

*IRP*

***Independent Reconfiguration Panel***

*ADVICE ON THE RECONFIGURATION OF THE  
UPPER GASTRO-INTESTINAL CANCER SURGICAL  
SERVICE IN THE SOUTH WEST PENINSULA*

Submitted to the Secretary of State for Health

4 June 2010

# **IRP**

## *Independent Reconfiguration Panel*

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**Abbreviations used in this report**

AUGIS	Association of Upper Gastrointestinal Surgeons of Great Britain and Ireland
CIOSPCT	Cornwall and Isles of Scilly PCT
Cllr	Councillor
CNS	Clinical Nurse Specialist
CT	Computed Tomography
FOI	Freedom of Information
HAOSC	Health & Adult Overview Scrutiny Committee
HASSC	Health & Adults' Services Scrutiny Committee
H&ASCOSC	Health and Adult Social Care Overview and Scrutiny Committee (pre 1 April 2009)
HDU	High Dependency Unit
(H)OSC	(Health) Overview and Scrutiny Committee
ICU	Intensive Care Unit
IOG	Improving outcomes guidance
IRP	Independent Reconfiguration Panel
MDT	Multidisciplinary team
NCAT	National Cancer Action Team
OG	Oesophago-gastric
PCN	Peninsula Cancer Network
PCT	Primary care trust
PET	Positron Emission Tomography
PHT	Plymouth Hospitals NHS Trust
RCH	Royal Cornwall Hospital
RCHT	Royal Cornwall Hospitals NHS Trust
RDE	Royal Devon and Exeter Hospital
RDEFT	Royal Devon and Exeter NHS Foundation Trust
SHA	Strategic health authority
(N)SSG	(Network) Site Specific Group
UGI	Upper gastro-intestinal
wte	whole time equivalent

## RECOMMENDATIONS

- 1 Patients requiring oesophago–gastric cancer resections should continue to have these operations performed at Derriford Hospital, Plymouth, as part of the specialist oesophageal–gastric cancer service for the population of Cornwall, Devon and the Isles of Scilly.**
  
- 2 This service must develop and improve for patients and carers. By June 2011, the NHS, through the Peninsula Cancer Network Board, should ensure that improvements are made based on an evaluation of how the service is working in practice. This evaluation should address all elements of the care pathway and be informed by the experiences of patients and their carers. Particular attention should be paid to ensuring effective co-ordination across the whole care pathway for each patient, that every opportunity has been taken to maximise the delivery of appropriate elements of the care pathway closer to the patient’s home, and how the clinical benefits of a specialist service are exploited for all patients. The evaluation should also ensure that the critical contribution of the specialist cancer nurses is reviewed and properly resourced.**
  
- 3 The Plymouth Hospitals NHS Trust must ensure that minimally invasive surgery for oesophageal-gastric cancer is the subject of further research and is fully exploited for the benefit of patients.**

## RECOMMENDATIONS

- 4 The organisation and cost of travel and subsistence should not be a source of unnecessary anxiety to patients and carers at a very difficult time. Cornwall and Isles of Scilly PCT must use the feedback of patients and carers to ensure that any potential issues are avoided with the right practical support from the specialist cancer nurses and others.**
  
- 5 Cornwall and Isles of Scilly PCT must engage patients and carers in a programme of work to identify and implement improvements to patient transport and subsistence arrangements within six months. This programme should include consideration of best practice elsewhere, options for dedicated transport between NHS facilities, a common policy and contract for the provision of patient transport services, and an inequalities impact assessment.**
  
- 6 Cornwall and Isles of Scilly PCT should continue to engage the public and the Royal Cornwall Hospitals NHS Trust in implementing its strategic plan *A Healthy Future for All*, including the future role of the Royal Cornwall Hospital, West Cornwall Hospital and St Michael's Hospital. The PCT and Trust must within six months produce a clear plan showing how facilities and capacity for delivering more services closer to the patient's home will be taken forward.**

## RECOMMENDATIONS

- 7 The Peninsula Cancer Network must complete the process of re-establishing an effective, functioning Partnership Group and review how the experiences of patients will be captured and used to design and deliver better cancer services. This process should be the subject of external assurance and changes made to meet national guidance and best practice. Changes should be made within six months.**
- 8 Cornwall and Isles of Scilly PCT, the Cornwall Health & Adults Overview Scrutiny Committee and local NHS organisations should together consider the lessons learnt from this experience and take action to ensure all service change proposals are developed in an environment in which there is an open and constructive relationship aimed at delivering improved services and better health outcomes for the people of Cornwall.**

## OUR REMIT

### *What was asked of us*

- 1.1 The Independent Reconfiguration Panel's (IRP) general terms of reference are included at Appendix One.
- 1.2 On 11 December 2009, Councillor (Cllr) Joan Symons, (then) Chair, Cornwall Health and Adults Overview and Scrutiny Committee (HAOSC) wrote to the (then) Secretary of State for Health, Andy Burnham, exercising powers of referral under the Local Authority (Overview and Scrutiny Committees Health Scrutiny Functions) Regulations 2002 (Appendix Two). The referral concerned the transfer of upper gastro-intestinal cancer surgery from Royal Cornwall Hospitals NHS Trust (RCHT) to the Derriford site of Plymouth Hospitals NHS Trust.
- 1.3 A referral on the centralisation of upper gastro-intestinal cancer surgery in the south west peninsula had also been received from Devon Health and Adults' Services Scrutiny Committee (HASSC). The Secretary of State wrote to Dr Peter Barrett, IRP Chair, on 21 December 2009 requesting that the IRP undertake separate initial assessments of the Devon and Cornwall referrals in accordance with the agreed protocol for handling contested proposals for reconfiguration of NHS services.
- 1.4 **One Panel member, Paul Roberts, Chief Executive of Plymouth Hospitals NHS Trust, declared a conflict of interest and consequently took no part either in the consideration and production of the Panel's initial assessments or subsequently of this report.<sup>1</sup>**
- 1.5 The IRP's initial assessment of the referral from Devon HASSC was provided on 18 January 2010 and the Secretary of State responded to the HASSC Chair on 15 February 2010 (see Chapter Three for further detail).
- 1.6 The IRP set out its initial assessment of the Cornwall HAOSC referral in a letter to the

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<sup>1</sup> In his capacity as Chief Executive of Plymouth Hospitals NHS Trust, Paul Roberts gave evidence to the Panel on 22

Secretary of State of 21 January 2010 (Appendix Three). The Secretary of State responded to Cllr Symons on 15 February 2010 advising that he had asked the IRP to undertake a review of the changes. Terms of Reference were set out in the Secretary of State's letter of 15 February 2010 to Dr Peter Barrett (Appendix Four).

1.7 The Panel was asked to advise by 4 June 2010:

- a. *whether it is of the opinion that the changes that have been implemented, based on improving outcomes guidance, with effect from 1 January 2010 provide a safe, sustainable and accessible upper gastro intestinal cancer surgical service for the population it serves, and if not, why not;*
- b. *on any other observations the Panel may wish to make in relation to the changes; and*
- c. *on how to proceed in the best interests of local people in light of (a) and (b) above and taking into account the issues raised by Cornwall Health and Adults Overview and Scrutiny Committee of 11 December 2009.*

*It is understood that in formulating its advice, the Panel will pay due regard to the principles set out in the Independent Reconfiguration Panel's general terms of reference.*

1.8 The Secretary of State asked the IRP to undertake a review taking account of the referral from Cornwall HAOSC. In doing so, the Panel has taken particular account of the issues raised by Cornwall HAOSC. However, our terms of reference required the Panel to review services for the population served by the upper gastro-intestinal cancer surgical service. The scope of this review, therefore, covers Devon (including the areas covered by Plymouth and Torbay PCTs<sup>2</sup>) and the Isles of Scilly as well as Cornwall. For convenience in this report, we refer to this area as the south west peninsula. The relationship between the two referrals from Devon HASSC and Cornwall HAOSC is explained in more detail in Chapter Three.

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March 2010.

<sup>2</sup> Throughout this report, references to Devon are intended to include Plymouth and Torbay.

- 1.9 Upper gastro-intestinal cancer includes cancers of the stomach (gastric), oesophagus (gullet or food pipe connecting the mouth to the stomach) and pancreas. In April 2006, pancreatic cancer surgery moved to the Peninsula Hepatico-Pancreaticobiliary Cancer Centre at Derriford Hospital as part of the UGI IOG implementation. The scope of this review, therefore, covers surgery for oesophago-gastric cancer (OG) which is the collective term given to cancers of the oesophagus and stomach.

## OUR PROCESS

### *How we approached the task*

- 2.1 NHS South West, the strategic health authority (SHA) was asked to provide the Panel with relevant documentation and, together with the relevant primary care trusts (PCT), NHS trusts and the Peninsula Cancer Network (PCN), to facilitate on behalf of the IRP site visits, meetings and interviews with interested parties.
- 2.2 The Cornwall HAOSC was invited to submit documentation and suggest other parties to be included in meetings and interviews. The Devon HASSC and the Isles of Scilly Health Overview and Scrutiny Committee (HOSC) were also invited to offer evidence to the Panel in light of concerns they had expressed about the proposals prior to their implementation.
- 2.3 The IRP Chair, Dr Peter Barrett, wrote an open letter to editors of local newspapers on 16 February 2010 informing them of our involvement (Appendix Five). The letter advised that the Panel would like to hear from interested parties in Cornwall including patients, local residents, local authority representatives, interest groups, clinicians and other staff. Press releases were issued on 16 February (Appendix Six) and 10 March 2010.
- 2.4 A sub-group of the full IRP carried out the review. It consisted of Peter Barrett, who chaired the sub-group, and three Panel members, Cath Broderick, Nick Coleman, and Brenda Howard. The sub-group undertook a two day familiarisation visit on 8 and 9 March 2010. This included site visits to Derriford Hospital, Plymouth and Royal Cornwall Hospital, Truro; West Cornwall Hospital, Penzance; Cape Cornwall Surgery, St Just and Penzance Heliport. At each hospital site, members received a tour of the oesophago-gastric cancer surgery patient pathway. The Panel also visited HeartSWell Lodge, Plymouth, a charitable facility available to families and carers whilst patients are receiving hospital treatment. On 25 March 2010, members visited the cancer service facilities at the Royal Devon and Exeter Hospital.
- 2.5 Members undertook four days of oral evidence taking between 22 and 25 March 2010 – in Plymouth, Truro and Exeter hearing from a wide cross section of individuals and representatives of relevant organisations. A further day of evidence taking was held on 17

May 2010 in Torquay.

- 2.6 Members were accompanied on visits and at evidence sessions by the IRP Secretariat. Details of the locations visited and people seen are included in Appendix Seven.
- 2.7 Emails were sent to all members of parliament (MP) representing Cornwall and Devon constituencies prior to the General Election inviting them to submit evidence to the Panel. Further emails were sent to MPs of Cornwall constituencies following the Election and the IRP Secretariat met Sarah Newton, Member of Parliament for Truro and Falmouth on 18 May 2010 to explain the Panel's processes and methods of working.
- 2.8 Other meetings and telephone conversations were held with Professor Sir Mike Richards, National Clinical Director for Cancer and End of Life Care, on 2 March 2010 and 2 June 2010, and David Land, Senior Policy Advisor, Commission for Rural Communities, on 21 May 2010.
- 2.9 A list of all the written evidence received – from the SHA, PCTs, NHS trusts, PCN, the (earlier) joint scrutiny committee, individual scrutiny committees, and all other interested parties is contained in Appendix Eight. The Panel considers that the documentation received, together with the information obtained in meetings, provides a fair representation of the views from all perspectives.
- 2.10 Throughout our consideration of these proposals, our aim has been to consider the needs of patients, public and staff taking into account the issues of safety, sustainability and accessibility as set out in our terms of reference.
- 2.11 The Panel wishes to record its thanks to all those who contributed to this process. We also wish to thank all those who gave up their valuable time to present evidence to the Panel and to everyone who contacted us offering views.
- 2.12 The advice contained in this report represents the unanimous views of the Chair and members of the IRP<sup>3</sup>.

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<sup>3</sup> As stated in para 1.4, Paul Roberts took no part in the consideration or production of this report.

## THE CONTEXT

### *A brief overview*

#### 3.1 **Historical context**<sup>4</sup>

During the 1990s, there was a growing recognition that cancer services in England were fragmented and poorly organised. *The NHS Cancer Plan: A Plan for Investment, a plan for reform* (DH 2000) set out a reform strategy and a number of specific recommendations to tackle these weaknesses. *The NHS Cancer Plan* recommended that all hospitals caring for cancer patients should be integrated into regional cancer networks. Within each network, curative services should be centralised into specialist cancer centres covering defined populations and a system should be established to co-ordinate care between these centres and other network hospitals (designated local units). The Plan also recommended that clinicians within each hospital should work together as a multi-disciplinary team (MDT). In response to the *NHS Cancer Plan*, the Peninsula Cancer Network (PCN) was established covering Devon, Cornwall and the Isles of Scilly with the aim of ensuring that all commissioners and providers of cancer care, the voluntary sector, and local authorities worked effectively together to deliver consistently high quality care for the residents. To deliver this aim and implement future Department of Health Guidance, the PCN adopted standard cancer network organisational arrangements including establishing network site specific groups (NSSG).

3.2 In 2001, a series of national documents were issued containing guidance for commissioners and providers on how to improve cancer outcomes. This included the publication of the *Guidance on Commissioning Cancer Services: Improving Outcomes (IOG) in Upper Gastro-Intestinal Cancers* (NHS Executive 2001). The IOG for upper gastro-intestinal cancers covers cancers of the stomach (gastric), oesophagus (gullet or food pipe connecting the mouth to the stomach) and pancreas. Oesophago-gastric cancer (OG) is a sub set of upper gastro-intestinal cancers (UGI) and is the collective term given to cancers of the oesophagus and stomach.

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<sup>4</sup> This information is drawn largely from the standard IRP information template, PCN minutes and papers, CIOSPCT papers, NSSG minutes, the Bolton Report and the two reviews by Griffin and Allum

- 3.3 In support of the IOG, standards were published in May 2002 defining the levels of care and requiring each Network to produce an *Action Plan* by September 2002. The subsequent PCN Action Plan recommended two centres (Plymouth and Exeter) for OG cancer surgery and was minuted as having been agreed by the PCN Board before being submitted to the SHA and National Cancer Action Team (NCAT) in 2002. During 2003, it became clear that the action plan did not have the support of all clinicians and senior managers and, in 2004, following representations to the SHA, it was withdrawn. In July 2005, following a period when the PCN UGI site specific group (SSG) had met infrequently, an external review was commissioned as a starting point for the NSSG to agree an IOG compliant plan for oesophago-gastric cancer. This review was undertaken by Dr John Bolton<sup>5</sup> during the autumn and the report published in December 2005.
- 3.4 The report recommended that the OG cancer surgical service at Royal Cornwall Hospitals NHS Trust (RCHT) should cease and that Plymouth Hospitals NHS Trust (PHT) and Royal Devon and Exeter NHS Foundation Trust (RDEFT) should continue to provide the service for the Network for an interim period with the intention of establishing a single site oesophago-gastric surgical service within three to five years. Although the PCN indicated that it wanted to implement the first stage of this review – the move of oesophago-gastric cancer surgery from the Royal Cornwall Hospital (RCH), Truro to Derriford Hospital, Plymouth – the RCHT Board requested that the eventual single site be identified first.
- 3.5 In 2006, the NSSG agreed to establish a single centre for OG cancer surgery by 2010 and the original *Action Plan* was amended, agreed by the PCN Board and submitted to NCAT. Formal agreement to the *Action Plan* was received from NCAT in October 2006. During this period, work continued on the process to identify and gain agreement on the location of the single site. In September 2006, the Network was peer reviewed and the lack of progress towards identifying a single site for upper GI cancer surgical services was raised as a concern. The PCN Board tasked the four PCT chief executives with agreeing a decision-making process for identifying a single location and to report back with a final decision and timeframe. This period coincided with the establishment in October 2006 of the Cornwall and Isles of Scilly PCT (CIOSPCT) and their

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<sup>5</sup> A review of oesophago-gastric cancer services in the Peninsula Cancer Network, 2005

announcement to undertake a strategic review resulting in the publication of *A healthy future* (January 2007).

- 3.6 In June 2007, the PCN Board agreed that Derriford Hospital, Plymouth should be the designated single centre for the PCN. In autumn 2007, NCAT confirmed to the Network the need to transfer upper GI cancer surgery from RCH to Derriford Hospital, Plymouth.
- 3.7 During this period, the elements of the *UGI Action Plan* covering the pancreatic cancer surgical service were developed to ensure that the Network had an IOG compliant pancreatic cancer service. The pancreatic cancer surgical plan was implemented in 2006 with Derriford Hospital, Plymouth as the site for the Peninsula Hepatico-Pancreaticobiliary Cancer Centre.
- 3.8 During autumn 2007, work began with the relevant health overview and scrutiny committees. In October 2007, Devon HASSC considered proposals for a single centre for the south west peninsula. The committee requested that Devon PCT undertake consultation on the proposals.
- 3.9 The Plymouth, Torbay and Cornwall committees considered the proposals in November 2007, all concluding that they did not constitute a substantial change in service.
- 3.10 In January 2008, NHS Devon's plans for public engagement on proposals for a single centre were supported by the Devon HASSC.
- 3.11 In early 2008, public concern over the transfer of cancer services out of Cornwall gathered momentum with a petition being presented to the Cornwall Health & Adult Social Care Overview and Scrutiny Committee (H&ASCOSC). The Committee received a further report from CIOSPCT in May 2008, setting out the case specifically for the reconfiguration of specialist upper GI cancer surgery. The Committee resolved at its May 2008 meeting that the proposals did not represent a substantial change to services and endorsed the proposed plans for public engagement. A period of public engagement was undertaken by CIOSPCT between May and June 2008.
- 3.12 At its meeting in July 2008, the H&ASCOSC revised its earlier decision and resolved that

the proposals did represent a substantial change to services. The Isles of Scilly HOSC also concluded that the proposals represented a substantial change and consequently a Joint Overview and Scrutiny Committee of Cornwall County Council and Isles of Scilly Council (Joint OSC) was formed to take forward consideration of the matter.

- 3.13 Legal advice was sought and received by RCHT about “*the proposals by CIOSPCT to cease commissioning upper gastrointestinal services from the Trust and to transfer commissioning of these activities to Derriford Hospital, Plymouth*”. This legal advice was provided in July 2008.
- 3.14 In August 2008, CIOSPCT commissioned an external review of oesophago-gastric cancer services in Cornwall to assess the current service, review clinical performance and in particular determine if the service was safe for patients. This review was conducted by Prof. S Michael Griffin and Mr William H Allum<sup>6</sup> and published in September 2008. This review concluded that the oesophago-gastric cancer surgery should cease at RCH as soon as practicable and be centralised within the south west peninsula. During the review process it became clear that to reach a conclusion on the future development of a PCN oesophago-gastric cancer surgical service, reviews would also be needed of the service in Plymouth and Exeter. The PCN therefore requested Prof. S Michael Griffin and Mr William H Allum to undertake these reviews. Their second report was published in February 2009 and recommended that the NHS develop plans to centralise the oesophago-gastric cancer surgical service for the south west peninsula at Derriford Hospital, Plymouth Hospitals NHS Trust. The plans would include the transfer to Derriford of oesophago-gastric cancer surgery from both RDEFT and RCHT, and were to be implemented with effect from January 2010.
- 3.15 In March 2009, Devon HASSC considered the proposals and resolved that in the Committee’s view the question of transferring services from Exeter to Plymouth was not one that required the formation of a joint committee with other local authorities. The Committee recognised “*that the clinical evidence is that the establishment of a single*

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<sup>6</sup> Prof S Michael Griffin, Professor of Gastrointestinal Surgery, Royal Victoria Infirmary, Newcastle, AUGIS President 2004-06 and Mr William H Allum, Consultant Oesophago-Gastric Surgeon, Royal Marsden NHS Foundation Trust, London

*centre for this specialist treatment should produce better outcomes for patients”.*

- 3.16 Also in March 2009, the Joint OSC of Cornwall County Council and Isles of Scilly Council determined that individual OSCs should consider whether the proposals continued to represent a substantial variation to services. A new unitary council for Cornwall was established on 1 April 2009, replacing the six district councils and one county council that had previously existed. A new health scrutiny committee was, therefore, established as part of the unitary arrangements. At its meeting on 27 April 2009, the Cornwall Council HAOSC reviewed the proposals and determined by a majority vote and subject to certain provisos that they did not represent a substantial change to services. The Isles of Scilly HOSC considered the proposals in May 2009 and decided that they did not constitute a substantial service change.
- 3.17 NHS planning for the implementation of the centralised service continued throughout 2009. Between March and June 2009, CIOSPCT and the PCN undertook a further period of public engagement including an Ipsos MORI survey and engagement events across Cornwall.
- 3.18 Between 15 and 30 July 2009, the four PCT Boards across the south west peninsula formally agreed the transfer of oesophago-gastric cancer surgical services from Exeter and Truro to Plymouth. Implementation planning took place between July and December 2009 with implementation due to be completed on 1 January 2010.
- 3.19 Legal advice was sought and received by CIOSPCT in October 2009 on the requirement to undertaken formal public consultation on the proposals for both the PCT and RCHT.
- 3.20 After hearing at its meeting on 19 November 2009, about the concerns of two clinicians from RDEFT regarding preparations for the transfer of minimally invasive oesophagectomy services, Devon HASSC resolved to refer the decision to transfer upper GI cancer surgery from the RDEFT to the PHT to the Secretary of State. Cllr Richard Westlake, Chair Devon HASSC referred the matter to the Secretary of State in a letter of 20 November 2009.
- 3.21 An extraordinary meeting of the Cornwall HAOSC was held on 10 December 2009 to

consider “*factors that have arisen since this Committee last considered the issue on 27 April...*” – notably conflicting evidence about whether full public consultation should have been undertaken. The HAOSC resolved that the proposals for the surgical treatment of upper-gastrointestinal cancer represented a substantial variation and that the matter should be referred to the Secretary of State for Health.

- 3.22 On 11 December 2009, Cllr Symons, HAOSC Chair wrote to the Secretary of State, Andy Burnham, exercising powers under Regulation 4 of the Local Authority (Overview and Scrutiny Committees Health Scrutiny Functions) Regulations 2002 referring the matter on the basis that the Committee “*is not satisfied that the service change is in the interests of the health service provision in Cornwall...*”. Particular concerns are outlined in Chapter Four.
- 3.23 The Secretary of State wrote to Dr Peter Barrett, IRP Chair, on 21 December 2009 requesting that the IRP undertake separate initial assessments of the Devon HASSC referral and the Cornwall HAOSC referral.
- 3.24 The IRP set out its advice on the Devon HASSC referral in a letter to the Secretary of State of 18 January 2010. The Panel concluded that it was reasonable to expect the local NHS to provide the assurance the Devon HASSC had sought about the future of the MIO service developed at Exeter in the centralised service at Derriford Hospital. It noted that, since the referral, further information addressing many of the concerns raised by the Devon HASSC had been produced as implementation had proceeded. The Panel advised that the NHS provide additional information to address any outstanding concerns. The HASSC’s referral letter and the Panel’s initial assessment are both available on the IRP website [www.irpanel.org.uk](http://www.irpanel.org.uk).
- 3.25 The Panel provided its advice on the Cornwall HAOSC referral in a letter of 21 January 2010 (Appendix Three) concluding that it wished to consider the issues raised further and would be willing to undertake a full review if requested. The Secretary of State wrote to Dr Peter Barrett on 15 February 2010 asking the IRP to undertake a full review of the proposals (Appendix Four).

## INFORMATION

### *What we found*

4.1 A vast amount of written and oral evidence was submitted to the Panel. The Panel is grateful to all those who took the time to offer their views and information. As previously stated in para 1.8, while considering the service provided for the whole of the south west peninsula, the evidence reviewed by the Panel takes particular account of the issues raised by the Cornwall HAOSC. The evidence put to us is summarised below – firstly general background information followed by an outline of the changes, issues raised by those opposed to the changes together with the views of proponents of the changes, and other evidence gathered.

#### 4.2 **Clinical Background**<sup>7</sup>

4.2.1 Oesophago-gastric cancer (OG) is the fifth most common malignancy (cancer) and the fourth most common cancer death. It affects approximately 13,500 people in the UK each year. The *National Oesophago-Gastric Cancer Audit 2009* reported people diagnosed with OG cancer were typically aged over 70 years (median age 72 years). However, the disease was not limited to the elderly; ten per cent of patients were aged under 55 years and one per cent were aged under 40 years. Overall, a substantial proportion of patients were frail. Around 20 per cent of patients had a least one co-morbidity and one in six were confined to bed for more than 50 per cent of the time.

4.2.2 In the UK, survival rates for upper GI cancer are lower than many other cancers. As with many types of cancer, the outcome of oesophageal and stomach cancer depends on both the stage of the disease (how far it has spread) and the patient's general health. As most oesophageal and stomach cancers are often only diagnosed in the advanced stages - many of the symptoms are insidious and non-specific - the prognosis for many patients remains poor. In England and Wales, around 63 people out of 100 will die within one year of diagnosis. Only 13 out of 100 people will still be alive five years after a diagnosis of stomach cancer with a corresponding figure of seven out of 100 people for those with oesophageal cancer. With these survival rates, there is a strong clinical imperative to

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<sup>7</sup> Information sources: *National Oesophago-Gastro Cancer Audit 2008 & 2009* (National Information Centre), Macmillan website – patient information, Cancer Research UK.

deliver improvements in outcomes.

#### 4.3 **Current surgical treatment patterns**<sup>8</sup>

4.3.1 OG cancer can be treated using surgery, chemotherapy or radiotherapy. Each can be used alone or in combination.

4.3.2 A high proportion of OG cancer patients present late when they are very unwell and often the only treatment option is palliative care. For this reason, one of the recommendations of the *National OG Cancer Audit 2009* is for OG cancer services to improve awareness of the disease among their population, local GPs and hospital clinicians so that more patients are diagnosed early and, therefore, have the opportunity for curative surgery.

4.3.3 The latest guidelines indicate that patients selected for curative treatment should undergo the following staging investigations:

- all patients should have a CT scan to determine if there is metastatic disease (spread of cancer from its primary site to other places in the body).
- patients with oesophageal cancer or cancer at the junction of the oesophageal and stomach (upper junctional cancer) should have an endoscopic ultrasound (EUS)
- patients with stomach cancer or cancer at the junction of the stomach with small intestine (lower junctional cancer) should undergo a staging laparoscopy

PET and PET-CT may improve staging accuracy and therefore affect treatment options.

4.3.4 The surgical resection (removal) of the tumour is the main curative treatment. Surgical treatment may be combined with pre-operative chemotherapy (neoadjuvant). This may involve either inpatient sessions or a number of day-long sessions. Stomach resection treatment also includes post-operative (adjuvant) cycles of chemotherapy. Surgery for OG cancer is a major procedure using complicated surgical techniques. Oesophageal cancer surgery involves an oesophagectomy - removing either part or all of the oesophagus with the surgeon pulling up a portion of the stomach into the chest and connecting it to the remaining normal portion of the oesophagus. The patient then has a

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<sup>8</sup> Information sources: Patient Information Plymouth Oesophago-Gastric Cancer Centre, Cancer Research UK, Macmillan website – patient information, National Oesophago-Gastro Cancer Audit 2008 & 2009 (National Information Centre), Cancer Research UK.

"new" oesophagus made up of the normal portion of the oesophagus not removed at surgery connected to a portion of the stomach pulled up into the chest. Stomach cancer surgery involves a gastrectomy - removing part or all of the stomach with the surgeon connecting the remaining stomach to the oesophagus or small intestine or, if the entire stomach is removed, connecting the small intestine directly to the oesophagus.

4.3.5 Following the operation, patients will be in a high-dependency unit (HDU) or intensive care unit (ICU) or equivalent beds for around 24/48 hours. In Derriford Hospital only around ten per cent of patients go to ICU with 90 per cent returning to the level 1 dependency beds on the ward. Patients undergoing OG resection have an expected stay in Derriford Hospital of around ten days with this being extended should complications arise.

4.3.6 The *National OG Cancer Audit 2009* reported approximately one in ten oesophagectomy patients and one in 12 gastrectomy patients needed a further operation to deal with complications during their hospital stay and a 30-day mortality rate of 3.2 per cent for oesophagectomies and 4.2 per cent for gastrectomies. This mortality compares favourably with the results of other national studies such as the previous AUGIS Audit in 2000 – 2002 (13.7 per cent and 10.3 per cent respectively) and the Scottish Audit of Gastro-Oesophageal Cancer 1997-2000 (overall mortality 12.9 per cent).

4.3.7 Given the high risks of surgery, and that the treatment requires pre-operative chemotherapy, oesophageal and stomach resection is only suitable for patients who are relatively fit, have sufficient strength to cope with major surgery and are found to have localised disease on staging investigations.

#### 4.4 **Cancer organisation and incidence in the south west peninsula**

4.4.1 The NHS Cancer Plan (2000) established cancer networks as the appropriate organisational model - in other words, a way of working to improve cancer services across England. Cancer networks bring together providers, commissioners, patients, carers and other stakeholders to discuss particular issues and problems in the light of national policy and local circumstances. They develop solutions or make proposals to ensure people living in a particular area have access to high quality cancer services.

4.4.2 The PCN includes the five acute trusts, four primary care trusts, and six providers of specialist palliative care services. It oversees provision of cancer services for around 1.6 million people covering Devon, Cornwall and the Isles of Scilly.

#### 4.4.3 ***Cancer trends across the Network***

In 2007, deaths from cancer accounted for 27 per cent of all deaths in the south west peninsula behind circulatory disease (36 per cent) but was the greatest cause of premature death (deaths under the age of 75 years) accounting for 38 per cent of deaths compared to 28 per cent caused by heart disease and strokes. Deaths from cancer in the south west peninsula for 2007 are set out below

**Table 1: South west peninsula cancer deaths by tumour site 2007**

Site	Age < 74	Total deaths
<b>Lung &amp; bronchus</b>	424	835
<b>Breast</b>	214	413
<b>Colorectal</b>	196	493
<b>Pancreas</b>	118	236
<b>Oesophagus</b>	115	261
<b>Stomach</b>	50	152
<b>All Cancers</b>	<b>2,127</b>	<b>4,811</b>

Extract: Cancer in the South West Peninsula - a baseline assessment (National Awareness and early Diagnosis Initiative website)

Data source: South West Public Health Observatory QuickStats

Note: The total figures for all cancers include cancers where the primary is not known.

4.4.4 Oesophago-gastric cancer incidence in England and the PCN for 2007 is set out below

**Table 2: 2007 Oesophago-gastric cancer incidence in England and the south west peninsula**

Tumour Site	Peninsula Incidence	England Incidence
<b>Oesophagus</b>	262	6487
<b>Stomach</b>	207	6330
<b>All cancers</b>	10,058	314,408

Extract: Cancer in the South West Peninsula - a baseline assessment (National Awareness and early Diagnosis Initiative website)

Data source: South West Public Health Observatory QuickStats

4.4.5 These incidence figures translate for Cornwall to around 90 people diagnosed with cancer of the oesophagus and 75 people diagnosed with cancer of the stomach per year. In total,

there are around 3,000 new cancers diagnosed in Cornwall per year. Therefore, oesophago-gastric cancers make up around one in 20 or five per cent of all cancers. Of the people diagnosed as having oesophago-gastric cancer in Cornwall, 72 per cent were diagnosed at RCH. The remaining 28 per cent were people from the north and east of Cornwall who routinely receive their acute care from Plymouth and Devon (based on data for period 2000-2005). Of the 72 per cent of patients who receive a diagnosis at RCH, which equates to approximately 120 patients per year, around 25 patients currently have a surgical resection. The change referred to the Secretary of State is that, since 1 January 2010, patients requiring surgical resection will have had their operation performed at Derriford Hospital, Plymouth.

#### 4.5 **Trust profiles, oesophago-gastric cancer surgery activity and outcome data**

4.5.1 Up to 31 December 2009, oesophago-gastric cancer surgery was provided at three locations – Derriford Hospital, Plymouth, Royal Cornwall Hospital, Truro and Royal Devon and Exeter Hospital, Exeter. From 1 January 2010 this surgery was centralised at Derriford Hospital, Plymouth.

#### 4.5.2 ***Trust profile - Plymouth Hospitals NHS Trust***

The Plymouth Hospitals NHS Trust provides a full range of acute and general hospital services, including an Accident and Emergency department, for approximately 450,000 people in Plymouth, north and east Cornwall and south and west Devon. In addition the Trust, working as part of a wider network of hospitals provides a range of tertiary or specialist services to a population of between 700,000 and two million in the south west peninsula depending on the type of care. Specialist services include kidney transplant, pancreatic cancer surgery, neurosurgery, cardiothoracic surgery, bone marrow transplant and plastic surgery. The Trust has three main sites, Derriford Hospital, Plymouth, the Royal Eye Infirmary, Plymouth and the Child Development Centre, Scott Business Park, Plymouth.

4.5.3 The Trust, in providing specialist services to a widely dispersed population has benefitted from the support of a charity, HeartSWell South West. This charity raises funds and runs patient, carer, family and friends accommodation in Plymouth at HeartSWell Lodge which is less than half a mile away from Derriford Hospital. Originally established for the benefit of cardiac patients, it now provides accommodation for all patients, carers, family

and friends irrespective of the condition being treated. The Lodge opened in 2001 following a public appeal and provides bed and breakfast accommodation in 11 single ensuite rooms and 16 double ensuite rooms. There are kitchen and lounge facilities where people can prepare and eat an evening meal after returning from Derriford Hospital or relax and talk to other residents. A courtesy bus service runs between HeartSWell Lodge and Derriford Hospital twice daily, Monday to Friday. Direct dial facilities to Derriford Hospital wards are provided in each bedroom. The bed and breakfast rates as at March 2010 are £39.50 for a single room and £51.50 for a double room. Individuals stay at the lodge for between five and seven days on average. The occupancy rate over a year is around 70 per cent. The PCT has adopted a policy to consider the needs of individuals using the upper GI service at Derriford Hospital on a case by case basis and, at the discretion of the Lodge staff, there is access to the Patient Voluntary Welfare Fund which will provide some financial support although not the full cost.

#### 4.5.4 ***Trust profile - Royal Cornwall Hospitals NHS Trust***

The Royal Cornwall Hospitals NHS Trust provides a range of acute and general hospital services, including an Accident and Emergency department, for approximately 420,000 people in west and mid Cornwall, a figure that can be more than doubled by visitors to the county during the busiest holiday period. Services are provided from three main sites, the Royal Cornwall Hospital, Truro (also known locally as Treリスケ), West Cornwall Hospital, Penzance and St Michael's Hospital, Hayle.

#### 4.5.5 ***Trust profile - Royal Devon and Exeter NHS Foundation Trust***

The Royal Devon and Exeter NHS Foundation Trust provides a full range of acute and general hospital services, including an Accident and Emergency department, for approximately 350,000 people in Exeter, east and mid Devon. The Trust also provides a range of tertiary or specialist services to a population of over 500,000 including the rest of Devon, Cornwall, the Isles of Scilly, Somerset and Dorset. Specialist services include cancer care, plastic and reconstructive surgery, orthopaedic surgery, paediatric care and renal services. Many of the services are based at the main Wonford site in Exeter including the West of England Eye Unit, the orthopaedic centre and the centre for women's health. Heavitree Hospital, Exeter provides a range of outpatient services. The Trust also runs the Honeylands Children's Centre, the Exeter Mobility Centre and the Mardon neuro-rehabilitation centre.

4.5.6 *Activity and outcome data - Plymouth Hospitals NHS Trust*

The Plymouth Hospitals NHS Trust MDT oesophago-gastric cancer surgical activity for 2004-2008 is set out below.

**Table 3: Plymouth Hospitals NHS Trust MDT oesophago-gastric cancer surgical activity for 2004-2008**

	2004	2005	2006	2007	2008	TOTAL
<b>OESOPHAGEAL CANCER</b>						
<b>New cases</b>	126	122	111	135	109	603
<b>Resection Rate (nos)</b>	27.0% (34)	27.0% (33)	33.3% (37)	20.7% (28)	31% (28)	27% (163)
<b>Hospital mortality</b>	6 (17.6%)	1 (3.0%)	1 (2.7%)	1 (3.6%)	0 (0%)	9 (5.5%)
<b>GASTRIC CANCER</b>						
<b>New cases</b>	67	89	48	78	62	344
<b>Resection rate (nos)</b>	16.4% (11)	13.5% (12)	23.0% (11)	21.8% (17)	19.4% (12)	18% (63)
<b>Hospital mortality</b>	1 (9.9%)	0 (0%)	1 (9.9%)	0 (0%)	2 (16.7%)	4 (6.4%)

Source: Griffin and Allum report 2009. (Hospital database, patient records and outcome data)

These data reflect the combined surgical practice of three surgeons and include seven procedures performed at Derriford Hospital by a surgeon from the RCHT. The one year survival following surgery for 2004-2006 was 80.7 per cent for oesophageal cancer and 80.6 per cent for gastric cancer.

4.5.7 *Activity and outcome data - Royal Cornwall Hospitals NHS Trust*

The Royal Cornwall Hospitals NHS Trust MDT oesophago-gastric cancer surgical activity for 2004-2008 is set out below.

**Table 4: Royal Cornwall Hospitals NHS Trust MDT oesophago-gastric cancer surgical activity for 2004-2008**

	2004	2005	2006	2007	2008	TOTAL
<b>OESOPHAGEAL CANCER</b>						
<b>New cases</b>	66	80	67	74		287
<b>Resection Rate 2004-2007</b>	15.2% (10)	11.3% (9)	17.9% (12)	20.3% (15)		16.0% (46)

(nos)						
<b>Resection at RCHT*</b>	10	9	8	12	9	48
<b>Hospital mortality</b>	2 (20%)	2 (22%)	0 (0%)	2 (16.7%)	0 (0%)	6 (12.5%)
<b>GASTRIC CANCER</b>						
<b>New cases</b>	42	29	45	29		145
<b>Resection rate (2004-2007)</b>	26.2%	11.3%	22.2%	44.8%		28.9%
<b>Resections at RCHT</b>	11	8	10	13	6	48
<b>Hospital mortality</b>	1 (9.1%)	0 (0%)	1 (10%)	1 (7.7%)	0 (0%)	3 6%

Source: Griffin and Allum report 2009. (Hospital database, patient records and outcome data)

\* Excludes 7 patients treated surgically at Derriford

The one year survival following surgery was 71 per cent for oesophageal cancer or gastric cancer.

#### 4.5.8 Activity and outcome data - Royal Devon and Exeter NHS Foundation Trust

The Royal Devon and Exeter NHS Foundation Trust MDT oesophago-gastric cancer surgical activity for 2004-2008 is set out below.

**Table 5: Royal Devon and Exeter NHS Foundation Trust MDT oesophago-gastric cancer surgical activity for 2004-2008**

	2004	2005	2006	2007	2008	TOTAL
<b>OESOPHAGEAL CANCER</b>						
<b>New cases</b>	106	89	123	98	74	490
<b>Resection Rate (nos)</b>	19.8% (21)	24.7% (22)	24.3% (30)	29.6% (29)	29.7% (22)	25.3% (124)
<b>Hospital mortality</b>	1 (4.8%)	0 (0%)	1 (3.3%)	2 (6.9%)	2 (9%)	6 (4.8%)
<b>GASTRIC CANCER</b>						
<b>New cases</b>	37	53	46	45	41	222
<b>Resection rate (nos)</b>	16.2% (6)	18.9% (10)	13.0% (6)	24.4% (11)	13.0% (6)	17.6% (39)
<b>Hospital mortality</b>	0 (0%)	1 (10%)	1 (16.7%)	1 (9.1%)	1 (16.7%)	4 10.3%

Source: Griffin and Allum report 2009. (Hospital database, patient records and outcome data)

The one year survival following surgery for elective oesophago-gastrectomy for cancer is

83 per cent and 64 per cent after elective gastric cancer resection.

4.5.9 The activity and outcome data reproduced in Tables 3, 4 and 5 are from the 2009 Griffin and Allum report and uses the same methodology for all three trusts. The table relating to RCHT only includes data up until 1 July 2008 and, therefore, contains a number of “blank” cells.

#### 4.6 **Facilities and Estate for oesophago-gastric cancer surgical service at Plymouth Hospitals NHS Trust**

4.6.1 Since 1 January 2010, the oesophago-gastric cancer surgical service for the south west peninsula has been provided at PHT in the Terence Lewis Building that was opened in 2007. The service is provided from the dedicated cardiothoracic facilities. Patients are nursed on Crownhill ward, a 26 bedded ward with five four-bedded bays, one of which provides level one dependency beds and six side bays. The cardiothoracic department has access to five dedicated operating theatres, one is used for vascular surgery, two for cardiac and two dedicated to OG and thoracic surgery. There are dedicated intensive care and high dependency units containing eight cardiac ICU beds (two isolation rooms), eight ICU beds (two isolation rooms) and six HDU beds. In addition, the hospital has a neurological and general ICU and HDU facility.

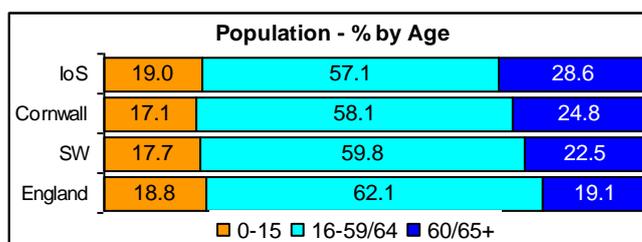
4.6.2 In the last two years, no patient has had an operation cancelled for OG surgery due to lack of beds or operating space, only as a result of the patient being unfit for surgery.

#### 4.7 **Demography, deprivation, access and transport**

4.7.1 The total population covered by the PCN is approximately 1.6 million people, of which around 530,000 live in Cornwall and the Isles of Scilly. Apart from the cities of Plymouth and Exeter, most people live in towns and in scattered rural communities. In Cornwall, one third of the population live in communities of less than 2,000 people.

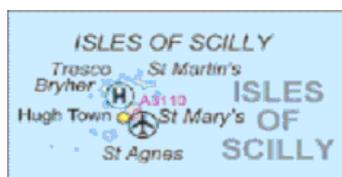
4.7.2 Along with issues of rurality, Cornwall also faces the challenge of “peripherality” with many communities a considerable distance from a major urban centre. This combination of rurality and peripherality means that, particularly for the population in the far west of Cornwall, there is a limited choice of health service providers compared with other parts of the country.

4.7.3 The population of Devon, Cornwall and the Isles of Scilly contains a higher proportion of elderly people compared to England and are areas of inward migration for people of retirement age. The ageing population of the south west is projected to increase further with time.



Source: Mean Age: Census 2001 / Age Breakdown: ONS Mid Year Estimates 2008

4.7.4 The coastal areas are particularly popular with older people. This has an impact on access to services in Cornwall since the main arterial roads run through the middle of the county and is significant when looking at oesophago-gastric cancer surgical services as most patients are over 70 years old.



GOSW 100018986 2009



2010 Google Maps, centred on Derriford Hospital, Plymouth

4.7.5 The English Indices of Deprivation 2007<sup>9</sup> are the Government’s official measure of multiple deprivation at small area level. Lower Super Output Areas (LSOAs) have between 1,000 and 3,000 people living in them with an average population of 1,500

<sup>9</sup> Source: Department of Communities and Local Government

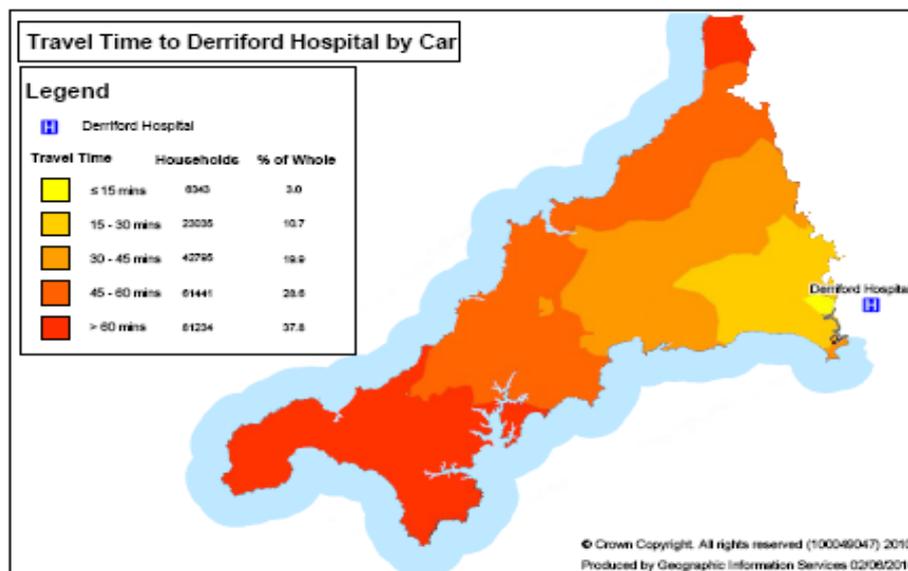
people. In most cases, these are smaller than wards, thus allowing the identification of small pockets of deprivation.

4.7.6 Indices of deprivation for 2007 show that:

- 11 per cent of Cornish LSOAs are within the most deprived 20 per cent nationally (36/328)
- eight Cornish LSOAs are in the most deprived 10 per cent in England
- the Isles of Scilly contains one LSOA, which is ranked in the fifth most deprived decile
- 29 per cent of Plymouth's LSOAs are ranked among the most deprived 20 per cent nationally (46/160)
- 16 Plymouth LSOAs are among the most deprived 10 per cent in England, with two being among the most deprived one per cent

4.7.7 The difficulty of travelling around Cornwall has been cited as a particular problem by the Cornwall HAOSC. Cornwall has no motorways, and few stretches of dual carriageway. Many roads are narrow and traffic congestion can be an issue especially in west Cornwall during the summer months when tourists can almost double the resident population. Truro (Royal Cornwall Hospital) and Plymouth (Derriford Hospital) are approximately 55 miles apart. A journey between the two sites on main 'A' roads takes in the region of 80 minutes. For patients in the far west of Cornwall, the journey is longer and more difficult as the roads are mainly of 'B' standard or lower categorisation. Examples of the return distances to Derriford Hospital, Plymouth include: St Just 170 miles, Falmouth 132 miles, Newquay 100 miles, Polzeath 91 miles, Truro 110 miles and St Austell 80 miles. All mileage is approximate. Panel members undertook the journey between Derriford Hospital, Plymouth and St Just in west Cornwall returning to Royal Cornwall Hospital, Truro to gain some feel for the difficulties patients may experience travelling by road.

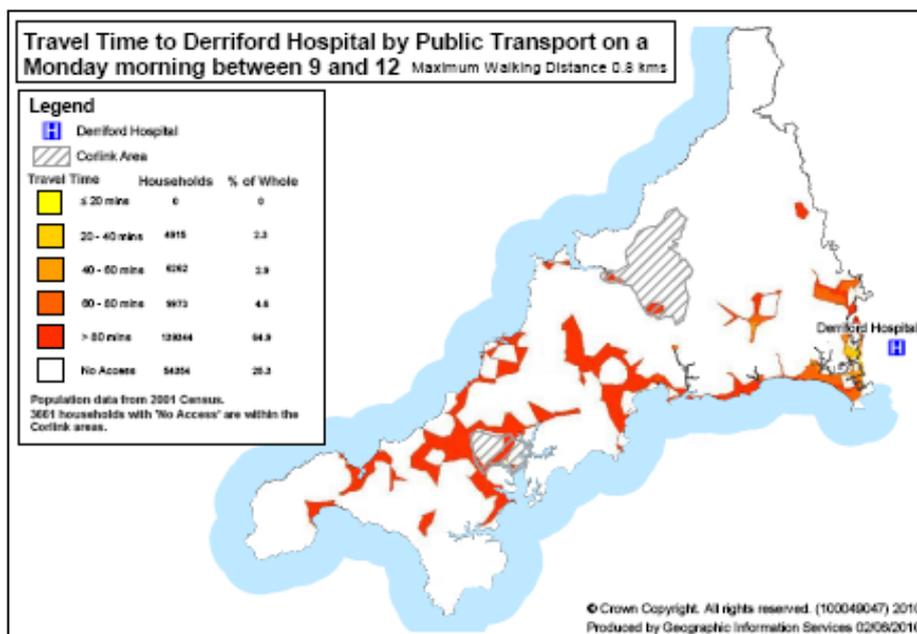
4.7.8 The following figure provided to the Panel by Cornwall Council illustrates travel time to Derriford Hospital by car from different areas of Cornwall.



This contour map<sup>10</sup> allows interpolation to fill large gaps. This accuracy may be low in areas that are sparsely populated with origins (census output area representing around 125 households)

- 4.7.9 Commercial bus services from the rural areas of west Cornwall are limited and involve very long journeys. From St Just, Hayle, Camborne and Redruth the journey time to Plymouth varies from 3 hours 45 minutes to 4 hours 30 minutes. There is one main railway line linking Penzance in the west with Truro and Plymouth. The journey from Penzance to Plymouth takes approximately two hours by train. Buses from outside the front of the railway station go directly to Derriford Hospital. The standard taxi fare from Plymouth railway station to Derriford is about £9.00 each way depending on the time of day.
- 4.7.10 The figure below, provided to the Panel by Cornwall Council, shows the travel time on a Monday morning between 9.00 am and 12.00 noon for a patient to travel from any given area of Cornwall to Derriford Hospital, Plymouth using public transport with a maximum walking distance of 0.5 miles.

<sup>10</sup> This map and the one on the following page is based upon Ordnance Survey material with the permission of Ordnance Survey on behalf of the Controller of Her Majesty's Stationery Office © Crown copyright. Unauthorised reproduction infringes Crown copyright and may lead to prosecution or civil proceedings. (100049047) 2010. Produced by Cornwall Council Geographic Information Services 2010



This contour map allows interpolation to fill large gaps. This accuracy may be low in areas that are sparsely populated with origins (census output area representing around 125 households)

4.7.11 The figure shows that 25.3 per cent (54,400) of households would have no access by public transport to Derriford Hospital between these times – one in four households. 5.2 per cent (11,200) of households would need to travel for less than an hour on public transport and 69.5 per cent (149,300) would need to travel for more than an hour on public transport.

4.7.12 CIO SPCT has a contract with Transport Access People (TAP) to provide a non-urgent patient transport service to the residents of Cornwall. For patients attending Derriford Hospital these journeys can be arranged through TAP. Special arrangements exist for residents of the Isles of Scilly. TAP books 250 journeys of this type per week.

4.7.13 PHT provides the following support to patients accessing Derriford Hospital:

- some free parking for disabled users
- free or reduced parking rate for patients/carers/family in particular circumstances
- patients who are on Income Support, Guarantee Pension Credit or some other benefits can claim back costs of parking or travel expenses (the Government Hospital Travel Costs Scheme)
- patients on a low income may be able to claim back travel expenses from the NHS low income support scheme

4.8 **Healthcare Commission<sup>11</sup> annual assessment**

4.8.1 The Healthcare Commission ratings for the hospital trusts involved are:

Trust Name	2008/09 rating		2007/08 rating	
	Quality	Financial management	Quality	Financial management
Royal Cornwall Hospitals NHS Trust	Weak	Fair	Weak	Fair
Royal Devon and Exeter NHS Foundation Trust	Good	Excellent	Excellent	Excellent
Plymouth Hospitals NHS Trust	Fair	Good	Fair	Good

4.8.2 From April 2010, all NHS trusts that provide health care, including PCTs with provider services, are required by law to be registered with the Care Quality Commission. To achieve registration providers must show they are meeting new essential standards of quality and safety across all of the regulated activities they provide.

4.8.3 The new system aims to ensure that people can expect services to meet essential standards of quality and safety that respect their dignity and protect their rights. It is focused on outcomes, rather than systems and processes, and places the views and experience of people who use services at the centre.

4.8.4 In 2010, RCHT, RDEFT and PHT all received an unconditional licence to provide services from the Care Quality Commission.

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<sup>11</sup> On 31 March 2009, the Healthcare Commission merged with the Commission for Social Care Inspection and the Mental Health Act Commission to form the Care Quality Commission.

#### 4.9 **The changes that have been implemented**

4.9.1 Following the changes to the OG cancer surgical service, implemented on 1 January 2010, all patients requiring OG cancer surgery now receive their surgery at Derriford Hospital, Plymouth. The rest of the OG cancer care pathway is unchanged even though the actual surgery is being undertaken in a different location. Prior to the changes, OG cancer surgery was undertaken at Royal Cornwall Hospital, Truro and the Royal Devon and Exeter Hospital.

4.9.2 This change has been enabled by the establishment of an appropriate specialist MDT, physically meeting at Derriford Hospital but with tele-conferencing links to RCH and the RDE allowing members of the local upper GI MDT to participate in the MDT process and to facilitate an end-to end approach to the care pathway.

4.9.3 The consultant surgeon previously undertaking OG cancer surgery at RCH and one of the two surgeons from the RDE have honorary contracts with Plymouth Hospitals NHS Trust to allow them to undertake OG cancer surgery at Derriford Hospital. A second surgeon from the RDEFT has transferred his employment to Plymouth Hospitals NHS Trust. In total, therefore, this has increased to six the number of consultant surgeons available to provide the OG cancer surgical service at Derriford Hospital.

4.9.4 No changes or additions to the Derriford Hospital estate were required to accommodate this additional surgical workload.

#### 4.10 **Issues raised by those opposed to the changes**

4.10.1 In its referral letter of 11 December 2010, the Cornwall HAOSC stated that *“the Committee were not satisfied that:*

- 1) *The objective clinical case put forward by the Cornwall and Isles of Scilly Primary Care Trust, Plymouth Hospitals NHS Trust and Royal Cornwall Hospitals NHS Trust was sufficient to outweigh the issues specific to Cornwall.*
- 2) *That the impact upon patients and their families of travelling lengthy distances from their homes, specifically patients travelling from the West of Cornwall which is a particularly deprived area, had been given sufficient weight.*

- 3) *The Committee was not convinced that the sustainability or options of a service within Cornwall had sufficiently been explored.*
- 4) *The Committee was not satisfied that patients, public and other stakeholders were sufficiently involved in the planning of the proposal and looking at other options.*
- 5) *The Committee noted the decision of Devon County Council on the 19 November 2009 to refer the transfer of Upper GI Cancer Surgical Services from Royal Devon and Exeter NHS Foundation Trust to the Plymouth Hospitals NHS Trust to the Secretary of State for Health, and the impact this might have on the clinical case.”*

4.10.2 Evidence from other parties opposed to the change broadly mirrored these concerns. Together with the concerns raised by the Devon HASSC in its referral, the following sections of the report outline what we heard in relation to each of these issues.

#### 4.11 **The clinical case and service quality**

4.11.1 The clinical case for the changes that have been proposed and implemented is founded in the *Guidance on Commissioning Cancer Services: Improving Outcomes (IOG) in Upper Gastro-Intestinal Cancer* (NHS Executive 2001) This guidance used the best evidence available at the time to set out the characteristics of a service with the capability to deliver the best possible care and outcomes for OG cancer patients.

4.11.2 The IOG has been applied in England and Wales, through cancer networks and commissioning, to reshape OG cancer services and by 2009 the majority of services for OG cancer had achieved compliance. At the same time there has been a steady fall in the numbers of surgeons and trusts undertaking oesophagectomies and oesophagogastrectomies - the specialist surgery for patients with oesophageal or gastric cancer. In 1997/98, 309 surgeons in 147 trusts carried out these procedures. By 2004/05, these surgical techniques were concentrated in the hands of only 188 surgeons in 96 trusts. Over the same period there was a fall in hospital mortality following one of these operations from 9.4 per cent to 4.9 per cent.<sup>12</sup>

4.11.3 The changes made that prompted this review came after several failed attempts to progress the implementation of the UGI IOG for the populations of Cornwall, the Isles of Scilly and Devon. Eventually, an independent clinical review was conducted in two stages and the subsequent report, published in February 2009, formed the basis on which the changes have been implemented. The review by Griffin and Allum included:

- the availability of specialist cover by appropriately trained and experienced surgeons and anaesthetists 24/7, and the sustainability of such cover in circumstances such as sickness absence and leave
- the availability of and access to hospital clinical nurse specialists (CNS) and allied health professionals important to the patient experience and quality of care
- the levels of workload that will impact on the necessary exposure the MDT needs to enhance overall experience. This is not just important in surgery, but is essential for both radiological and pathological expertise, as well as for all members of the MDT
- the range of operative procedures available to patients and how the choice of surgical technique compares to practice in specialist centres with the best outcomes
- the proportion of patients being selected for surgery, compared to the national average
- 30 day mortality and one year survival rates in comparison to national figures and the best outcomes obtained in specialist centres
- the potential for the facilities and team to be able to absorb the full workload and provide a reliable and sustainable high quality service to patients as a specialist oesophago-gastric cancer centre for the south west peninsula by 2010
- guidance to the commissioners of cancer services on whether there are clear and overriding reasons for the choice of oesophago-gastric specialist cancer centre, and whether one unit is best placed to take on this role

4.11.4 It concludes that a single centre is essential to deliver the following advantages to patients providing:

- strong and comprehensive multidisciplinary working allowing all patients to have their case considered by specialists from different disciplines to ensure they are not denied either radical or palliative therapeutic opportunities

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<sup>12</sup> Cancer Research UK Statistical Information Team 2007 and Cancer Reform Strategy DH, 2007

- broad practical experience
- sufficient referrals and patients suitable for surgery to maintain clinical expertise
- an environment providing for continuous professional development
- four or five oesophagogastric surgeons to provide twenty-four hour a day, seven day a week on-call cover for oesophago-gastric emergencies allowing for annual leave and utilising expertise on all sites in a hub and spoke arrangement.

4.11.5 The independent clinical review further concluded that such a centre would be best provided for the south west peninsula at the Derriford Hospital, Plymouth.

4.11.6 The evidence about the clinical case and service quality falls into three headings – the clinical case for centralisation, continuity and the quality of care, and minimally invasive surgery.

4.11.7 ***The clinical case for centralisation***

The Panel heard from a number of people who were opposed to the changes. Despite the view expressed by health professionals, that centralisation would lead to better outcomes, opponents stressed that no definitive evidence had been provided to support this view during stakeholders' discussion with the NHS. Nor, in their opinion, was there any conclusive published evidence of an association between centralisation and improved outcome. The Panel tested these assertions with a variety of clinicians involved.

4.11.8 The Panel met four of the six surgeons currently working in the new arrangements for providing oesophago-gastric cancer surgery in the single specialist surgical centre. They advised that oesophago-gastric cancer surgery is extremely complex with a high complication rate. One of the benefits cited to the Panel of establishing a single centre, with a large team, is that cases can be discussed with colleagues who have a wide range of experience. In addition, it allows consultants to work in pairs meaning that two surgeons are present at each operation. This benefits the patient as a greater range of experience and skills are available to be used immediately in the operating theatre environment. The Panel also heard that this arrangement, only possible in larger centres, provides an environment for continuous professional development for the consultant surgeons, which over time, has the potential to improve patient care. However, clinicians

did recognise concerns around the travel involved for patients and were clear about the need for well resourced local services to deliver all the other elements of the patient pathway.

- 4.11.9 The Panel heard that when dealing with small numbers of patients, mortality figures can be easily misinterpreted. Larger numbers of patients need to be included in an analysis than each hospital operates on each year, to ensure that the differences seen between centres are not due to chance, and represent real differences in outcome. The Panel heard from representatives of the PHT that their hospital mortality for oesophagectomy had been below three per cent compared to the most up to date national figure of five per cent across the UK.
- 4.11.10 The Panel sought the views of local general practitioners (GP) through the local medical committee (LMC) and CIOSPCT. A representative of the LMC, who was also a local lead for practice-based commissioning and sits on the Cornwall Practice-based Commissioning Steering Group, had spoken to colleagues at the LMC and practice members to get a local perspective. He advised the Panel that GPs understood the rationale for transferring the oesophago-gastric cancer surgical service from RCH to Derriford Hospital. As this type of surgery only involves a small number of patients there was general agreement that to improve outcomes and to deliver best practice it may be necessary to establish a large centre. The Panel heard that GPs were aware of the transport and financial issues associated with this move but felt that these issues were not new and were faced by patients needing treatment in other specialties. The Panel heard that there was not a strong desire amongst the majority of local GPs for the service to return to RCH. The CIOSPCT described for the Panel the involvement of GPs in the decision-making processes leading to the service change.
- 4.11.11 In advance of the formal sessions, the Panel heard concerns about the ability of RCH to treat emergencies with chest or abdominal trauma once OG cancer surgery had transferred. The Panel sought to explore this issue further but no evidence was subsequently presented that this constituted a risk to patients.
- 4.11.12 In considering the clinical case for centralisation, the Panel also sought the advice of Professor Sir Mike Richards, National Clinical Director for Cancer and End of Life Care.

A summary of his advice on this and other related issues is outlined at para 4.16.

4.11.13 ***Continuity and the quality of care***

The Panel also heard concerns about the continuity of care between RCH and Derriford Hospital. These concerns related to ensuring good communication between the local hospital and the specialist centre, and the loss of continuity of post-operative care from the surgeon. The Panel was told that at the time the service change was agreed in 2009 there was also agreement to provide additional CNS time in recognition of the need to ensure continuity of care when the service was transferred. The Panel was informed that at the time of its visit an additional CNS had been appointed although the individual was not yet in post. The Panel heard that once the new CNS is in post the existing CNS would be reducing hours worked and, therefore, the net increase in CNS time would be from one wte to 1.5 wte.

4.11.14 From written evidence received, the Panel noted that in the *Cancer Peer Review Report 2007* UGI CNS resource was raised as a concern for PHT, RCHT and RDEFT. Across the Network, the Peer Review team found that the CNSs were covering a high workload – around 200 new patients per annum each. Later in the review, the Panel was advised that in Cornwall extra investment had brought this number down to 150 and that there was a case for further reduction towards 100.

4.11.15 ***Minimally invasive surgery***

There are a variety of surgical techniques used in oesophago-gastric cancer surgery ranging from “open surgery” through to minimally invasive surgery – the planned and targeted use of minimally invasive techniques.

4.11.16 In its referral letter to the Secretary of State, Devon HASSC, whilst accepting the case for the centralisation of OG cancer surgery, expressed concerns regarding the proposed transfer of minimally invasive oesophagectomy (MIO) from the RDE to Derriford Hospital. The HASSC concerns focussed on the prospects for a successful transfer of the MIO surgical unit from Exeter to Derriford Hospital and, by inference, the potential loss of patient choice to have MIO surgery as practised at the RDE following the transfer of the service. They also expressed concerns about the maintenance of the international research into MIO undertaken by the Exeter team.

- 4.11.17 Considerable written evidence was also received expressing the same concerns and that MIO as practised at Derriford Hospital was not the same as MIO practised at RDE and, therefore, transferred patients would not have access to this particular technique.
- 4.11.18 The Panel heard from RDEFT staff and a number of consultant surgeons concerning MIO, including surgeons who had worked in Truro and Exeter. They confirmed to Panel members that MIO is not just a single operation, rather the planned and targeted use of minimally invasive surgical techniques to oesophago-gastric cancer surgery. The Panel was advised that all were in agreement that even before the transfer clinicians at Derriford Hospital had been undertaking minimally invasive techniques. By consolidating surgery on one site it had allowed consultants to benefit from each others' technical knowledge and experience, facilitating the development of MIO in the future. The consultants present expressed no concerns about MIO within the new larger team and in fact indicated that the team-based approach was in their opinion, providing real benefits to patients.
- 4.11.19 The Panel also heard that clinicians around the world are still not clear about the precise indications for minimally invasive techniques in oesophago-cancer resection. To help inform this debate high quality research with a sufficient sample size is required. The Panel was informed that the much larger Derriford team, working with Bristol colleagues is now able to plan a prospective randomised control trial with sufficient numbers to determine the exact role of the different forms of MIO and their outcomes. The Panel was told that this will help to inform the UK and the rest of the world where MIO sits in the treatment options. Initially a pilot study, the aim is to begin this research project within the next twelve to eighteen months.
- 4.11.20 The Panel received an initial progress report on centralising OG surgical services produced by PHT which shows that between 4 January 2010 and 12 March 2010 thirty one major resections were completed of which five were 3 stage MIO.
- 4.11.21 The Panel heard from the Devon HASSC that in January 2010 it had held a review meeting with clinical staff from Derriford Hospital to discuss concerns, including those relating to care of patients or their relatives when coming to Derriford. As a result of the

meeting the HASSC was, for the present, satisfied that the issues relating to the transfer had been addressed. HASSC members confirmed to the Panel that they had not formed a joint HOSC with Cornwall as their concerns only related to MIO. Panel members heard the view that engagement and communication had been poor and, coupled with what the Committee viewed as a lack of transparency, this had led to a lack of trust. More recently this had improved and HASSC members now felt a priority was for all organisations to communicate and to ensure lessons are learnt from the experience. They indicated that as far as they were aware the Devon patient transfer had gone smoothly and cited a number of letters in the local press from families and friends expressing their approval of the service. The HASSC confirmed that a further review meeting would be held in six months with clinical staff from Derriford Hospital to make sure their concerns are still being addressed.

#### 4.12 **Accessibility – the impact on patients and their families**

4.12.1 The Panel's terms of reference require it to consider the impact of service change on accessibility for patients and carers.

##### 4.12.2 *Patients' choice to undergo surgery*

The Panel heard from people opposed to the service change that transferring the service from RCH may lead to a patient choosing not to have surgery and that, therefore, the service change reduced patient choice. The Panel sought evidence on this issue. However, no specific examples were provided of where this had happened to date. Others suggested to the Panel that the increased availability of minimally invasive techniques arising from the service change increased choice for Cornwall patients.

##### 4.12.3 *Effects on the health and finances of patients and carers*

The Panel heard on many occasions about the difficulties people from the west of Cornwall found in travelling to Derriford Hospital and the financial burden this can place on patients and their carers, families and friends at a very stressful and emotional time.

4.12.4 The Panel also heard that people who are diagnosed with oesophageal or gastric cancer are of an age where asking for financial help is not an automatic response and that often people would just accept the financial hardship that went with treatment at Derriford Hospital.

- 4.12.5 The Panel heard from people opposed to the service change that the issue of accessibility had not been addressed at the start of the process and in their opinion was only considered late in the day during detailed implementation planning. The Panel heard that although accommodation is available for carers and family in Plymouth at the HeartSWell Lodge the cost for a ten day stay can be prohibitively expensive.
- 4.12.6 The Panel also heard from both patients and people opposed to the service change that the emotional impact of patients being separated from their carers and immediate family during the post operative period may adversely affect the outcome for the patient.
- 4.12.7 CIOSPCT representatives told the Panel that they had ensured HeartSWell Lodge accommodation was available to carers and family members should they wish to use the facility and that assistance with costs was considered on a case by case basis. They also told the Panel that travel costs to Derriford Hospital were capped for patients at £20. They confirmed that this was not the case for carers, family and friends though support in individual cases could be considered. The Panel also heard details of a project that is being set up by CIOSPCT and Cornwall Council to review social transport although the outcome of the project is not expected for at least 12-18 months.
- 4.12.8 The Panel also heard from the main provider of the current patient transport services that arrangements were complex for patients, with different criteria existing across Devon and Cornwall, and that the reimbursement model was not uniform. They also highlighted inconsistencies in carer and family travel. If the patient met the criteria for an accompanying carer then this was paid, but otherwise unless the carer or family member could be found a “free seat” in an already paid for journey, they would be charged at 40 pence per mile to use the service. The transport providers clearly did their best to make the arrangements work in the interests of patients and their carers.
- 4.13 **Sustainability issues**
- 4.13.1 The sustainability issues raised with the Panel only related to the services provided from the Royal Cornwall Hospitals NHS Trust.
- 4.13.2 The independent clinical review by Griffin and Allum, based on a detailed examination

of the service at RCH concluded that, whilst not “*unsafe or dangerous*”, the service was not sustainable. This assessment was largely based on the fact that the oesophago-gastric cancer service was run by a lone surgeon and a lone clinical oncologist. Further, there was no specific rota for out of hours cover for acute or post-operative oesophago-gastric emergencies, only an ad-hoc arrangement.

#### 4.13.3 *Maintenance of a surgical service in Cornwall*

Those opposed to the service change raised the issue of Office for National Statistics (ONS) population estimates that predict an increase in the Cornwall population over the next 10 years. They felt that this had not been fully taken into consideration during the service planning phase. Clinicians, in responding to this assertion, indicated that due to improvements in staging accuracy the number of OG operations is likely to fall in the future. Moreover, because of the incidence of OG cancer and indications for surgical resection, even significant changes in total population do not result in large increases in the number of cases.

4.13.4 On a number of occasions the idea of a “virtual centre” was raised with the Panel in which oesophago-gastric cancer surgery would continue at Royal Cornwall Hospital supported by “visiting surgeons” to resolve the lone consultant issue. Those opposed to the single site solution expressed a view that this option was never properly explored but, despite the Panel seeking further information, no one could offer an explanation of what such an arrangement would be or how it would work in practice and, in particular, address simultaneously the issues of out of hours cover and volumes required to maintain clinical expertise.

4.13.5 The Panel did hear from a number of the current surgeons that working in a larger team has brought benefits around the practical delivery of the service including leave and holiday cover and that with a larger pool of surgeons emergency cover arrangements for patients had improved. The consultants confirmed that the video-conferencing arrangements put in place for the specialist MDT were working well across the sites.

#### 4.13.6 *Wider services at RCHT*

Some local people and campaigners expressed concern to the Panel about the potential domino effect of transferring the oesophago-gastric cancer surgical service from RCHT

resulting in the loss, over time, of other services from Cornwall. They cited the history of West Cornwall Hospital, Penzance which they considered had been changed from a facility providing a full range of district general hospital services, including inpatient beds, into a day case, outpatient and diagnostic facility with only elderly medical admissions, a Casualty 24 hrs service and no 24/7 consultant cover. The Panel were informed of a petition about saving local cancer services in Cornwall that had gained a large number of signatories.

- 4.13.7 Senior staff from RCHT described to the Panel the recent work undertaken to develop a five year strategy and site development plan. This work was undertaken during 2009 through to March 2010. The Panel heard about significant service developments and associated estate upgrades for all three hospitals within Cornwall and work to ensure pathways of care are designed around the patient, wherever possible moving services closer to people's home. The draft plans were published in autumn 2009 and the Trust has just finished a period of public, staff and stakeholder involvement. In an effort to improve user involvement they have utilised existing carer and user groups, public meetings, social networking sites, production of a DVD and distribution of hard copies of the strategy.
- 4.13.8 During visits to local facilities, Panel members observed the enthusiasm for these plans amongst clinical staff. After a difficult period for the Trust, the Panel heard examples of how staff now seemed to have the confidence in the future to think about how their service could be developed within the new strategic framework. In particular, the Panel heard from West Cornwall Hospital staff who expressed enthusiastic support for the opportunity to develop a range of services including outpatients and diagnostic services closer to the patient's home and the benefits of the relatively new addition of a CT scan to the site facilities.
- 4.13.9 Panel members heard that full implementation of the RCHT strategic plan would involve a major reconfiguration of the existing facilities at RCH including a new endoscopy unit that would improve the diagnostic aspects of the oesophago-gastric cancer pathway, maximising the use of St Michael's Hospital, Hayle and delivering more care from West Cornwall Hospital. Members were told Phase One included new operating theatres at St Michael's Hospital, a new chemotherapy unit, an extended critical care unit, 23 hour

surgical unit, interventional radiology suite and improved facilities for diagnosis and treatment at West Cornwall Hospital. Panel members were told that the capital funding required for Phase One was just over £23 million and to date secured funding has only been identified for elements of Phase One amounting to £15 million. Capital funding for Phase Two and beyond would be included in the Trust's application for foundation trust status.

#### 4.14 **Consultation, involvement and engagement**

4.14.1 The Panel heard from the Cornwall HAOSC and some other stakeholders about conflicting evidence regarding the legality or otherwise of not undertaking a full public consultation on the proposals to consolidate the oesophago-gastric cancer surgical service for the PCN. They heard that two separate pieces of legal advice had been sought, one by RCHT and another by CIOSPCT.

4.14.2 The NHS confirmed to the Panel that they had not carried out a formal public consultation on the service change on the grounds that in their discussions with the Cornwall HAOSC (and before that with Cornwall H&ASCOSC) and other scrutiny committees involved, these committees had generally – though not consistently - agreed that the proposal to consolidate the oesophago-gastric cancer surgical service for the south west peninsula onto a single site did not constitute a substantial change.

4.14.3 The Panel heard from those opposed to the proposals that they believed formal public consultation was required and were aware that HAOSC members had seen legal opinion received by RCHT to this effect. However, they indicated they had not seen the legal advice provided to CIOSPCT. The Panel had previously been made aware that some councillors considered the decision not to undertake a formal public consultation could be unlawful. In discussions with councillors, it was confirmed that they had seen the legal advice provided to RCHT but they also had not seen the advice provided to CIOSPCT.

4.14.4 When discussing the chronology of events with the HAOSC, it became clear that the HAOSC membership had changed following unitary authority status. Few members remained from the original H&ASCOSC committee that had made the decision that the change was not substantive. The Panel was advised that new HAOSC members felt they were rushed into a decision soon after forming and were “not in possession of the full

facts” when they made their decision in April 2009 that the proposals did not represent a significant change. HAOSC members indicated that on viewing additional evidence regarding the legal advice received by RCHT, this position changed resulting in the referral to the Secretary of State for Health.

- 4.14.5 The Cornwall HOASC and those opposed to the service change considered that the PCT had not been open and transparent in their meetings and in their responses to questions about formal public consultation.
- 4.14.6 Individuals expressed their concern to the Panel that they had needed to resort to formal Freedom of Information (FOI) requests to gain information relating to the oesophago-gastric cancer surgery undertaken at RCH to update the data published in the Griffin and Allum report. They felt these data should have been made available as part of the surgical transfer background information and indicated that this request was still outstanding at the time of giving evidence.
- 4.14.7 The Panel heard detail of two PCT public engagement periods: May-June 2008 and March-June 2009. PCT representatives explained that it was considered important to get the views of patients with experience of using the services and the views of their carers. Letters were sent to patients and carers asking them to take part in the process. *Select Committee* style hearings and *Question Time* events were held in different locations. A substantial piece of engagement work was also commissioned from Ipsos MORI including half-day sessions with representative groups of local people, in depth interviews with patient, carers and people from “hard to reach” groups and a survey undertaken by means of telephone interviews with a 1,000 adults. 70 per cent of those engaged indicated that they would be willing to travel for OG surgery. This substantial piece of work was thorough and provided valuable patient and service user feedback resulting subsequently in amendments to the patient pathway to help mitigate concerns raised. However, the Panel heard from campaigners that this involvement was, in effect, after the proposal had been decided and that there was a lack of involvement with users and carers in developing the proposal.
- 4.14.8 A recurring theme during evidence from some campaigning groups and user representatives was that they had not been involved in the development of the proposals

and that public engagement and involvement mechanisms had not been fully used by the NHS. They felt they had little opportunity for their voice to be heard or to influence or express their concerns especially during the early part of the process. Individuals cited the example of the PCN Partnership Group, which had not met since July 2009.

4.14.9 The Panel heard from the PCN that a Partnership Group had been in place supported by a Network Partnership Facilitator who also facilitated local cancer user groups and patients sitting on the local NSSGs. Her role included facilitating a training programme for user representatives. The Panel heard that, in July 2009, the Partnership Group took the decision to disband as members felt a new approach and wider membership was required to take the agenda forward.

4.14.10 A representative of the Commission for Rural Communities provided evidence to the Panel on the conclusions of their Major Life Events programme, some of which had been undertaken in north Devon. The programme focuses on five *life events*, one of which is cancer, and investigates both the experiences of service users and also the work of service providers. The aim of the work is to understand better the challenges and thereby help to stimulate and inform service provision for people living in rural areas. The work showed that generally people are realistic about travelling further to specialist services when properly engaged in the discussion and their views valued. The key is to involve patients and carers at the beginning of the process. The work provided no evidence to support the view that, in itself, distance stops a patient taking treatment. People are more responsive to travelling distances if they can see that all opportunities to design services that reflect their need to travel or actively help them minimise the distance. Examples cited include (i) avoiding very early appointment times, (ii) ensuring all elements of the patient pathway have been evaluated for being delivered locally, (iii) if travelling is required, that a one-stop approach is taken to ensure a patient does not need to go back and forth over several days unless there is a good clinical reason. Patients and voluntary transport providers are often a rich source of ideas to improve and make the service more efficient.

#### 4.15 **Relevant policy and other documents**

4.15.1 During the review, the following policy and documentary sources were brought to the Panel's attention and have been considered as part of the evidence.

- *Guidance on Commissioning Cancer Services Improving Outcomes in Upper Gastro-intestinal Cancers - The Manual, NHS Executive, 2001*
- *Cancer Reform Strategy, DH, 2007*
- *Cancer Reform Strategy, Achieving local implementation – second annual report, DH, 2009*
- *Commission for Rural Communities: insights from users and providers of cancer care in England. Summary Report, 2010*
- *Commission for Rural Communities: Service Needs and delivery following cancer diagnosis – evidence based review*
- *National Oesophago-gastric Cancer Audit: An audit of the care received by people with oesophago-gastric cancer in England and Wales, NHS Information Centre, 2008*
- *National Oesophago-gastric Cancer Audit 2009: An audit of the care received by people with oesophago-gastric cancer in England and Wales. Second Annual Report, NHS Information Centre, 2009*
- *National Cancer Peer Review Programme: Service User Involvement in Cancer Care-Policy, Principles, Practice 2009*

4.16

**Advice from Professor Sir Mike Richards, National Clinical Director for Cancer and End of Life Care, 2 March and 2 June 2010**

**Key points**

- Upper GI cancer including oesophago-gastric cancer - smoking a significant risk factor
- Commonly affects people aged >60 years old
- 30 day post-operative mortality for oesophageal cancer has been amongst the highest of any elective surgery
- International evidence points to better outcomes in larger centres of activity than smaller ones
- 10 years ago around 160 hospitals in England were doing this surgery - now far fewer and outcomes have improved
- Despite these improvements, survival rates in England remain below international comparisons
- Early diagnosis is the key to further improvements in survival with a need to improve awareness and diagnosis services at the local level
- MIO techniques are developmental - more cases are needed for ongoing research to establish efficacy
- Radiotherapy and chemotherapy require multiple visits so it is right that these services should be available locally
- Telephone follow-up, local blood testing at a GP surgery can all mitigate rurality: care “nearer to home care”
- Some good examples of chemotherapy closer to home starting to emerge – for example, in East Kent
- National project working with the National Cancer Intelligence Network and the Commission for Rural Communities on analysis of cancer outcomes for people living in rural areas

## OUR ADVICE

### *Adding value*

#### 5.1 Introduction

5.1.1 The Secretary of State for Health asked the IRP to undertake a review of the proposals to transfer oesophago-gastric cancer surgery (OG)<sup>13</sup> from Royal Cornwall Hospital (RCH), Truro and from the Royal Devon and Exeter Hospital (RDE) to Derriford Hospital as part of the specialist OG surgical service for the population of Cornwall and Devon. The Panel was asked to take particular account of the concerns raised by Cornwall HAOSC in its referral letter of 11 December 2009.

5.1.2 OG cancer surgery was transferred from RCH and the RDE to Derriford Hospital, Plymouth on 1 January 2010. As a result, between 25-30 patients a year who would previously have had operations in Truro, and a broadly similar number in Exeter, now have their operations in Derriford Hospital.

5.1.3 The Panel commenced work on the review in February 2010. The Panel has reviewed the written evidence presented to it and the relevant national policy documents. The Panel spent seven days in the south west peninsula meeting the Cornwall HOASC, Devon HASSC, Royal Cornwall Hospital Trust (RCHT), Plymouth Hospitals NHS Trust (PHT), Royal Devon and Exeter NHS Foundation Trust (RDEFT), Cornwall and Isles of Scilly PCT (CIOSPCT), Peninsula Cancer Network (PCN), NHS South West, LMC representative, consultant medical staff, clinicians from all NHS Trusts affected by the proposed change, local stakeholder groups and members of the public. The Panel visited all three acute hospital sites – Derriford Hospital, RCH and RDE and, for Cornwall, the main health sites where diagnostic and staging investigations are carried out. The Panel also travelled by road from Derriford Hospital, Plymouth to St Just and other small communities in the west of Cornwall and used public transport between various locations.

5.1.4 This review is unusual for the IRP in that the service change had been implemented prior

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<sup>13</sup> The request from the Secretary of State for Health covered upper gastro-intestinal cancer. This includes cancers of the stomach (gastric), oesophagus and pancreas. Pancreatic cancer surgery transferred in 2006 and is therefore not included in this review.

to the Panel commencing work. This did, however, provide Panel members with the opportunity to talk informally to patients who were receiving their care via the new patient pathway during the tour of the facilities. During the evidence sessions it also meant that there was some experience of the new service arrangements. The transfer of oesophago-gastric cancer surgery from RCH and from the RDE to Derriford Hospital took place nine weeks prior to the Panel's first visit to the south west peninsula.

5.1.5 The concerns raised with the Panel regarding the changes focussed on the following issues:

- On safety, clinical and service quality:
  - that the clinical case for a specialised OG cancer centre at Derriford Hospital does not prove that outcomes will improve for Cornwall patients
  - that there would be a loss of continuity and therefore quality of care for patients
  - that the successful transfer of the MIO surgical unit from Exeter to Plymouth and the maintenance of internationally recognised research was not ensured
- On accessibility:
  - the possible negative impact of travelling further on patients' willingness to undergo OG surgery
  - the detrimental effects on the health and finances of patients and carers required to travel further to the service
- On sustainability:
  - options for sustaining OG cancer surgery services in Cornwall were not explored
  - undermining the future of the range of services provided by Royal Cornwall Hospitals NHS Trust
- The rigour of public involvement and consultation processes

5.1.6 The Panel has considered each of these issues in detail before reaching its conclusions. In doing so, the Panel's primary focus is the best interests of patients with oesophageal-gastric cancer in Cornwall, Isles of Scilly and Devon - now and in the future.

5.1.7 Overall, the Panel supports the view that the changes that have been implemented are in the best interests of patients and will provide safe, sustainable and accessible services for the population. The service is focussed on improving patient outcomes by providing the capability and expertise to deliver high quality care that can be sustained and improved into the future whilst more can be done to improve accessibility.

- 5.1.8 **Recommendation One**
- Patients requiring oesophago–gastric cancer resections should continue to have these operations performed at Derriford Hospital, Plymouth, as part of the specialist oesophageal–gastric cancer service for the population of Cornwall, Devon and the Isles of Scilly**
- 5.2 **Safety and clinical and service quality**
- 5.2.1 The Panel accepts the findings of the independent clinical review conducted by Griffin and Allum that the previous arrangements were not unsafe. Equally, the new arrangements have not raised any issues of safety during the review. Therefore, the focus of this review has been on the positive opportunities to improve clinical and service quality for patients.
- 5.2.2 *The clinical case for a specialised oesophago-gastric cancer surgery centre at Derriford Hospital*
- As the single most relevant source of the clinical case for change in this locality, the independent clinical review by Griffin and Allum has been the subject of much discussion and scrutiny. The Panel did not receive evidence that undermined its content, its credibility or the logic of its conclusions. Indeed, for the clinicians delivering the OG service that we spoke to, local GPs, the NHS organisations involved, the Devon HASSC and some patient groups, the report’s conclusions have been accepted as the basis for making the changes to the service.
- 5.2.3 The IRP heard from a number of people who, whilst not disputing its content, were not convinced by the clinical case, as represented by the Griffin and Allum report. They argued that the evidence, with particular reference to the available mortality and survival data, did not prove that outcomes for Cornwall patients would be better if they had surgery at Derriford rather than continuing at RCH.
- 5.2.4 The IRP’s view is that a prospective randomised clinical trial that compares surgical outcomes for OG cancer between large centres and their smaller counterparts is unobtainable and its absence is not an overriding reason for maintaining the status quo in the face of other types of evidence to the contrary. To do so would be to contradict what is generally observed in health services, where often the only way to develop clinical services

and improve outcomes is to progress change on the basis of a combination of research evidence, ongoing clinical audit and the views of experts in the field.

#### 5.2.5 *Continuity and the quality of care*

The Panel recognises the concerns expressed by people opposed to the service transfer that, by moving the surgical part of the pathway to Derriford Hospital, continuity of care could be affected. The new clinical pathway requires patients' care to be handed over between CNSs when they move from local hospital care to the surgical intervention in Plymouth and then back to local hospital care. The Panel was impressed by the UGI cancer nurse specialists across the Peninsula Cancer Network and acknowledged that they had put considerable effort into the development of their service to the point where it was clearly valued by patients, carers and their families. Nevertheless, the Panel concluded that their role as key worker is made more difficult by this transfer of care and that effective co-ordination across the whole patient pathway is much harder when two sites and two CNSs are involved.

5.2.6 The Panel reviewed the *PCN Peer Review Report 2007* and noted that the CNS resource was raised as a concern for a number of other cancer services including upper GI. At the time of the Peer Review, Network UGI CNSs had a workload of 200 new patients per annum. As part of the transfer arrangements, the CNS resource at RCH has been increased from one wte to 1.5 wte. Even with this increase it is estimated that the new patient workload will only reduce to 150. The Panel concluded that even with this additional resource, the CNS would find effective co-ordination across the whole care pathway for each patient difficult. The Panel considers it essential that this critical pathway co-ordination role is reviewed and then adequately resourced for the number of new patients entering the pathway.

5.2.7 The Panel reviewed the patient pathway and noted that much of the care was either delivered at RCH in Truro or patients were required to visit the Derriford Hospital on a number of separate occasions. The Panel agreed with the view that during the early development of the OG cancer surgical pathway there did not appear to have been a sufficient emphasis on delivering care closer to home and involving patients and carers in the process. Therefore, opportunities to increase the amount of care delivered closer to the patient's home have not yet been maximised in Cornwall.

5.2.8 The Panel considers it important that the NHS, through partnership working, reviews the location of the different elements of the OG pathway and establishes, based on best practice, the feasibility of delivering appropriate elements closer to the patient's home. This should include looking at mobile and community chemotherapy, elements of pre-assessment, 'giving the diagnosis' outpatient appointment and appropriate staging procedures.

5.2.9 The Panel noted that initial evaluation work had been planned. However because of the small number of patients involved it would be a number of months before sufficient data could be collected to enable conclusions to be drawn and therefore modifications to the pathway proposed. The Panel received a copy of the patient survey currently sent to each patient. The Panel are pleased that users and carers have influenced the way that implementation of the service is monitored and recommend that this approach to evaluation of the programme continues. The Panel considers it important that there is a clearly understood process for identifying and communicating to the population of west Cornwall and the south west peninsula the benefits that emerge from the consolidation of the oesophago-gastric cancer surgical service.

5.2.10 **Recommendation Two**

**This service must develop and improve for patients and carers. By June 2011, the NHS, through the Peninsula Cancer Network Board, should ensure that improvements are made based on an evaluation of how the service is working in practice. This evaluation should address all elements of the care pathway and be informed by the experiences of patients and their carers. Particular attention should be paid to ensuring effective co-ordination across the whole care pathway for each patient, that every opportunity has been taken to maximise the delivery of appropriate elements of the care pathway closer to the patient's home, and how the clinical benefits of a specialist service are exploited for all patients. The evaluation should also ensure that the critical contribution of the specialist cancer nurses is reviewed and properly resourced.**

5.2.11 ***Transfer of the minimally invasive surgery unit from Royal Devon and Exeter Hospital and the maintenance of internationally recognised research***

In its initial assessment of the referral from Devon HASSC, the Panel accepted that the committee's concerns about MIO were legitimate and should be addressed. The future of MIO as an integral part of a fully functioning specialist service is important for all OG cancer patients in the south west peninsula now and in the future.

5.2.12 MIO, as pioneered in this country by the Exeter team, is a developing technique that clearly offers great potential. However, it is also clear that it is not currently an appropriate procedure for all patients requiring OG surgery and whether it is likely to be so in the future is a matter yet to be determined. The Panel heard of research being planned in Plymouth with colleagues from Bristol, for a prospective randomised control trial with sufficient numbers to determine the exact role of the different forms of MIO and their outcomes. The Panel were told that this will help to inform the UK and the rest of the world about where minimally invasive techniques are best deployed during OG cancer surgery.

5.2.13 **Recommendation Three**

**The Plymouth Hospitals NHS Trust must ensure that minimally invasive surgery for oesophageal-gastric cancer is the subject of further research and is fully exploited for the benefit of patients.**

5.2.14 ***Overall assessment on safety and clinical and service quality***

Taking all the evidence received into account, the Panel's view is that the changes that have been implemented provide the best way of giving OG cancer patients in the south west peninsula the highest possible quality of care.

5.2.15 Although the Panel was not asked to consider the arrangements for increasing public awareness and early diagnosis of OG cancer, it is clear that these are key elements to bringing about further improvements in survival rates. The opportunity to do this exists through actively engaging with the National Cancer Early Awareness and Diagnosis Initiative at the earliest opportunity.

### 5.3 **Accessibility of the service**

5.3.1 While issues of accessibility were raised with the Panel by Cornwall HAOSC, they are at least equally relevant to the Isles of Scilly and parts of Devon.

#### 5.3.2 ***Travelling and the possible negative impact on patients' willingness to undergo OG surgery***

The Panel recognises the concerns put forward regarding accessibility and the financial impact on patients. The distances for patients, particularly those from west Cornwall, are substantial and coupled with the rural nature of the area, and often infrequent public transport alternatives, there is a heavy reliance on car use by a group of the population who are often aged over 70.

5.3.3 The Panel accepts that the cost of using voluntary patient transport, although capped at £20 for a single journey by the PCT, is often a source of anxiety for patients. Some people indicated to the Panel that in their opinion this cost could mean patients would choose not to have the surgery although, no evidence was received by the Panel to support this suggestion. It is important that the NHS continues to review its travel arrangements, involving substantial input from service users, to ensure that the cost and practicality of travel to Derriford Hospital do not have a detrimental effect on a patient's decision to have surgery.

5.3.4 The Panel's view is that, in the early stages, too little was done on either listening to the travel and accessibility concerns of Cornwall residents or on allocating sufficient resource to work in partnership with patients, carers and other stakeholders to develop innovative solutions. Most of the work with patients, carers and family around accessibility took place late in the process during the detailed implementation phase of the transfer and the Panel acknowledges that patients felt that these very real concerns had not received sufficient emphasis. The Panel acknowledges that CIO SPCT has agreed to cap voluntary patient transport costs for OG cancer patients in response to concerns raised during the Ipsos Mori work. A case-by-case review process is currently in place if all avenues for financial support have been exhausted.

5.3.5 Panel members learned that two national schemes exist to help patients with the cost of

travelling to and from hospital if they are in receipt of certain benefits, including Pension Credit guarantee credit or have a low income. People often require expert help to understand their entitlement or navigate the benefit system. The Panel acknowledges that currently the Royal Cornwall Hospital upper GI CNS undertakes a patient assessment and if financial needs are identified the patient is referred to financial experts such as the Citizens Advice Bureau or the Macmillan Support Centre. For Cornwall patients this may mean going to another location and discussing personal financial issues with someone who they have only just met at a time of high anxiety. The Panel concluded that this process should be reviewed to identify whether patient access to this financial advice and support could be improved.

- 5.3.6 The Panel accepts that the accommodation costs for relatives wishing to stay close to Derriford Hospital to provide patient support are very substantial and often prohibitively expensive for significant proportions of the population. It noted that the CIOSPCT had tried unsuccessfully to negotiate a reduced accommodation rate at HeartSWell Lodge, Plymouth. Although patients, carers and family can apply to charitable organisations for financial support to offset the cost of staying in HeartSWell Lodge, the Panel concluded that these arrangements were adhoc and did not provide any degree of certainty for patients at an already stressful time as they prepared for surgery.

5.3.7 **Recommendation Four**

**The organisation and cost of travel and subsistence should not be a source of unnecessary anxiety to patients and carers at a very difficult time. Cornwall and Isles of Scilly PCT must use the feedback of patients and carers to ensure that any potential issues are avoided with the right practical support from the specialist cancer nurses and others.**

5.3.8 ***Other negative aspects of travelling further to the service***

The Panel heard no evidence that examples of best practice from similar rural areas around the country had been explored by CIOSPCT or that there had been any significant approaches to relevant organisations such as the Commission for Rural Communities. The Panel was disappointed that the process of planning travel and subsistence had not involved substantial patient and carer involvement at an early stage. It also noted that when the different elements of the patient pathway were redesigned the opportunity was

not taken to work with patients to ensure the timing of services reflected the needs of patients who had to travel.

5.3.9 There is now a real opportunity to involve patients, public and other stakeholders in a review of patient and social transport services ensuring they have a major role in any subsequent redesign. In Cornwall, with CIOSPCT commissioning a number of services from Derriford Hospital (for 2009/10 approx 2,400 elective spells), coupled with the specialised commissioning volumes, it is the Panel's view that innovative solutions could be explored, including dedicated bus services, as provided elsewhere across the country.

5.3.10 Although the Panel saw evidence that an impact assessment had been carried out by CIOSPCT, the Panel considers that the inequalities aspect of this work could have been more robust and given greater emphasis.

5.3.11 After hearing evidence of the patient transport service arrangements, the Panel concluded that the fact the current service worked so well was in no small part down to the fact that the service provider had a "can do attitude". Often unnecessary time was spent resolving the practical issues they faced because local commissioners had not agreed comprehensive, consistent, and easy to understand criteria for accessing patient transport services.

5.3.12 **Recommendation Five**

**Cornwall and Isles of Scilly PCT must engage patients and carers in a programme of work to identify and implement improvements to patient transport and subsistence arrangements within six months. This programme should include consideration of best practice elsewhere, options for dedicated transport between NHS facilities, a common policy and contract for the provision of patient transport services, and an inequalities impact assessment.**

5.3.13 The other PCTs in the south west peninsula – Devon, Plymouth City and Torbay – might usefully consider the relevance of the recommendation above for their own populations.

#### 5.4 Sustainability issues

5.4.1 The Panel reviewed evidence with regard to both sustaining OG cancer surgery services in Cornwall and the wider issue of the future of the range of services provided by Royal Cornwall Hospitals NHS Trust.

##### 5.4.2 *Options for sustaining OG cancer surgery services in Cornwall*

The Panel heard from a number of people who opposed the change that they did not want to lose health services from Cornwall and that they felt that all the possible alternatives had not been explored. ONS population estimates for Cornwall predict an increase of approximately 90,000<sup>14</sup> by 2020 with the current population slightly older than that of England. People opposed to the change concluded that these two factors would mean an increased need for OG surgery. The Panel also heard from clinical experts that because of improvements in the staging accuracy of this cancer, which affects treatment options, the number of operations for OG cancer is likely to go down rather than up. Oesophageal cancer has an age-standardised incidence rate of 14.0 and 5.6 per 100,000 for men and women respectively and gastric cancer has an age-standardised incidence rate of 13.8 and 5.3 per 100,000 for men and women respectively. Of these people, only around 20 percent undergo a surgical resection<sup>15</sup>. Therefore, relatively large increases in population are unlikely to increase dramatically the number of operations performed.

5.4.3 The Panel heard on a number of occasions, although not from clinicians, the possibility of establishing a “virtual” centre, which it was suggested, would allow OG cancer surgery to continue at RCH. However, no credible evidence was presented of how the model could work in practice or enable the PCN to have an UGI IOG compliant oesophago-gastric cancer surgical service. The Panel, having considered the evidence, concludes that this “virtual centre” is aspirational with no practical substance.

5.4.4 As previously stated, the Panel reviewed and accepts the findings of the Griffin and Allum report. The Panel noted that before the transfer of OG cancer surgery, the Cornwall service was delivered by a lone consultant surgeon. The operational and professional challenges of lone consultant surgical services are well known. A lone

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<sup>14</sup> Office for National Statistics – Population projections

<sup>15</sup> National Oesophago-Gastric Cancer Audit, 2008. NHS Information Centre.

consultant needs to be continuously available during the working day and on-call commitments are generally onerous as even if the demands and calls out of working hours are infrequent, the requirement to remain accessible places a restriction on social and professional life. Lone consultants often have difficulty in attending meetings and taking study leave and annual leave. There are real risks that lone consultants become professionally isolated, with the potential for erosion of professional standards. Without the flexibility that increased surgical capacity brings, it becomes very difficult to plan a sustainable 24/7 service. Whilst the Panel fully acknowledges the dedication and flexibility of the RCH consultant, it agrees with the Griffin and Allum report and does not consider that the service, as configured prior to 1 January 2010, was sustainable.

- 5.4.5 People opposed to the service change raised the issue of the mortality statistics of the three individual centres. The mortality statistics are derived from a small number of patients. The Panel agrees with the view that, when dealing with small numbers of patients, mortality figures can be easily misinterpreted. Larger numbers of patients need to be included in an analysis than each hospital operates on each year, to ensure that the differences seen between centres are not due to chance, and represent real differences in outcome.
- 5.4.6 The Panel is satisfied that the option to continue providing OG cancer surgery at Royal Cornwall Hospital was unsustainable and that no other realistic option emerged.
- 5.4.7 ***The future of services at Royal Cornwall Hospitals NHS Trust***  
The Panel understands why local residents may have concerns about a potential domino effect of transferring the OG cancer surgical service from RCH resulting, over time, in the loss of other services from Cornwall. The Panel found no evidence that such a domino effect need happen, nor that there were any plans indicating that this might in the future.
- 5.4.8 CIO SPCT published a five year strategic plan, *A Healthy Future for All*, in 2009 that set out 10 priorities to guide the development of health services in line with local need. Their 2009 commissioning intentions aimed to transform community health services and included priorities for high quality acute services closer to home by delivering more diagnostic services in the community setting, including ultrasound, MRI, dual energy X-

ray absorptiometry (DEXA) scanning, echocardiography and audiology services. In autumn 2009, RCHT published its draft five year *Strategy: Our Plans 2010 – 2014* which takes into account these priorities and shows how RCHT intends to deliver the PCT required outcomes of acute healthcare services.

- 5.4.9 The Panel was impressed during visits to the local facilities by the level of enthusiasm amongst clinical staff for the RCHT Strategy. The Panel acknowledges the work undertaken to ensure public, staff and stakeholder involvement in the development of these plans. It considers that patients, Cornwall residents and CIO SPCT should continue to be fully involved in the further development of the Strategy and the detailed service improvement and operational plans that flow from it. This will help address the lack of confidence the local community has in the future of health services in Cornwall. Involvement is particularly important in developing the plans for the services to be delivered from West Cornwall Hospital and St Michael's Hospital to ensure opportunities for delivering services closer to the patient's home are maximised and have local support. It will also ensure that local people have an understanding of the financial challenges faced by the local health community in improving these facilities and enable them to be actively involved in the decision-making process.

5.4.10 **Recommendation Six**

**Cornwall and Isles of Scilly PCT should continue to engage the public and the Royal Cornwall Hospitals NHS Trust in implementing its strategic plan *A Healthy Future for All*, including the future role of the Royal Cornwall Hospital, West Cornwall Hospital and St Michael's Hospital. The PCT and Trust must within six months produce a clear plan showing how facilities and capacity for delivering more services closer to the patient's home will be taken forward.**

5.5 **The rigour of public involvement and consultation processes**

- 5.5.1 The Panel heard much evidence about a lack of involvement of service users and the wider population in developing the proposals. Some people also questioned whether the NHS had fulfilled its legal duty to involve people in this issue by not conducting a formal public consultation.

- 5.5.2 “Formal consultation” is a term used by many people in the NHS to describe the statutory requirement imposed on NHS bodies by the Local Authority (Overview and Scrutiny Committee Health Scrutiny Functions) Regulations 2002. These regulations require NHS organisations to consult with overview and scrutiny committees (OSCs) when they are considering a proposal for a substantial development of the health service in the area of the local authority, or for a substantial variation in the provision of service.
- 5.5.3 What is often misunderstood is that the duty to involve users, set out in section 242 (1B) of the NHS Act 2006, is also formal as it is a legal requirement. There is a common misconception that if the OSC is not consulted, because a proposal is not deemed to be a substantial variation or development to a health service, users do not have to be involved. This is not the case. NHS organisations must involve users where section 242 (1B) requires arrangements to be made for involvement activity (whether by being consulted, or provided with information, or in other ways), irrespective of whether the OSC is consulted or not.<sup>16</sup>
- 5.5.4 Therefore, even if an issue is not initially regarded as a substantial development or variation it does not mean that an NHS organisation can fail to involve users in planning the service.
- 5.5.5 The IRP is aware that during this process RCHT sought legal advice concerning the need for formal public consultation prior to a decision being made. CIOSPCT, on the other hand, sought legal advice about whether it had fulfilled its legal duty to involve people. The *legality* or otherwise of any process is a matter that can only be determined in a court of law. The IRP’s responsibility is to consider the rigour of involvement and consultation process.
- 5.5.6 The IRP was also made aware of the ongoing employment tribunal case involving a former chief executive of RCHT. This is a matter of employment law and, therefore, separate from and not relevant to the scope of the Panel’s review.
- 5.5.7 The Panel received no evidence that patients, carers and the public were fully involved in

discussing the case for change and development of the patient pathway. The Panel considers that the PCN should have done more to engage with patients, carers and the wider community during the development of the proposals. The Panel would expect to see the PCN and CIO SPCT involvement processes significantly strengthened. The NCAT *Service User Involvement in Cancer Care – Policy, Principles, Practice (2009)* document addresses many of the ‘foundation stones’ of user involvement which would result in a strong base for future engagement and consultations around other cancers. The Panel considers it essential that the PCN capture and evidence the patient experience as the starting point for any future work on service development. The Ipsos MORI work undertaken by CIO SPCT is a model for this type of approach. Engagement needs to be embedded and mainstreamed into all the work to develop and reconfigure services that takes place within the PCN area.

- 5.5.8 The Panel accepts the view that patients and user representatives were not adequately involved in the development of the proposals and that public engagement and involvement mechanisms were not fully used. This led to the public having little opportunity for their voice to be heard or to influence or express their concerns especially during the early part of the process. As a result of this experience, local people felt disenfranchised by the way the service change was handled and became suspicious of the whole process. In the Panel’s opinion, this understandable suspicion was exacerbated by the mixed messages at various times from different sections of the NHS community.
- 5.5.9 The Panel acknowledges that towards the end of the process CIO SPCT undertook two substantial periods of public engagement, the second of which involved engagement events across Cornwall and a PCN commissioned Ipsos MORI survey. Although late in the day, the Panel accepts that this provided residents of Cornwall with an opportunity to shape the implementation detail of the service change. CIO SPCT now needs to build on this work to ensure patient and user involvement is embedded at every level of service development and change and not just during the practical implementation phase.
- 5.5.10 The Panel does not accept that the PCN was instrumental in disbanding the Partnership Group in July 2009, rather that the group itself decided that it was no longer fit for

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<sup>16</sup> Extract from S242 Guidance, NHS Act 2006

purpose and should be reconstituted with more active representation from the PCTs and acute trusts and have stronger links with local organisations and patient groups. The Panel notes that only in May 2010 did this newly constituted PCN Partnership Group meet for the first time. Engagement and involvement of users and carers will not be effective without appropriate resources, support and organisational leadership. The Panel recognises that the new partnership arrangements will need strong support and facilitation to ensure their influence and effectiveness continues.

5.5.11 The Panel considers that effective change can be developed through alliance building and partnership working, significant steps towards which have already been made by strengthening the Partnership Group.

5.5.12 **Recommendation Seven**

**The Peninsula Cancer Network must complete the process of re-establishing an effective, functioning Partnership Group and review how the experiences of patients will be captured and used to design and deliver better cancer services. This process should be the subject of external assurance and changes made to meet national guidance and best practice. Changes should be made within six months.**

5.5.13 The Local Authority (Overview and Scrutiny Committees Health Scrutiny Function) Regulations 2002 require NHS organisations to consult relevant HOSCs on any proposals for substantial variations or developments to services. What constitutes a substantial variation or development is not specified.

5.5.14 The Panel reflected on the different approaches of the Cornwall HAOSC and Devon HASSC to considering this service change. It was clear to Panel members that the HASSC had a good understanding of the issues with experience relating back over a number of years. This had enabled them to have some continuity through the process even though some councillors had inevitably changed during the lengthy decision-making period.

5.5.15 The history of this service change is long and, over the relevant period, both expectations and requirements to involve people through effective processes have changed. Inadequate

community and stakeholder involvement in the early stages of planning change is, in the IRP's experience, a major cause of disputed service changes. With hindsight, the involvement of users and patient representatives in the PCN work leading up to and through the independent clinical review process was insufficient. This, combined with the absence of effective processes and agreements between the NHS and the HAOSC to manage service change, led to a breakdown in some key relationships.

5.5.16 It was of concern to the Panel that the Cornwall HAOSC process led to a decision to refer a service change to the Secretary of State only weeks before the planned transfer. With an agreed Partnership Framework between the HAOSC and CIOSPCT, to determine whether proposals are substantial, it should have been possible to resolve this earlier. The Panel recommends that the HAOSC and CIOSPCT review the lessons to be learnt from this experience to ensure the necessary processes are in place to avoid a similar situation arising in the future.

5.5.17 **Recommendation Eight**

**Cornwall and Isles of Scilly PCT, the Cornwall Health & Adult Overview Scrutiny Committee and local NHS organisations should together consider the lessons learnt from this experience and take action to ensure all service change proposals are developed in an environment in which there is an open and constructive relationship aimed at delivering improved services and better health outcomes for the people of Cornwall.**