care in Europe.

The change would affect approximately 50 women per year.

Benefits

The main benefits of the proposals detailed in this paper are as follows:-

Improving patient outcomes for local women

The services currently offered are good, but the aspiration is to offer even better services. Over time the aim is to match the very best standards in Europe. The scientific and professional evidence shows that centralising the most specialist surgery is higher volume centres can improve outcomes, including long term survival, and post operative mortality.

Supporting clinicians in cancer research and development

Creating a centre of excellence for the treatment of complex gynaecological cancers provides an important pool of patient data for randomised controlled trials. In time the proposed changes will help ensure that local patients can access the most innovative treatments that have previously only been offered in larger, more specialist hospitals.

Supporting ongoing learning and development

The model of care will allow out surgeons, clinical oncologists, specialist nurses and other clinicians to 'sub-specialise' developing greater experience and expertise in the treatment of gynaecological cancer.

A simpler, clearer structure for multi-disciplinary team working

Research has shown that effective multi-disciplinary team working is a crucial factor in improving the quality of cancer services. The proposed model of care outlines a clear division of the roles and responsibilities which will help clinicians manage every patient's care to the same high standards

More robust staffing arrangements

Staffing rotas for surgical lists is a complex process. The larger surgical team based in the specialist centres will be more resilient to these challenges because if one surgeon becomes unavailable, there are two others who may be able to cover.

Compliance with IOG clinical best practice guidance on specialist services

Centralising expertise and resources for complex gynaecological surgery in the two specialist centres is the best option to achieve compliance with the IOG. The national evidence is that this is the best way to improve long terms outcomes and survival rates for women with advanced, rare and complex gynaecological cancers.

Compliance with national policy and clinical best practice guidance on care closer to home

The proposed model of care ensures that localised care is available for patients who do not need centre level care and for those who have already been treated at the Centres; SaTH will continue to deliver a substantial service to meet the diagnostic, routine care and follow-up for the women affected by these proposals close to their own homes.

Timeframes

It is anticipated that specialist gynaecological cancer surgery could be transferred by March 2011 at the latest

NHS

Greater Midlands Cancer Network

Proposal for the Implementation of Gynaecological Improving Outcomes Guidance

Final Version September 2010

INTRODUCTION

1. In 1999 the NHS Improving Outcomes Guidance (IOG) for gynaecological cancers was published by the Department of Health. The IOG is designed to ensure the very best outcomes for women with gynaecological cancers and sets out the recommendations for the provision of specialist services for the diagnosis and treatments of such cancers.

2. The guidance specifically emphasises the benefits of ensuring that clinicians work multi-disciplinary teams that deal with large enough caseloads to deliver high quality services and the centralisation of the most complex gynaecological cancer surgery in specialist centres.

3. The IOG standards for centralisation cover specialist treatments only. Diagnostics, surgery for less complex cancers, chemotherapy, radiotherapy and palliative care should continue to be provided locally.

4. In 2004 the National Cancer Action Team called for action plans from all Cancer Networks setting out plans for delivering IOG compliant services. This included compliance with the gynaecological cancer IOG.

5. It is also important to note that this paper is set in the context of a report published earlier (December 2009) by the Cancer Czar, Professor Mike Richards. The report 'Professor Richards' second annual report for the Cancer Reform Strategy' revealed significant differences in one-year cancer survival rates depending on where patients live. Professor Richard's report emphasises the importance that both he and the Department of health attach to the IOG as a mechanism for improving outcomes.

6. In 2004 Shrewsbury and Telford (SaTH) submitted plans with University Hospital of North Staffordshire (UHNS) as part of the North West Midlands Cancer Network . This suggested a two site model with specialist surgery being performed at both UHNS and SaTH. The plans were deemed non IOG complaint by the Cancer Action Team. Royal Wolverhampton Hospital (RWH) as then part of the Black Country Cancer Network submitted plans for a single site based at New Cross Hospital, Wolverhampton. These plans were accepted by the Cancer Action Team.

7. On the 1st April 2006 The North West Midlands and the Black Country Cancer Networks merged to form the Greater Midlands Cancer Network (GMCN).

8. Serving a population of around 2 million the Network could at most support the two specialist surgical centres for Gynaecological cancer surgery.

9. In 2009 the GMCN commissioned a review of the specialist surgical services for Gynaecology, Head and Neck, Upper GI and Urological cancers Led by Professor Mike Lind, Professor of Medical Oncology at the University of Hull and Medical Oncologist (Hull, England).

10. This review resulted in the GMCN agreeing that the best option for gynaecological cancer services was centralisation of specialist surgery on two sites RWH and UHNS.

11. This conclusion is not based on the desire to comply with government guidance simply for the sake of it, but on the research evidence that the establishment high volume centres for specialist gynaecological cancer surgery is best clinical practice.

12. It is also the strongly held view of the GMCN, local PCTs and local clinicians that the centralisation of these specialist services will:

- Ensure we keep pace with national standards of best practice
- Ensure that services are sustainable well into the future
- Help local clinicians contribute to cancer research and treatment development
- Have a positive impact on the continuous professional development of doctors and nurses and help us to attract the brightest and best clinical trainees
- Facilitate better multi-disciplinary team working and better use of resources
- Over time it is anticipated that this improvement would help save more lives and offer faster recovery rates for local women

13. The proposed change to services will mean that around 50 women each year from SaTH will receive complex surgery in RWH or UHNS instead of SaTH. All diagnostics for cancer and aftercare will take place in SaTH as at present ensuring that routine and follow-up care is provided as close as possible to patients' homes. In a typical case the changes will affect a patient for approximately one week over a five year treatment programme.

Complex surgery – the current service model

14. Treatment for gynaecological cancer usually involves some combination of surgery, radiotherapy and chemotherapy and the care pathway – including follow up – is typically five years. Chemotherapy and radiotherapy require frequent trips to hospital and surgery usually requires one hospital stay of around five days, which could be reduced further with the development of laparoscopic techniques in higher volume centres.

15. Treatment can be separated into surgery for more straightforward and common gynaecological cancers, and complex surgery for more advanced, rarer and complex gynaecological cancers. The RWHT and UHNS currently provide surgery for virtually all gynaecological cancers led by Royal College Obstetric and Gynaecology subspecialist trained Gynae-oncologists at each site. SaTH provides services for some complex cases but not all and does not have a subspecialist trained Gynae-oncologist.

16. The SaTH service operates with a catchment population of around half a million. The IOG recommended catchment population is 1 million. It also operates without the two Gynae-oncology subspecialists recommended. It is led by a single committed consultant Gynaecological surgeon.

17. The service at UHNS operates with a catchment of slightly less than 1 million. UHNS presently supports the Multi-disciplinary team (MDT's)* at SaTH and Mid Staffordshire General Hospital. RWH Hospital similarly has a catchment of slightly less than 1 million and supports the MDTs at Kidderminster and Dudley Group of Hospitals.

* The MDT brings together people who are experts in different areas of medicine and care, and usually meet every week to discuss the diagnosis, treatment and care of individual patients with cancer.

18. All services are run by excellent professionals, achieve good outcomes and well supported by patients and the public. However all are at risk because of non compliance and the current arrangement is not sustainable in the long term.

19. The evidence suggests that centralising expertise and resources for complex surgery can improve long term outcomes and survival rates for women with advanced, rare and complex gynaecological cancers and it is the only way to ensure compliance with the widely acknowledged best practice contained in the IOG. Implementing the proposed model of care outlined in this document will help us reach our aspiration to match the highest survival rates and best standards of care in Europe.

THE PROPOSAL

20. Proposal to become IOG compliance

- Develop two IOG compliance centres for gynaecological cancers at UHNS & RWHT
- Keep less specialist gynaecological cancer surgery at SaTH
- Keep all other services (including initial assessment, outpatients, diagnostics, chemotherapy, radiotherapy and aftercare) as close as possible to where patients live

21. These proposals are subject to a number of conditions including the following:-

- There will be systems in place to ensure seamless transfer of care and information between hospital sites (medical and nursing) with clear demarcation of responsibility at different stages of the patient's pathway.
- The MDT at SaTH will maintain the primary position in planning the patient's pathway.
- The MDT at SaTH will be strengthened by the attendance of a subspecialist Gynae-oncologist surgeon from both UHNS and RWH.
- An outpatient clinic will be established at SaTH staffed by the subspecialist Gynae-oncologist and the local SaTH team to enable follow up close to home.
- Surgical and pre-operative assessment clinics will be established at Stoke and Wolverhampton to reduce as much as is possible patient travelling prior to the surgery.
- UHNS, RWHT and SaTH will ensure that appropriate formal contractual arrangements are made for the visiting Gynae oncologists.
- UHNS & RWHT will collect and provide outcome data for the commissioners and these will be monitored over the short and long term to ensure continuous service improvement

22. This service model proposed has been developed by local clinicians. It has taken into account national guidance and local circumstances and the recommendations of the Lind Report, which included Network User representatives (GMCN Patient Partnership Group, Local health economy Cancer user groups in: Wolverhampton, Dudley, Worcester, Shropshire, North Staffordshire, Stafford)

23. The proposed model of care involves developing two specialist gynaecological cancer centres at UHNS and RWH. These centres will work closely with the gynaecological cancer surgical unit at SaTH.

24. The specialist gynaecology cancer centres will:

- Perform surgery and some brachytherapy (internal radiotherapy) on intermediate and higher risk cervical cancer cases (approximately 90 percent of cases)
- Treat surgically higher risk endometrial cancer cases (approximately 20 percent of cases)
- Treat surgically when appropriate ovarian, vulval and vaginal cancers

25. The gynaecological cancer surgical unit at SaTH will:-

- Treat surgically lower risk cervical cancers (approximately 10 percent of cases)
- Treat surgically lower risk endometrial cancers (approximately 80 percent of cases)
- Manage the long term care of all gynaecological cancer patients in its catchment area
- Deliver the Chemotherapy and Radiotherapy treatment for all gynaecological cancer patients locally

26. This model of care will provide people living in the SaTH catchment with a service which fully complies with national clinical best practice guidance.

PATIENT IMPACT

27. SaTH treated 150 patients with gynaecological cancer (April 09-March 10) of these 113 underwent surgery. Approximately 50% of these women will require surgery for less complex cancers (unit level surgery) and approximately 50% will require more specialist surgery (centre level surgery).

28. Under these new proposals patients with suspected gynaecological cancer will continue to be referred to their local hospital for assessment and diagnosis as is currently the case. If specialist surgery is recommended by the SaTH MDT (attended by the gynae oncology surgeon from UHNS/RWH), then a referred would be made to a compliant centre (UHNS, RWH) the choice of hospital would be made the patient

29. This means that each year approximately 50 women who would have been treated in SaTH will now travel for specialist surgery in UHNS or RWH. The remainder of their care including assessment, diagnostics, chemotherapy, radiotherapy and follow up appointments will take place in SaTH thus ensuring that all treatment – with the possible exception of the specialist operation itself - is available as close to home as possible.

30. An average hospital stay for gynaecological cancer surgery is around five days. The proposed changes will therefore affect patients for less than one week over a typical five year treatment programme.

Impact on other services

31. The proposals contained in this document focus exclusively on specialist surgery for gynaecological cancer. They do not impact on any other aspects of gynaecological surgery or gynaecological cancer services provided at SaTH.

32. When services are moved from one hospital to another it is natural for people to question whether that decision somehow marks the start of a wider migration of services.

33. In this case the issues that triggered these proposed changes are only relevant to a specific number of patients and have no implications for other services.

34. As part of this review Professor Lind met with user representatives (as specified in section 22). Key issues raised include service access, travel times and the impact on services in the receiving hospitals; these issues are addressed later in this document. The users expressed a view that they are more than willing to travel for specialist services as long as they can i.e. seamless and delivered in a co-ordinated manner.

THE BENEFITS

35. The main benefits of the proposals detailed in this paper are as follows:-

Improving patient outcomes for local women

36. The services we are currently offering are good, but we aspire to offer even better services. Over time we aim to match the very best standards in Europe. The scientific and professional evidence shows that centralising the most specialist surgery is higher volume centres can improve outcomes, including long term survival, and post operative mortality.

Supporting clinicians in cancer research and development

37. Creating a centre of excellence for the treatment of complex gynaecological cancers provides an important pool of patient data for randomised controlled trials. In time the proposed changes will help ensure that local patients can access the most innovative treatments that have previously only been offered in larger, more specialist hospitals.

Offering an excellent training ground to attract the best doctors

38. As training for clinical specialities becomes more specialised, centres must prove they can offer access to a sufficient volume of patients to offer trainees a diverse and challenging learning experience. Current patient volumes in UHNS and RWH are not sufficient for us to be certain that both centres will be attractive to surgical trainees in an increasingly tough and competitive training environment.

Supporting ongoing learning and development

39. The model of care will allow out surgeons, clinical oncologists, specialist nurses and other clinicians to 'sub-specialise' developing greater experience and expertise in the treatment of gynaecological cancer.

A simpler, clearer structure for multi-disciplinary team working

40. Research has shown that effective multi-disciplinary team working is a crucial factor in improving the quality of cancer services. The proposed model of care outlines a clear division of the roles and responsibilities which will help clinicians manage every patient's care to the same high standards, with less duplication of effort, better record-keeping and closer monitoring.

More robust staffing arrangements

41. Staffing rotas for surgical lists is a complex process. The larger surgical team based in the specialist centres will be more resilient to these challenges because if one surgeon becomes unavailable, there are two others who may be able to cover.

Compliance with IOG clinical best practice guidance on specialist services

42. Centralising expertise and resources for complex gynaecological surgery in the two specialist centres is the best option to achieve compliance with the IOG. The national evidence is that this is the best way to improve long terms outcomes and survival rates for women with advanced, rare and complex gynaecological cancers.

Compliance with national policy and clinical best practice guidance on care closer to home

43. The proposed model of care ensures that localised care is available for patients who do not need centre level care and for those who have already been treated at the Centres; SaTH will continue to deliver a substantial service to meet the diagnostic, routine care and follow-up for the women affected by these proposals close to their own homes.

THE EVIDENCE

44. There is a considerable body of clinical evidence that supports the proposals made in this document (Appendix 1).

45. While the report shows that cancer mortality rates are declining it also indicates that the NHS need to do more if it is to move closer to the best survival rates to be found elsewhere in Europe.

The clinical evidence

46. It is in the nature of clinical evidence that it is often contested by different clinicians. It is by testing the evidence for different approaches that medicine advances. But when a consensus begins to emerge it is important that it be recognised.

47. The IOG for gynaecological cancers, published in 1999 was based on a review of the evidence called "Management of gynaecological cancers". The review and the proposed model of care was endorsed by an advisory group of national experts. The review concluded, among other things, that long term outcomes for this group of cancers were better in centres treating higher volumes of patients. This policy direction has been confirmed in the latest version of the Manual for Cancer's Peer Review Standards which was again endorsed by a national expert group on the basis of their experience and their understanding of the evidence.

48. Two outcomes of care in particular have been studied in relation to the size of a cancer service:

- Longer term survival after diagnosis (from 2 to 5 years) and
- Complications around the time of operation

49. Improved outcomes have been repeatedly shown for various cancers in higher volume centres in several countries. In most cases this research is done by comparing outcome in low and high volume hospitals. Most studies of gynaecological cancers have also found better outcomes in higher volume centres. For a list of the key policy documents and peer reviewed clinical papers please see appendix 1.

50. Clinical experts have tried to determine why outcomes are better in higher volume hospitals and the reason seems to involve greater sub-specialisation among surgeons and other clinicians in higher volume units. This enables them to develop

greater expertise with uncommon procedures and fine innovative ways of treating their patients.

51. The research leads to a number of clear conclusions:-

- There is a positive relationship between better outcomes for women with gynaecological cancers and larger treatment centres
- The change for surgeons to develop greater expertise in specific surgical procedures appears to be at the heart of this relationship
- The benefit arising from treatment in a large centre is greatest for patients needing highly skilled, largely surgical treatment. But the less intensive aspects of care – including follow-up care – can still best be delivered effectively in local settings

Developing the service model

52. In addition to examining the scientific evidence concerning the centralisation of specialist gynaecological cancer services we have also conducted an options review designed to explore alternative solutions. This review was conducted in three stages:

Stage 1 – Developing the service model

53. The service model was developed by local clinicians and service user representatives taking into account the specification set out in the IOG and more recent clinical developments, and the Lind Review.

Stage 2 – Confirming the service model

54. The Network Board took the view that it would be preferable to exclude any model of care that would not be seen by the Cancer Action Team as sustainable, deliverable or compliant

Stage 3 – Appraising the service model

55. The Network Board and IOG Steering Group fully support the recommendations of the Lind review for the development of two specialist surgical centres for gynaecological malignancies at UHNS and RWH.

56. Under the direction of the IOG Steering Group, a working group has been established, Chaired by the Gynaecological Network Site Specific Group Chair to ensure seamless plans and care pathways are developed in order that patient transfer and choice are at the heart of the service

CLINICAL SUPPORT

57. Local and national clinicians with wide ranging experience of specialist cancer care were closely involved in the development and assessment of the proposals described in this document including clinicians at UHNS, RWHT and SaTH clinical and lay members of GMCN gynaecological cancer site specialist group.

58. The development of the model of care has been clinician –led and has been subject to assessment and review by the Gynaecology NSSG and Patient User groups. The proposed model is viewed by those involved as the best solution to comply with the IOG

59. The proposed model of care is supported by clinicians at SaTH and the Medical Director at SaTH.

FINANCE

60. Specialist surgical services are paid for by the Primary Care Trust at a fixed national tariff, a set price for each procedure including the ward stay. Since the hospitals involved all the charge the tariff price, there will be minimal cost implications involved in the surgical aspect of these proposals.

    However, loss of income from 50 cases plus additional contracted out-patient work will not be recovered in any way by internal job plans and therefore an impact on SaTH's income.

61. Certainly these proposals are not designed to save money but rather to improve outcomes for patients and to ensure the longer term sustainability of the specialist gynaecological cancer service.

CONCLUSION

62. The GMCN Board believes that specialist gynaecological cancer services for the GMCN should be concentrated at UHNS and RWHT in order to ensure the best possible care and the best possible outcome for local women. Other key points that we urge the OSC to bear in mind when considering this paper include:

    - The concentration of specialist surgery in specialist centres would allow us to keep pace with national clinical guidelines designed to deliver best practice and best outcomes.
    - Concentrating specialist surgery will go hand – in hand with delivering routine care and follow-up care close to where patients live.
    - These proposals have been developed by local clinicians with patient representation.
    - The scientific/professional evidence supports proposals to concentrate complex cancer surgery in specialist centres.
    - These proposals are designed to ensure specialist gynaecological cancer services are safe and sustainable into the future. Our aspirations is to match the highest survival rates and best standards of gynaecological cancer care in Europe.
    - These proposals will affect about 50 women a year from SaTH

    These proposals are not driven by any sense of cost saving. The new proposed services may actually cost more money not less, it is expected that this is to be managed by SaTH, Primary Care Trusts and the tertiary centres.

IMPACT OF THE CHANGES – NEXT STEPS

63. The GMCN does not believe the proposed changes constitutes a substantial variation in local services based on numbers involved. They will affect 50 women a year from SaTH and involve a change in service location for just one week in a typical five year care pathway.

64. The pre-operative diagnostics and work-up and the follow-up care of all patients will continue at SaTH as will services for patients with other gynaecological cancers.

65. As the Lind review incorporated patient representation and have been involved in all stages of the process of commissioning and discussing the review, support the review recommendations the GMCN would wish to take advice from the OSC as to the extent of any further public consultation.

66. This programme would involve the dissemination of information about:-

- The service changes and new patient pathways
- Travel and access arrangements along with accommodation arrangements
- Who to contact for support and advice

67. Communication methods would include:-

- A series of meetings with the Health and Wellbeing Network, the local GP Forum and patient groups to ensure patients and carers understand the new care pathway and receive best advice
- Media initiatives and advertisements in local newspapers and online
- New patient information leaflets
- Leaflets and posters in outpatient departments and cancer information centres
- Information for all stakeholders available via the Acute Trust website.

68. The approach described above is informed by discussions with patient and public bodies and is supported by key stakeholders.

RECOMMENDATION

69. The Healthier Communities Overview and Scrutiny Panel are asked to consider the findings of this report. The panel is asked to support the recommendation that the proposed change does not constitute a substantial variation of service. The Panel is asked to support the suggested approach to further public communications and to comment on the details of the model.