Reconfiguration of Specialist Cancer Services in Greater Manchester and Cheshire

1. Background

Calman-Hine Report 1995

In 1995 the Calman-Hine Report set out a model for the delivery of cancer services across the country in which Cancer Units, treating commoner cancers would serve local populations, with cancer centres treating less common and complex cancers serving larger populations of about one million.

Calman-Hine reached this conclusion based on clear evidence of better outcomes for patients cared for by specialist teams, supported by appropriate infrastructure, in centres seeing the critical mass of cases required to maintain and build up expertise. It was clear that the organisation of services in the UK was an important contributory factor in the poorer survival rates for cancer in this country compared to those in Europe and other developed countries.

Cancer Plan

In September 2000, the Cancer Plan was published, setting out a ten-year strategy for the improvement of cancer services. The Cancer Plan signalled the intention to drive forward implementation of the Calman-Hine model of provision, as well as creating a more robust system of standards monitoring (via the cancer "Manual of Standards" and Peer Review process) and putting in place targets to reduce access times for cancer patients from referral to treatment. The plan acknowledged shortcomings in the infrastructure for cancer services, and also set out priorities for investment particularly in diagnostic equipment, radiotherapy and workforce development, and in preventive and screening services.

IOG Guidance

A set of guidelines, the *Improving Outcomes Guidance* (IOG), has been published laying down best practice in respect of the organisation of services for all major tumours. These include specific requirements on the types of patient and the types of cancer which should be treated at cancer units and at cancer centres. They also set out the volume of work which individual clinicians or teams should undertake in order to maintain the required skills and expertise.

2. Organisation of Cancer Services in Greater Manchester and Cheshire

Cancer Network

In Greater Manchester and Cheshire, in response to the Cancer Plan, the Cancer Network was established in 2001/02 in order to co-ordinate the planning and delivery of services, in line with the required model and to the required standards.

The population of the area experiences high levels of cancer, patients tend to present later in the progress of disease than in many other places, and there are generally poor survival rates with marked geographical inequalities.

Harrison Report

A review of the implementation of the Cancer Plan in Greater Manchester, carried out by Dr Chris Harrison, Medical Director of the SHA, in 2005, indicated that progress towards implementation of the Calman-Hine model had been slow and inconsistent. In particular, it was noted that cancer services continued to be based on dispersed generalist teams rather than on co-ordinated specialist teams and facilities. It was also clear that, the Department of Health regarded the development of cancer services in Manchester and Cheshire as not in line with the required model, and the pace of change as being too slow.

Dr Harrison's recommendations were for a three-tier model of specialist hospital provision:

- Lead Cancer Centre (Christie Hospital);
- Associate Cancer Centres;
- Cancer Units,

with the establishment of expert multi-disciplinary teams, across organisational boundaries, to ensure the proper planning and organisation of treatment for individual patients.

The principal recommendations were as follows

Cancer Units	**1. Cancer units, in local hospitals, should provide fully supported multi-professional teams for breast, lung and colo-rectal cancers and palliative care. For less common or rare cancers, cancer units should provide local teams for assessment, diagnosis, treatment (as defined in national guidance) and rapid referral to more specialist centres when necessary.**
Cancer Centres	**2. Associate cancer centres (Salford, South Manchester and Oldham with Central Manchester) should provide fully supported multi-professional teams for more complex urological, gynaecological, oesophago-gastric and haematological cancers and host the proposed Christie-managed radiotherapy and chemotherapy facilities (except in South Manchester because of its proximity to Christie). Associate cancer centres should also provide the cancer unit services for their local populations.**
Christie	**3. The lead cancer centre (Christie) should be a cancer centre on three sites (Chrisitie, Oldham, Salford) and provide fully supported multi-professional teams for some highly complex cancers. It should directly manage the new network of radiotherapy and major chemotherapy facilities and provide leadership, on behalf of the whole network, in respect of development of multi-professional teams, cancer research and relationships with associated academic bodies.**
Network-Wide Plans	**4. The cancer network action plans for specific cancer types should be adapted to reflect this framework and have strengthened implementation proposals, Chief Executive Leadership and public engagement and consultation arrangements.**
Commissioning	**5. PCT commissioners should agree a single service specification and single contract for the three-site cancer centre service to include radiotherapy and chemotherapy provision.**

These recommendations were supported by the Greater Manchester Strategic Health Authority and Department of Health.

3. The Proposed Location of Specialist Surgery/Treatment for More Complex Types of Cancer

It is intended that the diagnosis, treatment and care for the majority of people with the more common cancers – lung, breast, colorectal – should remain in cancer units such as Bolton.

The Harrison Report, however, put forward the following model for the location of specialist services for the treatment of rarer or more complex cancers – Urological, Gynaecological, Oesopho-gastric, Pancreatic, Head and Neck and Haematological.

Location of Specialist Services

Urological Cancers

The proposed pattern of urological cancer services is as follows:

Level 2:
Proposal – Four operating sites and four teams (two linked according to IOG criteria)
Locations – South Manchester University Hospitals Trust, Salford Royal Hospitals Trust, Central Manchester Children's Hospitals NHS Trust, Stockport Foundation Trust (Linked with South Manchester associate cancer centre)

Level 3:
Proposal – One team and one operating site
Christie Hospital NHS Trust (including some more complex level 2 procedures)

Implementation deadline is June 2007.

Gynaecological Cancers

The proposed configuration of specialist gynaecological cancer teams is as follows:

Proposal – Three teams and three operating sites
Locations – South Manchester University Hospitals Trust, Salford Royal Hospitals Trust, Central Manchester and Manchester Children's Hospitals NHS Trust (Saint Mary's)
Christie Hospital will also provide Gynaecological surgical cancer expertise as part of the specialist pelvic multi disciplinary team but will not be a designated "level 2" centre)

Implementation deadline is June 2007.

Oesophago-gastric Cancer

The proposed configuration of specialist oesophago-gastric cancer teams is as follows:

Proposal – Three teams and three operating sites
Locations – South Manchester University Hospitals Trust, Salford Royal Hospitals Trust, Central Manchester and Manchester Children's Hospitals NHS Trust

Implementation deadline is June 2007.

Pancreatic Cancer

Proposal – Two linked teams and two operating sites (NB assumed to be serving all of Greater Manchester and Cheshire, and Lancashire and South Cumbria population 4.5 million plus)
Locations – Pennine Acute (North Manchester), Central Manchester.

Head and Neck Cancers

The proposed configuration of specialist cancer teams for head and neck cancers is as follows:

Proposal – Three teams and three operating sites
Locations – Centre Manchester and Manchester Children's (MRI), Pennine Acute (North Manchester), South Manchester
(In addition skull base surgery takes place at the neurosurgical centre at Hope Hospital)

Implementation deadline is October 2008.

Specific arrangements are being developed for Thyroid cancer.

Haematological Cancers

The proposed arrangements for specialist haematological cancer teams are as follows:

Level 2:
Proposal – Four teams and six delivery locations
MDTs: North West, North East (Pennine Acute), Central Manchester, Christie
Level 2 Delivery locations: Bolton, Salford, Trafford, Christie, Oldham, MRI

Level 3 and 4:
Proposal – Two linked teams and two delivery locations
Locations – Christie, MRI.

4. How the Changes will Affect the Location of Care for Bolton Residents

Head and Neck Cancer
- Established multi-disciplinary team arrangements have been in place for some time between clinicians in Bolton and clinicians at Christie Hospital which enable complex ENT cancer surgery to be undertaken at the specialist centre. This will not change.

Oral Cancer
- Similarly, complex oral cancer surgery has historically been undertaken outside Bolton via the combined Oral Surgery service for Bury, Blackburn, Bolton and Burnley, for which the in-patient site is at Blackburn. This will not change.

Haematological Cancers
- Some Level 2 (more complex) haematological cancer treatment (such as leukaemias) is currently carried out in Bolton – approximately 5 – 6 new patients p.a. - and, under the Harrison recommendations, this would remain for the immediate future – subject to later review – with active participation of clinicians in a sector-wide (Wigan, Bolton and Salford) multidisciplinary specialist team.

Gynaecological Cancers
- Approximately 26 women p.a. currently have surgery for some complex gynaecological cancers in Bolton (cervical, uterine, ovarian, vulval). Under the new model, this surgery would be transferred to Salford by summer 2007.

Urological Cancers
- Approximately 36 patients p.a. currently have complex (Level 2) cancer surgery for urological cancers in Bolton (cystectomy, prostatectomy, penectomy, nephrectomy). Under the new model, this surgery would transfer to Salford by summer 2007.

Oesphogastric Cancers
- Since 2003, due to lack of appropriate infrastructure in Bolton, complex oesophogastric cancer surgery has transferred to Salford (approximately 16 patients p.a.), although Bolton clinicians remain a part of the multi-disciplinary team which diagnoses and agrees treatment plans for these patients and provides follow up care locally. This will not change.

Pancreatic Cancers
- Historically, people with pancreatic cancer from Bolton have received care at North Manchester. This will not change.

Salford

The Harrison Report identified Salford as an appropriate site to be one of the three Associate Cancer Centres because of its existing specialist MDT structures, its future as a centre for provision of radiotherapy, its academic links and research capacity and its links with the Christie Hospital.

5. Implementation of New Arrangements

Planning Groups

In order to plan properly for the implementation of the new arrangements affecting services for urological, gynaecological, upper gastro-intestinal and haematological cancers across the North West Sector, tumour-specific planning groups have been established. Lead Clinicians and Managers from Wigan, Bolton and Salford are members of each group. Their task is to

- Design the best future "pathway" for patients, identifying the respective roles of clinicians at the Cancer Units and the Associate Cancer Centre (ACC), ensuring that all patients are seen and treated within the cancer waiting time guarantees, as a minimum
- Agree and implement multi-disciplinary team (MDT) arrangements which enable relevant clinicians, from the Cancer Units and the ACC to plan the treatment of individual patients
- Identify the resources required in each part of the pathway and the financial impact of the shift in activity
- Identify any risks/issues
- Agree governance arrangements

Each group is charged with proposing plans by October, aiming for implementation of the shift of specialist surgery by June 2007.

Cross-sector MDTs have already been put into place and teleconferencing facilities are planned at each site in order to assist this.

Principles for New Pathways

As part of their terms of reference, each planning group has been required to observe the following principles in proposing future arrangements:

- Services, where possible, should be kept local, the IOG guidance being applied to the specialist elements of service only
- The viability of the cancer units should be considered in any models agreed
- The group should acknowledge the skills of staff currently working within the services and ensure these are put to best use within the models agreed
- The groups will take advice from the Steering Group to ensure coherence with strategy.

The process is overseen by a senior level Steering Group representing the three Trusts and three PCTs.

6. Patient and Public Involvement

The Harrison Report provides an interpretation of national guidance (The "IOGs" see above) in the context of Greater Manchester and Cheshire. This guidance is based on the best evidence available about what works in cancer care. Representatives of patients and the public were involved in the national working groups that produced the guidance.

The Harrison Report acknowledges the influence that discussions with patients and patient representatives had on its production. This was through informal discussions between the author and patients in clinics and on wards and through more formal discussions with a small number of representative groups. Overwhelmingly these discussions supported the concept of providing specialist care but balanced by providing as much less highly specialist care as possible near to where people live.

The Greater Manchester and Cheshire Cancer Network has an active Patient User Partnership group and there are two representatives on the Network Board. The Harrison Report was fully discussed and endorsed by the Network Board as being the correct strategy. An important statement in the report is that where changes to local services were required they should be further discussed through local consultative mechanisms.

In Bolton there is strong cancer patient and carer consultative group which meets bi-monthly. The Group was consulted locally on the implications of the Harrison proposals. The Group was also represented at the region-wide event held at the Reebok Stadium in

May, addressed by Dr Harrison, which explored the reasoning behind the proposals and the arrangements to plan and implement the changes. The Report was also presented to the Bolton Patienst Forum. It is intended to continue to consult these groups as more detail plans and timescales emerge.

7. Cancer Unit Services in Bolton

It is important to note that, although it is critical that changes in the location of complex surgery or treatment for these groups of patients (urology, gynaecology, upper gastro-intestinal and haematological) are properly planned, the majority of care for these patients – initial diagnosis, non-surgical and follow-up care in hospital and in the community - will remain local. It is also essential that local Cancer Unit Services are developed to support the care of people with more common cancers – lung, colorectal and breast. Across Bolton, a joint Hospitals Trust/PCT Cancer Task Group leads on planning for cancer services within the Local Delivery Plan (LDP).

In March 2005, in common with all other Cancer Units, Bolton received a peer review visit, scrutinising its local cancer services against the requirements of the National Manual of Standards. The findings of the Peer Review have now provided the basis for detailed action plans.

8. Summary

- In order to achieve better outcomes for cancer patients, the Calman-Hine Report, NHS Cancer Plan and Improving Outcomes Guidance requires a centralised model of care for people with rarer or more complex cancers
- Initial progress towards this model was slow in Manchester and Cheshire, leading to Department of Health review and a decision by the Greater Manchester SHA in 2005 to implement a three-tier model, entailing, in particular, the creation of cross-sector multi-disciplinary teams and the centralisation of complex surgery in three Associate Cancer Centres (ACCs) by Summer 2007
- This will affect the location of surgery for approximately 70 patients from Bolton each year, who require complex surgery for gynaecological, urological and upper gastro-intestinal cancers, who will in future have their surgery in Salford instead of Bolton
- In the immediate term Bolton will remain a provider of level 2 haematological cancer management. This will be reviewed in future.
- Lead clinicians from across the North West Sector have been charged with designing appropriate and effective pathways of care and MDT arrangements to allow this to happen
- Much of the diagnosis and care for these patients will remain local. Care for the groups of patients with more common cancers (lung, colorectal and breast) will remain in Bolton and local planning is focused on ensuring that all cancer patients locally receive timely, accessible and excellent care at each stage of their diagnosis, treatment and follow-up.

Ann Schenk
Director of Service Development
Bolton Hospital Trust