Report on the External Review of Gynaecological Cancer Services

in the Peninsula Network

Undertaken at the request of the Peninsula Cancer Network as set out in the letter of invitation dated 1st July 2009.

Date of Reviews

14th September 2009 Royal Cornwall Hospitals Trust (Truro)

15th September 2009 Plymouth Hospital NHS Trust

23rd October 2009 Royal Devon and Exeter NHS Trust

Purpose of the Reviews

- To review the Plymouth and Truro units with a view to providing a clinical assessment as to which hospital would be the preferred site for a second gynaecological cancer centre.

- As the service in Exeter is already operating as a designated centre for this service and this status is not in question, to provide assurance that the current patient pathways ensure that all complex gynaecological cancer cases including ovarian, are appropriately referred into the centre.

These reviews will provide an objective independent clinical opinion of the current service provision and will help inform the Network Board of the future shape of these services in order to provide IOG compliance by December 2009.

The Terms of Reference under which the review have been previously circulated by the Peninsula Network Board.

The Reviewers

The review panel comprised three members:

Professor David Luesley (Chair)
Gynaecological Oncologist, Clinical Director and Lead for the Pan-Birmingham Gynaecological Cancer Centre

Mr Charles Redman
Gynaecological Oncologist
Clinical Director, Specialist Surgical Services,
North Staffs University Hospitals NHS Trust

Ms Juliette Sim
Gynaecological Oncology Clinical Nurse Specialist
University College Hospital NHS Trust

Structure and Conduct of the Review

The reviewers visited each centre detailed above. The visit included meeting the core and extended MDT as teams and in most cases as individuals. The sites were also visited including patient facilities and various departments. It should however be noted that the fabric, estate and buildings infrastructure was not considered within the terms of reference provided by the Network for the visitors.

The clinical teams in each location provided written evidence of previous reviews, annual reports, work programmes, research output, MDT minutes and both provided sample sets of patient notes for inspection if required.

At the conclusion of each visit the visitors provided informal feedback to the clinical and managerial teams. This included a resume of what had been requested of the reviewers, the process that the reviewers would follow in making their report, and the timescale by which the reviewers would produce the report for the network.

Other Considerations

The network included further guidance in addition to the terms of reference. These in part related to the unique geodemographic challenges posed by the region, its transport infrastructure and social deprivation.

The reviewers were aware that the Peninsula Cancer Network strongly upholds the principle that patients should be treated as close to home as possible and proposals to transfer patients to a specialist gynaecological cancer centre(s) relate only to the surgical component of the total programme of care.

The reviewers were therefore asked to consider the range of services that could be provided from local District General Hospitals and recommend any actions required to ensure that as many elements of the patient pathway as clinically possible are retained locally without compromising the quality standards set out in the Improving Outcomes Guidance.

The reviewers therefore interpreted this as defining which of the two Trusts could offer the highest quality service relating to primarily to the surgical component(s) of the patient journey with the majority of the diagnostic and non-surgical components being delivered by the patients' "local" hospital as is currently the case.

Whilst it was inevitable the issues of geography, transport, demographics and deprivation were raised during our many discussions, we made it quite clear at the

time that although these issues were obviously important, they were outwith the remit of the clinical review.

Methodology

The reviewers all felt that the process needed to be as robust and transparent as possible. In order to achieve this and to ensure that the terms of reference had been fully met we decided to adopt the majority of the terms into a pre-agreed scoring grid system. Each term in the terms of reference was therefore considered a scoring item. In addition the items were weighted to try and reflect the importance that the reviewers placed upon each term. Thus "MDT working and patient pathways" was considered core to the provision of a high quality service [**Essential**] and accorded a weighting of three. Comments on the adequacy of the provided impact assessment was felt to reflect the degree of reflection and global or objective view and therefore important but less likely to affect high quality care [**Desirable**]. Given this it was accorded a weighting of two. Academic and research activity is considered to be a reflection of quality but the reviewers all agreed that high quality cancer services need not necessarily produce an academic output [**Additional**]. Additional items were accorded a weighting of one.

Terms of Reference Criteria

The Terms of Reference that were converted into scorable items with the weighting in brackets were:

MDT working and patient pathways [3].

The availability of specialist cover by appropriately trained and experienced specialist surgeons and the sustainability of such cover in circumstances such as sickness absence and leave [3].

The availability of and access to hospital clinical nurse specialists and allied health professionals important to the patient experience and quality of care [3].

The range of operative procedures available to patients especially those with complex tumours. We were aware that Plymouth has not been operating on vulval and cervical tumours in line with the previously agreed Network plan [3].

Evidence of integrated care with oncologists where multi-modality therapy is required [3].

Evidence that outcome data is being collected prospectively [2].

The Improving Outcomes in Gynaecological Cancers guidance anticipates improvements in 5 year survival for patients with these tumours by moving to specialist centres. As both of these services have changed significantly recently 30 day mortality and one year survival rates should be examined*. [3]

The potential for the facilities and team(s) to be able to absorb the full workload and provide a reliable and sustainable high quality service to patients as a specialist gynaecological cancer centre(s) for the West of the Peninsula [3].

To comment on the impact assessment provided by each Trust on the effect each of the potential reconfiguration options would have on their existing clinical services [2].

Guidance to the commissioners of cancer services on whether there are clear clinical reasons for the choice of one of these hospitals as the second gynaecological specialist cancer centre**.

* The reviewers considered this item in some detail and appreciated that outcome measures are considered objective measures of quality. There are of course problems in using crude survival data such as these and great care needs to used in their interpretation. For example, clinical teams may adopt a more conservative approach in elderly women with poor performance indices and not operate on them whereas other teams may have a more interventional approach. Whilst both approaches can be justified in relation to published evidence they may result in markedly different 30 day morbidities and one year mortality. Thus is becomes difficult to analyse without knowledge of possible selection bias.
Clearly, if analysis of the records provided did suggest significant variance between the two units then this would be of importance.
Both clinical teams and MDTs had excellent clinical records but the nature of this type of data does not lend itself to retrospective analysis of possible bias in case selection. We have therefore included the TOR as requested but felt that all parties should be aware of the concerns the assessors had in attempting to interpret these data.
There are also risks in comparing outcome data in gynaecological malignancies with other cancer sites. The natural history and types and timing of presentations vary considerably. For instance, one year outcomes in oesophogeal cancer may reflect far more on the quality of initial care than say in endometrial cancer, which generally presents in a much earlier phase of its natural progression.

**The reviewers felt that this item was a summation of all of the items that we felt should be included within the scoring system and thus was not independent.

Additional Criteria

In addition to the above eight criteria, the reviewers felt that there were other items of quality that would have a direct impact on service provision that should be included in the overall score. These included (with weighting):

Academic and research output, to include evidence of support for national and international clinical trials relevant to gynaecological cancer [1]

Supportive and palliative infrastructure to include intensive care facilities, anaesthesia and pain management. [1]

Information systems to support and enhance the patient pathway across individual Trusts and across the network [3]

Evidence of clinical leadership, team development and management [3]

Managerial leadership, support and engagement with the clinical team [3]

The thirteen criteria listed above formed the basis of our final "objective score". The individual reviewers agreed to score on a closed marking system.
A score of 1 suggested that the service was less than adequate for purpose.
A score of 2 suggested that the service was adequate for purpose.
A score of 3 suggested excellence.

The scores were allocated blind to the other two reviewers so that the final scores represented a summation of the individuals. Where there was wide disagreement further discussion by telephone and or e-mail was undertaken by the whole team to achieve consensus.
All items scored as either 1 or 3 were qualified in an appended subtext in order to make clear why the reviewers felt there were concerns (final score of 1) or where they felt there was an example of excellence or good practice.

As the reviewers were informed prior to the visits that the centre status of the Royal Devon and Exeter Hospitals NHS Trust was not within our remit, this methodology was only applied as a bench marking exercise and as an attempt to externally validate the model. The primary purpose of this visit, as defined by the terms of reference was:

- Review of the patient pathways from the 2 referring hospitals into the specialist MDT within Exeter.

- Provide assurance that in combination with the proposed arrangements in the West of the Peninsula, the existing and the proposed second centre will comprise a compliant Gynaecological cancer service for the Peninsula.

- Provide advice if any aspects of this service could be further improved.

Comparative Assessments

Item 1

MDT working and patient pathways

Unit	Score	Total (with weighting)	Cumulative Total
Truro	3	9	9
Plymouth	3	9	9

Both units had evidence of functional MDTs with satisfactory information back up and broad scope of involvement. We felt that both the MDTs and the patient pathways presented were of a standard to meet peer review for a gynaecological cancer centre.

Item 2

The availability of specialist cover by appropriately trained and experienced specialist surgeons and the sustainability of such cover in circumstances such as sickness absence and leave.

Unit	Score	Total (with weighting)	Cumulative Total
Truro	2	6	15
Plymouth	2	6	15

While both scored 2 for this item i.e. adequate, the unit in Truro is based upon two subspecialty trained gynaecological oncologists (which in the visitors' opinion is the minimum necessary for centre function given the projected workload). The Plymouth unit has one subspecialty trained gynaecological oncologist and two experienced gynaecologists one of whom holds the unit lead role and the other providing further back up in a part time capacity.

Both units acknowledged the need to further increase their establishment should they be accorded centre status.

Item 3

The availability of and access to hospital clinical nurse specialists and allied health professionals important to the patient experience and quality of care.

Unit	Score	Total (with weighting)	Cumulative Total
Truro	2	6	21
Plymouth	2	6	21

Both units employed the full range of nurse specialist and allied health care professionals and both saw the need to increase their establishment should they be accorded centre status. Truro has instigated an impressive programme of nurse development, by sending its CNS and senior ward nurses to the Gateshead Gynaecological Cancer Centre to ensure that the nursing staff are prepared for the care of complex surgical cases. The visitors were impressed by the work and dedication shown by the clinical nurse specialists on both sites who had a full understanding of the implications of either one of the two units becoming a centre whilst the other remained a unit. Both clinical nurse specialists have established robust Network-wide working practices with their colleagues in the rest of the Cancer Network, which should help to ensure effective supportive care pathways for patients, whichever, site is awarded centre status. The nurse specialists will be central to the success of any change in service configuration given the unique demographic challenges posed by the Peninsula network.

Item 4

The range of operative procedures available to patients especially those with complex tumours.

Unit	Score	Total (with weighting)	Cumulative Total
Truro	3	9	30
Plymouth	2	6	27

The visitors were aware of the changes that had occurred in the recent past and that cervical and vulval cancer work had been recently re-established in Plymouth although they had been providing a full range of procedures up until 2008. Plymouth has strengths in allied surgical disciplines therefore it could be possible to develop teams to deliver complex surgery in the future given the appropriate guidance and leadership.

Notwithstanding this, the Truro team has two subspecialists one with extensive experience of leading a large cancer centre, co-ordinating and providing this type of complex surgery. Furthermore, their plans for complex service delivery were well thought through and realistic. For this reason we accorded Truro a score of 3 and Plymouth 2.

Item 5

Evidence of integrated care with oncologists where multi-modality therapy is required.

Unit	Score	Total (with weighting)	Cumulative Total
Truro	3	9	39
Plymouth	2	6	33

Both teams showed adequate integration in this domain although the Truro team presented their team approach in a much more robust fashion. Individual team members were very much aware of each others activity. Although not specifically requested the Truro visit was supported by their palliative care physician indicating to the visitors the emphasis that the team placed upon end of life care and thus the complete pathway and full integration within the wider team. The non-surgical oncologists in Plymouth deliver a good quality service and there is obvious collaboration with colleagues throughout the Peninsula network.

Item 6

Evidence that outcome data is being collected prospectively

Unit	Score	Total (with weighting)	Cumulative Total
Truro	2	4	43
Plymouth	3	6	39

Both units demonstrated that they could and to a certain extent were collecting clinical data in a prospective fashion. The Plymouth system seemed more streamlined and efficient hence the difference in scores. This probably reflects the larger cancer administrative infrastructure present at Plymouth.

Item 7

The Improving Outcomes in Gynaecological Cancers guidance anticipates improvements in 5 year survival for patients with these tumours by moving to specialist centres. As both of these services have changed significantly recently 30 day mortality and one year survival rates should be examined

Unit	Score	Total (with weighting)	Cumulative Total
Truro	3	9	52
Plymouth	3	9	48

Both units report outcomes as good as if not better than available national data. This is commendable. As discussed in the introduction, these data are crude and not adjusted and subject to selection bias (in surgical terms). However, the visitors could not determine any obvious or major differences in outcome performance and are confident that whichever unit were to be accorded centre status would be able to produce continued improvements in long term survival that would be at least equivalent to currently available outcomes from elsewhere.

Item 8

The potential for the facilities and team(s) to be able to absorb the full workload and provide a reliable and sustainable high quality service to patients as a specialist gynaecological cancer centre(s) for the West of the Peninsula.

Unit	Score	Total (with weighting)	Cumulative Total
Truro	3	9	61
Plymouth	2	6	54

Projected activity data and patient flows have to be based upon SWICS reports that were provided. We also looked at individual unit's activity as estimated from their

MDTs. Such data are estimates and are helpful in overall service planning but may be subject to error. In terms of the likely flow from one to the other unit, we would predict a lower limit of 100 cases and an upper of approximately 120 cases. Experience from units and centres elsewhere might suggest these are underestimates as even over the last 5 years, more cases have been deemed as possible surgical candidates and in terms of ovarian cancer, more women are have more procedures (primary laparotomies, intervention debulking procedures and delayed debulking following neoadjuvant chemotherapy).
In terms of the fabric (wards, theatres, outpatients etc) the visitors' opinion was that both units could absorb the additional workload.
One would assume that if the designated centre were Plymouth, then all IOG work from Cornwall would come to Plymouth. Should Truro become the designated centre, then some patients from the east of the Plymouth catchment area might choose to be treated in Exeter thereby lessening the impact on Truro. In terms of the teams tasked to provide this work, Truro had a much more global view of the challenges that they might face and the strength of their team working was the reason we allocated a score of 3.

Item 9

To comment on the impact assessment provided by each Trust on the effect each of the potential reconfiguration options would have on their existing clinical services

Unit	Score	Total (with weighting)	Cumulative Total
Truro	3	6	67
Plymouth	1	2	56

Plymouth's impact assessment focused mainly on the impact of losing services. It suggested that some services might be degraded should it not become a gynaecological cancer centre. The visitors were not convinced that this would be the case, as many hospitals provide a wide range of high quality gynaecological services with well trained committed staff despite not being accorded gynaecological cancer centre status. It was not clear from the impact assessment provided what the positive benefits to patients from Cornwall might be.

Summary of scores based upon the initially agreed Terms of Reference

Unit	Cumulative Total
Truro	67
Plymouth	56

Additional Terms of Reference adopted by the visitors

Item 10

Academic and research output, to include evidence of support for national and international clinical trials relevant to gynaecological cancer.

Unit	Score	Total (with weighting)	Cumulative Total
Truro	3	3	70
Plymouth	2	2	58

Both units are research active as evidenced by their documentation and discussions with individual members of the team. Truro demonstrated how they had year on year increased recruitment into clinical trials and demonstrated a more enthusiastic approach. The year on year accrual into clinical trials was not related to the appointment of a gynaecological oncologist as the data presented evidenced that this phenomenon predated this appointment. Truro's Research Nurse regularly attended their MDM and when questioned with the CNS, was able to explain their joint working practices in the supportive care of patients entered into clinical trials. Plymouth also performed well in terms of overall recruitment into clinical trials and this appeared to be driven by the non-surgical oncologists in the MDT. Both units included recruitment into clinical trials as part of their MDT activity.

Item 11

Supportive and palliative infrastructure to include intensive care facilities, anaesthesia and pain management.

Unit	Score	Total (with weighting)	Cumulative Total
Truro	3	3	73
Plymouth	2	2	60

Both units were adequate in terms of provision. The Truro team visit also included meeting with the palliative care physician (this was not requested by the reviewers but the team themselves considered it to be important) who works closely with the gynaecological cancer team and attended their weekly MDM. We were, however, not concerned that Plymouth might lack these facilities. Plymouth had good facilities for friends and relatives to stay overnight if necessary.

Item 12

Information systems to support and enhance the patient pathway across individual Trusts and across the network.

Unit	Score	Total (with weighting)	Cumulative Total
Truro	2	6	79
Plymouth	3	9	69

Both units appear to have adequate systems that are robust enough to meet the challenges posed by the proposed re-organisation. As has been previously mentioned, the larger cancer management team in Plymouth has an advantage in manpower which reflects the fact that Plymouth already hosts other "Cancer Centres". The visitors took the view that this should be an advantage but also recognised the potential threat in that Gynaecological Cancer may find itself competing for support.

Item 13

Evidence of clinical leadership, team development and management

Unit	Score	Total (with weighting)	Cumulative Total
Truro	3	9	88
Plymouth	2	6	75

We felt that there were differences between the two teams and in their leadership. The clinical lead for gynaecological oncology in Truro is an internationally known gynaecological oncologist with experience of having led a gynaecological cancer centre elsewhere in the UK. This experience is evident in that within two years a robust functional team has been developed. The team has excellent back up in a

further subspecialty trained clinician who has demonstrated in a relatively short time his ability to address service related problems in a positive fashion (the re-organisation of colposcopy services in Truro). The high quality leadership reflects itself in the motivation and commitment of the other team members. The non-surgical members of the MDT all appeared to have been engaged in the development of the Truro proposal and demonstrated a good understanding of its content and the potential implications for their areas of work if centre status awarded.

The current lead in Plymouth is highly motivated and committed to developing services in Plymouth for women with gynaecological cancer but does not have an equivalent in depth oncology background. There would be challenges in making and developing a centre for this team. Plymouth has recently appointed a subspecialty trained gynaecological oncologist but he has only been in post for two weeks. During discussions with the non-surgical members of the MDT it appeared that they had not all been fully engaged in the development of the Plymouth proposal presented to the visitors. Much of the leadership demonstrated to us in the review was from the Director of Cancer Services and not the lead for Gynaecological Cancer Services. This could, of course, reflect a different culture within the Trust.

Item 14

Managerial leadership, support and engagement with the clinical team.

Unit	Score	Total (with weighting)	Cumulative Total
Truro	3	9	97
Plymouth	2	6	81

There were also differences in the way that senior management were involved in these proposals.

The visit to Truro was clearly led by their lead clinician in gynaecological oncology with support from the Chair, Chief Executive, Medical Director, Cancer Services Lead, Lead Cancer Nurse and Clinical Director of Obstetrics and Gynaecology. The executive team in Truro clearly demonstrated their commitment and support for the proposal and were open with regard to the challenges posed by it for their

organisation. They regard this as a potential flagship development for their Trust and the support given so far testifies to this commitment. All the executive team present were able to discuss all aspects of their proposal and were aware of the needs and challenges that a centre would pose for the organisation. The lead cancer nurse was clearly engaged and demonstrated support for the CNS in developing centre level patient care, this was evident in the implementation of centre level nurses competencies for CNS and ward staff and being in the advanced stages of recruiting another CNS for their existing service need.

The Plymouth team was led by the Deputy Chief Executive along with the Medical Director and the Director of Cancer Services. The proposed centre lead took a supporting role in the discussions. Although enthusiastic it seemed as if some members of the executive team might be unaware of some of the details of the bid and they relied heavily on their experience of running other site specific centres without due regard to the special needs of developing a gynaecological cancer centre.

Summary

By combining the scores from the above items into one grid:

Item	Truro Score	Plymouth Score	Truro weighted Score	Plymouth weighted score
1	3	3	9	9
2	2	2	6	6
3	2	2	6	6
4	3	2	9	6
5	3	2	9	6
6	2	3	4	6
7	3	3	9	9
8	3	2	9	6
9	3	1	6	2
10	3	2	3	2
11	3	2	3	2
12	2	3	6	9
13	3	2	9	6
14	3	2	9	6
Total	35	28	**97**	**81**

We are of the opinion that following our visits to Truro and Plymouth requested by the Peninsula Network that Truro should be designated as a gynaecological cancer centre.

Site Visit to the Royal Devon and Exeter NHS Foundation Trust
Friday 23rd October 2009

In order to complete the clinical review, the visitors (the same team that had completed the first two visits) visited the Royal Devon and Exeter NHS Foundation Trust, specifically the gynaecological cancer team. This team is currently recognised as the centre providing the specialised MDT and cancer services for women with gynaecological cancer in the Peninsula Network. It had been recognised at the outset that the current status of the gynaecological cancer centre was not an issue but in order that a broad picture of the services in the network could be gained the network board felt that a comprehensive clinical assessment of the gynaecological cancer centre in Exeter would be a valuable exercise.
The visitors concurred and felt that the visit would also afford a valuable opportunity of benchmarking the adopted scoring system.

The Visit
The visit took place on Friday 23rd October. We met with the core and extended gynaecological cancer MDT along with the Medical Director, chief operating officer and the senior managers responsible for delivering the service. We were shown the facilities and given details of MDT minutes, access to notes and the full annual report. The team had obviously gone to great efforts to provide as complete a picture as possible and it was quite clear to the visitors that the whole team felt involved in and proud of their service and commitment to patients. Of all the sites visited Exeter promoted the patient focus most strongly, both at the outset of the visit and throughout.
We also had the opportunity of meeting with the gynaecological cancer unit leads and their clinical nurse specialist counterparts from North Devon (Barnstaple) and South Devon (Torbay). The network appears to be inclusive, functions well and the integral parts are very supportive of one another.
As an exercise in validating our scoring template we applied the same criteria as we had when assessing Truro and Plymouth.

Item 1

MDT working and patient pathways

Centre	Score	Total (with weighting)	Cumulative Total
Exeter	3	9	9

Exeter has a well functioning, well attended MDT with clear patient pathways. North and South Devon are firmly embedded in the network.

Item 2

The availability of specialist cover by appropriately trained and experienced specialist surgeons and the sustainability of such cover in circumstances such as sickness absence and leave.

Centre	Score	Total (with weighting)	Cumulative Total
Exeter	3	9	18

Exeter has three subspecialist gynaecological oncologists and is well placed to provide cover for all gynaecological oncology eventualities. There is also a highly functional extended team including colorectal and urological surgeons who have developed novel and productive methods of working together as a functional team.

Item 3

The availability of and access to hospital clinical nurse specialists and allied health professionals important to the patient experience and quality of care.

Centre	Score	Total (with weighting)	Cumulative Total
Exeter	3	9	27

The centre and allied unit nurse specialists worked well as a team. The visitors did feel that additional CNS input might be necessary as workload increases, particularly the complexity of the work undertaken..

Item 4

The range of operative procedures available to patients especially those with complex tumours.

Centre	Score	Total (with weighting)	Cumulative Total
Exeter	3	9	36

The Centre is particularly strong in this area with a highly functional and innovative radical pelvic surgery team.

Item 5

Evidence of integrated care with oncologists where multi-modality therapy is required.

Centre	Score	Total (with weighting)	Cumulative Total
Exeter	3	9	45

The non-surgical oncology component of the centre's MDT is focused and fully integrated. There are close working relationships and a strong sense of team effort..

Item 6

Evidence that outcome data is being collected prospectively

Centre	Score	Total (with weighting)	Cumulative Total
Exeter	3	6	51

The data files presented at the time of the visit were exemplary containing ample evidence of robust, prospective data collection.

Item 7

The Improving Outcomes in Gynaecological Cancers guidance anticipates improvements in 5 year survival for patients with these tumours by moving to specialist centres. As both of these services have changed significantly recently 30 day mortality and one year survival rates should be examined

Centre	Score	Total (with weighting)	Cumulative Total
Exeter	3	9	60

The data and evidence made available to the visitors gave no cause for concern. There was no evidence to suggest undue early morbidity, indeed short term outcome

were considered to be good**.** Mortality at one year was considered to be within the same range as that seen for the other units visited.

Item 8

The potential for the facilities and team(s) to be able to absorb the full workload and provide a reliable and sustainable high quality service to patients as a specialist gynaecological cancer centre(s) for the East of the Peninsula.

Centre	Score	Total (with weighting)	Cumulative Total
Exeter	3	9	69

In terms of the fabric (wards, theatres, outpatients etc) the visitor's opinion was that the centre could absorb additional workload although it is certainly not clear exactly what that would be. Even if over 50% of the Plymouth workload elected to be treated in Exeter (50-60 additional cases), then we were of the opinion that Exeter had sufficient capacity to accommodate this.

Item 9

To comment on the impact assessment provided by each Trust on the effect each of the potential reconfiguration options would have on their existing clinical services

Centre	Score	Total (with weighting)	Cumulative Total
Exeter	2	4	73

Although it may not be possible to precisely predict the impact on Exeter of changes elsewhere in the network the visitors felt that the Exeter impact assessment might need to be expanded. This may be particularly pertinent if manpower needs to be recruited given the time required to ensure that manpower does not lag behind in a financially difficult climate.

Summary of scores based upon the initially agreed Terms of Reference

Centre	Cumulative Total
Exeter	73

Additional Terms of Reference adopted by the visitors

Item 10

Academic and research output, to include evidence of support for national and international clinical trials relevant to gynaecological cancer.

Centre	Score	Total (with weighting)	Cumulative Total
Exeter	3	3	76

There are good links with the medical school and a programme of collaborative basic science has been established. The support of clinical trials is also evident. The gynaecological cancer team are active within the "greater NHS" which is excellent for developing and maintaining the profile of the centre.

Item 11

Supportive and palliative infrastructure to include intensive care facilities, anaesthesia and pain management.

Centre	Score	Total (with weighting)	Cumulative Total
Exeter	3	3	79

There are good links with palliative care and an excellent patient support facility within the hospital complex. This facility not only now provides outreach to other units in the network but has a vibrant fundraising capacity which continues to support research within the centre.

Item 12

Information systems to support and enhance the patient pathway across individual Trusts and across the network.

Centre	Score	Total (with weighting)	Cumulative Total
Exeter	3	9	88

Exeter uses a web based dendrite system that supports the MDT and the network. Excellent patient MDT reports are produced; patient tracking and management are of a high quality.

Item 13

Evidence of clinical leadership, team development and management

Centre	Score	Total (with weighting)	Cumulative Total
Exeter	3	9	97

Clinical leadership is strong and focused. The team has been well developed and appears to deal with challenges in a measured and proactive fashion.

Item 14

Managerial leadership, support and engagement with the clinical team.

Centre	Score	Total (with weighting)	Cumulative Total
Exeter	3	9	106

The Trust management appeared supportive and involved and clearly the development of the gynaecological cancer centre at Exeter has been a well planned strategy that has been carefully nurtured over the years. There appeared to be good working relationships with the senior managers in the Trust who were both informed and engaged in the maintenance and development of this service.
With regard to the terms of reference set by the Network for the Exeter review:

Review of the patient pathways from the 2 referring hospitals into the specialist MDT within Exeter.

The system functions well. The two unit leads were very positive about the working relationship that they had with the cancer centre. Their only concern was the possible impact on their relationship as a result of changes elsewhere in the network.

Provide assurance that in combination with the proposed arrangements in the West of the Peninsula, the existing and the proposed second centre will comprise a compliant Gynaecological cancer service for the Peninsula.

We found no evidence that the proposals to create a second centre would in any way undermine the ability of the existing centre to remain IOG compliant.

Provide advice if any aspects of this service could be further improved.
We did not feel that there were any areas of concern and that the centre was functioning well and therefore made no recommendations for further improvement.

Conclusions
The visitors were impressed by the professionalism and team working within the gynaecological cancer centre at Exeter. It is clearly a patient focused service and very inclusive of its associated units. All those involved should be justly proud of the service that they deliver and we believe that this could be considered an exemplary gynaecological cancer centre.

The Peninsula network is fortunate to have this resource as it should be able to provide stability and leadership at a time of transition to a two centre network. The network should consider including the Exeter Gynaecological Cancer Centre in an advisory capacity relating to any transfer of services resulting from this review.

David Luesley.....Date.....

Charles Redman.....Date.....

Juliette Sim.....Date.....