



**Urological cancers**

**Why we need change**

**A case for change for specialist urological cancer surgical services**

**January 2013**

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## Foreword

Across North East and North Central London and West Essex – a population of 3.5 million – around two people a day require complex surgery to treat kidney, bladder or prostate cancer<sup>1</sup>. These patients require specialist, once-in-a-lifetime surgery to give them the best chance of controlling their cancer and reducing the risk of long-term side effects.

We have a highly-skilled and experienced workforce, passionate and committed to delivering the best care to the populations that we serve. However, the way in which services are currently arranged does not maximise the delivery of the highest quality of care, research and training that we are capable of.

We want to change this.

We need to diagnose urological cancers earlier, whilst also improving the care and support of people who have finished their treatment and are either living with their cancer, in remission or recovery. We also need to change the way that we organise hospital care. National and international evidence demonstrates a clear link between higher surgical volumes and better patient outcomes.

Specialist radiotherapy and complex chemotherapy are already concentrated in a small number of specialist centres. We believe that the same should be true of specialist surgery for kidney, bladder and prostate cancers.

We believe that the creation of single specialist centres and high quality local units will provide our patients with high quality diagnostic and therapeutic care and expand opportunities to develop research that benefits patients. This would put us in a position to be among the best in the world – both in the quality of our care and the opportunities for patients to take part in research and access new treatments. We aim to make changes that will be durable for a generation to create a platform that can support future innovation.

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*Specialist centres would help put us among the best in the world*

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We know, however, that specialist treatment is only a small part of a urological cancer patient's care. The vast majority of patient care would always take place at local hospital units and GP surgeries.

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*Specialist treatment is only a small part of a urology patient's care*

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Patients tell us that, where they are cared for in different hospitals, they want their care to be joined up and to the same high standards wherever they are. We understand this and are committed to making it happen.

In this document we make the case for changing urological cancer services across North East and North Central London and West Essex and describe how we believe we can radically improve patient outcomes and patients' experience of care.

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<sup>1</sup> 2010/11 complex surgery for kidney, bladder and prostate cancers

Our proposals build on an established clinical case for change – the [Model of Care for Cancer Services<sup>2</sup>](#), 2010 - a review of cancer care undertaken for the whole of London in 2009/10 by NHS Commissioning Support for London. This made a compelling argument to improve cancer services in the capital where access to and outcomes from cancer care were unequal and mortality rates from cancer were higher in London than the rest of the UK.

The *Model of Care* proposed integrated cancer systems as an organising principle for cancer care, and it set parameters for changes to cancer services that we are now acting on locally in North East and North Central London and West Essex. The review showed strong evidence that specialist hospitals and surgeons that treat more urological cancer patients achieve better outcomes for high risk surgical procedures and recommended that minimum thresholds for surgery be set. The review involved, engaged with, and received support from, clinicians, local authorities, patient and public representatives and other groups across London.

Developed by our partners across *London Cancer*, this case for change builds on the framework of the *Model of Care*, with the aim of bringing globally excellent cancer services to our patients in the most efficient and equitable way.

We welcome your views, feedback and comments on our recommendations for improving urological cancer surgical services.



**Professor Mark Emberton and Mr John Hines**  
Urological Cancer Pathway Directors and Consultant Surgeons

## 1. Background

Over recent months, clinicians in north east and north central London and west Essex have been working together to consider how we can deliver the best possible urological cancer services that our local populations deserve.

Clinicians representing all the hospitals in the area – together with GPs, nurses, health professionals and patient representatives – have developed this case for change for how we believe we can achieve better outcomes for patients.

This case for change focuses on improving specialist surgery for urological cancer, specifically bladder and prostate cancer and kidney cancer, and the most specialist aspects of the surgical treatment.

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<sup>2</sup> <http://www.londonhp.nhs.uk/wp-content/uploads/2011/03/Cancer-model-of-care.pdf>

## 2. Context: who's who

### London Cancer

As a recommendation of the London-wide *Model of Care for Cancer Services*, the NHS cancer care providers of North East London, North Central London and West Essex are working together in an integrated cancer system known as *London Cancer*. *London Cancer's* aim is to drive superior outcomes and experience for our patients and population of 3.5 million. *London Cancer* formed in April 2012.

*London Cancer's* aim is to make big improvements in cancer services. It will do this by giving clinicians the power to lead improvement programmes and placing patients' outcomes and experience at the heart of cancer care.

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*We want to work together to deliver big improvements*

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Representatives of the NHS trusts within *London Cancer* that provide urological cancer services are involved in developing these proposals:

- Barnet and Chase Farm Hospitals NHS Trust
- Barts Health NHS Trust
- Barking, Havering and Redbridge University Hospitals NHS Trust
- Homerton University Hospital NHS Foundation Trust
- North Middlesex University Hospital NHS Trust
- Princess Alexandra Hospital NHS Trust
- Royal Free London NHS Foundation Trust
- University College London Hospitals NHS Foundation Trust
- Whittington Health NHS Trust.

### Urological cancer pathway board

The pathway board is responsible for improving urological cancer outcomes and patient experience for local people. The board is led by the cancer pathway directors and its constitution can be viewed on the [London Cancer website](#)<sup>3</sup>.

### Commissioners

NHS commissioners are responsible for ensuring that health and social care services meet the needs of the population. The cluster primary care trusts (PCTs) – NHS North East London and the City and NHS North Central London – are leading engagement on this case for change and the proposed model of care developed by *London Cancer*. From April 2013, the responsibilities of primary care trusts (PCTs) will transfer to the NHS Commissioning Board, clinical commissioning groups (CCGs) and local authorities (for public health).

### NHS Commissioning Board

The NHS Commissioning Board (NHS CB) aims to improve health outcomes for people in England. As well as overseeing a comprehensive system of clinical commissioning groups (CCGs) with responsibility for commissioning the majority of services, the NHS CB directly commissions a range of primary and specialised services, including specialised cancer services.

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<sup>3</sup> <http://www.londoncancer.org/cancer-professionals/urological/urological-pathway-board-constitution/>

### **Clinical commissioning groups**

From April 2013, GPs, as a part of clinical commissioning groups (CCGs), will be responsible for ensuring local health services meet local needs – they will decide, for example, what local services are needed for patients and how care can be best organised. While the NHS CB will have responsibility for specialised services such as complex cancer surgery, CCGs across North East London, North Central London and West Essex will ensure that the whole cancer care ‘pathway’ delivers excellence for patients, from diagnosis to post-treatment support.

### **Local authorities**

Local authorities will have new responsibilities for public health, prevention and health promotion. Public Health England will be established from April 2013 and aim to improve people’s health and wellbeing.

## **3. Urological cancers**

### **Bladder cancer**

Around 400 cases of bladder cancer are diagnosed each year in our area. Bladder cancer becomes more common as people get older and is more common in men than in women. The symptoms of bladder cancer are blood in the urine and changes in urination. These are also the symptoms of a lot of other less serious diseases.

Eight out of 10 patients diagnosed have early bladder cancer. These early cancers are often limited in size and the degree to which they have spread. They can therefore be treated by relatively simple surgery that can take place in most hospitals.

A much smaller number of bladder cancers, less than 100 per annum, are more advanced and have spread further (metastasised). These often need to be treated with a combination of complex major surgery, radiotherapy and chemotherapy.

### **Prostate cancer**

Prostate cancer is the most common cancer found in men – around 1,500 cases of prostate cancer are diagnosed locally each year. However, very complex surgery is only required by a small number of people. In 2010/11, 220 complex operations for prostate cancer took place across the *London Cancer* area.

Prostate cancer differs from most other cancers in that small areas of cancer in the prostate are very common and may stay inactive (benign) for many years.

Prostate cancer can cause changes in urination, but these symptoms are often subtle when compared to the same symptoms caused by the less serious changes to the prostate gland seen in all men as they get older.

There are many different treatment types and each have different benefits and different side effects. Treatment options include monitoring the cancer (known as active surveillance), treatment with radiotherapy or brachytherapy<sup>4</sup>, hormone therapy or surgery.

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<sup>4</sup> See glossary at the end of this document.

We know that sometimes a patient's treatment decision can be influenced by the facilities available at different hospitals and the approaches favoured by different teams.

Patients with any new diagnosis of cancer need to be given clear information and unbiased support in making the difficult decision on what course to follow. Due to the range of treatment options, this is particularly important for prostate cancer patients.

If initial treatment fails or if the cancer spreads then treatment focuses on hormone therapy and chemotherapy. These patients should be able to discuss treatment options, impact of treatments and clinical trials of new drugs.

### **Kidney cancer**

Kidney cancer is relatively rare and is approximately twice as common in men as in women. Around 400 new cases of kidney cancer are diagnosed each year across north east and north central London and west Essex.

Kidney cancer is most commonly found incidentally while scanning patients for something else. It may also be picked up in outpatient clinics for people with the symptom of blood in their urine. There are relatively few treatment choices for kidney cancer and treatment is most often surgical.

Some surgical operations for kidney cancer are simple whereas others are very complex. All are becoming increasingly reliant on emerging technologies, such as keyhole (laparoscopic) surgery and robotically-assisted surgery.

Surgery should seek to save as much of the kidney as possible. A number of non-surgical treatment options also seek to do this.

If kidney cancer spreads then the aim of treatment is to control the cancer through new targeted therapies<sup>5</sup>. This often happens within clinical trials.

### **Other urological cancers**

While other urological cancers such as penis and testicular cancers are not the focus of this case for change, there are some co-dependencies which we need to consider. For instance, a highly-specialised operation to treat widespread testicular cancer following chemotherapy is carried out by kidney cancer surgeons, so we will take this into account when proposing changes to kidney cancer services.

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<sup>5</sup> See glossary at the end of this document.

## 4. Current services

### Bladder and prostate cancer

Of around 1,900 cases of all prostate and bladder cancers diagnosed in *London Cancer* each year, only 350 patients require complex surgery. This is just under 1 in 5 of all patients (18%).

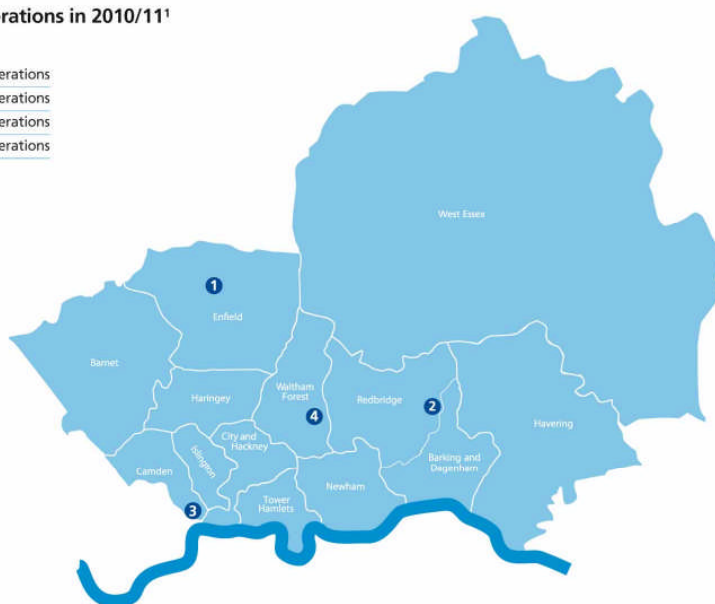
There are currently four bladder and prostate cancer surgical centres across North East and North Central London and West Essex<sup>6</sup>. Each centre serves a population of between 600,000 and 1 million. There are also a number of patients from other parts of London and south Hertfordshire who choose to have their complex pelvic procedure (to treat bladder and prostate cancer) at one of the *London Cancer* hospitals providing urological surgery.

In 2010/11, each surgical centre carried out between 54 and 89 complex operations – a total of 296. This total was made up of 220 operations for prostate cancer and 76 operations for bladder cancer.

We also believe that there are up to 50 bladder and prostate patients each year who do not get the complex surgery that they would benefit from. Our challenge is to ensure that everyone who needs specialist surgery should have access to appropriate surgery.

Complex bladder and prostate operations in 2010/11<sup>1</sup>

1	Chase Farm Hospital, Enfield	89 operations
2	King George Hospital, Ilford	82 operations
3	University College Hospital, Euston	71 operations
4	Whipps Cross Hospital, Leytonstone	54 operations



<sup>1</sup>Since 2010 a substantial number of Whipps Cross cases have taken place at University College Hospital (UCH) and since October 2012, by clinical agreement, Chase Farm cases have been operated on at UCH

<sup>6</sup>Since 2010, a substantial number of Whipps Cross cases have taken place at University College Hospital. Since October 2012, by clinical agreement, a temporary arrangement has been in place for Chase Farm patients to be operated on at University College London Hospital in response to an internal audit which demonstrated that optimal outcomes were not being achieved for some patients. This arrangement is not part of the review of urological cancer specialist services being led by *London Cancer*, but is a temporary local arrangement in response to clinical need.



## Kidney cancer

Of around 400 new cases of kidney cancer diagnosed in *London Cancer* each year, 300 (75%) require surgery.

Across North East and North Central London and West Essex, complex kidney cancer surgery is provided in all nine hospitals that treat and care for adult urological cancer patients. In 2010/11, they each did between 10 and 72 operations – a total of 292 operations.

Kidney cancer operations in 2010/11

1	Chase Farm Hospital, Enfield	72 operations
2	King George Hospital, Ilford	54 operations
3	The Royal London, Whitechapel	50 operations
4	University College Hospital, Euston	36 operations
5	Whipps Cross Hospital, Leytonstone	26 operations
6	The Royal Free, Hampstead	24 operations
7	Newham University Hospital	10 operations
8	Princess Alexandra, Harlow	10 operations
9	Homerton University Hospital, Hackney	10 operations



## 5. Why we need change

### National perspective

Whilst there have been significant improvements in cancer care in the UK over the past decade, there is further improvement needed to deliver world-class cancer services. While deaths from cancer have fallen, the UK still has a relatively high mortality rate.

National and international evidence demonstrates a clear link between higher surgical volumes and better patient outcomes. Specialist centres which have frequently practising specialist teams and full facilities, with high patient throughput, generally have better patient outcomes.

In 2002, the National Institute for Health and Clinical Excellence (NICE) published guidance on improving services for urological cancers<sup>7</sup> which recommended that patients with cancers that are less common or need complex treatment should be managed by specialist multidisciplinary teams in large hospitals or cancer centres.

<sup>7</sup>National Institute for Clinical Excellence, *Improving Outcomes in Urological Cancers: The Manual*, 2002

## London perspective

The NHS body responsible for the whole of London reviewed cancer services in the capital in 2009/10<sup>8</sup>. The review included an engagement process with key stakeholders and patient groups from across London and made a compelling argument for the need to improve cancer services in London. The review showed that access to and outcomes from cancer care were unequal across the city and that mortality rates from cancer were higher in London than the rest of the UK.

Londoners report a poorer experience of cancer services than other areas of England, and services are not always organised to deliver the best outcomes for patients. Despite having the highest population density, London has one of the smallest average catchment populations per hospital for all services. This means that hospitals in London are not able to take full advantage of the advances in medical care and economies of scale as specialist staff, facilities, and patients are spread across a relatively large number of hospitals.

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*“[A] number of London hospitals seeing a low volume of bladder and prostate cancer patients. [It] is clear that Londoners are not currently being provided the world-class service they deserve.”*

**Review of services across the whole of London**

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The review showed that there was evidence that specialist hospitals and surgeons that treat more urological cancer patients achieve better outcomes for high risk surgical procedures and recommended that minimum thresholds for surgery be set.

This London-wide review made wide ranging proposals for increasing early diagnosis, improving hospital care and taking a new approach to patients living with cancer. The proposals said that common treatments should be available locally to patients, but that specialist surgery should be concentrated.

For bladder and prostate cancer this ambition led to three specific surgical recommendations:

- That a maximum of five hospitals across the whole of London should provide complex bladder and prostate surgery<sup>9</sup>
- That each surgical centre should serve a population of at least two million
- That these centres should carry out a minimum of 100 operations for complex bladder and prostate cancer a year.

For kidney cancer, the clinical papers that form the London guidance concluded that the management of renal malignancies should be confined to specialist urology multi-disciplinary teams.

[Engagement on the London-wide case for change and model of care](#)<sup>10</sup> was held between August and October 2010. This involved clinicians, local authorities, patient and public representatives and other groups from across London. Letters were sent to 1,600 GP practices across the capital and a further 1,100 stakeholders were informed by email. A stakeholder event was attended by 80 delegates and proposals were met with a high degree of support. Many groups including LINKs, local authority overview and scrutiny committees,

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<sup>8</sup> NHS Commissioning Support for London, *Cancer Services: Case for Change, 2009; A Model of Care for Cancer Services*, 2010

<sup>9</sup> At the time there were more than 10 bladder and prostate centres across London, four in the *London Cancer* area.

<sup>10</sup> <http://www.londonhp.nhs.uk/wp-content/uploads/2011/03/Cancer-engagement-report.pdf>

GPs and clinical boards received presentations. Over 200 individual responses to a survey were received, and the overall level of support expressed for the proposals was mostly positive. As an indication of the breadth of engagement, the website itself received over 4,000 hits during the engagement process.

### Local perspective

Clinicians across North East London, North Central London and West Essex believe a more ambitious approach is required to deliver the world-class services that our populations deserve.

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*The way that things are organised does not allow us to provide the best care for our patients*

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There is clear evidence that surgeons performing high volumes of surgery have better patient outcomes. Therefore, we believe that consolidating complex surgery in fewer specialist centres would provide the best outcomes for our patients. **Our proposal is to provide complex surgery for bladder and prostate cancer in one specialist centre and complex surgery for kidney cancer in one specialist centre.**

These centres will be part of a well-defined pathway for patients that begins with all patients being diagnosed and assessed at their local hospital by teams whose members form part of the specialist centre. Only those patients who could benefit from complex treatments would need to travel to the specialist centre. Our proposal is to bring as much of the specialist expertise as possible (in terms of discussing treatment options and supported decision making) to be available to patients through their local unit/team.

This would benefit patients through reducing the risk of incontinence and post-operative complications. It would ensure that we can maximise the use of latest technologies and research breakthroughs, whilst also contributing effectively to the research effort – improving the quality of life and care not just for our own population but more widely.

### Why one specialist centre?

Clinicians have considered the configuration of specialist services to deliver the best possible outcomes for patients. The *Model of Care* has set the framework and the values for these proposals, and reflecting on this established clinical case for change, clinicians believe that there should be one specialist centre for bladder and prostate cancer and one specialist centre for kidney cancer for North Central, East London and West Essex.

Currently many hospitals are undertaking small amounts of surgery. There is overwhelming international evidence that for complex procedures, such as major cancer surgery, a higher volume of patients results in fewer complications, shorter lengths of stay and better outcomes for patients. Research shows that as volumes of patients increase, outcomes for patients improve. This means that the more patients treated, the better the outcomes for patients.

A large team is required to deliver surgical excellence. A single specialist centre would make it easier to ensure that patients receive care from health professionals with specialist expertise. This is because we could more easily sustain a critical mass of health professionals with specialist expertise to look after patients during and after their surgery and to have joint appointments with or rotate through local hospitals. A single surgical centre would have the volumes to invest in skills, technology and research, maximising the use of the most advanced techniques and facilities, such as robotics.

For complex procedures, training of specialist nurses, surgeons and fellows is more likely to be achieved through one large centre. A world class centre would also attract the most talented staff, increasing the skill of the team, and be more visible to industry partners and international expert peers. These staff would bring their expertise to patients at every step of their pathway, as they will be part of the combined multi-disciplinary teams at the specialist centre and local units.

A single specialist centre would make it easier and more affordable to support the routine use of molecular pathology in diagnosis and tissue banking<sup>11</sup> to support research. It would also help to co-ordinate access to clinical trials.

## 6. How we can improve services

### Earlier diagnosis and better support

We need to work with our colleagues in the NHS and outside to diagnose urological cancers earlier. Earlier diagnosis of bladder and prostate cancer would help to improve survival rates and access to care.

We will test innovative ideas, like giving GPs access to one-stop clinics for people with blood in their urine, so they can receive a definitive diagnosis more quickly. We will also seek opportunities to work with our medical colleagues outside of cancer care on joint screening programmes to help us find cancer and other serious health problems earlier.

We need to provide better information to patients and carers to help them make decisions about their treatment options. This is particularly important for prostate cancer for which there are a range of treatment options.

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*People would have support and care that is appropriate and convenient*

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During and after treatment we need to make sure that people are offered support, care and rehabilitation that is appropriate and convenient to them and is delivered as close to their homes as possible.

### Specialist services

Currently, our hospitals services are not organised to deliver the best possible outcomes for patients. We believe that all complex surgery for bladder and prostate cancer and kidney cancer should be performed in one specialist centre for bladder and prostate cancer (performing around 350 operations a year) and one specialist centre for kidney cancer (performing around 300 operations a year).

A specialist centre for kidney cancer should also perform an estimated 100 operations for non-cancerous disease which are currently being carried out across all of the hospitals in *London Cancer*. Again, this is supported by the evidence that the more surgery that a hospital does, the better its outcomes are likely to be.

This would mean that single clinical teams would treat a sufficient number of patients so that they could make continuous improvements. Clinicians believe that this would put us among the best in the world for clinical quality and outcomes from urological cancer care.

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<sup>11</sup>See glossary at the end of this document.

Specialist centres would also mean that surgeons have access to cutting-edge equipment and are surrounded by a multidisciplinary team comprising all the right types of highly-skilled clinicians and support staff.

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*Surgeons have the right equipment, can continuously improve, and are surrounded by a highly-skilled team*

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The specialist centres would need to have strong links to high-quality local urology units to enable high quality, seamless patient care. Staff at the local units and the specialist centre would be part of the same multi-disciplinary team, bringing specialist expertise to patients along the whole pathway.

Specialist centres would also provide a focus for research and clinical trials and enable excellence in training and education. Improvements in treatments, and in the advice that we are able to give patients on their treatment decision, rely on research and clinical trials. We believe that every patient with a new diagnosis of urological cancer should be offered the opportunity to participate in clinical research. We would therefore ensure that local urological cancer units were enabled to enrol and identify patients for clinical trials.

Teaching and training of urology teams would take place at both the specialist centre and local units.

### **Local units**

Local units would continue to have a significant role in caring for patients with urological cancers. They would provide all diagnostic tests, most elements of treatment, the majority of post-treatment follow-up, and ongoing care and rehabilitation. They would continue to be the first point of contact for early specialist advice required by GPs and would work with primary care and support patients in their follow up. The types of surgery which would be undertaken at a local urology unit and specialist centre are provided at appendix 1.

The medical and nursing care in local units would be to the same high standard as that in the specialist centre. Doctors would work jointly in both the specialist and local units to make sure that patients experience continuous excellent care.

All existing urology units which meet standards of care would continue to provide local services.

## **7. The patient pathway**

Specialist treatment is only a small part of a urological cancer patient's care. The vast majority of patient care would always take place at local hospital units and GP surgeries, and there would be no change in the referral patterns of GPs.

Patients with suspected urological cancer would be referred to a local unit by their GP where they would access a comprehensive diagnostic service led by a consultant urological surgeon linked to the specialist centre.

If a patient is diagnosed with urological cancer, a local multidisciplinary team would review their case in detail with the broadest range of specialists across the area. The team would aim to provide them with clear information about their condition and support them in making a decision about treatment. All local units across *London Cancer* would give patients the same

high-quality, consistent information and would include a member of the specialist centre team. *London Cancer* will take the lead role in ensuring this through standards audits.

A large number of patients, particularly those with prostate cancer, would receive all of their care at a local unit and would never go to the specialist centre.

Some patients would be advised by the multidisciplinary team that they need to go to a specialist centre for their surgical treatment or radiotherapy, should they choose these treatment options. In these cases, local units would will share with the treatment centre all of the relevant information that they have about the patient's care to date, including all the diagnostic tests already carried out.

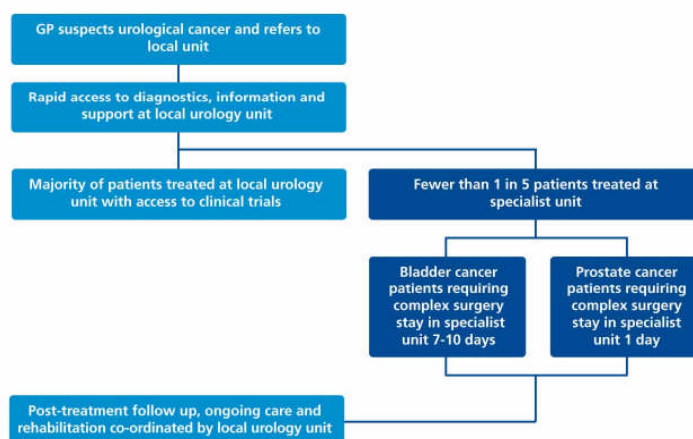
Following treatment at a specialist centre, patients would return to the care of their local unit as soon as it is appropriate to do so.

Most prostate cancer patients would be able to leave a specialist centre the day after complex surgery. Bladder cancer patients would need to stay in a specialist centre between seven to 10 days, due to the nature of the surgery. Kidney cancer patients would be able to leave a specialist centre and return to the care of their local unit around three days after complex surgery.

The local urology unit would carry out any subsequent treatments, as well as most of the ongoing care that patients require. Urological consultant specialists would work locally to oversee this care.

The team of staff at the specialist centre and local units would work together as a co-ordinated network, taking collective responsibility for each patient's care pathway. Clinicians involved in the changes would have a joint contract between the specialist centre and their current hospital, ensuring that local expertise is maintained and developed. The proposals would result in more joined up research, improved quality assurance and opportunities for service improvement across the whole patient pathway.

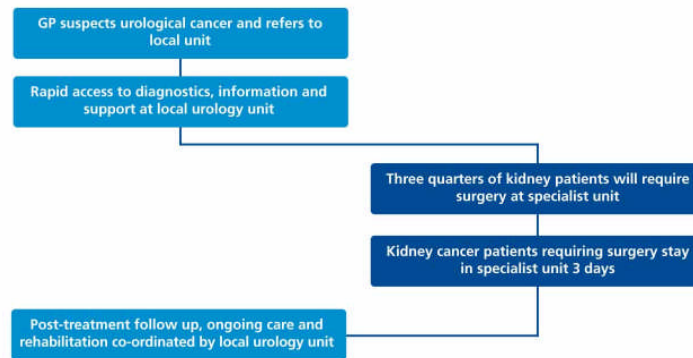
**Patient pathway – bladder and prostate cancer**



**Clinicians work across both local and specialist urological units**



## Patient pathway – kidney cancer



Clinicians work across both local and specialist urological units

## 8. What this means for patients

### Bladder and prostate cancer

The vast majority of bladder and prostate cancer patients would continue to receive their care at an existing local urology unit. Standards of care would improve at these units, ensuring that patients receive high quality care no matter where they are.

For the 350 patients per year who need once-in-a-lifetime surgery, they would receive world-class care in a specialist unit with access to the most advanced techniques and facilities from a highly-skilled multidisciplinary team.

Patients would have the best chance of surviving their cancer and have reduced risk of incontinence and post-operative complications.

The proposals would bring further advantages for patients in terms of having access to new treatments, such as bladder reconstruction, and rapidly emerging research, such as the use of artificial bladders.

### Kidney cancer

For the 300 patients per year who need kidney cancer surgery, and 100 patients per year who need non-malignant kidney surgery, they would receive world-class care in a specialist unit with access to the most advanced techniques and facilities from a highly-skilled multidisciplinary team.

While kidney cancer is relatively rare, the majority of patients require surgery. Currently, nine hospitals in *London Cancer* perform small amounts of surgery.

Patients would have a better chance of reduced complications and risk of incontinence, following their specialist surgery. This would help to improve the quality of life for kidney cancer patients.

## Travel and patient choice

We are committed to only asking patients to travel further when it is absolutely necessary for them to receive specialist care.

Specialising complex urological cancer surgery in fewer hospitals would mean an increase in travel times for some patients and a reduction in the choice of hospitals providing this type of surgery.

However, clinicians believe that the proposals would greatly enhance our ability to deliver the highest quality care and better outcomes for patients.

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*Many patients are already travelling for their treatment. Some would have to travel further but only when it is absolutely necessary*

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We estimate that around 200 to 250 bladder and prostate cancer patients requiring complex surgery (11% - 13% of all bladder and prostate cancer patients) per year would need to travel to a different hospital for their surgery. For kidney cancer, we estimate that around 220 to 270 patients per year would need to travel to a different hospital for their surgery. Clinicians believe that the benefits of reduced risk of post-operative complications and reduced risk of long-term incontinence far outweighs any inconvenience in further travel to receive the very best specialist care.

Many patients are already bypassing their local hospital to go to a hospital providing urological cancer surgery. Greater specialisation would increase the distances that some patients would need to travel. We will consider the impact on travel for patients and carers as we develop firm proposals for transforming urological cancer care. Patient groups are providing views on the travel implications for these proposals. Among the options being considered are improved car parking and taxi services for those in need.

## 9. Expected benefits

The expected benefits of the proposals are:

- Improvements in outcomes for patients having specialist surgery for urological cancers, both in the short and longer-term. A critical mass of urological cancer patients will mean that each surgeon carries out enough operations each year to continuously improve.
- Surgeons have access to the most up-to-date equipment and are supported by an expert team containing all of the right types of highly-skilled staff.
- As well as specialist surgery, the specialist centres will be able to deliver the most up-to-date radiotherapy, chemotherapy and targeted therapies. Shared/standardised methods will be based on best practice across the clinical teams.
- Delivery of services which are more productive and efficient through the minimisation of duplication and waste, in particular, to address the inefficient use of consultant time due to supporting a multi-site urological surgical service.
- Patients would experience a better co-ordinated pathway of care as doctors would work jointly in both the specialist and local units.
- The service is able to better attract national and international clinical staff to work in the speciality and offer higher quality clinical training to junior doctors and other health professionals.



## 10. Locations

Clinicians have considered where there could be benefits in co-locating bladder and prostate cancer or kidney cancer specialist units with other services.

### Bladder and prostate cancer

A specialist centre for bladder and prostate cancer would need to be in the same hospital as a small number of other key services to make sure that patients have the best and safest possible surgery.

Surgery for bladder and prostate cancer patients can have serious complications. The bladder and prostate specialist centre needs access to 24-hour interventional radiology as well as to pelvic emergency surgery. Clinicians would also want to co-locate the bladder and prostate cancer centre in a hospital which has specialist gynaecological cancer surgery. This is more important than being in the same place as kidney cancer surgery.

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*The specialist centres for kidney cancer and bladder and prostate cancer need not be in the same hospital but each should be located with other key services*

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Locations of other specialist services where there are co-dependencies with bladder and prostate cancer

- 24-hour interventional radiology (Queen's, Royal London, UCH)
- Specialist gynaecological cancer (St Barts Hospital, UCH)



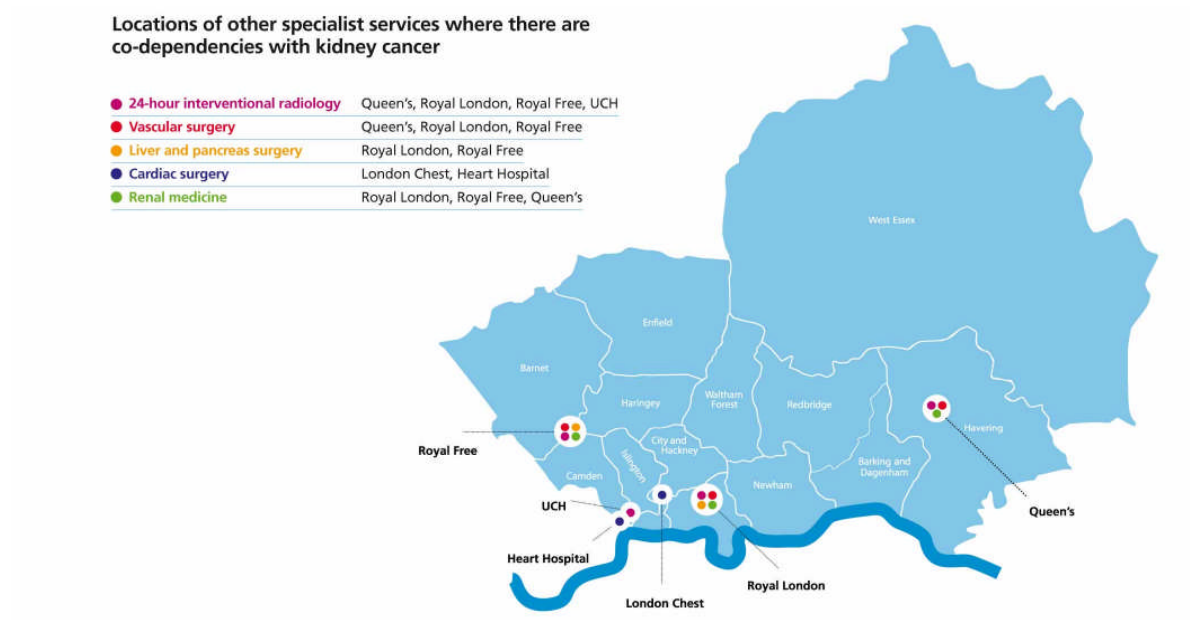
### Kidney cancer

Kidney cancer surgery is very complex and there can be serious complications. Surgery should take place near services such as 24-hour interventional radiology and vascular surgery so that they can respond to critical life threatening complications (such as haemorrhage).

The kidneys are close to other organs so kidney cancer surgery should ideally be carried out in a hospital with liver and pancreas surgeons. Kidney cancer can spread through blood vessels to the heart; the ability to enlist specialist assistance of a cardiac surgeon during surgery can be vital and life-saving.

Kidney cancer surgery should also take place in a hospital that has renal medicine and dialysis facilities; some patients will need their kidneys to be supported by dialysis during and after their surgery.

Being near these services is more important for kidney cancer surgery than being in the same hospital as prostate and bladder surgeons.



### Process for identifying recommended locations

A group of doctors, nurses and patients from across *London Cancer* has developed a clear specification and standards for the care that we would expect from local and specialist units caring for bladder and prostate and kidney cancer patients<sup>12</sup>.

*London Cancer* has started discussions with NHS hospital trusts currently providing urological cancer surgical services about how they could work together to implement the proposed model of care for North Central and North East London and West Essex. Expressions of interest have been submitted by hospital providers that are committed to delivering the criteria set out in the urological cancer service specification.

For the specialist centres, initial expressions of interest for prostate and bladder cancer surgery were received from University College London Hospitals NHS Foundation Trust and Barking, Havering and Redbridge University Hospitals NHS Trust (BHRUT). Following discussions and wide clinical engagement in December, only University College London Hospital submitted a formal commitment to provide the specialist centre for bladder and prostate surgery.



<sup>12</sup> London Cancer, *Service specification for urological cancers*, 2012

Initial expressions of interest for specialist kidney cancer surgery were received from BHRUT, Barts Health NHS Trust and The Royal Free London NHS Foundation Trust. Following discussions and wide clinical engagement in December, two trusts have formally expressed an interest in providing specialist kidney cancer surgery. Clinicians are continuing to discuss the preferred locations of centres, taking into account the required standards to meet the specification and locations of other key services to make sure that patients have the best and safest possible surgery.

On the basis of these expressions of interest, recommendations are being developed by *London Cancer* to commissioners of cancer services. Further information about the recommendations will follow in February.

No decisions will be made until after wider engagement has taken place to understand views on the proposed model of care for urological cancer services. Following engagement, decisions will be made by the NHS Commissioning Board and will be based on which hospitals are best placed to provide truly world class service in future.

## **11. How will we know that things are better?**

To be a specialist or local urological cancer unit, hospitals would need to commit to meeting the standards required. We would need to be absolutely sure that the changes that we introduce make things better.

To do this, we will measure the quality of our care prior to any changes being implemented, and at intervals during and after any changes.

Clinicians will be developing, together with patients, GPs and commissioners, a series of metrics against which improvements to care can be measured and regularly reported on.

## **12. Next steps**

This case for change document builds on the framework of the *Model of Care* and outlines ideas for how we believe we can improve services for bladder, prostate and kidney cancers.

We are now sharing this case for change with local patient and public representatives, local authorities, clinicians and other groups. We welcome any views or feedback on our ideas for improving services.

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*We are sharing our  
recommendations and  
seek your views*

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We are holding a series of engagement events between January and March 2013 which will be an opportunity for clinicians, patients and the public and local groups to discuss the recommendations and have their say. We will also formally discuss the recommendations with clinical commissioning groups and health overview and scrutiny committees. Following discussion with local stakeholders, clinicians will consider feedback from engagement and then finalise their recommendations for change.

If you would like to get involved, please email [cancer@elc.nhs.uk](mailto:cancer@elc.nhs.uk)

## **Glossary**

### **Brachytherapy**

A type of internal radiotherapy, which involves putting a solid radioactive material close to, or inside, the tumour.

### **Dialysis**

A form of treatment in which a machine replicates many of the kidney's functions.

### **Interventional radiology**

Techniques that rely on the use of x-ray images to guide treatment.

### **Molecular pathology**

Use of molecular and genetic approaches to identify and classify tumours through examining molecules within organs, tissues or bodily fluids.

### **Multidisciplinary team**

A group of doctors, nurses and others with expertise in a specific cancer, who together, discuss and manage an individual patient's care at diagnosis and other times.

### **Renal medicine**

The medical specialty dealing with kidney function and diseases.

### **Specialist or complex surgery**

A technical procedure that's difficult to learn and hard to sustain. Cystectomy and prostatectomy are examples of urological surgery that is complex.

### **Targeted therapies**

Drugs or other substances that block the growth and spread of cancer by interfering with specific molecules involved in tumour growth and progression.

### **Tissue banking**

Live tissue taken from tumours during surgery, for the purposes of medical research and education.

### **Urology**

The medical specialty concerned with the urinary system in males and females and the reproductive system in males.

### **Vascular surgery**

The surgical specialty concerned with the blood vessels.

## Appendix 1: Service specification for surgery for prostate, bladder and kidney cancers

The following table outlines which elements of urological cancer surgery are proposed to be centralised in the specialist centres, and which surgery will take place in the local units. Note that this is small element of the whole patient pathway.

### Pelvic (bladder and prostate) cancers

POINT IN THE SURGICAL PATHWAY	LOCAL PROSTATE/BLADDER UNIT	SPECIALIST PROSTATE/BLADDER CENTRE(S)
Assessment	<ul style="list-style-type: none"> <li>Carries out pre-operative assessment</li> </ul>	
Treatment for prostate cancer	<ul style="list-style-type: none"> <li>Carries out trans-urethral resection of the prostate (TURP)</li> <li>Does not carry out radical prostatectomies (removal of prostate)</li> </ul>	<ul style="list-style-type: none"> <li>Carries out radical prostatectomies (removal of prostate)</li> <li>Pelvic lymph node surgery</li> <li>Capacity for robotic surgery</li> </ul>
Treatment for bladder cancer	<ul style="list-style-type: none"> <li>Trans-urethral resection carried out by nominated surgeons only</li> <li>Does not carry out radical cystectomies (removal of bladder)</li> </ul>	<ul style="list-style-type: none"> <li>Carries out radical cystectomies (removal of bladder) and bladder substitution</li> <li>Pelvic lymph node surgery</li> <li>Carries out bladder reconstruction</li> <li>Small number of benign cystectomies</li> <li>Capacity for robotic surgery</li> </ul>

### Renal (kidney) cancers

POINT IN THE SURGICAL PATHWAY	LOCAL RENAL UNIT	SPECIALIST RENAL SURGERY CENTRE(S)
Assessment	<ul style="list-style-type: none"> <li>Carries out pre-operative assessment</li> </ul>	
Treatment of T1 and T2 disease*	<ul style="list-style-type: none"> <li>Does not carry out partial nephrectomies (surgery that spares part of the affected kidney) or nephro-ureterectomies</li> <li>May carry out some radical nephrectomies (removal of kidney) as agreed by specialist MDT and performed by specialist surgeons (i.e. those treating T3 and T4 disease at specialist centre)</li> </ul>	<ul style="list-style-type: none"> <li>Carries out appropriate surgery, including all nephron-sparing surgery (surgery that spares part of the affected kidney); partial nephrectomies and nephro-ureterectomies, with specialist team</li> <li>Benign renal surgery, renal pelvis surgery, ureteric surgery</li> <li>Capacity for robotic surgery</li> </ul>
Treatment of T3 and T4 disease*	Carries out palliative treatments only	<ul style="list-style-type: none"> <li>Carries out appropriate surgery with specialist team</li> <li>Retroperitoneal lymph node dissection for testicular cancer</li> <li>Radical Nephrectomies</li> <li>Capacity for robotic surgery</li> </ul>

T1, T2, T3 and T4 disease relates to the stage of the cancer (the size and spread). T1 is generally early stage cancer, and T4 is advanced.