Action Plan for Gynaecological Cancer Services

For Agreement by:	ASWCS Acute Trusts ASWCS Primary Care Trusts ASWCS Gynaecological Site Specialist Group ASWCS Board
For Approval by:	Avon, Gloucestershire & Wiltshire Health Authority Dorset & Somerset Health Authority
For Submission to:	Cancer Action Team

June 2004

Avon, Somerset and Wiltshire NHS
Cancer Services

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1 Executive Summary

1.1 This paper highlights the action plan for gynaecological cancers for the ASWCS Network. The plan covers seven ASWCS acute Trusts and eleven ASWCS PCT's Plans for the Swindon Health Community (Swindon PCT and Swindon & Marlborough Trust) will be co-ordinated with Thames Valley Network.

1.2 This action plan has been developed in conjunction with the ASWCS Site Specialist Group with representation from all ASWCS Trusts, as well as nursing representatives. It highlights the Networks' response to the Improving Outcomes Guidance for Gynaecological Cancers, and recommends specialist teams for vaginal, vulval, cervical, high-grade endometrial and ovarian cancers.

1.3 The plan acknowledges that until any capacity and development of the preferred option(s) is in place an interim position for patients may be required.

1.4 The Site Specialist Group **Appendix 1** met in April 2004 and requested a further review of the management of gynae cancers with the preference of considering either one centre for the whole Network or a joint Bath and Bristol centre and another for Somerset. **Appendix 2**

1.5 The Network appointed a project lead Chris May of Mayden consultancy currently doing work for the NHS who had conducted a review of gynaecological cancers in a London Network, with Professor Kitchener author of the Improving Outcomes Guidance for Gynaecological cancers to carry out the clinical review.

1.6 The view of the assessors after visiting the three proposed centre sites were that each team were offering safe and competent care to patients and that there would not be any improvement to patient care to consolidate the majority of cases on one or two sites in the short term, on the contrary the disruption to care would probably increase waiting times and cause patients to travel longer distances for treatment.

1.7 The review of gynae cancers in the Network has not been completed at the time of this action plan, with a stakeholders meeting planned for the evening of the 15 July to explore the rationale behind the recommendations and a time frame for implementation of a joint centre and what form this should take. Also, no physical site has been identified for the centre work as this may be subject to change in light of overarching Network strategic investment planning.

1.8 Indicative costs for management of gynae malignancies have been calculated using the Payment by Results tariff applied to a patient pathway. **Appendix 3**

2 Recommendations

2.1 That the three proposed centre sites within the Network (Taunton, Bath and Bristol) continue to carry out centre functions in the short term 2004 to 2006, with the following provisos.

- All rare gynae procedures (Pseudomyxoma's, exenteration, sarcomas etc) are referred to John Murdoch at St Michaels.
- All radiotherapy for cervical cancer including external beam therapy to be referred to the BHOC.
- East Somerset Trust to continue to send level one cases to Bath in the short term.

- East Somerset Trust to refer the ovarian cases between Taunton and Bath in the short term.
- Encourage links with the Taunton team to Bristol for education, trainee support and clinical advice where necessary

In the medium term 2006 to 2007 when the Somerset Oncology centre is functioning;

- East Somerset Trust to refer all gynae cases to Taunton.
- That Somerset appoints a further gynae oncologist to support Orla McNally.
- That all radiotherapy for cervical cancer including external beam therapy to be referred to the BHOC, Brachytherapy service will remain at Bristol.
- All rare gynae procedures as above (exenteration etc.) to be referred to John Murdoch in Bristol.
- That Bristol appoints a further gynae oncologist to cover potential supra-network cases and fulfil the European Working Directive.

In the long term (5years) from the date of this report;

- Support Bristol to provide the centre MDT and specialist service for the Network
- Support Bath to join Bristol as a joint centre based in Bristol (the site to comply with over arching Bristol planning process and the ASWCS Strategic Framework for Specialist Cancer Services)
- Request that managers and clinicians from the two health communities (Bristol and Bath) with involvement of PCT commissioners agree an appropriate shift of workload phased over a manageable period of time.

2.2 That the Network gynaecological site specialist Group develops a more proactive role to ensure joint working across the Network and help deliver the recommendations as described above.

2.3 This paper forms the strategic plan for gynaecological cancer services for ASWCS. Operational quality against agreed national and local quality measures will be assessed by a national peer review process due to take place in 2005.

3 Introduction

3.1 Gynaecological cancer services had NICE 'Improving Outcomes Guidance for Gynaecological Cancer published in 1999 with standards applicable for the 2001 national Quality Assurance Assessments available in that year, which have subsequently been amended for the second national peer review round due to progress in 2004.

3.2 The 'Improving Outcomes Guidance' set out recommendations for future service delivery of gynaecological malignancies. The Guidance recognised that the most critical aspects of clinical decision-making and service delivery require sufficient caseload to justify bringing together the scarce specialist skills and facilities necessary to permit effective multi-professional and multi-disciplinary care. This requirement is balanced against the need to provide services as close to the patient's home as possible, but ensuring the patient receives high quality, safe and effective care.

3.3 The service model in the 'Improving Outcomes Guidance' formed the basis of following Guidance in building assessment services at cancer unit level and treatment services at cancer centre level. Both the centres and units should have in place multidisciplinary teams if treatment of gynaecological cancer is carried out.

3.4 The key recommendations of the Improving Outcomes Guidance are;

- Dedicated diagnostic and assessment services should be established in cancer units, to which all women with possible or suspected gynaecological cancers should be referred. This includes women with symptoms and those who present through the cervical screening programme.
- There should be specialist multi-professional gynaecology oncology teams based in cancer centres. These teams should be responsible for the management of all women with ovarian cancer and the majority of women with other gynaecological cancers.
- The specialist gynaecological oncology and palliative care teams in each cancer centre and associated cancer units should agree clear local policies for the management of women with advanced or progressive disease.
- There should be rapid and efficient communication systems for liaison and cross referral between all levels of the service. Audit should take place across the entire service delivery Network.

3.5 The Network carried out an external peer review process in June 2000 and the outcome attempted to combine the ASWCS agreed standards with the 'Improving Outcomes Guidance' standards. It was assumed that the three levels proposed then would provide a realistic implementation of the national standards at that time.

3.6 The suggested levels were then; gynae cancer centre, gynae cancer unit and gynae cancer assessment as defined below;

- Gynaecological Cancer Centres should be accredited to assess and treat all gynaecological malignancies.
- Gynaecological units should be accredited to assess all gynaecological malignancies, and to treat ovarian, endometrial (stage1a & b, grade 1 or 2) and cervix stage 1a2 cancers. In particular, units should not treat invasive cervical, vaginal or vulval cancers or the more complex endometrial cancers. These more complex cancers should be referred to an accredited Gynaecological Cancer Centre for treatment.
- Trusts accredited for assessment only should refer all gynaecological malignancies for treatment to an accredited Gynaecological Cancer Centre or unit as appropriate.

3.7 The Network recognised then that local circumstances would necessitate modifications in the way the national guidance is implemented. The rurality of the counties in the ASWCS Network where access is difficult for the patients might require a different approach to the one, which would be applicable for urban areas.

3.8 The following recommendations were made as an outcome of the accreditation;

- The UBHT Bristol and the RUH Bath were accredited as gynaecological cancer centres, with a joint strategic plan to include the joint appointment of a gynae oncologist and the development of joint treatment protocols.
- Weston Area Health Trust, East Somerset Trust, Taunton & Somerset Trust and Swindon & Marlborough Trust were accredited as cancer units. North Bristol was asked to seek accreditation as a unit or aim for assessment only linked to the accredited gynae cancer centre in Bristol.

3.9 In November of 2001, a paper was written for the Network Board 'Gynaecological Cancer Services in the ASWCS Network, Implementation of level two standards'. This paper outlined a strategy for implementing level two standards. Level one standards were considered met within the Network and assessed both by local accreditation in 2000 and the national Quality Assurance Assessment in 2001.

3.10 The ASWCS Board requested a strategy to implement the level two standards to move all ovarian cancers from the gynae cancer units to the gynae cancer centres, with a timetable to match the Cancer Plan funding, i.e. April 2001 to March 2004.

The November 2001 Board were asked to receive the Network Implementation of level two standards document and consider the options for approval.

3.11 The Board asked for a presentation from the Gynaecological teams on the implementation of level two standards at the March 2002 Board. Unfortunately the timing coincided with the policy 'Shifting the Balance of Power' and the existing Board was destabilised with most of the previous members not in post. The representation on the Board at that time was unable to draw a conclusion, with the result that the level two standards were not reconfigured.

3.12 The Network Gynaecological Site Specialist Group met on the 5 March 2004 and reviewed two major objectives;

- Implementation of Improving Outcomes Guidance
- Achieving service targets

3.13 The SSG reviewed the current status of the cancer centres and units within the Network and the numbers of patients managed on each site. The outcome of this meeting was to review options for a cancer centre/s in the Network to meet the Improving Outcome Guidance recommendations.

4 The Intended Outcome of the Option Appraisal

4.1 The DoH, and the two Strategic Health Authorities Dorset and Somerset and Avon, Gloucester and Wiltshire and the PCT's who commission services from the acute Trusts would like to understand the complexities of reconfiguring this service, the effect on, and benefit for patients, the investment needs and the practicalities of moving services around the Trusts.

4.2 The process will also clarify to the gynaecological teams the strengths and weaknesses of any local solutions and whether these will be viable options to meet the requirements of the IOG.

5 The Following Options were Proposed

Option A One centre, which would be a conurbation of the current Bristol and Bath centres on either site, offering a service for level one and two cancers.

Option B One centre, a Bristol/ Bath conurbation, plus a further centre in Taunton.

6 The Key Issues

6.1 What is the additional benefit for an individual patient resulting from surgical treatment in the centre, compared with decentralised arrangements?

6.2 The facilities (staff, space, equipment, infrastructure ITU & HDU etc.) available on the sites interested in becoming a centre or satellite.

6.3 What do patients feel about the trade off between the benefits of having surgical treatment in a centre versus the difficulty for them and their families of travelling to a hospital distant from their home and local services?

6.4 How will the centre(s) work effectively together and operate robust MDTs for the management of patient's treatment?

7 Configuration of Gynaecological Services

7.1 This plan for gynaecological Cancer Services has considered reconfiguration as a developmental process, taking into account the changes to the gynae standards as a result of the second round of peer review.

7.2 The round two peer review standards have addressed the division of secondary and tertiary cancer services in terms of local and specialised teams, and the standards now require Networks to identify geographical divisions in terms of localities.

7.3 The review of standards outlines two levels of care, local care and specialist care provided by two types of MDT- local and specialist, the different type of teams are determined by the following criteria;

7.4 Local Gynae Team

7.4.1 Local gynae teams provide local care for their own catchment, referring patients to specialist gynae teams for specialist care. Some MDT standards may be fulfilled by MDTs acting in combination, others may not. An important underlying principle in the IOG guidance for Gynae Cancer is the principle of the consolidation of services for relatively infrequent procedures.

7.5 Specialist Gynae Team

7.5.1 Specialist gynae teams provide specialist care for their referring catchment. The principle of consolidation of services requires that there should be not more than one specialist team in any one hospital.

7.5.2 In order that specialist teams experience the full range of practice for gynae cancers they are required to function as the local gynae team for their local catchment area.

7.5.3 The IOG guidance is based on centre teams providing tertiary services for a number of referring unit teams, for the majority of Networks only one or at most two specialist teams can be supported.

7.5.4 Should the Network propose an alternative model to that above a case would need to be made on the basis of exceptional circumstances and agreed with the relevant Strategic Health Authority and the Cancer Director.

7.5.5 The specialist MDT should not only meet to make multidisciplinary decisions, but also have a constant and experienced team performing the major surgical procedures, therefore the surgical operations and immediate post op care should all be carried out in the same host hospital of the team

8 Building The Gynae Cancer Network

8.1 The standards assign the responsibility for establishing the gynae cancer network arrangements to the Network Board, acting in agreement with the NSSG and the PCTs.

8.2 The local progression of this process is as follows:

- Agree the identity and location of local teams across the Network
- Agree the identity and location of specialist teams
- Agree the referral arrangements between the PCTs and the local teams including specialist teams acting in their capacity as local teams for their own secondary catchment population
- Agree the referral arrangements between the local teams and specialist teams
- Produce the Network configuration of teams

8.3 A core principle in the revised standards is that the plans will fully meet the Improving outcomes Guidance, if the informed view of the Network is that full implementation of the Guidance is not in the best interests of patients this needs to be made clear. The onus is on the Network to demonstrate why they are proposing a configuration that differs from that in the National Guidance, and how quality of care is not impaired.

9 Current Identity and Location of Local Teams Across the Network

9.1 The following tables outline the locations, population and teams across the Network. See also **Appendix 4**.

Trust	Location
East Somerset Trust	East Somerset
Taunton & Somerset Trust	West Somerset
Weston Area Health Trust	North Somerset
United Bristol Healthcare Trust	Bristol
North Bristol Trust	Bristol
Royal United Hospital Trust	Bath
Swindon & Marlborough Trust	Swindon

10 PCT Catchment Populations

PCT	Population	Gynae Network
South Somerset	105,000	105, 000
Taunton Deane	143,000	143,000
Mendip	109,000	109,000
Somerset Coast	140,000	140,000
B&NES	181,000	181,000
Bristol South & West	200,000	200,000
Bristol North	240,000	240,000
North Somerset	190,000	190,000
South Gloucestershire	240,000	240,000
West Wiltshire	160,000	160,000
Kennet & North Wiltshire	185,000	185,000
Swindon	185,000	-
Totals	**2,078,000**	**1,893,000**

11 Current Identity and Location of Specialist Teams

Specialist Team	Location
United Bristol Healthcare Trust	Bristol
Royal United Hospital Trust	Bath

12 Current Referral Arrangements between PCTs and Local Teams

12.1 The Cancer Action Team provide a template for Improving Outcomes requiring a description of the organisation of the cancer service for gynaecological cancers, **Appendix 6,** The table below identifies the current referral arrangements in the Network see also **Appendix 5**

PCT	Referrals to:
South Somerset	East Somerset Trust
Taunton Deane	Taunton & Somerset Trust
Mendip	RUH Bath, East Somerset Trust
Somerset Coast	Weston Area Health Trust & T&S

PCT	Referrals to:
Bath & North East Somerset	RUH Bath Trust
Bristol South & West	UBHT
Bristol North	North Bristol Trust & UBHT
North Somerset	UBHT & Weston Area Health Trust
South Gloucestershire	North Bristol Trust
West Wiltshire	RUH Bath
Kennet & North Wiltshire	RUH Bath & Swindon & Marlborough Trust
Swindon	Swindon & Marlborough Trust

13 Current Referral Arrangements Between the Local and Specialist Teams

13.1 Below is a table outlining the current referral arrangements between teams **Appendix 5 & 6**.

Specialist Team	Local Team
United Bristol Hospitals Trust	North Bristol Trust Weston Area Health Trust Taunton & Somerset NHS Trust
Royal United Hospital Trust Bath	East Somerset Trust
Radcliff Hospital NHS Trust Oxford	Swindon & Marlborough Trust

14 Network Configuration

14.1 Local Gynae Team

Criteria	Local Teams
Should not be more than one in any one hospital	All Network Trusts
Should be listed as part of the named services of a named locality in the Network	All Network Trusts

14.2 Specialist Gynae Team

Criteria	Specialist Team
Should not be more than one in any one hospital and/or Trust	All proposed specialist teams
Should be the only gynae MDT in the Hospital and/or Trust	All proposed specialist teams
Should be the only one or two in the Network	Proposed configuration currently compliant
Should act as the local gynae team for its own secondary catchment population	All proposed specialist teams
Should be listed as part of the named services of a named locality in the Network	All proposed specialist teams

15 Proposed Referral Arrangements Between Local and Specialist Teams

15.1 The tables below outline the proposed referral arrangements within the Network. See also **Appendix 5**.

Specialist Team(s)	Referring Local Team
United Bristol Hospitals Trust and Royal United Hospital Trust Bath joint service based in Bristol long term	North Bristol Trust Weston Area Health Trust Taunton & Somerset NHS Trust (very rare cases) RUH Bath (very rare cases)
Taunton & Somerset NHS Trust (2006)	East Somerset Trust
Radcliff Hospital NHS Trust Oxford	Swindon & Marlborough Trust

15.2 Configuration for diagnostic, local and specialist team below is the table outlining the referral flows to specialist teams in the Network.

	Teams	Trusts
a	Diagnostic team only:	None
b	Diagnostic team & local Care:	East Somerset Trust
		Taunton & Somerset Trust Weston Area Health Trust North Bristol NHS Trust RUH Bath NHS Trust

	Teams	Trusts
		UBHT Swindon & Marlborough NHS Trust
c	Gynaecological Specialist Team(s)	UBHT & RUH joint centre Taunton & Somerset Trust (2006)

16 Gynaecological Multidisciplinary Team

There are currently three gynae specialist MDTs meeting in the Network the following tables indicate the membership and meeting times of those MDTs. Core membership will be determined by attendance, which is outlined in the standards (measures);

'The MDT should meet weekly and record core members attendance, core members or their arranged cover should attend at least half of the meetings, members personal commitment is reflected in their attendance, not relying instead on their cover arrangements'

(Non-attendance at the central specialist MDT by a core team member will indicate that the member is not part of the specialist MDT and should therefore not be carrying out specialist gynaecological surgery).

16.1 Taunton & Somerset NHS Trust MDT

MDT Member	Name	Organisation
Gynaecological Oncologist	Miss Orla McNally	Taunton & Somerset Trust
Consultant obstetrician/gynaecologists	Mr David Wrede Mr Robert Fox	Taunton & Somerset Trust
Oncologist	Dr John Graham	BHOC
	Dr Mary Tighe (Associate specialist haematology/oncology)	Taunton & Somerset Trust
Pathologist	Dr H Klys	Taunton & Somerset Trust
Radiologist	Dr J Hunter Dr Paul Burns (cover)	Taunton & Somerset Trust
Specialist nurse	Mrs Sue Golby Ms Tracy Evans (cover)	Taunton & Somerset Trust
Research Nurses	Ms Judith Mathie Ms Jo Taylor	Taunton & Somerset Trust

16.2 United Bristol Healthcare Trust MDT

MDT Member	Name	Organisation
Gynae Oncologists	John Murdoch Robert Anderson	UBHT
Oncologists	Paul Cornes (clinical oncologist) Chris Williams (medical oncologist) John Graham (clinical oncologist, leaving end of July)	BHOC
Radiologist	Heather Andrews	UBHT
Histopathologist	Joya Pawade	UBHT
Nurse Specialist	Jenny James Anna Stafford Jayne Alexander	UBHT
MDT Co-ordinator	Kim Waring	UBHT

16.3 Royal United Hospital Bath MDT

MDT Member	Name	Organisation
Gynaecological Oncologist	Nicholas Johnson Kenneth Jaaback (Accredited specialist gynae onc.trainee) Shashikant Sholapurkar (Associate specialist)	RUH RUH RUH
Oncologists	Olivera Frim Paul Cornes Ed Gilby (Medical Oncologist) Chris Williams (Medical Oncologist	RUH BHOC/Bath RUH BHOC
Histopathologist	Lynn Hirschowitz	RUH
Radiologist	Louise Robinson Caroline Styles Simon Malthouse	RUH RUH RUH
Nurse Specialist	Frances Ralli Tracie Miles	RUH RUH

17 Workload data

The option appraisal sanctioned by the Board included an analysis of workload across the 6 Trusts in the Network who would be either offering a central service or referring patients to a centre, this data will follow for the meeting planned for the 15 July.

18 Financial Implications of Proposed Network Configuration

In the short term, there will be no extra investment required to continue the services across the three sites the plan is to develop a service that is gradualist, evolutionary and affordable. In the medium term when Somerset Oncology Centre is established Somerset need to appoint a further gynae oncologist to support Ms McNally. Also in the medium term Bristol need to appoint a further gynae oncologist to cope with the workload especially of the referred highly specialised cases and the constraints of the European Working Time Directive. An indicative pathway of costs for managing complex gynae procedures has been attached as **Appendix 3.**

19 Management of Risks

19.1 The following risks have been identified with regard to the implementation of this Guidance and are represented in the table below.

Risk	Cause(s)	Solution/Prevention
No sign up from CEs	Disagreement with proposal Affecting, organisations future vision No funding to support changes	Help identify potential savings of retaining good quality patient care in local health communities Negotiate vision in line with overall local and national objectives Clarify work & funding shifts, often a trade off
Flooding of cases to centre teams	Clinical teams who agree to referring their patients to a centre, do so without planned phasing causing a flood of demand at the receiving Trust	Agreeing appropriate funding for capacity at the centre(s). Phasing the shift in workload over several years. (The gynae proposal would only require a change in referral pattern between Yeovil and Taunton).
Specialist MDT fails	Lack of attendance from core members Video conferencing funding	Facilitate support for the MDT through Trusts clinical & management leads & Governance procedures Network to work with key

Risk	Cause(s)	Solution/Prevention
		groups to determine specification & locate funding streams
	Clinical conflict	Work with the teams for a solution and look to the SHAs for support
	Centre split over three sites	Negotiate good joint working between the sites through a more robust NSSG
Reduction in quality of outcomes	Clinicians not using clinical guidelines	Encourage use of clinical guidelines, jointly agreed across sites, to be tested by national peer review
	No funding identified for key appointments/facilities	Gain support for quality cancer services from the PCTs through the Board
Increase in waiting times	Consolidation of cases without teams and facilities in place	Ensure phased approach to consolidation, developing robust teams and review of workforce, developing or redesigning facilities
Failing peer review	Action Plan not accepted	Agree support through Board, Commissioning Group and from SHAs
	Support of all organisations to initiate change	Work as a Network to develop information and communication structures
	Measures not met across Network	Work with individual organisations to achieve measures where possible and the commissioning group to review measures that require funding. Keep PCTs well informed of service gaps
	No funding identified	

19.2 The option appraisal requested by the Network Site Specific Group was carried out with a view to rationalising the number of teams carrying out rare gynae cancer procedures across the Network. The Network had four teams carrying out the surgical treatment of ovarian cancer diagnosed preoperatively or referred after diagnostic laparotomy or laparoscopy, and three teams carrying out level one cases; the surgical treatment of high risk 11 or higher endometrial cancer (stage 1,

grade 3, stage11 or higher), the surgical treatment of squamous carcinoma of the cervix of stages more than 1a, and all adenocarcinomas of the cervix, the surgical treatment of vaginal or vulval cancer and the surgical treatment of recurrent cancer.

19.3 The opinion of the clinical expert reviewer (Professor Henry Kitchener, author of the gynae IOG) who carried out the option appraisal for the Network, was that the three proposed centres were all currently offering safe competent care for patients in their localities and by centralising cases on one or even two sites in the short term would not enhance the care of patients and further, require them to travel for treatment.

19.4 The view of the Network is that a pragmatic approach to gynae services needs to be adopted, making use of existing resources as there is currently no money in the system to build up a centre on any one site, and it would disadvantage patients in the short term. However the long term solution for gynae services which may change in light of overarching Network strategic capital investment plans is to develop a cancer centre in Bristol jointly with Bath and for Somerset to function as a centre with support from Bristol.

20 Implementation Plan

20.1 The recommendation of the option appraisal is that the changes across the Network for gynae cancer services should follow a pathway of implementation phased over a number of years and considered as short term, medium term and long terms goals. The vision is in line with Option B of the proposal which is a conurbation of the Bristol and Bath service based in Bristol and a further centre function in Somerset but linked for support to the Bristol team.

20.2 Below is a table demonstrating the phased implementation of gynae services.

Trust	Short term 2004 -2006	Medium term 2006	Long term 2006 on
Taunton & Somerset	Carry out centre function Refer very rare cases to Bristol Pick up 50% of ovarian case from Yeovil Link to Bristol for education & support	Carry out centre function with the oncology centre in place Appoint a further gynae oncologist Pick up all of Yeovil level 1 & 2 work Link to Bristol for education & support	Carry out centre function with links in place for support from Bristol
RUH Bath	Continue to provide a local service Refer very rare cases to Bristol	Continue to provide a local service Refer very rare cases to Bristol	Merge service with Bristol on a Bristol site in line with overarching strategic plans.

Trust	Short term 2004 -2006	Medium term 2006	Long term 2006 on
	Pick up 50% of ovarian cases and all level one cases from Yeovil Refer all cervical radiotherapy to BHOC	Cease doing Yeovil referrals Refer all cervical radiotherapy to BHOC	 Refer all gynae radiotherapy to BHOC
UBHT, St Michaels	Continue to provide a local service Pick up rare referrals from the other two sites Offer support for education and trainees to the other sites	Continue to provide a local service Pick up rare referrals from the other two sites Offer support for education and trainees to the other sites	Merge service with Bath on a Bristol site in line with overarching strategic plans

20.3 The current and planned implementation by Trusts across the Network offering a local and specialist services is shown as **Appendix 5.**

21 Approval of Plan

This plan has been approved and agreed by:

Mr John Giles, Gynaecological Site Specialist Group Chair

Signed ..... Date .....

Mr Robin Smith, CE, Mendip PCT

Signed ..... Date .....

Mr James Scott, CEO East Somerset NHS Trust

Signed ..... Date .....

Mr Ed Colgan, CE, Taunton Deane PCT

Signed ..... Date .....

Mr Nick Chapman, CEO, Taunton & Somerset NHS Trust

Signed ..... Date .....

Mr Mark Gritten CEO Weston Area Health Trust

Signed ..... Date .....

Mr Ron Kerr, CEO, United Bristol Healthcare Trust

Signed ..... Date .....

Mr Mark Davies, CEO, Royal United Hospital Bath

Signed ..... Date .....

Dr Kieran Morgan, Director Public Health, BaNES PCT

Signed ..... Date .....

Mrs Sonia Mills, CEO, North Bristol Trust

Signed ..... Date .....

Ms Linda Prosser, Director of Commissioning & Partnerships, Bristol S&W PCT

Signed ..... Date .....

Ms Lyn Hill-Tout CEO, Swindon & Marlborough NHS Trust

Signed ..... Date .....

Ms Jane Leaman, Director Public Health Swindon PCT

Signed ..... Date .....

Mr Simon Cawthorn, ASWCS Medical Director

Signed ..... Date .....

Mr Mark Gritten, ASWCS Chair & CEO, Weston Area Health Trust

Signed ..... Date .....

Mr Trevor Jones CEO, Avon, Gloucestershire & Wiltshire StHA

Signed ..... Date .....

Sir Ian Carruthers, CEO, Dorset & Somerset StHA

Signed ..... Date .....