

North West London Strategic Health Authority

<p>TITLE OF REPORT: TOWARDS A CANCER STRATEGY</p>
<p>EXECUTIVE SUMMARY:</p> <p>North West London SHA and the West London Cancer Network (WLCN) made a commitment in 2004 to produce a Cancer Strategy for the sector. At its Board Meeting on 14 July 2004, the WLCN agreed a phased process for producing the Cancer Strategy.</p> <p>The phased process is set out below:</p> <ol style="list-style-type: none">1.1 The development of a Position Paper, which clarifies where we are now and what issues need to be addressed.1.2 Reaching agreement about priorities and establishing a work programme to address the most urgent issues.1.3 Transforming the Position Paper into a Strategy by incorporating the results of the work undertaken through the work programme and ensuring synergy with the broader North West London Sector Strategy. <p>The first of these phases has now been completed and the draft Cancer Position Paper is attached.</p> <p>A draft work programme has also been produced and will be considered by the West London Cancer Network Board at its next meeting on 20th July 2005.</p> <p>Once the draft work programme has been agreed by the WLCN Board, it is intended that the work programme and Position Paper should be circulated widely for comment and consultation.</p>
<p>ACTIONS REQUESTED:</p> <p>The Board is asked to:</p> <ul style="list-style-type: none">• note the process for producing a full Cancer Strategy• note and endorse the Position Paper as the first stage of this process• agree that the draft Position Paper and WLCN's proposed Work Programme be circulated widely for comment and consultation, once endorsed by the West London Cancer Network Board.• Expect to receive a final Cancer Strategy document by January 2006, which has taken into account:<ul style="list-style-type: none">▪ views received during the consultation period,▪ the broader North West London sector strategy▪ the outcome of workstreams that will have been progressed.

SHA OBJECTIVE/S SUPPORTED BY THIS PAPER:

- Delivering the public health agenda
- Developing and implementing new models of primary care
- Improving hospital efficiency

SHA STRATEGIC AIM/S SUPPORTED BY THIS PAPER:

- To develop and implement a coherent strategic plan for NW London
- To provide and support effective leadership in the sector

RACE EQUALITY ASSESSMENT:

- There is a lack of good information on the incidence of cancer and cancer treatment among black and minority ethnic (BME) groups in NW London. One of the aims of the final NW London cancer strategy will be to improve equity of access to cancer services including prevention, treatment and care, for transient and BME population groups.

RISKS ATTACHED TO THIS PROJECT/INITIATIVE:

- Insufficient Clinical Engagement secured and maintained to enable development of a fully effective model of Networked care.
- Insufficient MDT cooperation between Primary, Secondary and Tertiary care to meet IOG standards required for Peer Review in January 2006.

PUBLIC/PATIENT INVOLVEMENT:

- This paper will form the basis of forthcoming cancer stakeholder events in NW London later this Summer and Autumn.
- WLCN have appointed a User Involvement Consultant and a Patient Information Manager to take forward user involvement at a Trust and PCT level. The User Involvement Consultant will have a particular role around engaging BME groups in cancer work, as well as around palliative care, in line with recent NICE guidance. BME interests are also a focus for the work of the Patient Information Manager.

RESOURCE IMPLICATIONS:

- Time resource required from Strategy, Operations and Public Health directorates working in conjunction with West London Cancer Network.
- Financial support comes from PCTs.

Barbara Gill
Acting Director of Strategy
July 2005

West London Cancer Network

**North West London Strategic
Health Authority**

Position Paper

July 2005

EXECUTIVE SUMMARY

Introduction

The position paper provides information about the issues and challenges for cancer services across NW London with the intention of allowing the sector to set priorities for future development and investment. West London Cancer Network (WLCN) and its constituent parts have much to be proud of and together represent some of the foremost providers of cancer services in Europe. Exciting innovation in cancer care is stimulated by the formidable influence of Imperial School of Medicine and the investment of 21% of the entire English Research and Development (R&D) Levy fund.

A substantial programme of change has been undertaken since the publication of the National Cancer Plan and WLCN will be assessed in a Peer Review in January 2006. The paper will be complimented by a directory of cancer services for the network which will identify the institutions, teams and pathways for each type of cancer which will be published in the next 6 months prior to Peer Review. The principle issues for the Network and NW London Strategic Health Authority (NWL SHA) are identified below.

Issues

- **Meeting “Improving Outcome Guidance” from NICE** The Tumour Working Groups (TWGs), the WLCN and NWL SHA face a substantial task to meet new guidance. Particular tumour sites requiring focused effort in the short term are: upper gastrointestinal, urological, head and neck cancers and haematological malignancies (see Table in Section 4).
- **Waiting times** National cancer waiting times targets of 62 days from referral to treatment for urgent patients deemed urgent by their GP and 31 days from diagnosis to treatment in December 2005 will prove challenging. Achievement is reliant upon accurate data to indicate the bottlenecks and breaches. The lack of resources to collect data, manage patient flows across multiple MDT’s within and outside the sector poses a significant barrier to meeting these targets (Section 1).
- **Endoscopy** is the key diagnostic investigation that enables the early diagnosis of oesophageal and gastric (upper GI) cancers, and colorectal (lower GI) cancer. Additional funding is necessary, to improve capacity, for staff development, the upgrading of endoscopy database systems, and to replace aging equipment (Section 5).
- **Cancer Centre Development** The installation of replacement Linear Accelerators and building of the brachytherapy suite by December 2006 will place a strain on capacity that may increase waiting times. In the mid term (4-7 years), the main issues for the cancer service will be the provision of the additional services required by the relocation of Mt Vernon. In the long term (8-10 years) there will be a redevelopment of Hammersmith Hospitals NHS Trust (HHNT) cancer services likely to be consolidated in purpose built facilities (Section 2).
- **Screening** Efforts need to continue to be made to improve the number of women screened for breast and cervical cancer in NW London. The introduction of colon cancer screening poses a considerable challenge both due to the implementation of the screening programme and also the possible implications on diagnostic and treatment services in the sector (Section 3).

- **Workforce** All the TWGs have highlighted difficulties around recruitment of key staff which is hindering the effective delivery of high quality cancer services. There are major problems with the availability of key groups of medical staff, in particular Histopathologists. The lack of therapy radiographers has a significant impact on radiotherapy waiting times. There are also national skill shortages in oncology and stem cell nursing and radiation physics. Poor availability of data managers and MDT coordinators hampers development of audit of clinical outcomes (Sections 4 and 8).
- **Supportive and palliative care** Supportive and palliative care services fall short of new guidelines and require organisational and workforce solutions (Section 7).
- **Cancer Information Systems** The networked model of care clearly defined information systems to be in place. Connecting for Health means that all significant existing systems will be replaced by 2010. Efforts need to be made to ensure that the existing systems are supported as far as possible to yield at least some useable information in the interim and that the new systems properly reflect the demands of cancer services (Section 2).
- **Patient and Public Involvement** The patient and user perspective on our cancer services is a key area for Peer Review. This needs further development in NW London, in particular addressing the needs of Black and Minority Ethnic Communities (Section 10).
- **Research and Development** Clinical services need to support the research agenda of Imperial and the West London Cancer Network including the development of specific research facilities at the Hammersmith to support recruitment to clinical trials, collaborations with other cancer centres both nationally and internationally and developments with the pharmaceutical industry (Section 9).

Provisional priorities. A meeting of the WLCN team, representatives of the SHA and cancer clinicians looked at the issues raised in this document and have made a first suggestion of what the priorities should be for the next two years.

2005-6:

- Support for Peer Review in January 2006.
- Delivering greater clinical engagement and increased MDT cooperation between local, secondary and tertiary care.
- IOG implementation: UGI, Head and Neck, Haematology, Urology, and Pancreatic Cancers.
- Meeting cancer waiting time targets and reducing non-urgent waiting times.
- Investing in diagnostic services development in particular endoscopy

2006-7:

- Improving the sectors performance in prevention and screening in Primary Care.
- Increased cross border and Pan London coordination.
- Developing the information services to provide improved clinical, outcome and managerial data.
- Developing the cancer workforce.

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INTRODUCTION

The purpose of this Position Paper is to inform readers about the current state of cancer services in NW London. It was produced jointly by NWL SHA and WLCN.

This paper was produced by bringing together contributions from many different people. The Chair of each TWG produced the sections within Section 5 and members of WLCN provided most of the national and local context. Imperial College and the West London Cancer Research Network contributed to Section 10 and relevant lead clinicians produced the sections on diagnostic and therapeutic services.

When all of the contributions were first merged, we had a very long document that described cancer services in some detail. In order to make it more manageable for readers, it was distilled down to focus on the key issues facing each part of the service. The information that was removed from the longer version of this document will be edited soon and posted onto the WLCN website (www.wlc.nhs.uk), so that more information about our services will be available to those who wish to access it.

It is important for readers to be aware that this document deliberately focuses on issues and concerns. Cancer services in NW London are provided to a very high standard. But since we are keen to ensure that the services continue to develop and improve, areas of concern have been highlighted in this document to provide a basis for determining our priorities.

Following the production of this document, a workshop was held to identify which of the issues highlighted in the document needed to be addressed most urgently. The list of issues that were identified has now become the WLCN's draft work programme for the next 18 months. The work programme is still in draft form to enable readers to have an opportunity to comment on our proposed priorities.

As issues on the work programme get addressed, the Position Paper will be updated. It is intended that the process will be dynamic and that the document will always accurately reflect the issues and challenges facing cancer services in NW London. This initial document will provide a useful baseline from which progress can be measured.

We hope that this document will assist patients and the public as well as those working within the NHS, to understand our services better. We also hope that it will make it easier for anyone with an interest in cancer services to be able to contribute their views on our services and on our proposed priorities.

SECTION 1 NATIONAL CONTEXT

Calman-Hine Report

The Calman-Hine Report¹, published in 1995, kick started a programme of improvements to cancer services. The report highlighted the fact that outcomes for people with cancer in the UK were considerably poorer than those in other developed countries. While the reasons for this were multi-factorial, fragmented organisation of cancer services was considered to be hindering good quality of care.

The report developed a set of principles for cancer services. Services must not only be of good quality but easily accessible. There should be systems to make sure that cancer is recognised early. Patients should have good information, including options for treatment, and should have psychological support throughout their experience, making cancer services much more patient centred.

The report made recommendations about the structure and organisation of local cancer services. There should be two types of facility delivering cancer services: units and centres. Cancer units would provide basic cancer services to their local population. Cancer centres should provide these basic local services, but also serve a wider population with more specialist services, including complex surgery, radiotherapy and the more advanced forms of inpatient chemotherapy and sophisticated diagnostic techniques, provided. These centres might comprise more than one hospital.

The report also suggested a system of networks to bring together all cancer services in an area. Primary care was acknowledged to play an important role as a focus of care and arrangements for closer working with cancer centres and units were recommended.

A number of recommendations focused on professional practice. There should be more surgical sub-specialisation in cancer and more specialist nurses, as well as greater multi disciplinary team working across all professions involved in cancer care. A lead clinician should co-ordinate the range of services provided within a cancer unit and make sure that they are of a high quality. Cancer units should include consultation in palliative medicine and access to counselling and other psychological support. The commissioning process, affecting the range of cancer services provided, should also be developed.

Since the publication of the Calman-Hine Report, there have been a number of successor documents aimed at putting the vision and principles of the report into practice. These include the NHS Cancer Plan; "Shifting the Balance of Power: Next Steps"; and "Improvement, Expansion and Reform, The Next Three Years." Most recently there was the "NHS Cancer Plan: Three Year Progress Report, Maintaining the Momentum," published by the Department of Health in October 2003.

NHS Cancer Plan

This plan, published in September 2000, established a central plan for implementing the proposals in Calman-Hine and a programme of investment and reform to tackle cancer - including prevention, diagnosis, treatment, care and research.

¹ A policy framework for commissioning cancer services : A report by the Expert Advisory Group on Cancer to the Chief Medical Officers of England and Wales ,1995, Department of Health, London

The four main aims of the Cancer Plan are to:

1. Save more lives.
2. Ensure people with cancer get the right professional support and care as well as the best treatments.
3. Tackle the inequalities in health that mean unskilled workers are twice as likely to die from cancer as professionals.
4. Build for the future through investment in the cancer workforce, through strong research and through preparation for the genetics revolution, so that the NHS never falls behind in cancer care again.

Improving Outcomes Guidance (IOG)

Central support has been provided for the development of national guidance on clinical standards. This has been published regularly involving rigorous reviews of the evidence and expert opinion. Section 4 of this volume provides further details of these publications and an assessment of services in NW London against these standards.

Peer Review

Peer review is to become the principal means by which improvements to cancer services are to be measured. Peer Review visits (NW London's are scheduled to take place in January 2006) aim to assess whether services are safe, whether their quality is improving and that they are clinically and cost effective. The process is concerned with reviewing an organisation's compliance against a set of detailed measures, but also with a qualitative assessment against a broad set of objectives for the delivery of services, encompassing the whole system of patient care and the patient and carer experience, within which there are diverse needs, preferences and choices. Cancer peer review will therefore provide a mechanism to enable the overall quality of cancer services to rise.

The Manual of Cancer Services Standards (updated in 2004) contains the measures for the quality assessment of services and is the mechanism by which cancer services will be able to demonstrate that they are meeting the Standards for Better Health². The Manual now incorporates the recommendations contained within the relevant national publications and the new Improving Outcomes Guidance published by the Department of Health and/or by the National Institute for Clinical Excellence (NICE).

It is intended that Cancer Peer Review will report to the Healthcare Commission (formerly Commission for Health Improvement (CHI) on progress on the implementation of NICE guidelines, co-ordination of care across organizations and the patient experience. Self assessment and reviews should encourage development and learning for all involved, as well as disseminating good practice, benefiting Multi Disciplinary Teams (MDTs), Primary Care Trusts (PCT) commissioners, Trusts and patients.

²Standards for Better Health – Health Care Standards for Services under the NHS – A Consultation. Department of Health. February 2004

System Reforms

At the time of developing this Position Paper a complex national programme of system reforms is underway including:

- Establishment of Foundation Trusts
- Roll out of a National Tariff and Payment by Results
- Increased procurement from the Independent Sector
- Development of Patient Choice through initiatives such as Choose and Book

All of these reforms impact directly on the planning, commissioning and resourcing of cancer services. In particular, the encouragement of a 'mixed economy' of care through use of the Independent sector and establishment of Foundation Trusts, will create a more competitive environment between secondary and tertiary care providers.

Cancer Networks are founded on the principle that the interests of patients and the clinical pathway should take precedence over the interests and aspirations of individual organisations. The system reforms outlined above will make it more challenging for Cancer Networks to deliver effective Networked care. However, they also make it even more important that organisations are focused on the patient journey.

Waiting times

Achieving national cancer waiting times targets for December 2005 will prove challenging for the whole of the NHS. It requires the removal of traditionally long waits for diagnostics (especially imaging and endoscopy) from months to days and a culture change in the way hospitals work together to ensure streamlined and timely referral mechanisms. Achievement is also reliant upon adequate data to indicate the bottlenecks and breaches. Trusts need to work closely with primary care colleagues to map the patient's whole pathway.

Trusts in NW London have highlighted a lack of MDT coordinators, diagnostic delays, speed of pathology reporting and complex patient pathways for urology, Upper and Lower GI as key issues to be resolved in achieving these targets.

Connecting for Health

The National Connecting for Health Programme means that all significant existing systems will be replaced by 2010. The plans for the deployment of new systems in NW London are ambitious. In 2005/6, the core patient administration systems of five out of eight trusts and seven out of eight PCTs will be replaced placing a further strain on the issues of data collection for the running of the network. Efforts need to be made to ensure that the new systems properly reflect the demands of cancer services and that the existing systems are supported as far as possible to yield at least some useable information in the interim.

WEST LONDON CANCER NETWORK

NW London Boroughs and Hospitals



LABEL	HOSPITAL	TRUST
H 1	Central Middlesex	North West London Hospitals NHS Trust
H 2	Ealing	Ealing Hospital NHS Trust
H 3	Northwick Park	North West London Hospitals NHS Trust
H 4	Hillingdon	Hillingdon Hospital NHS Trust
H 5	Royal Brompton	Royal Brompton and Harefield NHS Trust
H 6	West Middlesex	West Middlesex University NHS Trust
H 7	Chelsea and Westminster	Chelsea and Westminster Healthcare NHS Trust
H 8	St. Mary's	St. Mary's NHS Trust
H 9	Charing Cross	Hammersmith Hospital NHS Trust
H 10	Hammersmith	Hammersmith Hospital NHS Trust
H 11	Harefield	Royal Brompton and Harefield
H 12	Kingston	Kingston Hospital NHS Trust
H 13	Mount Vernon*	North West London Hospital NHS Trust
H 14	Royal Marsden*	Royal Marsden NHS Foundation Trust

* Within NW London SHA but not part of the West London Cancer Network

SECTION 2 THE LOCAL AGENDA

WLCN covers an ethnically diverse population of 1.8 million. The population has high geographic mobility - with high proportions of students, migrants and short term residents. This has implications for screening programmes and continuity of care.

There is a lack of good information on the incidence of cancer and cancer treatment among black and minority ethnic (BME) groups in NW London. One of the aims of the final NW London cancer strategy will be to improve equity of access to cancer services including prevention, treatment and care, for transient and BME population groups.

Health Services Infrastructure and Planning

NW London's eight PCTs are responsible for most of the revenue budget and they work with their local acute Trusts and other providers to plan and provide cancer services. Most cross-boundary initiatives, e.g. cancer or diabetes, are led by an agreed PCT with support as appropriate by the SHA. For pan-London issues, the five SHAs share lead responsibilities and host specialist functions e.g. NE London has a lead responsibility for cancer.

HHNT is the main cancer centre in the Network and the principal site for clinical cancer research for Imperial College. The Trust provides a two-site cancer service. All solid and malignant tumours are treated with the exception of paediatric cancer. The Trust is one of three national centres for the treatment of germ cell and choriocarcinoma. A holistic approach to patient care is given with patient information and support services being integral to the service and based on both sites.

Patients from Hillingdon, Harrow and parts of Brent and Ealing, receive some of their chemotherapy and radiotherapy at Mount Vernon Cancer Centre. Cancer surgery is not provided at Mount Vernon. Following a comprehensive review by Bedfordshire & Hertfordshire SHA, it was decided that the Mount Vernon Cancer Centre should be moved into a major new acute hospital at Hatfield in Hertfordshire. The move of the Cancer Centre away from the Mount Vernon site has implications for the population of outer West London. NWL SHA is leading processes to consider the potential for Ambulatory Radiotherapy in alternative sites in outer NW London. The Pan-Networks and SHAs Steering Group, established to oversee the transition from Mount Vernon to Hatfield, is committed to developing and maintaining effective cancer services in NW London. Efforts will be made to keep clinical teams together, during the transitional period.

The Marsden in Fulham Road provides highly specialist cancer services. It is a Foundation Trust and is keen to raise its profile within West London. There is considerable scope for collaborative working with the Marsden and WLCN is working on an effective and constructive service planning strategy.

A wide range of private cancer treatment is available in NW London. Some of this care is privately funded and some commissioned by NHS providers when otherwise unable to meet demand. Independent, especially voluntary sector, providers are particularly important in the provision of supportive and palliative care.

New players in the provision of health services in NW London, particularly Treatment Centres, pose continuing challenges to coordinating already complex patient pathways and to embedding effective multi disciplinary working.

Key Issues for the Hammersmith Hospitals Cancer Centre

- Recruitment of suitably qualified staff to meet demand and networked model of care. There are national skill shortages in oncology and stem cell nursing, radiation physics and therapy radiography. Trust is active in developing new roles and responsibilities and recruiting staff in innovative ways.
- National cancer waiting times targets for December 2005. Achievement of these targets is reliant upon having adequate data to indicate the bottlenecks and breaches. There are concerns that changes required to achieve the target across the WLCN may not be timely enough because of the lack of resource to collect data, manage patient activity, problems with software and a lack of engagement across the network.
- Peer review and JACIE accreditation. Significant co-ordination of these processes is required; a system is in place to ensure that this happens. Key areas of concerns are data collection and patient user involvement for peer review.
- Installation of replacement linacs and brachytherapy for December 2006 deadline. Significant delays in the decision making process have shortened the deadline significantly. Communication of this programme and management of radiotherapy waiting times is essential across the sector. Provision for capacity has been built into the programme to manage waiting times, however, cancer waiting time targets for December 2005 may bring additional problems.
- In the mid term (4-7 years), the main issues for the cancer service will be the provision of the additional services required by the relocation of Mt Vernon, including changes in the provision of chemotherapy and radiotherapy. In the long term (8-10 years) there is likely to be a redevelopment of HHNT with cancer services consolidated in purpose built facilities with access to all the latest technologies e.g. positron emission tomography (PET) scanning, magnetic resonance imaging. (MRI), Proton Beam therapy, Genetics and stem cell services. This will enable the centre to continue to deliver high profile excellent cancer services within consolidated networks.

West London Cancer Network

The West London Cancer Network (WLCN) was established in 1999 (see map on page 9). The ultimate accountability for managing the cancer agenda rests with the Cancer Network Board reporting to NWL SHA. The Network is supported by a small Management Team including Network, Clinical and Nurse Directors and support staff.

The recent National Audit Office Report 'The NHS Cancer Plan: A Progress Report'³ has highlighted the importance of Strategic Health Authorities, working through PCTs, ensuring that Cancer Networks have the resources they need to deliver an effective and sustainable performance. Last year the Network established an SLA with the PCTs which binds them to a contribution to core costs. This represents real progress. However, the resourcing level secured is the absolute minimum needed to deliver on the cancer agenda.

³ The NHS Cancer Plan: A Progress Report National Audit Office. March 2005

The work programme of the Network Board and the Network Team is substantial current priorities include:

- Leading on the development of all local Improving Outcomes Guidance plans.
- Leading the sector wide peer review programme – Peer Review visits to all Trusts and PCTs planned for January – March 2006.
- Reviewing and developing the Network Board governance arrangements
- Leading the development of networked clinical care across Specialist and Local MDTs.
- Establishing a sector wide clinical governance programme.
- Providing clinical leadership development to all clinicians who undertake sector wide roles.
- Developing and managing a service redesign programme including single and multi organisational projects.
- Leading the development of the infrastructure needed to support local and specialist MDTs whose membership is drawn from multiple hospital sites.
- Jointly leading with the St HA a work programme to ensure all Trusts deliver on the cancer waiting time targets.
- Establishing and supporting a Cancer Users Forum.
- Leading the development of sector wide arrangements to support and inform cancer commissioning.
- Working jointly with the Workforce Confederation to develop a workforce plan for cancer which supports the service strategy.
- Leading on a cancer informatics programme to enable clinical audit and improved activity reporting and analysis.

The WLCN has also highlighted issues on which there will need to be an emphasis in the preparations for Peer Review:

- **Performance management** Clearer more robust processes need to be introduced to manage the outputs of the network clinical and tumour groups and to monitor progress against the Network cancer commissioning priorities.
- **Leadership** An important part of the Network infrastructure includes development of the lead cancer roles taken by clinicians and managers in Trusts and PCTs. Many of these roles are dictated by national guidance e.g. lead cancer clinician and lead cancer nurse. There is a difficulty in filling these positions with influential staff due to the many calls on senior personnel time. All of these key posts need to be related to the network and supported by the network team.
- **Clinical Advisory Group** An important aspect of the lead cancer role is to ensure that the cancer agenda has an adequate profile in the organisation and is managed in a focused manner. Work examining alternative models for securing clinical advice for the Board and securing effective clinical leadership of the cancer agenda is being taken forward.
- **Clinical Governance** Robust links with local Trust and PCT clinical governance structures and processes are needed so that Network clinical protocols and clinical reconfiguration changes are embedded in local arrangements and subject to regular monitoring.
- **Service Improvement** The purpose of Service Improvement is to help Trusts and PCTs to improve capacity and the patient experience through service and workforce role redesign. WLCN employs a full time Service Improvement Lead

(SIL), as one of the core team. At present the network is rolling out a two-year programme supported by a small team of Service Improvement Facilitators. Their focus will be on implementing the evidence based '10 High Impact Changes' for cancer. The work programme will also include:

- Contributing to efforts being made to achieve cancer waiting times.
- Helping Trusts to fulfil the requirements of Peer Review.
- Supporting the development of whole patient pathways for specialist MDTs working across multiple sites.
- Developments in video-conferencing.
- Developing the workforce: including enhancing clinical leadership and team building and the MDT coordinator roles within the network.

Finance and Cancer Commissioning

There is not yet a clear understanding of the totality of the investment made in cancer services provision across the Network, nor how the NW London spend compares with that in other Networks and whether this represents value for money. The introduction of Payment By Results and the national tariff may help to provide a clearer understanding. Until this happens, this remains a significant gap in the baseline data on cancer spend in NW London.

A total of £570m new money was made available nationally for investment in cancer services between 2001/02 and 2003/04. The PCTs in WLCN received a total of £23 million of this new cancer investment. The cancer tracking exercise conducted by the Department of Health in 2003 and 2004 assessed that approximately £12 million (52%) of the resource made available to West London PCTs had been invested in cancer service developments. This situation may change with earmarked funds becoming mainstreamed to PCT budgets.

In the future, cancer plans will need to be costed, prioritised, agreed and progressed through routine and ad-hoc planning, funding and commissioning arrangements at PCT level. There is some concern this will make the realisation of cancer priorities within a climate of overall and variable deficits across NW London more difficult. Money allocated for cancer services needs to be better identified and protected.

The Network is planning to establish a new Cancer Commissioning forum to develop a sector wide approach to cancer commissioning in the future. This will ensure that cancer commissioning is clearly driven by quality standards and patient pathways to drive up standards of care.

Workforce availability

Recruitment of suitably qualified staff to meet demand and the networked model of care is a significant problem. There are major problems with the availability of key groups of medical staff, in particular with regard to Histopathologists (meaning that Histopathology advice is often absent at MDT meetings) and Dermatologists. There is also a general recognition that increasing radiographer numbers would produce improvements in the radiotherapy service for which some cancer patients are having unacceptable waits (three months for some skin cancer patients). National guidelines suggest a minimum of 64 radiographers are required to run 6 linear accelerators for 8 hour days. Currently the Hammersmith whole time equivalent establishment is 42.6. There are also national skill shortages in oncology and stem cell nursing and radiation physics.

Poor availability of input data clerks is also causing problems for the Tumour Groups' participation in clinical audit. The Lung TWG for example has indicated that it is unable to participate in the National Lung Cancer Data Project for this reason.

Capacity Issues

A number of Groups have highlighted capacity issues with regard to endoscopy which is the key diagnostic investigation that enables the early diagnosis of oesophageal and gastric (upper GI) cancers, and colorectal (lower GI) cancer. There is strong evidence that many of these deaths could be prevented by an earlier diagnosis. Additional funding is necessary, either to improve facilities, for staff development, the upgrading of endoscopy database systems, or to replace aging equipment.

Brachytherapy services in particular are inadequately funded in NW London. This affects prostate cancer patients as well as gynaecological and head and neck cancer patients. A dedicated brachytherapy suite is being installed at the Hammersmith.

Information Technology

High quality cancer services depend on the availability of accurate data. The networked nature of cancer services means that unusual demands are placed on the information systems available. At present, these systems are unable to meet the information needs of the network; a situation that is unlikely to improve significantly until National Connecting to Health Programme is complete.

Tumour working groups require improved information support for audit, to analyse outcomes and to connect to existing national registries.

Cancer Waiting Times

Trusts have addressed this data requirement so far by employing extra staff and adding functionality to existing core systems and/or by developing stand alone databases. There are recognised problems with the accuracy of the data collected. Information regarding waiting times will become increasingly important with the new targets for cancer care due to come into effect in 2005.

Activity Information

This information is currently obtained from: Thames Cancer Registry, HES data (coming from PAS systems), CMDS data (from PAS systems), in-house systems within trusts (clinical specialty systems, prescribing systems, pathology systems, radiology systems etc). There needs to be improvement in the availability of information to better support service improvement.

Cancer Registration

In order to improve the timeliness and accuracy of this data, the existing manual collection needs to be improved. The changeover to electronic submission of registration by Trusts needs to continue before being superseded by NpflT. A network action plan is underway to address these two streams of work. In addition there is a severe shortage of data technicians in London which needs to be addressed.

The WLCN website could be used to provide better communications support for all of the network groups and to enhance work on patient information and user involvement.

There are significant information needs for TWGs to allow effective team working without using an excessive amount of clinician time. Video conferencing may for some teams help join teams on different sites. In addition there is a need for an information strategy to underpin the daily working of the MDTs collecting data and generating reports to improve communication with other sectors in the health economy as well as the patient and his carers.

SECTION 3 HEALTH IMPROVEMENT

This section highlights the efforts made to promote good health and prevent cancer and issues surrounding the screening programmes in NW London, particularly the problems surrounding the West of London Breast Screening Service (WoLBSS).

Cancer Prevention

Factors which predispose to the risk of developing cancer include those that are relatively fixed e.g. genetic makeup and those which are relatively easily modifiable e.g. lifestyle. It has been estimated that up to 60% of cancers may be attributed to factors that are amenable to change:

- Smoking
- Diet
- Obesity
- Alcohol
- Exposure to certain chemicals or substances
- Sun exposure.

Survey information from 1994-1996 showed that around 30% of NW London's population smoked. Rates were highest in the inner London boroughs, and studies have shown even higher rates among younger age groups and people of lower social class. There are also varying rates across West London of obesity and alcohol consumption.

The PCT has a key role to play in reducing the incidence of cancer. It does this by encouraging, supporting and promoting healthy behaviours, which as well as helping to prevent cancer can reduce the incidence of other diseases such as coronary heart disease and diabetes. Early intervention is crucial and therefore much of their work is targeted at children and schools.

PCTs are now very actively engaged in health promotion and cancer prevention activities, chiefly focused on:

- Smoking prevention and cessation: Smoking is a major risk factor for cancer. Information is available One to one support sessions, group motivational support and drop in clinics are available to assist people give up smoking. Workplace group clinics are also offered. Pregnant women, manual and low income workers, black and ethnic minority groups and older people where smoker numbers are higher, are targeted.
- Healthy eating: the aims of this work is to get the '5 a day' message across and making fresh fruit and vegetables more affordable and accessible. Food co ops have also been introduced successfully in many parts of NW London. Much of this work is targeted at schools.
- Increasing physical activity /healthy weight management: exercise referral schemes are now widely available across NW London. PCTs work with schools to encourage more sport.

As well as the initiatives described above, PCTs are active in developing and disseminating health promotional literature and in further initiatives around sun awareness, breast awareness and men's health. In some areas, cancer prevention

strategies focus on the most common cancers in the local population i.e. breast, lung, colorectal and prostate.

Issues

- Further work is needed to reduce the smoking rates in West London
- There should be a more coherent strategy of health promotion across the Network PCTs e.g. on alcohol consumption and sun safety. Links should also be strengthened in relation to pan-London work.
- Stronger links should be created with other disease areas where there are common health promotion interests.

Further work is needed to ensure that the general population is aware of the symptoms which might be caused by cancer and to seek early professional advice.

Screening Programmes

This part of the Section deals with the two major screening programmes underway within the UK, namely breast and cervical screening. In 2006, screening for bowel cancer will be introduced in England. This will have significant resource implications, but these have not yet been quantified.

Breast Screening

The NHS Breast Screening Programme provides free breast screening every three years for all women in the UK aged 50-70 (extended from 64 to 70 in 2004).

Nationally around one-and-a-half million women are screened in the UK each year. In September 2000, research was published which demonstrated that the screening programme has lowered mortality rates from breast cancer in the 55-69 age group⁴. It is estimated nationally that the programme is on course to save 1,250 lives per year (25 per cent reduction in mortality) by the year 2010. The rate of cancers detected nationally per 1,000 women screened and the standardised detection ratio have risen steadily.

Breast screening in London is not as well attended as elsewhere in the country and does not reach national targets for uptake. There is evidence that the method of offering breast screening locally and across London has had less success than elsewhere in the country. This may be at least in part be as a result of the high population turnover.

The national target is that 70% of eligible women aged 50-64 should be screened. In 2002-03, coverage (the percentage of the total eligible population screened) in England for the population aged 53-64, which is the age range now highlighted in the DOH statistical bulletin, was 75.3%. In London in 2002-03, coverage for women aged 53-64 was at 64.3%, considerably lower than the national average. In NWL SHA it was 56.2%. The uptake rate (the response to an invitation rather than the measure of the population screened i.e. coverage) at 61%, in London is significantly lower than the national average of about 75%. Local statistics also show that the proportion of women who are being screened outside the recommended time for

⁴ Effect of NHS Breast Cancer Screening Programme on Mortality from Breast Cancer in England and Wales, 1990-8: Comparison of Observed with Predicted Mortality. BMJ 2000:665-669

screening, i.e. greater than 36 months between screens, is unacceptably high. However statistics show that when women from West London do attend the programme they are receiving a high quality service.

The challenge is to encourage eligible women irrespective of socio-economic status, ethnic diversity or special needs.

Services in NW London

Breast Screening services for the West London population are provided by (WoLBSS) and the North of London Breast Screening Service (NoLBSS).

WoLBSS is managed by HHNT, provides breast screening to seven PCTs⁵. WoLBSS has the second lowest uptake of all breast screening units and the data indicates that between 1996-2002, on average 45% of all women invited for screening did not respond to their invitation. Women are invited to a specialised breast screening unit, which can either be mobile (strategically deployed depending on the target population), hospital based, or permanently based in another convenient location such as a shopping centre. The recent visit to WoLBSS from the London Quality Assurance team commended the unit on the arrangements they have in place for ensuring the quality of the service.

NoLBSS is managed by Barnet & Chase Farm Hospitals Trust. NoLBSS provides breast screening to the population of Brent, Harrow and Hillingdon within the Network. It is based at Edgware Hospital and serves an age-eligible population of 165,000 women. Like WoLBSS there are issues about the uptake of the service and the length of time between screens but otherwise the service complies with national requirements. A static site has been developed at ACAD at Central Middlesex Hospital in conjunction with North West London Hospitals Trust and various initiatives are being developed in order to improve coverage and uptake, including second timed appointments, pre invitation letters to women aged 49, the use of more accessible sites and pre paid reply cards sent with the invitation. The Unit is also looking critically at the skill mix of the workforce providing the service.

Both NoLBSS and WoLBSS are developing static sites to serve the inner city populations where it is proving increasingly difficult to site mobile services.

Both of these services are part of the overall services providing screening to London women. This is in addition to local initiatives. Pan-London work includes the possibility of developing infrastructure that will support all London Breast Screening services e.g. centralising call/recall services, providing a single call centre for women to access, the development of a digitised mammography which will have the potential to be more flexible to women's needs in terms of being able to choose where she has her mammogram taken.

Issues

- Continue to local initiatives to improve coverage and uptake.
- Agree responsibilities with PCTs with regard to health promotion and look to developing new ways of collaborative working.
- Continue the development of the workforce.

⁵ Hillingdon, Kensington and Chelsea, Westminster, Hounslow, Ealing, North Surrey and Hammersmith and Fulham PCTs

- Participate in pan-London initiatives.
- Consider the introduction of digital mammography.

Cervical Screening

The NHS Cervical Screening Programme (NHSCSP) provides cervical screening for women aged 25 to 64 on a three yearly basis for women aged 25 to 49 and on a five yearly basis for women aged 50 to 64. Nationally approximately 3.5 million women were screened in 2003/04. In NW London 555,600 women were eligible for screening of whom 74.1% of women were screened. This compares with a coverage of 80.1% nationally. As with breast screened the coverage and uptake of cervical screening are consistently lower in West London compared to national figures.

Within West London cervical screening is provided by four programmes which reflect the four old Health Authority areas. All areas are involved in initiatives aimed at increasing coverage through a variety of targeted activities both to health professionals and to women.

All parts of the programme participate in the national quality assurance scheme. The recent visit to Hammersmith Hospital laboratory highlighted some issues about the work of that laboratory in relation to pathologists based elsewhere and the need to strengthen the IT infrastructure, which will need to be resolved within the next few months.

At the present time the cervical screening programme is undergoing a major change with the introduction of a new method of detecting pre-cancerous changes of the cervix. The new technology is known as Liquid Based Cytology (LBC). LBC will require that staff involved in taking, processing and interpreting samples will all need to be retrained in the new technique before it can be brought into routine use within West London. The means that all smear takers and laboratory staff will need to be involved. NW London as well as needing to convert to LBC also hosts the London Training School which will be providing the training to all London laboratories.

As well as introducing a new technique for the reading of cytological specimens LBC processing machines are able and indeed run more efficiently if they are able to process large volumes of specimens, about 80,000 specimens per year. The effect of this is to bring about a centralisation of the laboratories providing the processing and reading of cervical cytology.

In NW London it has already been agreed that there should be two sites processing cervical samples for the whole sector, based at Northwick Park and Hammersmith Hospitals. An additional site for the reading of smears has been agreed at St Mary's Hospital. (These samples will be processed by Northwick Park Hospital.) Northwick Park Hospital has already introduced LBC. The laboratory at Hammersmith Hospital will be introducing it shortly.

LBC has several advantages over conventional cytology:

- It is easier and quicker to read
- A higher proportion of samples can be read

These will contribute to making the programme more effective and improving coverage.

One of the benefits of LBC is that it is easier and quicker to interpret than conventional cytology. In recognition of this it is proposed that there will be a new target for turning around results to women, so that all women will receive their results within one week of their test being taken.

Within the colposcopy service issues have been identified in relation to the availability of colposcopy nurses and the waiting times for colposcopy.

Issues

- Continue initiatives to increase uptake and coverage.
- Resolve issues relating to the organisation of Hammersmith Hospital laboratory.
- Continue the introduction of LBC in line with national targets.
- Consider the preparation needed to ensure compliance with proposed new turn-around time for results.
- Ensure the availability of colposcopy nurses and compliance with waiting times for colposcopy (see Gynaecology Tumour Group section).

Colorectal Screening

There is a national guidance that a national colorectal screening programme will be introduced in England in 2006. This programme will cover all people aged 50 to 70. It is understood it will use faecal occult bloods as the primary screening test. For people in whom the test proves to be positive a further procedure will be required. As yet it is unclear what the national protocol will be. However, whatever is agreed will put pressure on an already stretched endoscopy service. (It is anticipated that the newly published NICE Guidelines for referral for suspected cancer may have the effect of increasing the pressure on endoscopy services.) Further guidance is awaited on this.

IMPROVING OUTCOMES GUIDANCE (Department of Health, NICE) COMPLIANCE IN NW LONDON

Tumour Group	Existing/Prospective Guidance	Comments on Compliance
Breast cancer	Improving outcomes in breast cancer. Manual update August 2002. Familial Breast Cancer published 2004.	Generally Good. Some preparatory work will be needed by the network
Colorectal cancer	Improving outcomes in colorectal cancer. Manual – 1997, revised IOG guidance issued in June 2004.	Significant issues arise from new guidance because earlier detection is being encouraged. A substantial agenda.
Lung cancer	Improving outcomes in lung cancer. Manual issued in 1998. New guidelines – February 2005.	Guidance urges increased treatment options for lung cancer patients. Revenue implications.
Gynaecological cancer	Department of Health Guidance issued 1999.	An area of significant progress to date.
Upper gastro-intestinal cancer	Manual for improving outcomes for upper gastro-intestinal cancers issued in 2001.	Good progress achieved to date, but more work still needed. The possibility of a London-wide pancreatic cancer centre is still under review.
Urological cancer	Guidance issued in 2002.	Excellent progress, but many detailed issues still require development across the Network.
Haematological malignancy	Guidelines issued in 2004.	These will have major implications for the Network and pose a substantial area of new work.
Head and neck cancer	Improving outcomes guidance issued in 2004.	No major reorganisation in NWL required but changes to Mount Vernon have implications for patients.
Cancer of the brain and central nervous system	Improving outcomes guidelines issued for consultation in 2005, planned to be published in 2006.	No major reorganisation in NWL anticipated.
Skin cancer	NICE guidelines due 2006.	Urgent preparatory work needs to get started, e.g. establishing a TWG in recognition of the new guidelines.
Paediatric cancer	National guidance expected in the summer of 2005.	Will need to be examined on a London-wide basis.
Specialised Commissioning	Regular NICE or Royal College guidelines issued.	Commissioning arrangements in place but cost pressures relating to these services continue to rise.
Bone Cancer	Guidelines expected in 2006.	Some preparatory work will be needed by the network
Supportive and Palliative Care	Guidelines issued in 2004.	Considerable work to be done to meet Guidance. A detailed work programme is in place.
Urgent Referral for suspected cancer	Guidance issued in June 2004.	This guidance will have a major impact on the provision of services within West London and will involve substantial changes in practice in primary care

Key

Work to date	Current work	Future work
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SECTION 4 TUMOUR WORKING GROUPS

Introduction

This section describes services relating to each tumour group and the issues facing them as they work to improve services. Each section is a distillation of the report provided by the Tumour Working Group and focuses on strategic issues for the network and specific issues for the group.

The table above sets out the present state of guidance in relation to each tumour group, describes (at a broad level) the extent of compliance within NW London and highlights those tumour groups that have been the focus of concerted work over the past few years as well as those on which there is a current focus.

1 – BREAST CANCER

Breast cancer is the most common form of female cancer, accounting for almost 30% of all cases of cancer in women. Screening is an important part of the Breast cancer services and is described in detail in Section 3.

Strategic Issues

WLCN complies with many of the key recommendations in the NICE guidance. Most units comply with four week waiting times for treatment and five working days for triple assessment results. However each unit undertaking breast surgery must be managing at least 100 new breast cancers each year. Some centres in WLCN fall below this target and will be identified in Peer Review.

Issues highlighted by TWG

The West London Cancer Network Breast Tumour Working Group (TWG) includes eight Hospital Trusts, seven of which are within the Network. The question of whether Kingston should be part of the South West London Cancer Network is under review.

- It is felt that there is a need for the MDTs in the different Trusts to link their activities possibly by video-conferencing.
- The breast cancer service is being adversely affected by the increasing demand on the symptomatic breast service in secondary care. Further increase in capacity will be needed to avoid increasing times from diagnosis to treatment for breast cancer patients.
- At present there is only a very limited lymphoedema service. A programme is underway to improve this but there has been difficulty in recruiting to the specialist nurse post. Further work is needed to find the right person.
- Protocols for Capecitabine, Faslodex, and Bondronat treatments are needed
- A service improvement programme for the Network is needed.
- Recruitment to National cancer Research Network (NCRN) trials over the whole Network needs to be encouraged.
- Further work is required to develop a pathway for breast reconstruction across the Network.
- Sentinel Lymph Node Biopsy needs to be routine practice across the Network.

- Data collection remains limited and a single system is needed. Developing data collection with British Association of Surgical Oncology (BASO) data base is suggested.
- Developing skills for clinicians other than radiologists to undertake ultrasound scanning of the breast is needed in order to shorten waiting times for diagnostics.

2 – COLORECTAL CANCER

Colorectal cancer is the sixth most common cause of death in the UK (19,000 deaths per annum) and the second most common cause of death from cancers. If detected early, the 5-year survival rate is good, but the condition is frequently diagnosed at a later stage when the survival rates are poor. Screening for bowel cancer in the UK will commence in 2006. A national working group has been established to develop the national implementation programme. Once national guidance is available as to what form the service will take, detailed work will be needed in West London to look at how the service will be organised and offered locally.

Strategic Issues

The application of the new guidelines for urgent referral will substantially increase the number of in patients requiring urgent assessment. Work has already started on the introduction of a primary care referral protocol. These new guidelines and the introduction of screening will place an additional burden on endoscopy services which are already under severe strain.

Protocols and service sharing in NW London are difficult to manage efficiently because of the nature of the patient pathways. For example at Northwick Park and West Middlesex Hospitals, some patients attend the Hammersmith Hospital, while others attend cancer centres at Mount Vernon or the Royal Marsden.

There is likely to be a significant change in practice over the next 5 years as laparoscopic techniques for the treatment of colon cancer become more frequently applicable.

The new guidelines require that MDTs should review links with specialist services so that patients with respectable liver metastases and anal cancer are referred appropriately. In particular liver surgery for colorectal cancer is poorly coordinated within NW London – work is needed on the referral pathways.

Emergency patients should be managed by MDT members specialising in colorectal cancer. A piece of cross trust collaboration has provided the environment for the appointment of new surgeons to provide emergency and specialist surgical services. It is possible that some emergency colorectal cancer patients in WLCN are operated on by non specialists because of the nature of the emergency rotas or other pressures within the service.

Issues highlighted by TWG

The MDTs in West London for colorectal surgery tend to work in isolation and there is a need to ensure that the service is equitable and meets the same standard across the network.

- Draft clinical protocols from the TWG are available and must be completed for Peer Review in January 2006.

- Strengthening the TWG attendance will ensure that there is a more homogeneous view of service development needs.
- There needs to be funding identified for a Network agreed audit.

There are issues outstanding from Peer Review in 2002, which will become high priorities at the next round.

- In particular the 2002 Peer Review noted that the facilities required to ensure accurate and timely diagnosis at Charing Cross were inadequate. A Change for Patients project has mapped the patient pathway and identified the "bottlenecks" with the intention of reducing waits. Further service reorganisation is expected with the appointment of new gastroenterologists within the sector.
- The 2002 Peer Review also identified that additional staff to support the MDT at West Middlesex Hospital are needed in order to ensure better communication with primary care and data collection. This may apply to several other local MDTs as well.

3 – LUNG CANCER

Lung cancer remains the leading cause of cancer death in men and the second most common cause for women in the United Kingdom. Since the 1960s, when the link between smoking and lung cancer became accepted there has been a significant reduction in the incidence of lung cancer. In WLCN in the period 1991-2002, the number of registrations for men dropped by almost half and for women by almost 25%. Lung cancer is common amongst Bengali and Chinese communities.

Prevention is the principal means by which the impact of lung cancer on the population can be radically reduced (See Section 3).

If a chest X-ray or chest computed tomography (CT) scan suggests lung cancer, patients are offered an urgent referral to a chest physician who is a member of the lung cancer MDT. Rapid access to expert specialist assessment is important for lung cancer patients so that the relatively small numbers for whom potentially curative treatments (surgery or radical radiotherapy) may be beneficial can be identified.

Strategic Issues

Despite the grim prognosis of lung cancer a number of new strategies and treatments are having a positive impact and work needs to be done to portray this disease in amore positive light.

All Trusts have the capability to appropriately diagnose and stage lung cancer apart from invasive surgical staging or (PET) scanning. The new NICE guidelines recommend that every network must have a system of rapid access to PET scanning for patients who are potential candidates for surgery or radical radiotherapy. Currently PET scanning is only available at the Hammersmith, the Marsden, at Mount Vernon and in private facilities in London. This requirement will pose capacity issues for the WLCN. St Mary's is conducting a PET audit.

It is also proposed that inoperable patients be treated using the hyperfractionated accelerated radiotherapy (CHART) regimen. This is widely supported across the tumour group, but there are significant resource implications because patients have to be admitted for twice daily radiotherapy, and additional radiographer time is required.

Issues highlighted by TWG

- Communications between cancer units and centres are not as easy as they might be. The Lung tumour group has highlighted problems in relations with North West London Hospitals.
- The TWG has also discussed the importance of developing communication technology such as teleconferencing, an effective EPR and systems for making PACS compatible. This would further multi disciplinary working within and across Trusts, enabling the safe transfer of patient data from cancer unit to cancer centre and would compensate for deficits on some sites.
- At present lung cancer audit data is only kept on an individual trust basis (and not by all trusts) and not across the network.
- Lung cancer research is generally not as active as it might be because of the traditionally poor outcomes of the disease. This needs to change.

4 – GYNAECOLOGICAL CANCERS

Gynaecological cancers are a diverse group of diseases. The most common cancers affect the ovaries, cervix or endometrium (lining of the uterus). Ovarian cancer is responsible for more deaths than all the other gynaecological cancers combined, ranking fourth after breast, lung and bowel cancer as the leading cause of cancer death in women. Diagnosis of ovarian cancer can be difficult. In the majority, the disease has progressed to a late stage at time of diagnosis and the prognosis is poor. However survival rates for ovarian cancer have improved and are better in WLCN than in SE England as a whole. Population screening to identify pre-cancerous lesions, using cervical cytology and colposcopy, are associated with a significant reduction in the incidence of cervical cancer.

All gynaecological cancers are investigated and managed according to strict Network derived guidelines and protocols. About 90% of the referrals to the Gynaecology Cancer Centre at the Hammersmith are from WLCN. Some parts of the network still refer elsewhere for cancer centre services e.g. a proportion of women presenting to the Chelsea and Westminster Hospital will be treated at the Marsden Hospital.

Strategic Issues

Improving outcomes in gynaecological cancers is an area of significant progress in NW London. A major gynaecological cancer centre now exists at the Hammersmith Hospitals following a period of reconfiguration of services. The new centre and TWG are confident that they have achieved the targets as laid out in the NICE/IOG guidance. The centre considers that most of the national peer review standards are already being met.

The tumour group has highlighted the need to replace the linear accelerators on the Hammersmith site and to develop modern brachytherapy facilities for WLCN. The case for renewal of the linear accelerations and brachytherapy has recently been approved.

Issues highlighted by TWG

- Network wide audit could be improved which might assess local diagnostic pathways and follow-up regimens. More work is needed across the network, principally more efficient clinical data collection and its subsequent distribution across the network.

- The centre has also underlined the importance of developing video and data conferencing facilities. Integral to this total IT solution would be individualised shared care referral and discharge patterns for all the units in the network. This would greatly enhance communication and provide a platform for audit, clinical governance and future development.
- There are concerns about the ability of some trusts to meet the waiting times for colposcopy.
- There are also concerns about the quality of the data available in relation to colposcopy waiting times because of problems with some IT systems. The TWG should audit what the issues are for this Network.
- There are also concerns about the availability of colposcopy nurses. The TWG together with trusts and PCTs should work together to modernise the service and look at the available skill mix.

Issues for the Gynaecological TWG arise from the difficulties in the screening for cervical cancer. (See section 3)

5 – UPPER GASTRO-INTESTINAL CANCER

Cancers of the oesophagus, stomach and pancreas are referred to collectively as upper gastro-intestinal cancers. Pancreatic cancer is dealt with below. Oesophageal and gastric cancers are rarely diagnosed until they reach an advanced stage.

Strategic Issues

Oesophageo-gastric cancer teams serving populations of more than one million are now recommended.

Current patient pathways for Oesophageal and Gastric care in NWL are complex. WLCN has agreement for a single Oesophageo-Gastric Centre on the St Mary's Hospital site. This plan is to be achieved by April 2007. An implementation working group is to produce a final plan for the WLCN board in December 2006. A joint MDT for Charing Cross and St. Mary's clinical practice has been established.

Further work to achieve the single centre model is needed as follows:

- The integration of the Harefield practice.
- The role of neighbouring cancer centres (Mt Vernon and Marsden) following the centralisation of oesophago-gastric cancer surgery.
- The potential impact of centralising gastric cancer surgery on the surgical capacity of local Trusts.
- Detailed work needs to be conducted to identify service and workforce redesign options, transferable resources from individual Trusts and the additional investment necessary.
- With reversal of flows being considered by e.g. West Berks, an agreed forum for confirming changes of direction needs to be identified.

In common with other tumour groups, upper GI specialists have highlighted the need to enhance the capacity of endoscopy services.

Issues highlighted by TWG

- Documented local referral policies for diagnostic services for suspected cancer are needed and the TWG will be developing these in the light of the new configuration over the next 6 months.
- It is a priority for the TWG and specialist MDT to achieve a network wide audit of cancer specific outcomes from the treating centres.
- The capture of data to underpin the work of the new specialist MDT and its related local MDTs is essential to ensure adequate continuity of care.

Pancreatic Cancer

In NW London in the period 1991-2002, registrations for pancreatic cancer remained 100% constant for men (at 89 registrations per 100,000), with a similar picture for women. Diagnosis of pancreatic cancer is difficult for GPs to detect on the basis of symptoms alone. Jaundice and/or pain can be caused by pancreatic cancer.

Strategic Issues

Those likely to have pancreatic cancer should be referred to a specialist pancreatic cancer team in the cancer centre, who would serve a population of between two and four million. The Hammersmith Hospitals has a major clinical and academic interest in both malignant and benign pancreatic disease. In September 2005, Pancreatic transplantation will move from St Mary's to the Hammersmith Hospital.

In London, two Pancreatic Cancer Centres have been confirmed for NELCN and SELCN. The status of services currently provided by Hammersmith, The Royal Marsden and The Royal Free Hospitals is being assessed by an independent review panel over the summer in 2005. The Department of Health has confirmed that two more centres can be approved for London.

Issues for the TWG

Tumour group meetings have been recently established. The referral process to the Hammersmith and management guidelines were agreed, a communication pathway clarified and an action plan agreed. These agreements now need to be widely disseminated.

6 – UROLOGICAL CANCER

Urological cancers cover 5 main tumour sites: prostate, bladder, kidney, testis and penis. They are common, particularly prostate cancer, which has increased by 77% over the past ten years in NW London, while bladder cancer has reduced by almost 40% over the same period. Prostate cancer incidence is highest amongst Black communities. Testicular cancer whilst still rare is the commonest cancer in men under 45.

Strategic Issues

Following national guidance in 2004, a two centre model has been established to serve the WLCN resident population of 1.8 million. The surgical centres are to be based on the Charing Cross site and at Northwick Park Hospital. It is expected that the specialist centres will be operational by April 2007. Supra network teams will manage the rare cases of complex testicular and penile cancer.

Issues relating to individual cancers

Prostate Cancer

Brachytherapy for prostate cancer patients is currently offered at St. Mary's and Mount Vernon Hospitals. Brachytherapy services in general are inadequately funded. Development of the service will need to be considered together with the other users of brachytherapy techniques – primarily gynaecological and head and neck cancer services currently based at HHNT.

It is expected the benefits of shorter stay and reduced morbidity from the developments in laparoscopic and robotic surgery for prostate pelvic cancer will be proven in the UK. New systems of treatment with robotic and laparoscopic surgery will need to be funded and adopted within the network. At present robotic surgery is undertaken at St Mary's.

The network needs to establish where a salvage treatment service for radiotherapy patient failures is to be sited and equip this with at least one minimally invasive option (cryotherapy or focussed ultrasound).

Renal cell cancer

It is important that the management of renal cell cancer is agreed by all participants in the network. Patients with bilateral tumours or cancer in a solitary kidney should be treated in the specialist centres. Laparoscopic partial and radical nephrectomy are undertaken for renal cancer within Imperial Hospitals Urological Combined Centre (IHUCC) and at Northwick Park. At present there are inconsistencies in the service which individual centres offer. A formal clinical and referral pathway for renal cell cancer services should be agreed.

Complex cancer cases with supradiaphragmatic extension are treated at Charing Cross and the surgery undertaken in conjunction with the Royal Brompton and Marsden Hospitals. This highly specialised service lies outside the current guidance but continues to be developed and attract referrals from other cancer networks. A formal appraisal of this service and process mapping needs to be undertaken by the TWG.

Testicular Cancer

The initial diagnosis and surgical treatment by orchidectomy is carried out by the local urological cancer team. Staging and further reviews for testicular cancer are currently delivered by the supra-network specialist cancer team at HHNT with Mount Vernon Cancer Centre. A national service for testicular cancer, and rare retroperitoneal tumours requiring retroperitoneal surgery is provided at Charing Cross.

Formal development of the testicular cancer MDT is needed with agreement on all pathways into the cancer centres.

Penile Cancer

A supra-regional service at University College London Hospital (UCLH) provides care for WLCN patients. Some specialist penile cancer surgery is undertaken at Charing

Cross Hospital. The specialist penile dermatosis clinic at Chelsea and Westminster Hospital provides a national diagnostic service. The scope of this service requires more coordinated work across the whole of North London.

Issues highlighted by TWG

- A priority for the Tumour Working Group is to further develop the patient pathway for all tumour types in Urology and to complete protocols for treatment and referral required for Peer Review.
- Regular audit is needed to inform protocol development. Pan network audit projects to assess clinical outcomes for each major tumour type should be funded by the network.
- Considerable administrative support is required to encourage effective cross-working between different Trusts. Further investment will be needed to support the development of both the local and specialist MDT's and pathway coordinators and specialist urological cancer nurses.
- The new Urology MDT management system being developed in the Charing Cross centre may be the answer and further work is needed to see if this can become a network wide model.
- A unified patient information system is needed for the network. This would improve information and support to patients and carers.
- Waiting times for diagnosis are a significant issue for patients with Urological cancer. Improvements can be made by teaching Urologists to undertake simple ultrasound examinations in the clinic. The network needs a programme of education for ultrasound for both consultants and juniors.
- Increased participation in clinical trials is needed.

7 – HAEMATOLOGICAL MALIGNANCY

Haematological malignancy is a general name for three main types of cancer: Leukaemia, Lymphoma and Myeloma. There is great variation in the presentation and severity. Some haematological cancers quickly produce symptoms, others cause few or no symptoms and are found only by chance. Haematological cancer is diagnosed and managed by a team, which is also mostly associated with the routine provision of general haematology services in Trusts.

Strategic Issues

An agreed plan for implementing the NICE guidance is expected in July 2005. The issues arising from the guidance are as follows:

- Haematological cancer patients should be treated by a multidisciplinary team covering a population of more than 500,000 population. To achieve this objective, the consolidation of individual Trust services into a smaller number of teams is needed. NW London's population would suggest a maximum of three local and one specialist team. Further issues include the need to consolidate treatment services and define the patient pathway to the Haematological Cancer Centre.
- Multidisciplinary teams need to include a clinical nurse specialist and a palliative care specialist. The sector has managed to increase the number of haematology cancer nurse specialists (see the Supportive and Palliative Care section). Further medical, administrative and specialist nursing staff will be needed to ensure the MDTs work in an effective and unified manner

- Some types of haematological cancer, especially lymphoma, can be difficult to diagnose accurately and requires a variety of tests from a range of disciplines to come to a final conclusion. Most of these services are available within the Network. However they have not been integrated and access has been variable. A proposal is being developed which will integrate services currently available within the Network and ensure their optimal use. Where services are not readily available within the Network an agreed pathway for extra Network referrals will be developed, where it would be an advantage to do so to make the best use of scarce resources. The aim is to develop an agreed pathway for diagnostic specimens and integrated reporting to clinicians.
- People with neck lumps should have rapid access to diagnostic services. The sector is in the process of developing a system of rapid diagnostic clinics for lumps in the neck to speed the diagnosis of lymphoma and head and neck cancer. Lump clinics will need to be of a multi-disciplinary nature either supervised by General or Ear Nose and Throat (ENT) surgeons and, ideally, involving a histo-cyto-pathologist.
- Complex chemotherapy for acute leukaemia should be carried out by specialist teams. At present the service is very fragmented across WLCN. Two trusts treat less than 5 cases in a year and only 3 treat more than 10. A significant reduction of centres treating this serious condition is needed to meet the spirit of the IOG.
- High-dose therapy and transplantation should be carried out in accredited centres. The Hammersmith centre is an accredited centre and is undergoing the JACIE process at present.

In addition to these challenges posed by the IOG, WLCN will support the service for HIV patients who have haematological and other cancers at Chelsea and Westminster Hospital. Links will need to be created to ensure these patients are also considered by a haemato-oncology MDT.

8 - HEAD AND NECK CANCERS

Head and neck cancer is not a single entity and includes many different types of disease, most of which are uncommon and some, rare. There are over thirty specific tumour sites in this group, which as a whole accounts for 2,700 deaths per year in England and Wales. Mouth cancers are associated with high consumption of alcohol and tobacco. As well as groups that smoke tobacco, high rates of mouth cancers have been found among minority groups e.g. Somali, Yemeni and Ethiopian communities where the chewing of carcinogenic plants is common. The majority of the cancers arise from the surface layers of the upper aerodigestive tract (UAT): the mouth, lip and tongue (oral cavity), the upper part of the throat and respiratory system (pharynx), and the voice-box (larynx). Head and neck cancer also includes thyroid cancer.

Strategic Issues

Over the next five years, assessment and treatment services should become increasingly concentrated in Cancer Centres serving populations of over a million patients. Multidisciplinary teams will be expected to treat at least 100 new cases of upper UAT cancer each year.

At present the NW London centres are situated at the Charing Cross, which undertakes surgery, radiotherapy and chemotherapy, and Northwick Park, which links with Mount Vernon for radiotherapy and serves patients in Hillingdon, Brent and Harrow and parts of Hertfordshire. Both units see in excess of 150 new patients each year.

Unlike other tumour groups, UAT cancer services do not require a major programme of centralisation, but instead need to ensure there is appropriate discharge of patients back to referring units, where support services, e.g. speech therapy & dietetics services are needed. At present it is believed patients may be being treated there already. However this needs to be confirmed and services organised and streamlined.

In conjunction with Haematological malignancy services, diagnostic clinics for neck lumps will need to be developed (see Haematological Malignancy 7 above).

Services for thyroid cancers are currently devolved and will require to be mapped and centralised.

The Network will need to work with the SCG to look at the configuration for skull base tumours across London.

Work will also need to be done with PCTs and the SCG to look at Network-wide commissioning for these services.

9 - CANCER OF THE BRAIN AND CENTRAL NERVOUS SYSTEM (CNS)

The brain is host to the greatest variety of tumours of any organ in the body. Primary CNS tumours are rare. The UK incidence has often been quoted as between 5-25 per 100,000 population (4000 new cases per year in UK). A GP may still only see around ten new patients with primary brain tumours during their career. By comparison, cerebral metastatic carcinoma is common. Most metastases will be multiple and may herald preterminal disease.

Strategic Issues

NWL is largely compliant already with the new guidelines with centralization of cancer centre services on the Charing Cross Hospital to serve a population in excess of one million in NW London. The CNS tumour group is compliant with 5 of the generic criteria for Peer review at the present time. Compliance would not be difficult to achieve for another 10.

Issues highlighted by TWG

- Investment is required at many stages of the patient pathway to fulfil the requirements of a modern oncological service, including the consolidation of the MDT meeting working practice, dissemination of referral and treatment protocols to the network, dissemination of MDT decisions to clinical notes and relevant parties and co-ordination of the patient pathway
- Equitable access for all patients to the neuro-oncology service needs to be ensured. This should be audited. All network cases, suitable for treatment, should be referred and discussed appropriately

- The National Standards require work on the dissemination of referral protocols to the network and coordination of the patient pathway through the treatment centre and beyond
- The Peer Review standard most difficult to comply with relates to the agreement of a minimum data set and recording data items such as waiting times along the patient pathway particularly as the pathway is spread across the network. At the present time this data is not easily found and additional resources will be required.

10 – SKIN CANCER

Skin cancer is the commonest cancer to affect man. It is conventionally divided into melanoma and non-melanoma skin cancer. The incidence of skin cancer is rapidly increasing because of increased sun exposure. Incidence of skin melanoma in NW London has shown about a 30% increase over the past ten years⁶. The majority of skin cancers in NW London are dealt with by dermatologists.

Strategic Issues

NICE/IOG guidelines are due to be published in July 2005. It is likely that NW London will not be compliant because of the following factors:

- NW London is affected by the national shortage of Dermatologists. Of the 400 consultant positions in the UK, there are 95 vacancies. In NW London, Charing Cross Hospital is manned only by locum consultants. At the Hammersmith, one consultant post is filled by a locum, as is the case at St Mary's and Hillingdon Hospitals. Additional personnel are required.
- There is no uniformity of service provision across the network. Only 4 hospitals have rapid access clinics specifically for skin cancer and only one of these is a walk-in clinic. Sufficient (not in all hospitals) rapid access clinics to cope with the workload from the whole network are required. GP awareness of skin cancer, diagnostic skills and index of suspicion need to be raised
- Public awareness of skin cancer is increasing but knowledge is still patchy. Few people fully understand the dangers of sun exposure, particularly to children, the types of sun block available or the level of sun protection factor (SPF) protection required. There may be a need for an integrated public information strategy which reflects the risks of the local population for West London (see Health Improvement Section 3)

Issues highlighted by TWG

There is no Skin Cancer Tumour Working Group in WLCN and this needs to be established urgently. Hammersmith Hospital has a multi-disciplinary team that meets monthly. It has produced Trust strategies for the management of melanoma, squamous cell carcinoma and basal cell carcinoma. St Mary's and Chelsea and Westminster have MDT meetings but the frequency is not known and as yet, no protocols have been developed by these teams. St Mary's, Chelsea and Westminster, Charing Cross and Ealing hospitals have multi-disciplinary clinics for skin cancer. The network needs to have agreed clinical management strategies for all skin cancers.

⁶ Thames Cancer Registry Data, number of registrations, West London resident population, 1991-2002

The Hammersmith Hospital has recently audited melanoma within the hospital over two 5 year periods to look for trends in early diagnosis and survival. This audit showed little change in the last decade i.e. patients are not being identified and treated any earlier and prognosis has not significantly changed in that period.

An area wide reporting system for skin cancer is required. Resource allocation cannot be planned without this data.

11- PAEDIATRIC CANCERS

Each year in the UK there are approximately 1500 new cases of cancer diagnosed in children under the age of 15, according to the United Kingdom Childhood Cancer Study Group (UKCCSG). Children and their families commonly have to travel long distances to receive specialised care and the impact on family life during therapy can be significant. The distinct needs of young people with cancer have been increasingly recognised over recent years. Overall survival rates for children are now approximately 70%. It has been estimated that 1 in 1000 young adults is a cancer survivor.

Within West London, children who are diagnosed with a cancer during childhood are managed under the care of the Thames Paediatric Oncology Centre. This centre spans across the services provided by Great Ormond Street, UCLH, the Marsden and Bart's and the London Hospitals. Travel into these centres can be difficult for families on a regular basis and in order to keep care local to patients' homes shared care units have been established at local hospitals. These work closely with the Paediatric Oncology centre. Currently there are Shared Care Units at Northwick Park & Central Middlesex Hospitals, St Mary's Hospital, Chelsea and Westminster Hospital. A Unit also operates across Ealing, West Middlesex and Hillingdon Hospitals. These services were created following the London and SE England review of paediatric cancer in 2001/2.

National Guidance for Cancer Services for Children and Young people is expected in the summer of 2005 and local services will need to be reviewed when this guidance is available as it is anticipated that current arrangements will not be fully compliant with national requirements.

12 - BONE MARROW TRANSPLANTS (BMTs)

Paediatric BMTs are commissioned by a separate consortium. Two commissioning consortia have been established covering all PCTs in London and S.E. England. One (for Adult BMTs) is led by Croydon PCT and the other (for Paediatric BMTs), is led by Bexley PCT. A planning forum covering the same PCTs has been set up for sarcomas and rare cancers and this is also led by Bexley PCT. Work continues to develop care pathways and shared care arrangements for rarer cancers.

The number of adult BMTs has increased and BMTs for both adults and children are set to rise, as providers become more skilled in transplanting matched unrelated donors. PCTs have also experienced cost pressures particularly from the introduction of anti fungal drugs designed to reduce infection rates.

For other rarer cancers the main issues appear to be the continuing need for additional investment to meet new NICE or Royal College requirements on staffing levels and new drug regimes. For example all PCTs were obliged to pay towards the cost of a new Sarcoma surgeon to stabilise the service by coping with extra activity and meeting outcomes guidance.

Issues for Service Providers and Commissioners

- The rising costs of providing specialist cancers. e.g. PET scanning is of particular concern given recent guidance.
- The research subsidies and 'soft moneys' used to part fund service provision, and the implications when these funds end.
- Local provision of services for adolescents with cancers - most are treated at UCLH, but at some stage investment will be required locally to provide specific facilities and staff.
- Continuation of work to develop links between Paediatric Oncology Special Care and cancer centres to improve the local management of children with cancer.

SECTION 5 DIAGNOSTICS

This section looks at the three key diagnostic services supporting cancer services: Pathology, Imaging and Endoscopy. It follows a similar approach to the last section, identifying strategic issues and more local issues.

1 - PATHOLOGY

Strategic Issues

Pathology is now included as part of the Topics in the Manual of Cancer Services 2004 (See Section 1 National Context). Persistent problems with recruiting and retaining staff are hindering the sector's ability to comply fully with the spirit and some of the detail of national expectations. In common with some other cancer services, pathology has undergone a process of centralisation e.g. centralisation of Central Middlesex and Northwick Park services on the Northwick Park site. This has had desirable affects in terms of achieving greater compliance with national guidelines but difficulties remain.

Recruitment of Consultant Histopathologists and Cytopathologists remains a major problem and the general staffing problems in pathology departments mean that attendance at multidisciplinary team meetings can often be patchy. At unit level, the difficulty of finding Histopathologists to attend MDT meetings is severe. As a result the histopathology reports are simply read out at meetings, without there being any discussion about their significance in individual cases. Histopathologists with a particular interest in specific organ systems are very hard to find.

Local Issues

- **Clinical Audit:** Clinical Audit is seen as very important in improving the accuracy of diagnosis and sharing skills. Unfortunately this is not occurring in West London as widely and regularly as required, in particular pathologists at a second centre are not given the opportunity to review a diagnosis if a patient is referred there for treatment. There is also no regular audit at individual centres of all pathology cancer reports from a particular organ system. Audit by network pathologists has not taken off because of opposition by individual pathologists to being told who to obtain opinion from. The increasing practice by expert histopathologists to charge for their opinion may also affect this
- **Research:** The research opportunities opened up by the centralisation of services are being realised at the centres, but as yet the network opportunities have not been grasped
- **Teaching:** Within the overall training programme of Specialist Registrars (SpRs), there needs to be more secondment opportunities to allow pathologists with special interests to share their expertise with general pathologists.

2 - IMAGING

Imaging is crucial to the diagnosis and staging of cancer and consultant radiologists are core members of MDTs. There is a wide variation in the provision of imaging facilities across the Network. Full NHS general radiology services are provided at all acute trusts. However MRI facilities are provided (by the independent sector) at Northwick Park, Central Middlesex and West Middlesex Hospitals.

Strategic Issues

Imaging faces many of the same issues as Pathology in having to meet the requirements of the Manual of Cancer Standards and deal with staffing difficulties. Imaging is particularly sensitive to the general pressures placed on acute services e.g. 4 hour trolley waits.

Two recent areas of NICE guidance have a direct bearing on Imaging. Women with a family history of breast cancer and Surveillance of Women with previous chest radiotherapy for Hodgkin's are specified to the same quality as the NHS Breast Screening Programme.

In Section 4 Tumour Working Groups, the Lung Cancer section, highlighted the difficulty with the provision of PET scanning within the network, which is carried out at Hammersmith Hospitals, at the Paul Strickland Scanning Centre at Mount Vernon and by the independent sector. A London wide review of PET scanning is now underway as well as a Department of Health initiative looking at the involvement of the independent sector.

The radiology workforce is going through radical service redesign in accordance with the Changing Workforce Programme. This sees the introduction of the four tier workforce (assistant practitioner, state registered practitioner and advanced practitioner and consultant practitioner) in response to workforce shortages. The shortage of consultant radiologists also limits input to TWGs. A further contribution to relieve the pressure on radiologists could be made through increasing the skills of other clinicians, e.g. surgeons, in the technique and interpretation of ultrasound.

Local Issues

Local and specialist multidisciplinary team working, common imaging protocols and clinical audit are being developed. An active Radiology Service Improvement Board exists across the network. Research activity is largely conducted as part of other NCRN trials, but some e.g. the comparative effectiveness of magnetic resonance imaging in breast cancer (COMICE) trial is a predominantly imaging-led trial assessing the impact of pre-operative breast MRI on the clinical outcomes of women with primary breast cancer. The Trust / network policy for rapid notification of an unsuspected diagnosis of cancer has been ratified and adopted by the Radiology Board in December 2004. A draft list of duties is being circulated to the lead clinicians and information on the provision of MDT core members collected by the Board.

3 - ENDOSCOPY

Endoscopy within the NW London sector is provided at St Mark's Hospital (which is a National Training Centre for Endoscopy) and Central Middlesex Hospital (both part of North West London Hospitals NHS Trust), in addition to West Middlesex, Hillingdon, Ealing, St Mary's, Hammersmith, and Chelsea and Westminster Hospitals.

Endoscopy is the key diagnostic investigation that enables the early diagnosis of oesophageal and gastric (upper GI) cancers, and colorectal (lower GI) cancer. There is strong evidence that many deaths could be prevented by an earlier diagnosis. This is particularly true for lower GI endoscopy and existing demand in general continues to increase for this strongly. Hospital Episode Statistics (HES) data show an increase in colonoscopy and flexible sigmoidoscopy numbers of +66% and +86% respectively, over the 5 year period between 1996-2001. Year on year demand for endoscopy continues to increase significantly across the sector. An example is St Mark's Hospital, where there has been an increase of +12-13% per annum (1999-2004) in

endoscopic procedures performed. St Mark's performed over 10,500 procedures in 2004, including the most colonoscopies in England (5000/year). The introduction of the National Colorectal Cancer Screening Programme in 2006 will increase demand further.

Strategic Issues

IOG highlights endoscopy as the optimal investigation for the diagnosis of oesophageal, gastric and colorectal cancer. Patients suspected of having gastrointestinal cancer are being seen within the 2 week cancer plan target across the sector. There has been a negative impact on endoscopy waiting times for patients not in this group in some instances. Following an endoscopic diagnosis of cancer, it is clear that pathways are in place that should ensure patients receive whatever additional investigations are required (e.g. imaging by CT, MRI or ultrasound), and that treatment is received quickly within a multidisciplinary team environment. Figures suggest that despite adhering to the 2 week rule, the majority of cancers are identified on routine (non-urgent) endoscopy lists. The reasons for this need speedy identification to prevent inefficient use of precious endoscopy services.

As well as improvements in waiting times, London has seen a number of further changes with regard to endoscopy services, including the development of a National Training Programme in Endoscopy since 2004. This was commissioned by the North East London Workforce Development Confederation and incorporates centres of endoscopic excellence to ensure high quality endoscopic practice. Quality assurance initiatives within endoscopy units have also been introduced as well as there being improvements in information technology and data collection.

SECTION 6 THERAPIES

This section looks at the issues affecting chemotherapy and radiotherapy in improving cancer services and follows a similar approach to the two previous sections.

1 - Chemotherapy

Chemotherapy services for solid tumours are available at Hammersmith Hospitals, St Mary's, Chelsea and Westminster, West Middlesex and Northwick Park. Mount Vernon and the Royal Marsden also provide chemotherapy to West London residents. Services for haematological malignancy are provided at all the hospitals listed above and Hillingdon Hospital.

Strategic Issues

Standards for chemotherapy services are included in the Manual of Cancer Services 2004 and national guidelines for the delivery of intrathecal chemotherapy (ITC) have been produced.

For many DGHs the bulk of chemotherapy is administered for haematological cancers. As discussed in the previous section, the haematological IOG has implications for local chemotherapy services as the thrust of the IOG is to combine current services and it is recommended that haemato-oncology centres should not serve populations of less than 500,000. The logical conclusion of this is to merge current services and limit the numbers of DGHs providing local services. However solid tumour chemotherapeutic services rely on the expertise of their local haemato-oncology service.

Local issues

A process of devolving chemotherapy regimens from the cancer centre to the cancer units is underway. Different models of devolved services provision are being tested, including stand alone services, centrally managed but operating from additional sites and a peripatetic model. HHNT has supported the development, which will assist in the relief of some of its capacity and environmental problems. However the safety requirements of administering chemotherapy mean that there are resource implications for the units and to date the centre has only been able to identify and release minimal resources to assist with the development of devolved services.

As with other parts of the cancer services in NW London, successful devolved chemotherapy services will rely on the availability of key staff including nurses, pharmacists, pharmacy technicians, consultant oncologists and junior medical staff. Developing devolved services runs the risk of destabilising chemotherapy services at the centre and at those units where services remain static. However this should not deter attempts to continue the process of devolution, provided the financial consequences are not overlooked.

Consideration also needs to be given to the development of home based chemotherapy services.

The implementation of the haematological IOG will have implications for solid tumour chemotherapy services. When there is agreement on the configuration for haematological- oncology services a strategy for chemotherapy services within West London should be developed.

2 - Radiotherapy

Radiotherapy is a key element of treatment for around 50% of people with cancer. Treatment is prescribed by clinical oncologists, most of whom specialise in two tumour types. Treatment has to be planned, verified, and quality assured by reference to computerised imaging, planning and simulation systems, involving radiotherapists, physicists, bioengineers, specialist imaging, nursing and technical staff. The use of this specialised workforce, and of equipment with stringent accommodation and safety requirements, make radiotherapy a relatively centralised service, whose location generally determines the centre of a cancer network.

External beam radiotherapy is provided within NW London at:

- Hammersmith (2 linacs) and Charing Cross (4 linacs).
- Mt Vernon, non-surgical oncology Centre for Mt Vernon Cancer Network (8 linacs by 2006), due to move 2012 – 2013 to a new hospital in Hatfield.
- Royal Marsden, Chelsea branch (4 linacs by 2006) – part of the joint Centre for SW London Cancer network.
- The private sector in the Harley Street Clinic, Cromwell and Parkside Hospitals, offer external beam radiotherapy.

Brachytherapy is provided at Hammersmith Hospital, Mt Vernon, Royal Marsden and also St Mary's.

Strategic Issues

Demand for radiotherapy services is increasing. Where radiotherapy is the first definitive treatment in a care pathway, it is critical to meeting the NHS Cancer Plan targets (current and 2008) for waiting times from diagnosis and referral. Peer Review standards for radiotherapy include waiting times which are currently met (at Level 1) in West London. However waiting time targets of 48 hours and 2 weeks respectively for palliative and radical waiting times will not be met.

Teaching and training opportunities, but also pay rates, are critical to recruitment and retention. There are acknowledged shortages of, and competition for, specialist staff, particularly therapy radiographers and physicists. The number of physicists at the Hammersmith does not meet the Institute of Physics and Engineering in Medicine (IPEM) standards (a further requirement of Peer Review).

All four radiotherapy sites plan to install new additional or replacement linacs by December 2006 – equipment and part of the installation costs being funded by DH to ensure no machines over 11 years old are in regular use. Treatment chambers (bunkers) can be as expensive as the machines. Two spare bunkers at Charing Cross and the retention of one old machine for back-up, will allow for some expansion. A dedicated brachytherapy suite is being installed at Hammersmith Hospital. Innovative demountable bunkers for Mt Vernon will facilitate their transfer to Hatfield.

Following recent reviews at HHNT, the Trust will continue to provide a service on two sites medium term. Longer term plans will depend on overall Trust site configuration, and resolution of outer NW London futures. Options have been considered for retaining an ambulatory service at Mt Vernon, following the establishment of a new cancer centre at Hatfield. Clinical risk, referral and communications complexities, workforce issues and cost mean these options may not be viable. Possibilities of a DGH based service (e.g. at Northwick Park or Hillingdon) are to be tested separately late in 2005.

Local Issues

Radiotherapy protocols have been developed within each cancer network, but not to date between networks. Audit at the Hammersmith is linked to SpR training. Training places are provided there for undergraduate radiographers and postgraduate physicists.

The procedures and work instructions required for accreditation with a quality system are being developed, such that they comply with The Ionising Radiation (Medical Exposure) Regulations (IR (ME) R) requirements. It is expected that accreditation with a quality system will be sought before the end of 2005.

SECTION 7 SUPPORTIVE AND PALLIATIVE CARE

Palliative care is the care of patients with progressive and incurable disease. It includes terminal care, although it should be offered as early in the course of the disease as is appropriate to patients' needs and is not limited to the dying phase. Traditionally it has been centred on patients with cancer, who still represent 95% of patients cared for by specialist palliative care services nationally. Care must be provided holistically and in a form individualised to the cultural and religious needs of patients from diverse ethnic backgrounds.

Palliative care for those with later or incurable cancer, may be delivered in general settings (with or without specialist advice to generalist providers) or by multi-disciplinary specialist palliative care teams and services. Most care takes place within primary care, where patients can receive care from specialist palliative care community support teams based in DGHs. Access is not equitable for all residents in terms of location. Some patients have considerably further to travel and this leads to lower utilisation.

Specialist inpatient and day care is provided in 6 specialist palliative care units, inpatient care only in one and day care alone in a further centre. Four of these services are voluntary providers, and 2 out of the 8 are not within the boundaries of the WLCN. All patients resident within the network fall into the catchment area of at least one inpatient service. Because hospital, community and inpatient services may be provided to the same area by different services, many patients will access two or even three separate specialist palliative care (SPC) providers. Such data as exist, suggest that fewer than 20% of those who die of cancer do so in a SPC inpatient setting, and overall it is likely that fewer than 50% of patients dying of cancer receive community support. The proportion is probably higher during hospitalisation.

Strategic Issues

As well as the issue of inequity of provision described above, sometimes care can be poorly coordinated across providers, particularly between SPC providers and primary and secondary care teams. The specialist providers are likely to be under reporting on their workload as data is not collected on the number of patients accessing more than one specialist provider.

NICE Guidance on Improving Supportive and Palliative Care Services for patients with cancer was published in March 2004. The Steering Group of the Supportive and Palliative Care Network has initiated plans and working groups to oversee implementation. NW London is unlikely to be compliant with many of the new developments and initiatives which are expected. This is principally because of lack of funding and recruitment and retention of all professional groups, but particularly of specialist medical and senior nursing staff. Recruitment difficulties mean that not all patients have appropriate access to specialist medical and nursing care at all times in all settings.

User involvement, particularly for specialist palliative care services, is poorly developed and proving problematic to achieve. The nature of the patient population cared for means that few patients are physically able to participate in discussions, other than on a one-off basis, and involvement is often on a proxy basis through carers, who do not necessarily reflect the concerns of patients themselves.

The guidance places an emphasis on issues such as whether patients' preferences for site of death are met and on boosting research and training. The funding that has

been made available for cancer patients with palliative care needs has been used to address inequity of provision and to maintain a fair balance between care settings and between NHS and voluntary providers. The End of Life Initiative has provided some additional funding to develop care pathways at the end of life for people with other conditions as well as cancer and in the full range of care settings.

Funding Issues

A significant piece of work for 2005-2007 is the development of new transitional arrangements for the sector. These are needed to manage the following changes in funding flows for the sector wide three year investment plan (2003/2006) which came into force on 1 April 2005. Part of these arrangements will include setting up a risk sharing fund to:

- Offset a total sector wide reduction in allocation by £200k.
- Redress the imbalance created by a new funding formula which has resulted in PCTs receiving allocations either insufficient or in excess of the value of their commitments in the plan.
- Prepare for the likely introduction of Payment by Results for Palliative Care Hospices in April 2008.

SECTION 8 TEACHING, TRAINING AND WORKFORCE

There are significant recruitment and retention difficulties across west London that are hampering high quality cancer care. Examples quoted earlier include the acute shortage of Histopathologists, which is causing daily problems in the level of advice that can be given to surgeons when operating - further problems have been highlighted in Radiology, Specialist nursing, Medical Physics and other disciplines.

A recent scoping exercise undertaken for WLCN suggested work on a tumour group basis to:

- Map staff requirements along patient pathways.
- Redesign workforce to make best use of the scarce supply of specialist skills, shape succession planning, enable career development and consider use of support workers from local labour markets.

In the short term, action is required to

- Improve support arrangements for multidisciplinary teams and cross-boundary working.
- Develop clinical leadership.
- Identify and communicate good practice examples.

Full details of the initial findings in NW London that shaped these proposals can be found in 'Developing the Workforce Strategy' prepared by Practices Made Perfect Ltd.

A fixed term appointment has now been made to develop a robust workforce information dataset for the cancer workforce in NW London, which will then inform the development of a cancer workforce strategy and supporting plan.

This section will be updated once details of this work become known. Meanwhile there needs to be concerted action across the Network to develop new roles and responsibilities and recruit staff in innovative ways.

SECTION 9 RESEARCH AND DEVELOPMENT

Introduction

The aim of cancer research in NW London is to support and enhance the contributions made by researchers, clinicians, Imperial College and NHS bodies to improve and develop the prevention, treatment and care of the full range of cancers with a view to extending the length and improving the quality of life. In order to achieve this, the NHS must contribute to the conduct of research and take the lessons learned from it, incorporating them into routine clinical practice. Hence as a part of its planning process the NHS must consider the needs of research alongside the provision of clinical services.

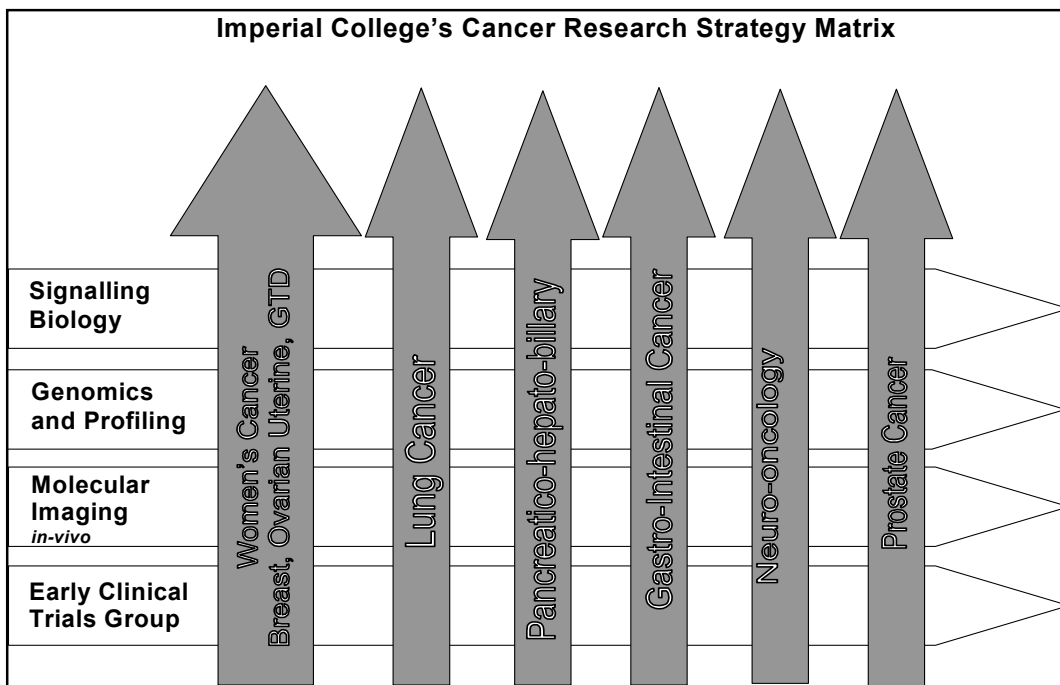
Context

The academic/NHS environment in NW London has a number of advantages as a location for both participating in, and leadership of, cancer research of all types. Major assets include:

- Imperial College, which conducts world class research in the field of cancer.
- The very large investment of NHS Research Support Funding (the R&D Levy) allocated to the sector, amounting to 21% of the entire English R&D Levy fund.
- A significant number of patients who may be recruited to participate in research.
- The establishment of the West London Cancer Research Network with the aim of increasing the number of patients participating in clinical trials.

Imperial College School of Medicine (ICSM) Principles of the Cancer Strategy

It is Imperial College's mission to conduct excellent (5*) research into cancer, and to translate the fruits of this research into patient care. As part of this there is a need to develop a corporate identity and home for the Cancer Theme and in order to achieve this it is important to collaborate formally with outstanding external organisations.



Interaction with Cross Cutting Research Themes

Several cross cutting themes specific for Cancer have been identified (see illustration above).

- ***Translational Signalling Biology*** Translational Signalling Biology represents the largest group in Cancer. This large critical mass offers opportunities for growth in several tumour sites.
- ***Genomics and Profiling*** The objective for this strand is to develop the full potential of Imperial in biomics, bioinformatics and statistics. A users group has been created in cancer metabonomics and the intent is to submit a major Medical Research Council (MRC) grant co-application between metabonomics and cancer medicine in October 2005. Interaction with the Clinical science Centre (CSC) microarray centre is developing strongly. The Cancer Theme has driven the Affymetrix Translational Medicine Initiative which is now close to agreement, and will be the first such centre enabling clinical molecular profiling in the UK.
- ***Molecular Imaging in-vivo*** will be developed to fully realise the advantages of molecular imaging approaches for cancer.
- ***Early Clinical Trials Group*** Imperial wishes to create a Cancer Early Clinical Trials Group to develop translational research capabilities and take up the opportunities presented by the GlaxoSmithKline (GSK) development. With support from the McMichael Centre at Hammersmith we are successfully developing early clinical trials. The group will be up and running fully by the time the GSK building opens.

Women's Cancer

ICSM would like to see the coalescence of the Gynaecological Cancer Centre, the Breast Cancer Unit, and the National Gestational Trophoblastic Disease Unit and the creation of a Centre for Prevention and Treatment of Women's Cancer on the Hammersmith site. These plans are for a 9 floor building will house clinical, translational and laboratory facilities that underpin the full range of activity of our strengths in women's cancer thereby providing a nucleus of research, which should provide a ripple effect to other areas of cancer research.

Neuro - Oncology and Proton Therapy

The creation of a post for a professor of radiotherapy is under discussion and would improve the prospects of academic neuro-oncology. In particular negotiation have taken place with Hitachi and Siemens to bring Proton Therapy to the Hammersmith, which would be the first such site in the UK. This advanced approach to radiotherapy is established in neurological and paediatric tumours, and is likely to find wider applications in common solid tumours.

External Collaborative Progress

We have made very good progress by establishing a sister partnership agreement with the MD Anderson Cancer Centre in Houston. A recent meeting in Houston demonstrated the opportunities for active collaboration and these are now ongoing. Formal links with the Institute of Cancer Research (ICR)/Royal Marsden have been developed in the shape of an invited joint application for a national ovarian cancer research unit funded by the Helene Harris Memorial Trust.

West London Cancer Research Network

In 2003/04 WLCRN achieved its accrual target for National Cancer Research Network (NCRN) trials (8% accrual into NCRN portfolio trials in April 2004). The trials originate from both NCRN epidemiology, cancer prevention, surgery and pharmaceutical clinical trials and NTRAC (National Translational Research Network) early testing of novel anti-cancer therapeutics and diagnostics. From a baseline of 1.7% in 2001/02 to 3.6% in 2002/03, this is a considerable achievement. West London is one of the biggest improvers in cancer clinical trials recruitment in the country. This is directly attributed to the development of the NCRN infrastructure in West London, including 17 staff (15.5 WTE) working across 11 hospital sites.

WLCRN is now recruiting into 69 NCRN studies. The main tumour areas have been lung, breast and colorectal studies although 'miscellaneous sites' (comprising psychosocial type studies) also showed a significant increase. There is still at present too low a rate of recruitment (3.5%) into randomised treatment trials (as distinct from non-interventional studies) compared to other Networks. A target of 6% was set for 2004/05. This will be achieved by further expansion in the trials portfolio and continued engagement with clinicians.

A number of issues remain to be addressed in taking forward a successful approach to cancer research in NW London:

- Trusts need to take more effective control of contracting arrangements for commercial trials and manage income in ways that ensure both the appropriate reimbursement of direct costs of research support services and the generation of funds for strategic investment in research staff
- The basic clinical services to support research need to be in place including adequate pharmacy support for trials, adequate radiotherapy facilities, adequate and timely access to imaging and specialist histopathology
- Arrangements could be made to allow the easier transfer of patients between different parts of the service and geographical sites to enhance recruitment and offer more patients the opportunity to participate in interventional trials.

SECTION 10 - PATIENT AND PUBLIC INVOLVEMENT

Involving patients and their families and carers in decisions about treatment as well as taking local populations' concerns into account in future planning of cancer services, are both critical components of the prospective NW London cancer strategy. This section sets out suggested good practice in the involvement of patients and the public in delivering and developing cancer services and attempts to assess how the Network is performing in this area. It is a key area that will come under scrutiny in Peer Review.

Methods and levels of consultation

Cancer Networks should have established Partnership Groups involving patients, carers, and local health and social care professionals. Networks should take their views into account when planning to implement IOG recommendations as well as more generally. The Partnership Group is also likely to have effective relationships with local self-help and support groups who can help facilitate consultation with users.

In NW London, a programme has been developed to support local user involvement leads and representatives in network initiated plans. A User Involvement Consultant has been appointed and a Patient Information Manager for the network, to take forward user involvement at a Trust and PCT level. The User Involvement Consultant will have a particular role around engaging BME groups in cancer work, as well as around palliative care, in line with recent NICE guidance. BME interests are also a focus for the work of the Patient Information Manager. Particular issues that need addressing are:

- Better information about services in appropriate languages and mode of communication i.e. in tapes, videos and in ethnic TV, newspapers and radios.
- Availability of interpreting and other communication support services in all cancer clinics including in Breast Screening Services.
- Outreach workers to raise cancer awareness including symptoms and signs of cancer among BME communities.
- More culturally sensitive prevention services for men e.g. Muslim men from the Bengali community, newly arrived refugees.
- Support services for carers from BME communities, particularly single parents looking after a child with cancer.
- Effective involvement of patients, carers and community groups in the development of the strategy and service planning.

Engaging with other Patient and Public Involvement Systems

Networks and their Partnership Groups need to engage with local Patient and Public Involvement (PPI) systems. Any existing local mechanisms for engaging with patients and the public can be used for cancer related proposals or any cancer activity needs to be complementary to them. Many groups and forums exist to support patients' views, and there are also many voluntary sector organisations that will want to play a part in involving those affected by plans for change.

Networks need to link in with their local PPI fora, Patient Advice and Liaison Services (PALS) and Overview and Scrutiny Committees (OSC). An agreement is advisable with local OSCs about criteria for when it will be appropriate for OSCs to be consulted and when it will be appropriate for them to be simply kept informed about

developments. It is important for OSCs to understand that the IOG recommendations themselves are not subject to OSC consultation.

Consulting on IOG recommendations

Where the IOG recommends a change in the configuration of services, networks should not have to consult on the case for change on the basis that NICE has already gone through a consultation process on the IOG. However, it is appropriate that Networks should take account of the requirements of sections 7 and 11 of the Health and Social Care Act 2001 by consulting on the specific proposals/ solutions they are putting forward, including:

- Choices for change (where applicable)
- How the change should be managed
- When the change will take place
- What the newly configured service will look like

Patients, the public and their representatives should be fully involved in drawing up options upon which to consult. This will ensure that proposals are already informed by those affected by the potential changes.

It is important to be clear when consulting on the implementation of the IOG recommendations that people are not being asked for their views on whether the change will happen, but on how the change can be best implemented etc. Involvement can go badly wrong if people believe they are being invited to explore a wide range of possibilities when in reality only limited options are open to them. It will therefore be important to consider what work should be undertaken to engage with patients, the public, staff and the local media to explain why the change is necessary.

In NW London, the extent of consultation around IOG configuration issues has been limited. Much of the effort to date has been with clinicians to determine the best options from a clinical point of view. With the NICE IOG guidance programme now clearly before the Network, it will be important to determine on a case by case basis the level of involvement necessary to implement the recommendations.