

# **Improving Outcomes Guidance – the way forward**

## Revised approach to improving cancer services

### Board direction 24 September 2010

The previous approach to achieving compliance with Improving Outcomes Guidance (IOGs) for gynaecological and head & neck cancers has been overtaken by changes in emphasis on service reconfiguration. These changes called for a reappraisal of our approach to improving services for patients across the Peninsula. The revised approach was approved by the Peninsula Cancer Network board on 24 September 2010.

## 1 Introduction

Two recent developments suggested that a shift was needed in the approach of the NHS in Plymouth, Devon, Torbay and Cornwall and Isles of Scilly to service reconfigurations. Firstly the Department of Health issued four key tests for any service reconfiguration. Secondly, the report of the Independent Reconfiguration Panel on upper gastro-intestinal centralisation pointed to the need to revise processes, with particular emphasis on wide engagement from the start, and certainly before any solutions are proposed.

These new factors called for a re-assessment of the previous approach to gynaecological and head & neck cancers. This new approach will be incorporated into a wider framework for quality improvement in cancer care in the Peninsula. The whole pathway must be taken into account, surgery being one – albeit important – element.

Given clinical advances since IOGs were first produced, there remains the possibility of conflict between the demands for IOG compliance and the need to demonstrate the clinical case for change. Existing clinical reviews in head & neck and gynaecology cancer services need to be set against the new tests to see how well they satisfy the requirements.

## 2 IOGs – the position in the South West Peninsula

There has been considerable work to ensure that gynaecological and head & neck cancer services comply with their IOGs, with the emphasis on surgical care.

## **Gynaecology**

In Devon and Cornwall, the Royal Devon & Exeter Hospital was designated in 2004 as the sole Specialist Gynaecological Cancer Centre. Royal Cornwall Hospitals (Truro) and Plymouth Hospitals are both Local Gynaecological Cancer Units, with non-surgical treatment of all gynaecological cancers being provided in all five acute trusts, including South Devon Healthcare (Torbay) and Northern Devon Healthcare (Barnstaple).

However, analysis by the lead gynaecological surgeons from all five trusts suggests that far more vulval, cervical and ovarian cancers should be managed by the Specialist Gynaecological Centre than previously indicated by clinicians. They estimate that this would result in around 300 additional patients from Plymouth and Cornwall being managed by Exeter, rather than the 32 previously suggested.

Analysis of the current distribution of surgical activity, undertaken by the South West Public Health Observatory and the Cancer Registry, has confirmed that the majority of services in Devon, Plymouth, Torbay and Cornwall need further work to comply fully with the IOG. In particular patients with ovarian cancer were still being treated at trusts other than the designated Specialist Gynaecological Cancer Centre at the RD&E.

The Peninsula Cancer Network, the four primary care trusts serving Devon and Cornwall and the five acute trusts therefore agreed that a second Specialist Gynaecological Cancer Centre should be created. The National Cancer Action Team has also agreed with the principle, given the number of additional patients identified.

The route to the Specialist Centre(s) would continue to be through local hospitals, which would also continue to carry out pre-assessments and follow-up care.

An independent clinical review by leading UK specialists, supported by all four PCTs and the local acute trusts, was commissioned by the Peninsula Cancer Network to provide an objective appraisal of the services.

The reviewers' report, published on 1 December 2009, concluded that:

1. The Royal Devon & Exeter (RD&E) service, which serves patients from Torbay to North Devon, was "exemplary"
2. The second specialist centre should be created at Truro, with Plymouth retaining its current status as a cancer unit

A series of meetings were arranged with existing gynaecological cancer patients in the Derriford catchment area, so the review and its implications could be discussed. The outcomes from this engagement are available separately.

## **Head & neck**

In Devon, Plymouth, Torbay and Cornwall, there are currently three multi-disciplinary teams (MDTs) that treat patients with head and neck cancers, based at:

- Derriford Hospital, Plymouth
- Royal Cornwall Hospital, Truro
- Royal Devon and Exeter Hospital, Exeter/Torbay Hospital, Torquay/North Devon District Hospital, Barnstaple

The National Cancer Action Team has agreed to two centres for Devon, Plymouth, Torbay and Cornwall.

The team in the east has agreed referral criteria for those cases which travel to the RD&E for their surgery. Torbay patients have been treated at Exeter since April 2008, in accordance with the implementation plan agreed in 2007.

However, in the west, agreement has yet to be reached on the referral criteria for patients between the two Trusts in Truro and Plymouth.

A clinical review by leading UK specialists, supported by all four PCTs and the local acute Trusts, was commissioned by the Peninsula Cancer Network to provide an objective appraisal of services. The review had two distinct components:

- To review the Plymouth and Truro head & neck teams with a view to providing a clinical assessment as to which hospital would be the preferred site for a second head & neck cancer centre.
- As the service in Exeter is acting as the specialist centre for the service and this status is not in question, to provide assurance that the current patient pathways ensure that all complex head and neck cancer cases are appropriately referred into the centre.

The review was designed to provide an objective independent opinion of the current service provision and to help inform the Network board of the future shape of these services in order to provide IOG compliance. The review visits took place from 30 November 2009 to 2 December 2009.

The review report did not follow the terms of reference, leaving the outcome inconclusive. However, having already agreed to the approach in the peninsula, the NCAT subsequently reaffirmed that a solution based on two centres – one at Exeter and one in the west - remained acceptable in meeting the IOG.

### 3 What has changed?

#### **New tests for service reconfiguration**

On 29 July 2010, David Nicholson set out in detail the tests that must be applied to “all future proposals for substantial service change”, saying:

*The goal of any change to services must be to ensure patients get the best care possible, delivered to the highest standards in the most effective, efficient and personalised way.*

*It is vital that the NHS continues to modernise and improve, and to meet the challenges of QIPP, but this must go hand-in-hand with an NHS where improvements are driven by local clinicians, patients and their representatives from the ground up. These tests are designed to ensure this will happen. The recent history of service reconfiguration demonstrates that where change is well planned and well managed, better decisions are made and implementation is more effective.*

*I am also determined that the new tests do not become overly bureaucratic, and that we avoid a ‘one size fits all’ approach. The Secretary of State has also made it very clear that GP commissioners will lead local change in the future. With that in mind, I am asking local GP commissioners, in conjunction with PCTs, to lead this process locally and assure themselves, and their SHAs, that proposals pass each of the tests.*

This means proposed reconfigurations must demonstrate:

- Support from GP commissioners
- Strengthened public and patient engagement
- Clarity on the clinical evidence base, and

- Consistency with current and prospective patient choice

At the same time, commissioners will be expected to apply a 'test of reasonableness' covering the balance of evidence and stakeholder views, while stakeholders will need to provide "valid and robust evidence to support their position", to avoid "potentially-vexatious objections".

On the issue of clinical evidence, the Nicholson letter says that "local commissioners will need to consider both the strength of the clinical evidence and the support from senior clinicians whose services will be affected by the reconfiguration. It will be for commissioners and their provider partners to determine the specific composition of the clinical body to engage, though this should include representatives from across the patient pathway and from different relevant clinical specialties. It is recommended that clinicians should lead in gathering this evidence, considering current services and how they fit with the latest developments in clinical practice, and current and future needs of patients."

On the issue of patient choice, it says: "Services should be locally accessible wherever possible and centralised where necessary. Patient choice and contestability are powerful drivers for improving quality and efficiency in the provision of services. In this context, local commissioners will need to consider how the proposed service reconfiguration affects choice of provider, setting and intervention; and the choice this presents the patient compared with the current model of provision."

### **Independent Reconfiguration Panel**

On 15 February 2010, Andy Burnham informed Cornwall OSC that the Independent Reconfiguration had recommended a full review of the transfer of upper GI services to Plymouth.

The new Secretary of State, Andrew Lansley, published the outcomes on 22 July 2010, endorsing the IRP's position that "the [upper GI] changes that have been implemented are in the best interests of patients and will provide safe, sustainable and accessible services for the population".

He also accepted all eight of the IRP's recommendations. While the first three were tied to upper GI cancers, the remaining five all have relevance to proposals for other cancers:

4. The organisation and cost of travel and subsistence should not be a source of unnecessary anxiety to patients and carers at a very difficult time. Cornwall and Isles of Scilly PCT must use the feedback of patients and carers to ensure that any potential issues are avoided with the right practical support from the specialist cancer nurses and others.
5. Cornwall and Isles of Scilly PCT must engage patients and carers in a programme of work to identify and implement improvements to patient transport and subsistence arrangements within six months. This programme should include consideration of best practice elsewhere, options for dedicated transport between NHS facilities, a common policy and contract for the provision of patient transport services, and an inequalities impact assessment.
6. Cornwall and Isles of Scilly PCT should continue to engage the public and the Royal Cornwall Hospitals NHS Trust in implementing its strategic plan A Healthy Future for All, including the future role of the Royal Cornwall Hospital, West Cornwall Hospital and St Michael's Hospital. The PCT and Trust must within six months produce a clear plan showing how facilities and capacity for delivering more services closer to the patient's home will be taken forward.
7. The Peninsula Cancer Network must complete the process of re-establishing an effective, functioning Partnership Group and review how the experiences of patients will be captured and used to design and deliver better cancer services. This process should be the subject

of external assurance and changes made to meet national guidance and best practice. Changes should be made within six months.

8. Cornwall and Isles of Scilly PCT, the Cornwall Health & Adults Overview Scrutiny Committee and local NHS organisations should together consider the lessons learnt from this experience and take action to ensure all service change proposals are developed in an environment in which there is an open and constructive relationship aimed at delivering improved services and better health outcomes for the people of Cornwall.

Unless the new process follows these avenues, there will be a risk that they too are referred to the IRP, with attendant delays.

### **Overview and Scrutiny Committees**

The independent clinical review of gynaecological cancer services was discussed with OSCs in early 2010. Cornwall and Isles of Scilly OSCs both noted the recommendations of the independent clinical review, Plymouth adopted the following resolution:

1. Members welcomed the principle of developing centres of excellence but recognised that patients had other outcomes to consider such as emotional and financial wellbeing. Given that Plymouth was a city with pockets of deprivation, the panel sought assurances that the needs of patients having to travel would be met and supported, along with those of their families.
2. Recommended that the findings of the independent clinical review could not be supported because the report fails to provide the assurances the panel would need in respect of:
  - evidence to demonstrate that a second centre at Truro would make a significant difference to clinical outcomes for patients from Plymouth;
  - addressing the issue of individual choice for women over where their surgery should take place.

The issues raised by the OSC broadly reflected those arising from the local patient engagement events in the Derriford catchment.

Both OSC and patient voices further underline the need to develop processes that are closely in line with the four new key tests and with the guidance set out by the IRP.

## **4 The PCN approach**

The PCN aims to help improve the quality of care and of the patient's experience with all types of cancer in the Peninsula, from the beginning to the end of each pathway. The approach is therefore designed to prioritise areas for improvement, given limitations on resource, develop potential solutions and support improvements where these system-wide rather than purely local.

This means working with patients, clinicians, GP commissioners and other stakeholders to:

- Understand the good and less-good aspects of current services
- Understand current and future demand for services
- Understand what improvements could and should be made (the case for change)
- Understand how these improvements could be put into practice
- Understand how improvements and attendant changes would fit within commissioning and provider trust strategies
- Implement changes

The groups involved throughout this process will be:

- Clinicians involved in cancer care
- GP consortia and other clinicians (eg public health)
- Patients
- OSCs
- Other stakeholders (eg LINKs, social care, MPs, charitable & support groups)
- Wider public

The same stakeholders will also need to be involved in shaping the process itself, so a robust system emerges for the longer term and for other services.

The identification of current strengths and shortcomings will also draw on:

- Peer review – national (assessing compliance with IOGs)
- Peer review – local
- Outcome measures (such as the National Lung Cancer Audit (LUCADA) and DAHNO for Head and Neck, as well as more local audits)
- Regular analysis of the quality of patient outcomes
- Patient experience including observational visits, surveys and other engagement
- Independent clinical reviews
- The existing independent clinical reviews for gynae and for head & neck

All these elements will take time, given the number of services involved.

### **Clinical involvement in evidence and development**

Network Site Specific Groups (NSSGs) will be the fulcrum for specialist clinical input to the process. They will be responsible for:

- Advising on whether the existing independent clinical reviews provide evidence of compliance with the four new key tests for reconfiguration
- Advising on standards, including clinical outcome and patient experience standards
- Advising the PCN on the current strengths and shortcomings of services their own pathway
- Collating clinical evidence to inform potential ways forward
- Developing proposals
- Mapping associated governance, accountability and reporting arrangements
- Appraising options

### **Support from GP commissioners**

The PCN will approach GP consortia to see how best they would like to be engaged in the process of developing proposals for cancers, ensuring ownership. The picture is complicated by the different stages of development of consortia across the Peninsula, so a variety of approaches may be necessary.

### **Public and patient engagement**

The PCN is currently working on a Patient, Carer and Public Involvement Strategy, 2010-2014. As the IRP suggests, this will ensure that “the experiences of patients will be captured and used to design and deliver better cancer services”.

The strategy will cover reconstitution of the Partnership Group, and supporting arrangements.

Involvement must be comprehensive. Assessment of the quality of current services – both clinical and non-clinical aspects – will need to include survey work and the direct participation of patients. They will then need to be involved in developing solutions, appraising options and implementing change.

### **Patient choice**

Any proposal will need to be tested against the ideal of sustaining, if not enhancing, patient choice. The balance between choice and quality might be explored further with patients, but the work commissioned in the Peninsula from Ipsos MORI shows clearly that people are happy with the principle of travelling further for the best treatment.

### **Overview and Scrutiny Committees**

The IRP's final recommendation, that "all service change proposals [be] developed in an environment in which there is open and constructive relationship" with OSCs, also suggests involvement at an early stage. This will be based on a common approach and shared information around the Peninsula.

### **Strategic fit and affordability**

As well as meeting the Nicholson criteria, the PCN, PCTs, GP commissioners and acute trusts need a shared vision of how developments in cancer care fit within local strategies. This means both PCT strategies for better health and trusts' service strategies, taking into account affordability. Individual developments, such as gynaecological or head & neck, should not be seen in isolation.

This calls for compatibility of strategies with each other in terms of key issues, such as the balance between local access and centralisation of specialist care.

## **5 Making it happen**

Given the vast array of services, for all cancer patients and from the beginning to the end of each pathway, it will take time to construct a comprehensive improvement programme for the Peninsula. The process will also need to be refined in the light of experience.

A developmental approach will enable the NHS in the Peninsula to focus on selected services where some work has already been carried out, while refining the model for the future.

Given the uncertainty created by the reviews of gynaecological and head & neck cancers, the new approach will be adopted for these services. Independent reviews have been carried out, expectations have been raised and, in the case of gynaecological services, clinicians, OSCs and patients have been engaged.

Initial meetings have already been arranged to bring together the acute clinicians involved in gynaecological and head & neck services, to discuss the way forward. In line with the new approach, these will consider process as well as clinical issues.

The various NSSGs will also need to consider the framework and its implications.

In all cases, wider engagement work with other groups identified in section 4 (above) will be needed to bring new perspectives on the potential framework for improving cancer care

A steering group will oversee:

- Development of the wider process for handling all future developments, as outlined above
- All stages of the work on the priority services

Membership: To be defined

Sitting below the steering group will be one sub-group per service to drive day-to-day progress.

Membership: To be defined