

Information Pack:

Proposals to relocate specialist Upper Gastrointestinal Cancer Surgery to improve outcomes for patients from Cornwall and the Isles of Scilly

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Introduction

For some time health services across the Peninsula have been developing plans to consolidate the delivery of specialist upper gastrointestinal (Upper GI) cancer surgery. The Peninsula Cancer Plan also includes proposals for some Head and Neck cancers and specialist Gynaecological cancers to be consolidated in fewer centres to improve the outcomes for patients. A further engagement process in September will address Head and Neck and Gynaecological cancers. The current Peninsula plan for specialist Upper GI cancer surgery requires services to have moved from Royal Cornwall Hospitals Trust to Plymouth Hospitals Trust by December 2007 and services at Royal Devon and Exeter NHS Foundation Trust to continue until 2010.

We are proud of the high standards of clinical care provided by clinicians at the Royal Cornwall Hospitals Trust. The recent Healthcare Commission patient survey results confirm the high value placed on our local acute Trust. For the vast majority of cancer patients, Royal Cornwall Hospitals Trust will remain their hospital of choice. The plans set out in this document have come in response to national clinical guidelines that give clear advice about treating patients in centres with a higher volume of specialist surgical cases so that improved patient outcomes can be achieved.

The local NHS has one objective in proposing these changes, and that is to give the small number of patients who require surgery for upper gastrointestinal surgery each year the opportunity to benefit from the best possible outcomes.

We recognise that this planned change has created some concern locally and this information pack, alongside a series of public engagement events, has been created to provide key background information to explain the rationale behind the planned changes to upper GI cancer surgery and better understand the concerns of local people and how these may be addressed.

The information pack sets out the clinical evidence prompting this proposal, how the patient pathway for patients will change, and importantly provides reassurance about the vast majority of cancer services that will remain in Cornwall.

The PCT, working closely with the Royal Cornwall Hospitals Trust, has done much to improve local access to services over the last year. We want to encourage local people to continue to campaign for good local health services. Our joint commitment to deliver further improvements in this area remains undiminished. However, we need to recognise that not all health services can be provided locally. We believe that whilst a small group of patients will need to travel further for their surgery, we are confident that the outcomes will improve. Standing still is not an option.

Plymouth Hospitals NHS Trust has developed a strong reputation as a specialist surgical centre, and already provides many services to Cornish patients on this basis. This includes treatment for cardiac surgery, kidney transplant, neurosurgery and plastic surgery.

When asked, nine out of ten patients treated by Plymouth Hospitals NHS Trust (92%) rated their care as either 'excellent, 'very good' or 'good'.

We are proud of the outcomes being achieved by our clinicians in this field, and confident that we are well prepared to care for patients from Cornwall and the Isles of Scilly requiring surgery for upper GI cancer.

As a specialist centre, we are experienced in recognising the specific needs of patients who travel some distance for treatment but the specialist care we provide is only a small part of the overall care a patient receives. Much of a patient's care will be given by doctors and medical staff at hospitals and GP surgeries closer to their home. We work with those clinicians to support patients' individual needs and make their experience as comfortable as possible, ensuring they can be discharged to local care as soon as clinically appropriate.

We are committed to working with our clinical colleagues at the Royal Cornwall Hospitals Trust to develop a patient pathway which is truly patient centred.

Our hospital Trust has recently published a 10 year plan to further develop our services and move forward on Foundation status.

Paul Roberts
Chief Executive

Mr James Palmer
Medical Director (Clinical Services)

Upper Gastrointestinal Cancer – key facts

Upper GI cancer refers to cancer of the stomach and of the oesophagus (gullet or food pipe connecting the mouth and stomach). Every year in Cornwall around 90 people are diagnosed with cancer of the oesophagus and 75 people are diagnosed with cancer of the stomach. In total there are around 3,000 new cancers diagnosed in Cornwall per year so upper GI cancer makes up around 5% (one in 20) of all cancers.

Upper GI cancers are rarely seen in people under the age of 45 (1-2% of the total) and around half of people diagnosed with upper GI cancer are over 75. Survival rates for upper GI cancer are lower than many other cancers although there has been some improvement in recent years. In the UK, only 15 out of 100 people will still be alive 5 years after diagnosis of stomach cancer and 8 out of 100 for oesophageal cancer. There is therefore a strong clinical imperative to drive improvements in outcomes.

Current patterns of treatment

Of the 165 people per year in Cornwall diagnosed as having upper GI cancer, 72% were diagnosed at the Royal Cornwall Hospital (RCH) (based on data for the period 2000-2005). The others were people from the north and east of the county who routinely receive their acute care from Plymouth and Devon. This means around a quarter of patients in Cornwall would not be directly affected by any changes in services at RCH.

Surgery to remove the tumour (a resection) is technically complex. Of the approximately 120 patients per year being diagnosed and treated at RCH around 25 patients currently have a surgical resection. Under this proposal these operations would be carried out at Derriford Hospital. Assessment, diagnostic tests and follow up care after surgery would be undertaken locally within Cornwall. In addition to this some patients go through an assessment and staging process but do not proceed to surgery. The remaining patients may be treated using radiotherapy, chemotherapy or receive palliative care. Under the proposals these services would all continue to be provided locally.

The focus on Upper Gastrointestinal Cancer

Proposals were brought to the Cornwall Health and Adult Social Care Overview and Scrutiny Committee in November 2007 to make changes to the delivery of specialist cancer surgery in three clinical areas: upper gastrointestinal, head and neck and some gynaecological cancers. The proposals to provide such surgery from specialist centres were also presented to the Isles of Scilly Overview and Scrutiny Committee in January 2008.

This first engagement process is focused on proposals for Upper GI cancer surgery, where surgery is currently being performed outside national guidance. The clinical case for change is therefore most pressing in this area.

We will hold a further period of engagement with local patients and other stakeholders focused on proposals for Head and Neck and Gynaecological cancer surgery in September 2008. As well as allowing the full engagement of the new Local Involvement Network (LINK), this will also provide an opportunity to reflect on the feedback from our engagement on Upper GI cancer surgery – both in terms of the engagement process and the views expressed.

Proposals

The National Cancer Action Team produced the Improving Outcomes Guidance (IOG) which the planned changes to upper gastro-intestinal cancer surgery are based upon. This guidance was developed by leading surgeons from across the country, all united in wishing to improve outcomes for patients.

Following an external review of the Upper GI services in all the Trusts in Devon and Cornwall the team has made two separate recommendations for services in the South West Peninsula. Services provided at Plymouth Hospitals Trust (PHT) and the Royal Devon and Exeter NHS Foundation Trust (RD&E) are currently deemed IOG compliant until 2010.

Services provided at the Royal Cornwall Hospitals Trust (RCHT) have been classified as non-compliant based on the recommendation that specialist gastro-intestinal teams should draw on populations of more than a million people, or at least 500,000 for sparsely populated areas. This reflects the need for surgeons to be treating sufficient patients to maintain the skills to ensure the best possible outcomes. The RCHT population (72% of Cornwall and Isles of Scilly's 539,100 residents) equates to about 388,000 people. PHT currently serves a population of 768,000 and RD&E a population of 538,000 people.

Ensuring the best outcomes for patients

Cornwall and Isles of Scilly Primary Care Trust has a duty of care to commission services for its local population on the basis of the best clinical evidence. This role includes taking appropriate action in the commissioning of specialist cancer surgery.

There is considerable evidence from the UK and USA that centres treating large numbers of people have better outcomes, including improved survival and lower complication rates, than smaller centres.

There are a number of reasons why specialist centres have better outcomes including the following:

- the number of surgeons specialising in the particular type of work at a centre allows for sharing of expertise, experience and training opportunities for new surgeons

- the provision of specialist specific on call for out of hours emergencies following surgery
- more scope to develop new techniques for surgery and in all aspects of the management of patients affected by this cancer.

The data reported to the South West Cancer Registry from hospital episode statistics for the period January 2003 to March 2006 is as follows.

	Number of operations	Deaths less than 31 days after surgery		Deaths at one year after surgery		Survival at one year after surgery	
		Number	%	Number	%	Number	%
Plymouth Hospital NHS Trust	158	11	7%	33	21%	125	79%
Royal Devon and Exeter NHS Foundation Trust	108	6	6%	23	21%	85	79%
Royal Cornwall Hospital NHS Trust	80	9	11%	31	39%	49	61%
South West Strategic Health Authority	917	66	7%	267	29%	650	71%

Because the number of cases for this specialist surgery is relatively small there is always some caution about drawing too many conclusions from one set of statistics. However, local evidence can be put in the context of wider national and international studies on which the national guidance was based.

Looking more broadly at national and international learning a recent paper published in the British Journal of Surgery (Source: Peterson-Brown S. Surgical volume and outcome Br J Surg 2007;94:523-524) concludes that for upper gastrointestinal cancer higher volume centres have lower mortality. A recent editorial in the British Journal of Surgery concluded that for upper GI surgery 'higher-volume centres have lower mortality'.

Large studies have shown that mortality (death rates) differed in the following ways:

Number of operations per year	Mortality (death) rate
Less than 20	7.1%
22-38 per year	5.8%
40-61 per year	4.0%

Source: Pal N, Axisa B, Yusof S *et al.* Volume and outcome for major GI surgery in England. J Gastrointest Surg (2008) 12:353–357

Data on the performance of hospitals in the Peninsula, and the issues surrounding this data are discussed in the Health Impact Assessment in Appendix One.

Upper gastro-intestinal surgery is a major clinical procedure with survival rates that are below many other cancers. The evidence around survival rates gives an indication that patients are best seen in larger specialist centres. This is not a judgement on any one centre of treatment but a recognition that the emphasis must always be on how services can be improved following national clinical guidance.

The proposed patient pathway

The vast majority of care provided to patients diagnosed with Upper GI cancer will be provided locally. This will include the pre-assessment of patients booked for surgery, thus minimising travel time for patients. Patients booked for surgery will receive a range of information in advance of their admission, including advice on parking, carer accommodation etc. In addition, recognising that some patients have already told us of their concerns about attending an unfamiliar hospital, all patients will be offered a visit to Plymouth Hospitals NHS Trust in advance of their admission. Patients will be admitted to Derriford Hospital the day before their booked surgery, so that pre-operative anaesthetic assessment can be carried out. Patients will be discharged back to their local consultant at the Royal Cornwall Hospitals Trust, usually around 10 days after surgery.

Caring for patients' needs

Proposed changes to the location of treatment for patients has included due consideration of patients' needs. It has been recognised that extra distance can pose real challenges for patients and their family or friends but efforts have been made to minimise that impact.

Clear information leaflets and advice on where to find help and support will routinely be made available to anyone who has to travel further for treatment. Appointments will be scheduled with due regard for the travel times of patients travelling from different parts of Cornwall and the Isles of Scilly.

As described above, the upper gastro-intestinal cancer patients who will receive their surgery at Plymouth Hospitals Trust will routinely be able to have their pre and follow up appointments in their local hospital (including at the Royal Cornwall Hospital).

Patient and Relative Accommodation

Plymouth Hospitals NHS Trust have an Accommodation Lodge available to patients and families when attending Derriford Hospital. The facility has 27 rooms.

Address: Heartswell Lodge
7 Blunts Lane, Derriford, Plymouth, PL6 8BE
Telephone: 01752 315900
Opening Times: 0900 – 2130 (Mon-Fri); 0900-1900
(Weekends/B-h)

Cost: £35 single; £47 twin per room
More Info: www.heartswell.org.uk

In parallel to the period of engagement, the PCT will explore whether it is able to provide assistance to those suffering financial hardship.

Support with Transport to/from Derriford Hospital

For those requiring assistance travelling to hospital, Plymouth Hospitals NHS Trust have a Single Point of Contact Telephone Booking Service. Patients can contact the Booking Service by telephone on 0845 0539100. They will be asked for information about the journey required and their transport needs. Patients whose medical condition requires the skills or support of clinically trained staff or equipment on or after their journey or whose health would be detrimentally impacted if travelling by other means, will receive medical transport, available free of charge. If an ambulance or voluntary car is required, this will be booked for the patient. Voluntary transport is available at a per mile rate (40p) capped at £20 each way, so that patients who have to travel the furthest are not unduly disadvantaged.

A carer may accompany patients if it is deemed medically necessary. Unfortunately such transport is not available for relatives and visitors.

The Healthcare Travel Costs Scheme (HTCS) provides financial assistance to patients on low incomes or specific qualifying benefits or allowances who do not have a medical need for medical transport, but who require assistance with their travel costs. Such patients are reimbursed in part or in full for fares incurred in travelling to traditionally hospital-based NHS services under the care of a consultant, if their journey meets certain criteria.

The Patient must be in receipt of the following specific qualifying benefits:

- Income Support
- Income Based Jobseekers Allowance
- Working Tax Credit (with a disability or severe disability element) or Child Tax Credit (where the award notice shows income is £15,050 or less)
- Pension Credit Guarantee Credit
- War Disablement Pensions and one of the qualifying benefits/credits (where they are attending hospital for reasons other than their accepted war disability)
- Patients may also be eligible to assistance through the NHS Low Income Scheme

More detailed clarification of eligibility is provided in the DH Guidance: Healthcare Travel Costs Scheme (March 2008).

A commitment to providing services closer to home

One of the key concerns expressed is about changes to upper gastro-intestinal cancer surgery representing a reversal of commitments set out in A

Healthy Future for Cornwall and the Isles of Scilly to provide care closer to people's homes. That is not the case.

The change is based on Cornwall and Isles of Scilly Primary Care Trust's duty of care to commission services that meet national clinical guidance developed by clinical experts.

The 25 patients affected should be set within the context of the 2,168 patients diagnosed and treated for cancer at RCHT for the year ending 31st March 2008. The proposal to move upper GI cancer surgery will affect 1.1% of all cancer patients currently treated in Cornwall.

Cancer specialities provided within Cornwall include the following:

- Colorectal
- Paediatrics
- Breast
- Lung
- Brain/Central Nervous System
- Skin
- Urology
- Haematology
- Sarcoma

The recent Department of Health report from the Health Minister Lord Darzi, *Leading Local Change*, talked about the principle of providing services that are 'centralised where necessary, localised where possible'. Services in Cornwall and the Isles of Scilly are being developed on this basis. Continued efforts are being made to provide services closer to home, where clinically safe and effective.

For example, currently all residents in Cornwall and the Isles of Scilly who require NHS treatment for Wet Age Related Macular Degeneration (WARMD) or for vitreo retinal conditions – both eye treatments - have to travel out of the county to receive treatment either at Torbay, Plymouth, Exeter or beyond.

The PCT has recently agreed with RCHT that two new services will be established at the Royal Cornwall Hospital to provide access to local treatment for patients and avoid the need to travel out of the county. This will mean that approximately 350 people every year, who currently have to travel out of the county for treatment, will now be able to receive their treatment in Cornwall. It is expected that these new services will be available in Truro by the end of the summer 2008.

Other specialist treatment undertaken elsewhere

3% of planned care is specialist care provided in tertiary care centres. This includes cardiothoracic surgery, neurosurgery and specialised burns. It is not therefore unusual for patients from Cornwall and the Isles of Scilly to travel out of the local area for specialist treatment where there is clinical need.

Indeed, patients from across the country routinely travel to different locations for treatment, either through exercising their choice or to access specialist care. This may involve visiting either regional or national centres of excellence.

Similarly, although it is less common some patients come to Cornwall from outside of the health community for specialist treatment. During 2007/08, 748 patients from outside Cornwall were treated at the Royal Cornwall Hospitals Trust (in addition to care provided to visitors to the county).

Moving forward

This information pack has been produced to support the engagement with local patients and members of the public. It includes information requested by the Overview and Scrutiny Committee and other patient groups.

To support the process of informing the public about the planned changes to upper gastro-intestinal surgery a series of public engagement events have been planned.

This approach has been developed based on the PCT's experience of running an ongoing monthly programme of public engagement since the launch of its Strategic Review (*A Healthy Future for Cornwall and the Isles of Scilly*) in October 2006. Each month, the PCT Board meeting is supported by a series of engagement opportunities including Select Committee and Question Time events. This approach has been welcomed by a range of local and countywide community and voluntary groups and forums.

The channels that will be available in this public engagement programme are:

- The PCT website will feature a page giving access to this information pack, an e-mail and postal address for responses or questions and a phone number for queries or advice. Copies of the information pack will be available to download from the website or can be sent by post on request.
- The PCT will host 'Select Committee' hearings in different locations across the county. These hearings will be chaired by Professor Nick Bosanquet (a member of the national Cancer Reform Strategy Advisory Board). The purpose is to allow interested individuals or groups the opportunity to engage in face-to-face discussions with key individuals representing NHS organisations or clinicians. It recognises that some individuals may wish to discuss personal or sensitive issues and this can best be done in a closed meeting with a relevant panel of experts. People will need to book an appointment at least three days in advance of the Select Committee hearings taking place and spaces will be allocated as people come forward to book a slot.

The arrangements for these meetings are as follows:

11am-1pm on Mon 2 June 08	Select Committee Meeting	Truro – (Benefits Dept) Carrick District Council, Carrick House, Pydar Street TR1 1EB
3pm-5pm on Mon 2 June 08	Select Committee Meeting	Penzance – (Lounge) Queens Hotel, The Promenade TR18 4HG
11am-1pm on Tues 3 June 08	Select Committee Meeting	Bodmin – (Dining Room) The Shire House, Bodmin Town Council, Mount Folly Square PL31 2DQ

- The PCT will also host 'Question Time' open public meetings in different locations cross the county, which anyone can attend, in order to listen to the information presented and take part in the discussions. The event will begin with a presentation showing the key facts given in the public information pack and then questions will be invited from the audience to which the expert panel members, including clinicians, will respond.

The arrangements for these meetings are as follows:

Date:	Meeting:	Venue:
3.30pm-5.00pm on Tues 10 June 08	Question Time Meeting	Truro – The Alverton Manor, Tregolls Road, Truro, TR1 1ZQ
7pm-8.30pm on Tues 10 June 08	Question Time Meeting	Penzance – (Main Hall & Side Room) St Johns Hall, Penwith District Council, Alverton Street TR18 2QR
7pm-8.30pm on Wed 11 June 08	Question Time Meeting	Bodmin – (Suite) The Shire House, Bodmin Town Council, Mount Folly Square PL31 2DQ

Full details of the public engagement programme will be shared with the local population through a press release issued on 19 May to local media and paid advertising in local newspapers giving details of how people can access information, use the channels to ask questions and feedback their comments.

The feedback from each of these engagement channels will be captured and summarised in a report, which will be presented to a special meeting of the Cornwall Health and Adult Social Care Overview and Scrutiny Committee planned for late June 2008.

At this meeting proposals for the way forward in delivering safe and effective specialist upper-gastrointestinal cancer surgery for patients from Cornwall and the Isles of Scilly will be confirmed, taking into account feedback received during the engagement process.

Submitting your comments

Please note the deadline for any comments received via e-mail or by post is Friday 13 June. The engagement programme will end on this date.

The contact e-mail address is: enquiries.ciospct@cornwall.nhs.uk

The contact postal address is: Engagement Team, Cornwall and Isles of Scilly Primary Care Trust, Sedgemoor Centre, Priory Road, St Austell PL25 5AS

The web page giving details of the engagement programme can be found via the PCT's Internet homepage www.cornwall.nhs.uk/ciospct

Contact

If you have any questions please contact the PCT's Engagement Team by e-mail on: enquiries.ciospct@cornwall.nhs.uk or telephoning 01726 627867.

Appendix One

Health Impact Assessment on the proposed changes to upper gastro-intestinal cancer surgery in Cornwall and the Isles of Scilly - information and scoping

Purpose

This Health Impact Assessment (HIA) concerns the impacts on the health of the population of Cornwall of moving surgery for upper gastro-intestinal (GI) cancer from Royal Cornwall Hospital (RCH) in Truro to Derriford Hospital in Plymouth.

How common is upper GI cancer in Cornwall and the Isles of Scilly?

The term upper GI cancer refers to cancer of the stomach and of the oesophagus (gullet or food pipe connecting the mouth and stomach). Every year in Cornwall around 90 people are diagnosed with cancer of the oesophagus and 75 people are diagnosed with cancer of the stomach¹. In total there are around 3000 new cancers diagnosed in Cornwall per year so upper GI cancer makes up around 5% (one in 20) of all cancers.

Upper GI cancers are rarely seen in people under the age of 45 (1-2% of the total) and around half of people diagnosed with upper GI cancer are over 75¹. Survival rates for upper GI cancer are lower than for many other cancers although there has been some improvement in recent years. In the UK 15 out of 100 people will still be alive 5 years after diagnosis of stomach cancer and 8 out of 100 for oesophageal cancer².

The risk of developing an upper GI cancer is increased by smoking and alcohol intake³. Even moderate amounts of alcohol have been associated with an increased risk⁴. Being overweight also increases the risk⁵ whereas eating fruit and vegetables can reduce the risk⁶.

How many people in Cornwall and the Isles of Scilly would be affected by the proposed changes?

Of the 165 people per year in Cornwall diagnosed as having upper GI cancer, 72% were diagnosed at RCH (based on data for the period 2000-2005). The majority of the others were people from the east of the county who were diagnosed at Derriford hospital and also some people from north Cornwall diagnosed at the Royal Devon and Exeter Hospital¹. The total population of Cornwall is 539,100. The upper GI cancer service at RCH therefore serves a population of around 388,000 (72 % of 539,000). The remaining population of Cornwall would not be directly affected by any changes in services at RCH.

Of the 120 patients per year being diagnosed and treated at RCH around 25 patients currently have a surgery to remove the tumour. Under the proposal these operations would be carried out at Derriford Hospital. In addition to this some patients go through an assessment and staging process but do not proceed to surgery. The remaining patients may be treated using radiotherapy, chemotherapy or receive palliative care. Under the proposal these services would all continue to be provided locally.

What are the likely health impacts of the proposed changes?

1. Quality of care and survival rates

a) research evidence

There is considerable evidence from the UK and USA that centres treating large numbers of people have better outcomes, including higher survival and lower complication rates, than smaller centres particularly for oesophageal cancer^{7,8,9}. There are two separate factors contributing to improved surgical outcomes, firstly the number of operations performed by the surgeon and secondly the number of patients treated at the centre. The effects of these two factors are difficult to separate out as surgeons performing high volumes of operations tend to work in large centres. However the overall relationship between larger volumes of patients and better survival rates is clear.

National guidance based on the research data and the opinion of experts in the field recommends that 'oesophago-gastric cancer teams should draw patients from a catchment area of one to two million. (The minimum acceptable population size, for sparsely populated areas only is 500,000)'.¹⁰

b) local data

Examining local data from existing centres is problematic and requires cautious interpretation. The main problems are

- deciding which outcomes are most indicative of quality of care
- small numbers – variations in outcomes from year to year and centre to centre may arise by chance and not reflect quality of care
- different characteristics of patients, for example if patients attending one centre have more advanced cancer or more coexisting medical problems than patients at another centre, then their outcomes may be worse even if the care they receive is equal to other centres.
- the accuracy and completeness of data

All hospitals report data on admissions, diagnoses and operations in the form of hospital episode statistics (HES). This data relies on accurate coding of each episode.

Hospital episode statistic data for upper GI surgery for the period January 2003 to March 2006 is as follows.

	Number of procedures	Deaths before 31 days		Survival at 1 year	
		Number	%	Number	%
Plymouth Hospital NHS Trust	158	11	7%	125	79%
Royal Devon and Exeter NHS Foundation Trust	108	6	6%	85	79%
Royal Cornwall Hospital NHS Trust	80	9	11%	49	61%
South West Strategic Health Authority	917	66	7%	650	71%

There have been some concerns about the accuracy of HES data. This data has therefore been checked against clinical data on a patient by patient basis over a 3

year period. On this basis, the data is judged by the South West Cancer Information Service to be accurate.

There were also concerns that the relatively small numbers of operations at RCH may lead to higher mortality by chance in the time period used. We have therefore looked at RCH data for the maximum time period possible ie January 2002 to March 2007. The results are as follows.

Number of operations 109
30 day mortality 9/109 = 8%
1 year survival 75/109 = 69%

Although it is not possible to exclude chance in the differences between centres, it is clear that the results for Cornish patients at RCH are not as good as can be achieved by high volume specialist centres.

2. Impact of travel

Under the proposals, patients would need to travel to Plymouth for surgery. They would also need a pre-operative assessment and depending on local agreement patients may be able to be seen locally for this. They would also need a follow up out-patient appointment, which would probably be in Plymouth. Patients undergoing surgery stay in hospital for around 10 days but this varies considerably depending on age, other medical conditions and medication. Most patients would be admitted at least one day before surgery avoiding the need for early morning travelling. All other care and follow up would be provided locally within the patient pathway.

The distance from Truro to Derriford is 60 miles. So the maximum additional journey distance in travelling to Derriford rather than Truro is 60 miles. This takes approximately 1½ hours by road but may be longer in summer traffic. For some patients the additional journey will be considerably less e.g. for a patient in Bodmin the additional journey time would be 5 minutes and no additional distance. A survey of upper GI surgery patients at RCH showed that on average it would take patients an hour longer to travel to Plymouth than to Truro.

There may be psychological effects associated with travelling further from home for surgery, in terms of the stress of the journey and isolation from friends and family who may not be able to visit. This may add to the great emotional stress of having cancer. However many patients from Cornwall with other conditions already travel to specialist centres out of county including Bristol and London.

It is important that the psychological and financial implications of the additional distance are carefully considered in order to minimise negative health impacts.

3. Health inequalities

Nationally, people living in areas of socioeconomic deprivation are more likely to die from cancer at an earlier age than more affluent people. This is mainly due to increased risk factors, e.g. smoking and alcohol, and more advanced disease at diagnosis. There is also evidence that people from rural areas have worse outcome from cancer than people in urban areas, mainly due to more advanced disease at diagnosis^{11,12}. It is important that people from these areas are encouraged to recognise and report early symptoms and that they receive prompt diagnosis and treatment.

There are high levels of socioeconomic deprivation and rurality in some parts of west Cornwall. Not everyone has access to a car or to public transport. The cost of fares or of petrol and parking may be a burden on friends and families wishing to visit patients in hospital following surgery.

There are also concerns that people in Cornwall may choose sub-optimal treatment by opting for radiotherapy or chemotherapy provided locally rather than radical surgery further from home.

4. Health impacts on the wider community

In view of the small number of patients involved, it is unlikely that there would be any significant economic, employment or environmental factors that would have an impact on the health of the population.

Conclusion

Developing a specialist centre in the Peninsula with clinical expertise in upper GI cancer surgery, including training and research, should bring health benefits for the peninsula as a whole and is in line with national guidance. For people in east Cornwall there are no significant negative health impacts to balance against this. However for those in the west of the county, there are potential negative health impacts particularly around the considerable distance to the centre. There is a potential to increase health inequalities across the county. Therefore a change to the service requires careful consideration of these issues and mitigation of negative health impacts in order for patients to benefit from improved clinical outcomes.

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15 May 2008

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Appendix Two

The role of the Peninsula Cancer Network

The Peninsula Cancer Network was formed in response to the National Cancer Plan published in September 2000 which identified a programme of investment and reform to produce the fastest improvement in cancer services in Europe.

The already well established cancer services based in the acute Trusts in Truro, Plymouth, Torbay, Exeter and Barnstaple formed the clinical basis for the Network. With the formation of Primary Care Trusts, links were forged with General Practice and Community Nursing Services and the inclusion of hospices, other voluntary agencies and patient/carer representatives has ensured that the whole health community is engaged in the work of the Network.

Representatives from all these organisations including lead surgeons, physicians, oncologists, pathologists, radiologists, nurses and allied health professionals meet regularly in Network Site Specific Groups (NSSGs) Other cross cutting Groups deal with Specialist Palliative and Supportive Care, Drugs and Therapeutics, Chemotherapy and Primary Care services.

The Peninsula Cancer Network has been taking forward local plans to implement the Improving Outcomes Guidance for the wide range of cancers, which are agreed by the National Cancer Action Team. The next phase of its work is to further improve services through the implementation of the Cancer Reform Strategy across the Peninsula.