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Management Executive

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Dear Colleague

COMMISSIONING CANCER SERVICES IN SCOTLAND: GUIDANCE FOR PURCHASERS AND PROVIDERS IN PLANNING THE SERVICE CONFIGURATION FOR CANCER CENTRES AND UNITS

Summary

MEL(1996)54 set out a planning framework for the development of cancer services in Scotland in line with the recommendations in the revised report on Commissioning Cancer Services in Scotland by a sub-committee of the Scottish Cancer Co-ordinating and Advisory Committee (SCCAC). Further guidance by SCCAC on the criteria which should be used by Health Boards and Trusts in planning the configuration of Cancer Services has now been prepared, a copy of which is attached at Annex A.

Action

Health Boards and Trusts should take this guidance into account in preparing plans for reconfiguring cancer services.

It is recognised that the timing of release of this guidance does not allow sufficient time for the submission of initial plans for the configuration of services by end September, as originally envisaged in MEL (1996) 54 (Milestone 3). These should now be submitted to the Management Executive by 31st October 1996.

This letter and attachements have also been sent for information to the professional organisations and other bodies listed in Annex B.

Yours sincerely

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Annex A

GUIDANCE FOR PURCHASERS AND PROVIDERS IN PLANNING THE SERVICE CONFIGURATION FOR CANCER CENTRES AND UNITS

1. The planning framework for the development of cancer services in 1996-97 outlined in the MEL on cancer services (MEL(1996)54) set out a number of milestones. The purpose of this note is to provide Health Boards and Trusts with the guidance referred to in the second milestone. This relates to the criteria which should be followed in determining whether a hospital (or group of hospitals) should be designated as a cancer unit.

2. More detailed clinical guidance will become available via the Focus Groups set up jointly by the Scottish Cancer Co-ordinating and Advisory Committee and the Scottish Cancer Therapy Network, and the Cancer Guidance sub-group chaired by Professor Haward in England. The second report from the SCCAC Commissioning Cancer Services Sub-Committee on primary and palliative care will be complete by the end of the summer 1996. It is anticipated that this will contain guidance on the communications interface between primary, secondary and tertiary care.

Criteria

3. The revised report on Commissioning Cancer Services in Scotland by a sub-group of the Scottish Cancer Co-ordinating and Advisory Committee outlined the main criteria which should be used in deciding on the appropriate configuration of cancer services. These criteria include:

- the establishment of multi-disciplinary clinical teams with interests, time commitment and expertise in particular tumour sites;
- the availability of good pathology and audit data (staging and outcomes);
- a caseload which should at least meet the minimum requirements necessary to ensure the provision and maintenance of appropriate diagnostic and therapeutic expertise;

- good communication systems with local primary care, other secondary care teams and tertiary care providers, including specialist palliative care services; and

- established and continuing joint working between relevant cancer units and centres to determine common treatment protocols, movement between hospitals, involvement of patients in clinical trials, and devolution of work.

This note considers in more detail the implications of these general criteria.

Multi-disciplinary Clinical Teams

Functions

4. A multi-disciplinary team is a group of specialists relating to a particular tumour type who work together under appropriate leadership with the following aims:

- to achieve accurate and speedy diagnosis;

- to plan and implement effective integrated treatment and care;

- to communicate effectively with the patient, with all other professionals and agencies involved in the care of the patient, and with its own members; and

- to audit its activities and outcomes.

Personnel

5. Multi-disciplinary teams will include representatives of relevant medical and/or surgical specialties for the treatment of each tumour type, nursing, diagnostic, paramedical, pharmaceutical and administrative/secretarial staff with relevant training and expertise in the care and treatment of patients with cancer. Other professionals should be included in the team as appropriate. In some disciplines appropriate postgraduate qualifications and accreditation systems already exist and should be

strictly adhered to. A named member of staff of each team should be designated as the team co-ordinator. In addition each Trust should designate a lead clinician with overall responsibility for cancer services provided by the Trust.

6. Since a Cancer Unit may consist of more than one hospital it is not necessary for each hospital to have its own multi-disciplinary team for each tumour type. The key requirements are: that there is an appropriate multi-disciplinary team for each type of tumour being treated in the unit; that it functions effectively, especially if it is in more than one location; and that emergency referrals are appropriately channelled to ensure that they receive effective care and treatment from the relevant multi-disciplinary team. Cancer Unit teams must liaise closely with the relevant staff of the associated Cancer Centre.

Pattern of Work

7. Members of the team should meet on a regular basis to discuss treatment plans for newly referred cases and to review the progress of patients who are already receiving treatment.

8. National guidelines on treatment and case management are now being developed for many tumour sites. The development of local treatment protocols should be documented and based on these guidelines where they are available.

9. The team format should ensure that all those involved in the care of the patient are fully informed of the treatment plan and that clear procedures are in place for communicating information between relevant people. Primary care professionals, especially GPs, need to be informed about the treatment plan and the side effects of the treatment, including what information has been given to the patient and relatives and be aware of actions to be taken if complications arise.

Laboratory Services

10. Access to high quality laboratories is essential to ensure the successful introduction of cancer units and centres. All pathology laboratories (haematology, cytopathology, histopathology, clinical chemistry, immunology, genetics and microbiology) providing diagnostic services to cancer units and centres should be

adequately staffed and equipped to enable them to perform to the exacting standards necessarily demanded. Laboratories should be accredited by CPA (UK) ltd and should participate in relevant technical and interpretative external quality assurance schemes.

11. The histopathology and cytopathology services must be led by an experienced consultant pathologist with overall responsibility for the diagnostic service. As the numbers of specialist consultants available in any one unit or centre are likely to be limited, arrangements for adequate cover may need to be made with other units and centres.

12. It is recognised that the introduction of cancer units and centres is likely to result in increased demands on diagnostic services, not only in numbers of requests, but also in their complexity. There is a need, therefore, to ensure that laboratories have an adequate number of medical, scientific, MLSO and secretarial staff to meet service demands. Laboratory staff should regularly attend appropriate scientific and continuing education meetings. Consultant pathologists should be registered with the Royal College of Pathologists CME Scheme.

13. It is essential that both cytopathologists and histopathologists should participate in ongoing audit of the services. This will involve pathologists with an interest in a particular diagnostic area meeting regularly with their clinical and laboratory colleagues from elsewhere to discuss problem cases, and to develop diagnostic and therapeutic protocols. Pathologists will also be expected to organise regular clinico-pathological meetings in their local unit or centre. There should be regular review and correlation of cytopathology and histopathology, and comparison with other diagnostic modalities, such as imaging, to ensure a high quality, cost effective service.

14. Routine pathology reports should conform to best available practice. It is appreciated that the detailed requirements and content of a surgical pathology report will vary depending on the nature of the specimen. It is expected that protocols outlining minimum datasets for inclusion in reports will be developed by specialty interest groups.

15. Histopathology and cytopathology slides should be retained for a minimum of 10 years, and tissue blocks indefinitely to facilitate future case review, audit and research.

16. It is acknowledged that some hospitals wishing to be designated as Cancer Units will not have access to on-site pathology services. In such cases evidence will need to be provided that appropriate arrangements will be set in place to ensure these services are provided to meet the above requirements.

Caseload

16. Although the number of cases treated has sometimes been regarded as an important criterion in determining where patients should be treated, available data on the common tumour sites, including breast, colorectal, oesophogeal and pancreatic cancer show no consistent pattern between caseload and outcome. One study of breast cancer (from Yorkshire) suggested a direct relationship between consultant caseload (over 30 cases per year) and outcome, but this has not been substantiated by other data, including that from the recent Scottish Cancer Therapy Network breast cancer audit.

17. Caseload may clearly be significant however in relation to the economics of providing adequate facilities for the diagnosis and treatment of patients. Cancer units with relatively small caseloads may find it difficult to provide the required standards of care cost-effectively. To some extent the patterns of service provision which will develop will need to take account of differing local circumstances including problems of access for patients in relatively sparsely populated areas.

18. Paragraphs 37-38 of the revised report "Commissioning Cancer Services in Scotland" considered the tumour sites which should be treated in cancer units. Essentially these comprise the common cancers, i.e. those cancers with an incidence of over 50 cases per 100,000 population. These would include breast, colorectal, lung and skin (excluding melanoma). Cancer units could also play a major role in the management of cancers of intermediate frequency - i.e. 8-30 cases per 100,000 population per year. These would include pancreas, stomach, bladder, kidney, prostate, cervix, ovary, uterus as well as some haematological malignancies and melanoma. A key feature here is close collaboration with colleagues in the relevant cancer centre on aspects of patient care which may frequently be conducted jointly between the cancer unit and centre. For uncommon cancers (less than 8 cases per 100,000 population per year) such as head and neck cancers most of the care and treatment of patients would ordinarily be carried out in the cancer centre.

19. All of these caseload numbers should be treated as guidance rather than precise rules to be followed. The key requirements are that purchasers should explore with potential cancer units (for each tumour site) their ability to provide services which meet the required standards of care and should assess the cost-effectiveness of these services, taking into account the need to ensure accessibility for patients.

Communication Links

20. Cancer units and centres must develop and implement systems which ensure rapid and effective communication between all healthcare professionals involved in each patient's management. There must be adequate means of communicating information on referral, diagnosis and treatment, follow-up and supportive/palliative care.

21. There should be sufficient administrative support, and the unit or centre should be equipped with facilities (including fax and e-mail where the latter is a feasible option) to aid rapid and accurate information transfer. Particular importance is attached to the rapid communication to each patient's GP of the patient's diagnosis, treatment plans, treatment given and the information which has been provided to the patient and the relatives/carers. An equal degree of importance attaches to rapid communication with hospices and palliative care teams. The need for confidentiality should be recognised in all communications.

Joint Working

22. Purchasers and providers should review existing services and establish appropriate plans covering primary, secondary and tertiary care to ensure:

- clearly defined referral pathways for each tumour site, including where appropriate the contribution from the relevant Cancer Centre to the work of the Unit on a tumour specific basis;

- treatment protocols for each tumour site treated by individual cancer units (as designated), including entry into clinical trials where appropriate.

National guidelines are in preparation for breast, colorectal, lung cancer and for palliative care, and are already available for cancer of the ovary;

- care plans for individual patients including discharge and follow up arrangements;

- communications protocols covering communications between and among all those involved in each patient's care, including, for example, specialist medical, nursing and pharmaceutical staff, specialist palliative care, professions allied to medicine, members of the primary care team, social work services and voluntary organisations as appropriate;

- minimum standards of information required at each stage of care and transfer between primary, secondary and tertiary care. The guidance set out in the recently published SIGN Pilot Edition of a Minimum Data Set for Immediate Discharge is equally applicable at the interface between cancer centres and units as it is between hospital and primary care.

23. The above plans and protocols should be developed for both inpatient and outpatient care and should take into account re-referral of patients between primary, secondary and tertiary care. In some instances patients who have already been diagnosed and treated and returned home may find it necessary to self-refer if symptoms occur. Protocols should include guidance to cover these circumstances.

Quality Assurance

24. It will be necessary for Cancer Centres/Units to collect and monitor a minimum dataset to include operative morbidity and mortality, local recurrence and survival rates. These data should be subject to review on an annual basis. Performance and audit figures should be produced annually and be available to purchasers. It is acknowledged that this may create additional information requirements.

Cancer Centres

The SCCAC Sub-Committee Report "Commissioning Cancer Services in Scotland" (April 1966 - issued under cover of NHS MEL(1996)54) set out in paragraphs 21-29

the range and types of tumours expected to be managed by Cancer Centres. However, since Cancer Centres may also act as the Cancer Unit for their local population this guidance equally applies to them.

Further Guidance

It is acknowledged that under some of the above headings there is as yet little information on which to base specific guidance. This is kept under constant review and further guidance will be provided as it becomes available.

More specifically advice on staffing, facilities and training issues will be developed over the next few months. This too will be circulated as soon as it becomes available.

Further guidance on the configuration of cancer centres will also be prepared.

Other Sources of Guidance

25. The next page lists a number of documents which may provide useful guidance to purchasers in planning the reconfiguration of cancer services. This list is minimal and readers are encouraged to seek out other publications in this area.

OTHER SOURCES OF GUIDANCE

Guidance on the Structure and Function of Cancer Centres
Board of Faculty of Clinical Oncology, The Royal College of Surgeons

Improving Outcomes in Breast Cancer - Guidance for Purchasers
Clinical Outcomes Group Sub-Committee, Department of Health (Chaired by Professor R Haward of the Yorkshire Cancer Organisation

Guidance for the Referral of Patients with Breast Problems
NHS Breast Screening Programme/Cancer Research Campaign
Joan Austoker et al

Guidelines for Surgeons in the Management of Symptomatic Breast Disease in the United Kingdom
European Journal of Surgical Oncology, Vol. 21, 1 Suppl.A October 1995

The Interface between the Hospital and the Community: The Immediate Discharge Document
The Scottish Intercollegiate Guidelines Network (SIGN), The Royal College of Physicians, 9 Queen Street Edinburgh.

Commissioning Cancer Services in Scotland. Report to the Chief Medical Officer, Scottish Office Department of Health. Scottish Cancer Co-ordinating and Advisory Committee. April 1996

A Policy Framework for Commissioning Cancer Services. A Report by the Expert Advisory Group on Cancer to the Chief Medical Officers in England and Wales.

Annex B

COMMISSIONING CANCER SERVICES IN SCOTLAND
GUIDANCE FOR PURCHASERS AND PROVIDERS IN PLANNING THE SERVICE CONFIGURATION FOR CANCER CENTRES AND UNITS

Professional bodies/other organisations to whom this letter and Annex have been sent:

- Royal College of Surgeons, Edinburgh
- Royal College of Physicians, Edinburgh
- Royal College of Physicians and Surgeons, Glasgow
- Royal College of General Practitioners, Scottish Council
- Royal College of Obstetricians & Gynaecologists
- Scottish Standing Committee, Royal College of Radiologists
- Scottish Standing Committee, Royal College of Pathologists
- College of Radiographers
- Royal Pharmaceutical Society of Great Britain, Scottish Department
- Conference of Royal Colleges and Faculties in Scotland
- British Medical Association, Scottish Office
- Scottish Association of GP Fundholders
- Scottish Joint Consultants' Committee
- Royal College of Nursing Scottish Board
- Scottish General Medical Services Committee
- British Association of Paediatric Surgeons
- British Paediatric Association
- Chairman, National Medical Advisory Committee
- Chairman, National Nursing, Midwifery and Health Visiting Advisory Committee
- Chairman, National Dental Advisory Committee
- Chairman, National Paramedical Advisory Committee
- Chairman, National Pharmaceutical Advisory Committee
- Chairman, National Advisory Committee on Scientific Services