Peninsula Cancer Network NHS
Devon and Cornwall

Closer working between gynaecological cancer staff at Plymouth and Truro

Briefing – September 2011

1 Improving cancer services

At its meeting in September 2010, the Peninsula Cancer Network (PCN), which works on behalf of the NHS across Devon, Cornwall and the Isles of Scilly, revised its approach to improving cancer services.

This means that, as a matter of good practice, process is now aligned with the four 'key tests' issued by the Department of Health in July 2010. These tests are designed to demonstrate:

1. Support from GP commissioners
2. Strengthened public and patient engagement
3. Clarity on the clinical evidence base, *and*
4. Consistency with current and prospective patient choice

The emphasis of the PCN's revised process is on making the greatest improvements possible along the entire patient 'pathway', from diagnosis, through treatment to aftercare.

It has also been developed to reflect the report of the Independent Reconfiguration Panel, published in July 2010. In particular, this called for the PCN to "review how the experiences of patients will be captured and used to design and deliver better cancer services".

Considerable effort has since been invested in developing a robust framework for patient and carer involvement, as outlined in a paper to Overview and Scrutiny Committees (OSCs) this summer. The main results have been a document called 'User Involvement Principles and Strategic Framework' and, following a series of involvement events, the creation of a Patient and Carer Working Group.

This group, bringing together members from each of the five established local patient groups in the Peninsula, became fully established in July 2011.

The PCN is now in a position to put the revised process into practice for gynaecological cancer services.

2 Gynaecological cancer services - background

Cancer networks across the NHS are expected to ensure the quality of local services by complying with national Improving Outcomes Guidance.

Under the IOG for gynaecological cancer (1999), the Royal Devon & Exeter Hospital was designated in 2004 as the sole Specialist Gynaecological Cancer Centre within Devon and Cornwall. Royal Cornwall Hospitals (Truro) and Plymouth Hospitals are both Local Gynaecological Cancer Units, with non-surgical treatment of patients with gynaecological cancers being provided

in all five acute trusts, including South Devon Healthcare (Torbay) and Northern Devon Healthcare (Barnstaple).

Ultimately, interpretation of compliance with the IOG lies in the hands of the National Cancer Action Team (NCAT).

NCAT agreed in 2007 that, while the IOG suggested the population of the Peninsula would support only one gynaecological cancer centre, its geography meant a second centre – in addition to Exeter – would be acceptable. An alternative proposal from RCHT, PHT and the PCN, involving the continuation of surgery at both Truro and Plymouth, was rejected.

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

This had two distinct components:

1. 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.
2. As the service in Exeter was already operating as a designated centre for this service and this status was not in question, to provide assurance that the patient pathways ensured that all complex gynaecological cancer cases, including ovarian, were appropriately referred into the centre.

The reviewers' report, published in December 2009, concluded that:

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

A series of meetings were arranged with existing gynaecological cancer patients in the Derriford catchment area, so the review and its implications could be discussed.

The clinical review was also discussed with OSCs in early 2010, with Plymouth adopting the following resolution:

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

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

Further engagement was then put on hold pending publication of the Independent Reconfiguration Panel report and details of the Department of Health's four key tests, which led in turn to the PCN's revised process and development of the Patient and Carer Working Group.

3 Gynaecological cancer services - current position

The NHS Operating Framework for 2011/12 recommends that cancer networks continue working to ensure full implementation of IOGs. In the Peninsula, gynaecological cancer has yet to comply with the guidance.

At present, staff at both Royal Cornwall Hospitals NHS Trust (RCHT) and Plymouth Hospitals NHS Trust (PHT) continue work as separate specialist Multi-disciplinary Teams (MDTs). The national quality-assurance programme known as peer review highlighted early in 2011 that this way of working did not meet its criteria and needed to be addressed.

In summer 2011, RCHT, PHT and the PCN therefore agreed that their own staff should work more closely together. Technically, this means the creation of a single specialist MDT for gynaecological oncology, spanning the two trusts.

As a result, patients will be able to have their treatment planned by a fuller range of specialists, who share their expertise but otherwise continue to work as now at their own hospitals. Final decisions on treatment will be taken by the women and their own consultants, as now.

Clinical leadership will be provided by Mr Tito Lopes, Consultant Gynaecological Oncologist at RCHT.

In June 2011, NCAT also said that a single MDT working across two sites might be acceptable for gynaecological cancers. Mike Richards, National Clinical Director for Cancer, said in a letter to Nigel Acheson, PCN Medical Director:

> “Taking into account the geography and location of services in the Peninsula you asked if NCAT would find it acceptable to receive a plan from the Cancer Network which included a single specialist MDT operating between Truro and Plymouth with surgical services being provided on both sites.
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> “The geography in the Peninsula certainly justifies special consideration and in respect of gynaecology specifically we felt that it could be possible to secure the services necessary to deliver IOG compliance in this way with some careful planning.”

The letter also recommended that the PCN consider quality-assurance arrangements covering gynaecological cancer surgery in Bristol/Bath, where a similar solution has been agreed.

In parallel, and in line with the key tests and the revised PCN approach, the PCN Medical Director has concluded that evidence is very limited on whether centralisation for gynaecological cancer surgery would improve outcomes further for patients, given the improvements that have been made at RCHT and PHT since IOG publication in 1999. The Bristol/Bath case highlights the lack of consensus among clinicians on the validity of the evidence as the basis for centralisation.

The independent clinical review of 2009 did not differentiate between RCHT and PHT in respect of the evidence of improved clinical outcomes, stating: “Both units reported outcomes as good as, if not better than, available national data. 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.”

4 Gynaecological cancer services – the future

The future for gynaecological cancer services can be divided into two:

1. Creation of the single MDT, with closer working between staff at the two hospitals, as an essential precursor to...
2. Development of proposals to improve patient experience and outcomes along the entire pathway. While this is designed to include plans for IOG compliance in the West that are acceptable to NCAT, it will also help provide equity with the East, and enable experiences and good practice to be shared.

The first element is largely technical, involving issues such as the alignment of work plans at the two trusts, so MDT members can 'meet' each other via teleconference on a weekly basis to discuss the management of individual patients. This is essential to ensure that patients' care is planned with the benefit of consideration from the combined experience and skills of the single MDT. It also meets the requirements of peer review, but has no wider implications for patients in terms of travel, for example.

The second element is where there are real opportunities to improve services along the entire pathway, from the point at which the patient first becomes involved with the NHS, through treatment such as chemotherapy, radiotherapy and surgery, to follow-up appointments and aftercare.

Although the pathways in the East of the Peninsula, focused on Exeter, are fully compliant with IOG, this is nevertheless an opportunity to consider the patient experience and share good practice, putting East and West on an equal footing.

Clinicians will work therefore with GP commissioners, recent patients, carers and other stakeholders to:

- Understand the good and less-good aspects of current services
- Understand current and future demand for services
- Understand what improvements could and should be made
- Understand how these improvements could be put into practice
- Understand how improvements and attendant changes would fit within commissioning and provider trust strategies
- Develop proposals for the West that will be acceptable to NCAT

Patients and carers will be drawn from those with recent experience of gynaecological cancer. The way in which they are involved will be in line with the views of the PCN's Patient and Carer Working Group.

OSCs, GP commissioners and other stakeholders will also be asked how they would like to be involved in, or updated on, the process.

The overall aim is to arrive at plans for improving gynaeological cancer services that have been developed openly and by consensus, that will secure agreement from NCAT as being in line with IOG, and that will bring real improvements along the full patient pathways across the Peninsula.

As indicated by NCAT, in the West this should enable gynaecological cancer surgery to continue at both sites, as long as suitable safeguards are built in.

This development process may take time, especially as it is the first occasion on which the PCN's new process for service improvement has been put into practice.

Nevertheless, the intention is to secure NCAT approval for the West by summer 2012.