

KEEP CANCER CARE IN CORNWALL CAMPAIGN

Response to

**Cornwall and Isles of Scilly
Primary Care Trust**

And

Peninsula Cancer Network

Proposals to relocate specialist

Upper Gastrointestinal Cancer Surgery

**Prepared by the Keep Cancer Care in Cornwall Campaign
May 2008**

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INTRODUCTION

This document should not need to exist.

Unfortunately the cancer patients of Cornwall and a large proportion of the public feel that this is the only way they will be heard.

In November 2007 the Cornwall & Isles of Scilly Primary Care Trust (CIOSPCT) co-presented with the Peninsula Cancer Network (PCN) to Cornwall County Council's Health & Adult Social Care Overview and Scrutiny Committee (HASCOSC) a proposal for the removal of, Upper Gastro-Intestinal Cancer Surgery (UGICS), Head & Neck Cancer Surgery (HNCS) and complex Gynaecological Cancer Surgery (CGCS) from the Royal Cornwall Hospitals Trust (RCHT) in Cornwall to Devon.

There is a possibility of other cancer services being removed later when they have been ratified. HASCOSC agreed to the proposals in their entirety as not being substantial.

The CIOSPCT have termed this removal of services as the Peninsula Plan. The removal of cancer surgery services is reported to be in response to a Department of Health Document on Upper Gastro-Intestinal Cancer called 'Improving Outcomes Guidance' (IOG) produced in 2001.

In March 2008 the CIOSPCT decided as a result of public protest to institute an engagement process but only on UGICS and this process according to the Chief Executive of the CIOSPCT was to inform the public why the decision had been made.

HASCOSC on 20 May 2008 agreed with the format of the engagement process and the time period of just four weeks with six meetings, two in each of three areas of Cornwall in weeks three and four. The CIOSPCT have prepared an information pack in relation to their removing UGICS from Cornwall. This engagement process will close on 13th June 2008.

The Cornwall & Isles of Scilly Cancer Patient and Carer Group, Key members of the CIOSPCT Patient Forum and a 'sounding board' body of stakeholders called the Reference Group had **NOT** been consulted on the proposals to remove any cancer services from Cornwall prior to November 2007.

The engagement process now occurring is shorter and of a different format to that presented in draft form by the CIOSPCT to the Reference Group in March 2008. They were not presented with a finalised engagement process for them to agree to.

The CIOSPCT at the same time they announced plans for an engagement process into the almost immediate removal of UGICS announced that they would engage with the public in September 2008 on the remaining two cancer surgery services.

This delay of seven years since the publication of the IOG document in 2001 brings into question the reason why the CIOSPCT is insisting on the urgent removal of UGICS and yet is prepared to wait several more months before engaging on the possible removal of the other two cancer surgery services.

This split engagement process increases the anxiety for the relevant cancer patient groups. It is also not a cost effective way of using public funds.

There is **NO** Statutory Patient Voice in Cornwall at this time and the CIOSPCT and HASCOSC have refused to delay the engagement process into the removal of UGICS until the new Patient Organisation LINKs is formalised.

BACKGROUND

Based on data from the mid 1980s to 1999 the Department of Health produced in 2001 IOG guidance to commissioners of NHS services with regard to UGI cancer care. There have been other IOG's produced in relation to other services.

The guidance recommended that to improve certain cancer patient outcomes hospitals needed to serve a population of 1 – 2 million. The CIOSPCT and the PCN refer to these as 'Centres of Excellence'. Within the IOG document provision was made for rural populations such as Cornwall that the minimum number needed was 500,000. The All Welsh Cancer Steering Group (AWCSG) in 2008 also recognised that fact and set a criterion to provide services for that size of population.

- “Each team should aim to draw patients from a catchment area with a population of one to two million. (The minimum acceptable population size, for sparsely populated areas only, is 500,000.)”
page 29 paragraph 3 IOG UGI 2001

**Guidance on Commissioning Cancer Services,
Improving Outcomes in Upper Gastro-intestinal Cancers
Department of Health January 2001**

- “Ideally a population of 500,000 would support 2-3 surgeons and associated team members. A full ITU must be available with a specialist intensivist. An anaesthetist with experience in one lung ventilation should be available as should an HDU. Ideally a nutrition team should also be operational in the hospital”. **4.2.8**

**Professor JN Baxter
Consultant Upper GI/General Surgeon
Swansea NHS Trust**

**Management of
Upper Gastrointestinal
Cancer Services in Wales
Revised Publication
January 2008**

**A guideline by the All Wales
Upper Gastrointestinal
Cancer Steering Group**

- “Guidelines are not some holy writ. They need to be interpreted for the patient in front of you”

“Guidelines written in another part of the world must be adapted to suit the local situation”

Cancer World March/April 2007

Within the Peninsula Plan there is no evidence that the guidelines have been interpreted for the patient in Cornwall nor adapted to suit the local situation.

The total population of Cornwall and the Isles of Scilly is 539,100. Cornwall has one of the fastest growing populations in the country particularly in the over 60s this appears not to have been taken into consideration within these proposals to remove cancer services from Cornwall.

Historically about 120,000 of the population have routinely travelled to Devon for their acute hospital care with the result that a large proportion of health funding allocated to Cornwall has always been spent in Devon.

The CIO SPCT and the SWSHA rather than serve the population of Cornwall as a whole within county have opted to 'stand still' on the provision of services for a population within its county borders and continues to send patients outside of Cornwall for routine as well as some specialist care.

If this historical migration of patients from Cornwall to Devon were reversed then the RCHT catchment population would more than fulfil the criterion of both the IOG and the AWCSG documents. For the vast majority of these patients the difference in the travel distance and time from home to the RCHT is marginal and the resultant carbon footprint would be less than with the present arrangements and future proposals.

As part of the Peninsula Plan to obtain compliance with the IOG for a population base of 1 – 2 million proposals were placed before the Devon Overview and Scrutiny Committee (DOSC) in October 2007 by the PCN and Devon's PCT (DPCT) for the removal of UGICS surgery from the Royal Devon & Exeter Hospital (RD&E) to Derriford in Plymouth (PHNT).

The RD&E has challenged the removal of their UGICS to PHNT and the DOSC considered the removal of this as a substantial change to service and called for a public consultation which we are led to believe has since been suspended to consider other options.

Without RD&E patient numbers transferring to PHNT means that even with the removal the UGICS from Cornwall to PHNT the Peninsula will still not be compliant with the IOG guidelines of a 1 – 2 million population.

This then casts serious doubt on the necessity of such an urgent removal of UGICS from Cornwall by the CIO SPCT.

It must be questioned the reasoning behind HASCOSC deciding in November 2007 that the removal of three cancer surgery services with the possibility of

other services once they had been ratified as being not substantial, when their counterparts in Devon in October 2007 made exactly the opposite decision over one service.

It is interesting to note that within the CIOSPCT information pack there is a letter from the Chief Executive and Medical Director of PHNT extolling the virtues of their hospital. There is no such inclusion by the CIOSPCT of one from the RCHT; it has to be asked why?

It should also be noted that the recent national Healthcare Commission survey showed that 93% of patients rated their overall care throughout the RCHT as excellent, very good or good.

Within the introduction of CIOSPCT pack they have proclaimed that “the one objective in proposing these changes is to give the small number of patients who require surgery for UGICS each year the opportunity to benefit from the best possible outcomes”.

There is no evidence to suggest that removing the UGICS service from RCHT and providing it within PHNT that cancer patients from Cornwall will have improved outcomes. In some areas of Cornwall there is evidence in the CIOSPCT information pack that there may well be a negative health impact with the centralisation of cancer surgery at PHNT.

KEY FACTS

Cornwall has one of the fastest growing populations in the country with those over 60 being the largest group. 2008 ONS figures show that there are 101,171 people over 60 in Cornwall and this is predicted to increase by 80% over the next twenty years.

“In people aged between 45 and 54, the combined incidence of cancers of the oesophagus, stomach, and pancreas is 20 per 100,000 (1 per 5,000); **amongst those over 55, it is 155 per 100,000 (about 1 per 650)**”
(IOG DH 2001 pages 18 -19)

In Cornwall approximately 165 patients a year are diagnosed with Upper Gastro-Intestinal Cancer. This is above the national average yet surgery for these patients is being removed from within their county.

“Assessment, diagnostic tests and follow up care after surgery would be undertaken locally within Cornwall”. (CIOUSPCT Info pack May 2008)”.

One of the key facts for cancer patients to be able to cope with their disease is the rapport and confidence they build by continuity of care with their Cancer Care Team from Medical Staff including the Surgeon through to the dietician.

The proposal with the Peninsula Plan calls for split site care, part to be delivered in their local hospital (RCHT) and the main most complicated section, where the cancer patient needs to have acquired deep trust in the Surgeon, which doesn't happen overnight; is going to be performed in another county up to 85 miles away at PHNT

Cancer is a stressful disease and this will be expounded by having to travel for a vital part of treatment to an area you don't know, to a surgeon you have not had time to develop a rapport with and very possibly because of the distance and cost without loved ones with you.

Focus on Upper Gastro-Intestinal Cancer

The CIOUSPCT are concentrating at this time on UGICS only. They reason that this is because surgery within Cornwall is being performed outside of national guidelines. They do not qualify in relation to what section of the guidelines they are referring to, but their paper gives the impression that it is a sub-standard service.

This has caused a great deal of anxiety throughout the cancer patient groups and public within Cornwall, which could have been allayed if the CIOUSPCT had been more open, honest and transparent within their document and by making it clear that they were referring to population numbers and not the quality of surgery that occurs within Cornwall.

They acknowledge within their paper that there is provision made within the IOG for rural populations of 500,000 to have their own UGI Cancer Centres.

They have produced very interesting figures to show why Cornwall does not qualify but PHNT and RD&E do

“This reflects the need for surgeons to be treating sufficient patients to maintain the skills to ensure the best possible. 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”. (CIOSPCT Info Pack page 6 ‘Proposals’).

They have strict catchment figures (basic local population numbers served by a hospital) for RCHT yet for PHNT and the RD&E they have used Tertiary Population figures (basic population numbers plus a wider population base which covers a small limited number of highly specialised services like neurosurgery).

The basic catchment population for PHNT is **460,000** and for the RD&E is **350,000** compared to that of the RCHT at about **418,000**.

None of the basic population figures for the hospitals within the Peninsula Plan qualify under any of the compliance figures allowed for in the IOG.

It is therefore very difficult for the population of Cornwall and particularly the cancer patient to understand why they have yet again been chosen by their commissioners of NHS services to have their services centralised out of the county.

ENSURING THE BEST OUTCOMES FOR PATIENTS

Every commissioner of NHS services has a duty of care to commission services for their population that are safe, appropriate and where possible close to the patient’s home and this must be based on the best clinical evidence available. Their role in this the CIOSPCT believes includes taking appropriate action on the commissioning of specialist cancer surgery.

To illustrate their duty of care they report that 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.

They list some of the reasons why specialist centres have better outcomes

- “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”.

Also included is a comparative data table with a very odd timescale Jan 2003 – March 2006 for PHNT RD&E and RCHT

“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 are 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”.

In response to a Freedom of Information request from us the South West Strategic Health Authority included a paper with the following information

“Oesophago-Gastric Cancer Surgery within the Peninsula

1.2 Information on clinical outcomes in relation to upper gastrointestinal cancer surgery which has been provided recently by the South West Public Health Observatory
.....The small numbers also mean that there is unlikely to be any statistical significance in comparisons between the services”.....

We would like to draw your attention to an extract of a press release from the PHNT website in relation to a recent report of death rates from hospital acquired infections

‘In response to the publication of data by the Office of National Statistics purporting to show deaths related to hospital infections, Dr Alex Mayor, Consultant and Medical Director at Plymouth Hospitals NHS Trust, said’:

“This data is highly misleading and does not show what it claims. We absolutely refute it because:

It is not a true representation of the number of deaths from infections and that needs to be made abundantly clear. We cannot stress this enough – such misleading data only serves to unnecessarily frighten any patients coming into our hospital for treatment.”

We believe that the previous two statements regarding statistics must also be applied to those contained within the CIO SPCT Information Pack and those presented by the PCN to HASCOSC in May 2008.

We asked in early March 2008 via a District Councillor for current comparative data from the PCN of all the hospitals within the Peninsula Plan but this was refused under the umbrella of patient confidentiality.

The CIOSPCT information pack includes the following information which at best is limited at worst misleading.

‘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’.

There is no indication in the example above used to justify the removal of services from Cornwall by the CIOSPCT of the numbers required to qualify as a high volume centre.

We include for ease of reference our evidence from UK and USA journals which in some examples does give the number of cases needed to qualify as a high volume centre

■ **A systematic review of the impact of volume of surgery and specialization on patient outcome**

M. M. Chowdhury*, H. Dagash, A. Pierro

Conclusion: High surgeon volume and specialization are associated with improved patient outcome, while high hospital volume is of limited benefit.

Department of Paediatric Surgery, Institute of Child Health and Great Ormond Street Hospital for Children, London WC1N 1EH, UK

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■ **Comparing outcomes after transthoracic and transhiatal esophagectomy: a 5-year prospective cohort of 17,395 patients.**

Connors RC, Reuben BC, Neumayer LA, Bull DA

Controlling additionally for hospital volume showed high-volume centers (more than 10 esophagectomies per year) had significantly lower mortality rates than low-volume centers (10 or fewer esophagectomies per year, $p=0.024$).

Dept of surgery, University of Utah School of Medicine, Salt Lake city, UT 84132, USA **Am Coll surg 2007 Dec**: 205(6):735-40 Epub 2007 Sep 20

■ **Hospital volume does not influence long term survival of patients undergoing surgery for oesophageal or gastric cancer**

A.M. Thompson T. Rapson, F.J. Gilbert and K.G.M. Park, for the Scottish Audit of Gastric and Oesophageal Cancer

“There was no relationship between hospital volume and postoperative morbidity or mortality or between survival and volume of patients either for hospital of diagnosis or hospital of surgery.

Conclusion: This population-based study of oesophageal and gastric cancer suggests that the link between hospital volume and long-term survival for patients undergoing surgery requires re-evaluation.

Department of Surgery and Molecular oncology, University of Dundee, Dundee, Epidemiology and Statistics Group, Information and Statistics Division Edinburgh and Department of Radiology, University of Aberdeen and Department of Surgery, Aberdeen Royal Infirmary, Aberdeen, UK **BJS 2007, 94:578-584**

■ **Centralisation of oesophageal cancer services; the view from the periphery**

A.A. MILNE, J. SKINNER, G. BROWNING
Department of General Surgery, Victoria Hospital, Kirkcaldy

There is debate as to whether patients requiring resection for oesophageal cancer should be referred to specialist centralised units rather than being managed by general surgeons in district general hospitals (DGH). The aim of this study was to determine the effects of centralising oesophageal cancer surgery on

outcome and quality of service for patients with oesophageal cancer in a peripheral region.

In conclusion, survival rates are not necessarily improved by centralisation of oesophageal cancer surgery and quality of service may be poorer. **J.R.Coll.Surg.Edinb., 45, June 2000, 164-167**

The CIOSPCT have also included the table below. Again this is misleading as there is no indication at what stage the mortality (death) rates refer to

“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”

The figures above cannot be found in the paper cited and it is unclear how the CIOSPCT and the PCN arrived at them.

There appears to be no real consensus of opinion among the medical profession both here and abroad as to whether a high volume hospital produces better outcomes or whether it is the actual skill of the surgeon or indeed improved diagnostic procedures to enable earlier detection and better staging of the disease.

What is clear however is that operating on more than 10 patients a year is considered high volume for both hospital and surgeon as shown by articles in many current National and International Medical Journals

There is sufficient current clinical evidence that the RCHT provides a cancer service to the population in Cornwall that clearly meets National and International Standards and which on examination appears to indicate that the Cornwall and Isles of Scilly Primary Care Trust the Peninsula Cancer Network and the South West Strategic Health Authority are ignoring this evidence in the attempt to make a case for centralising UGICS services at PHNT.

There is evidence within the CIOSPCT information pack that the outcomes for some cancer patients in Cornwall may in fact be worse with the centralisation of cancer surgery at PHNT.

“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.” (Page 17 CIOSPCT Information pack 19 May 2008)

Dr Caroline Court
Consultant in Public Health
Cornwall and Isles of Scilly PCT

Felicity Owen
Medicine Director of Public Health
Cornwall & Isles of Scilly PCT
Cornwall County Council
Council of the Isles of Scilly
15 May 2008

THE PROPOSED PATIENT PATHWAY

Centralising UGICS or for that matter any other service out of county will disadvantage the population of Cornwall more than many other areas as Cornwall has one of the highest rates of deprivation within Europe with most areas within the county affected.

Although within the Peninsula Plan it is proposed that diagnostic assessment and post-op follow up care will be provided in Cornwall, the emotional and financial implications for the patient and family to have to travel to Plymouth for cancer surgery and to stay for a minimum of 11 days have not been properly addressed, despite claims that the CIOSPCT have made efforts to minimise the impact.

We are aware that at present patients who need open heart surgery and neurosurgery are only treated out of the county and are suffering the same hardships both emotionally and financially as the cancer patient may have to.

This does not make it right or acceptable to impose this on another group of vulnerable patients and the issue of centralisation for rural populations must be fully and urgently addressed. It should occur only for the truly very rare conditions.

“the patients themselves can find it very hard to get to and from the Cancer Centre. This may be a small issue for someone who is young and fit, but it is a big one for more elderly cancer patients”.

(Cancer World Nov – Dec 2005)

CARING FOR PATIENTS NEEDS

For those who are on low incomes or specific qualifying benefits or allowances there is a scheme which provides financial assistance but this only applies to travel costs.

The CIOSPCT say within their pack that they will explore whether it is possible from them to provide assistance to those suffering financial hardship.

We believe that this should have been explored and documented prior to these proposals for centralising UGICS services to PHNT being presented to HASCOSC in November 2007 and the fact that six months later they have still not done it shows serious flaws in CIOSPCT’s due consideration of patients’ needs.

PATIENT AND RELATIVE ACCOMMODATION

The CIOSPCT have kindly within their pack included information on the accommodation available for patients and relatives at PHNT with location, number of rooms available and the cost per night for single and double occupancy. What they have not done is show the financial implication for the average wage earner in Cornwall which results from centralisation of services.

Financial Implications to patients of centralisation

Earnings by residence (2007)

	Penwith (pounds)	South West (pounds)	Great Britain (pounds)
Gross weekly pay			
Full-time workers	350.6	433.4	459.0
Male full-time workers	362.1	480.0	500.7
Female full-time workers	334.3	364.2	394.8
Hourly pay			
Full-time workers	8.60	10.77	11.50
Male full-time workers	8.36	11.59	12.17
Female full-time workers	8.83	9.57	10.48

Source: ONS annual survey of hours and earnings - resident analysis

Average Inpatient stay for UGICS 11 days

Heartswell Lodge Plymouth

£35 single x 11 nights = **£385**

£47 double x 11 nights = **£517**

Average earnings in Penwith = **£350.60 minus £385 = minus £35**

Average earnings in S. West = **£433.40 minus £385 = £48**

We have not taken into account food for the relatives for the 11 day stay nor travel/parking costs. Neither have we taken into account the normal cost of maintaining their main residence.

During an in-patient stay at Derriford for surgery the average wage earner in Cornwall will find themselves in serious negative equity this will inevitably greatly increase their and their family's stress at an already difficult time.

The implications for patients travelling on public transport because of centralisation has been addressed by an article

Compiled by Eric & Rhoda Kirman

Appendix 1

AA based mileage chart for private transport

Appendix 2

As the cost of petrol/diesel is changing almost daily we have not included a costing within our mileage chart.

It should be noted that 20.5% of households in Cornwall does not own a car.

North Cornwall	17.1%
Penwith	27.0% (source 2001 Census)

We have also not quantified the increase in the carbon footprint due to the proposed centralisation of some cancer surgery services.

A COMMITMENT TO PROVIDING SERVICES CLOSER TO HOME

It is evident from the diverse and in some respects totally unrelated conditions that the CIO SPCT have included in this section that they are pulling out all the stops to justify their reasoning that centralising UGICS to PHNT is only on clinical grounds, which they have so far failed to show. Again they have used statistics, which we now know from previous statements within this paper, could well be unreliable.

Within their information pack the CIO SPCT have included a list of cancer specialties provided within Cornwall.

“Cancer specialities provided within Cornwall include the following:

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

Of the nine cancer specialities listed above, three of them Sarcoma, Skin and Brain/Central Nervous System (Neuro-oncology) are awaiting a decision from the PCN on whether they will be centralised following the recent publication of

IOG's concerning them. These three plus Children and Young peoples service were part of the presentation by the PCT/PCN to HASCOSC in November 2007 when they accepted the proposals in the report in its entirety as being not substantial.

This means no further action needs be taken by the CIOSPCT, in other words the CIOSPCT does not need to take this back to HASCOSC, they can if they want move them out of county tomorrow because HASCOSC agreed the proposals were not substantial.

Please note that although they are still provided within Cornwall the CIOSPCT list above does not include UGICS, H&NCS or CGCS which to us indicates that there is a determination that these services will go.

OTHER SPECIALIST TREATMENT UNDERTAKEN ELSEWHERE

We have already visited this in our earlier response under the patient pathway but it is important enough to restate here;

“We are aware that at present patients who need open heart surgery and neurosurgery are only treated out of county and are suffering the same hardships both emotionally and financially as the cancer patient may have to.

This does not make it right or acceptable to impose this on another group of vulnerable patients and the issue of centralisation for rural populations must be fully and urgently addressed. It should occur only for the truly very rare conditions”.

MOVING FORWARD

The CIOSPCT engagement process includes three select committee hearings when individuals or groups may engage in face-to-face discussions with key personnel representing NHS organisations or clinicians and three open question events one of each in Bodmin Truro and Penzance

The select committee hearings have been allocated a two hour time slot and the open question meetings one and half hours a total of ten and half hours over four days available for the public to express their concerns. This at first seems a reasonable amount of time just over one working day in three

locations allocated specifically to the centralisation of a cancer service out of the county.

This though needs to be put into perspective and compared to another recent engagement event hosted by the CIO SPCT

From the 16th April – 28th April 2008 the CIO SPCT along with NHS representatives from other organisations toured Cornwall to explain about the national 18 week Waiting Time Initiative.

A minimum of two hours was spent at each of these locations:

Bude Launceston Torpoint Liskeard Wadebridge Newquay
Redruth Falmouth Truro Par Hayle.

That is twenty two hours almost three working days in eleven locations to engage face-to-face with the public on a Waiting Time Initiative.

The time and the number of locations allocated to face-to-face public engagement on the centralisation of a cancer services out of the county hardly then seems adequate and gives a clear indication that the CIO SPCT is not really interested in what the patient or public feel or have to say about the centralisation of cancer services out of the county.

What has also not been addressed in the CIO SPCT information pack is the effect that centralisation has on a District General Hospital and other groups of patients when a service is removed.

IMPACT ON A DISTRICT GENERAL HOSPITAL WITH THE REMOVAL OF CANCER SURGERY

■ **GUEST EDITORIAL**

***Ann R Coll Surg Engl* 2007; 89: 335–336**

doi 10.1308/003588407X183265

The Royal College of Surgeons of England

Centralisation of upper gastrointestinal cancer surgery

“Although in all these settings, patients with more severe disease presentations will continue to be transferred to larger centres, it seems a very real risk that hospitals not designated as upper gastrointestinal cancer centres will face de-skilling of their surgical cadre and thus it seems unfair that organisational changes

designed to enhance outcome for one group of patients (cancer sufferers) may lead to disadvantaging of other groups of patients”.

Ajith K Siriwardena MD FRCS
Consultant Surgeon, Hepatobiliary Surgical Unit,
Manchester Royal Infirmary, Oxford Road,
Manchester M13 9WL, UK

■ **Specialist Centres**
Can surgeons heal the wounds?

Anna Wagstaff

“The pressures to remain as local as possible are obvious. Quite apart from the resentment among surgeons who are denied the right to treat cancer patients, hospitals feel threatened as their patient volume falls”

“As a result, some upper GI surgeons in district hospitals have withdrawn from diagnosing and staging cancers, which results in some patients having to travelfor minor procedures, such as staging laparoscopies or palliative bypasses”.

Cancer World November – December 2005

If UGICS is removed from RCHT and taken out of the county, over five years we have estimated that more than £2 million that should go to the Royal Cornwall Hospitals Trust (RCHT) will go instead to Plymouth

We believe that this estimated reduction in income for just this one service will make it very difficult for RCHT to expand its services, to attract future top quality personnel and for the new RCHT management to repay its historical debt.

There are real worries that the PHNT will not cope with the proposed increase in patient numbers from RCHT and RD&E if this centralisation goes ahead.

In 2007/08 PHNT cancelled 1,300 operations at short notice, how many more will need to be cancelled to cater for the increase in cancer surgical patients?

CONCLUSION

As we stated in our opening sentence in the introduction

“This document should not have to exist”

The reasoning for the centralisation of some cancer services is based on data that is now 10 – 20 years old and the Department of Health guidance as to whether UGICS needs to be centralised is nearly 8 years old.

Rural populations are recognised by the Improving Outcomes Guidance and the All Wales Cancer Steering Group but have been ignored by the South West Strategic Health Authority, Peninsula Cancer Network and Cornwall & Isles of Scilly Primary Care Trust.

To justify the centralisation of UGICS from Cornwall to Plymouth the CIOSPCT and the PCN have used figures of outcomes between cancer centres in Cornwall and Devon produced by the South West Public Health Observatory (SWPHO) which the SWPHO have themselves stated are statistically insignificant in comparing services from the three cancer centres within the Peninsula.

Data from a medical journal used by the CIOSPCT to show mortality rates by operation volume cannot be found in the paper cited.

Hospital population figures used by the CIOSPCT are skewed and therefore not relevant.

The CIOSPCT and the PCN failed to engage with the relevant cancer patient groups, the public, the stakeholders on the Reference Group or even their own Patient and Public Information Forum prior to the proposals for removing several cancer surgery services from Cornwall to Devon presented to HASCOSC in November 2007 and are now, only as a result of public protest, holding token meetings to explain why they made their decision to remove some cancer surgery from RCHT to Devon.

It is unclear whether HASCOSC were aware that in October 2007 the RD&E had challenged the removal of the UGISC to PHNT and that without the

RD&E UGICS patients going to PHNT the Peninsula would still not be compliant with the IOG of a 1 – 2 million population base.

It is also unclear whether HASCOSC, when they made their decision in November 2007, that the removal of several cancer surgery services to be completed by August 2008 and for possibly other cancer services when ratified to be removed from RCHT as unsubstantial, were aware that their counterparts in Devon had in October 2007 found that the removal of just one cancer service from RD&E to PHNT was substantial and had called for a full public consultation which we understand has been suspended to consider other options

The HASCOSC minutes of the meeting in November 2007 at which these centralisation proposals were first presented and agreed to as being not substantial, give no indication of the level of scrutiny carried out by the committee that allowed them to make that decision.

Centralisation of any NHS service is always going to cause outrage in a local population, none more so than when that population is rural, sparsely populated and in many respects isolated.

Cornwall, as a rural sparsely populated and relatively isolated county is also in the unfortunate position of being one of the most deprived areas in Europe, with a weekly wage well below the national average.

The population of Cornwall is one of the fastest growing in the country with above national average of those over 60 and this age group is predicted to increase by 80% over the next 20 years.

It is in this age group that unfortunately cancer is most likely to occur. This is also the age group of people that would find it the most difficult to travel long distances as would their loved ones and friends.

Centralising services out of Cornwall causes more hardship and emotional stress for its population than it would in many other areas of the country including large parts of Devon.

Many households in Cornwall are without their own transport and are poorly served by public transport, which is also expensive.

The majority of the population are very pleased with the services provided by the RCHT with 93% confirming that they thought the services were excellent very good or good.

Cornwall has an excellent Cancer Centre with much of the buildings and equipment provided by funds raised by the people.

Within the RCHT there are Multi-Disciplinary Teams (MDT) for all cancer patients with Specialist Surgeons, Oncologists, Physicians, Radiologists, Cancer Nurse Specialists, Dieticians, Physiotherapists, Palliative Care Specialists, Nurse Practitioners, and where appropriate a Speech Therapist.

If UGICS and possibly other cancer surgery care services are removed there is a real danger of deskilling of the work force, a loss of other services and the inability to recruit top class personnel in the future.

“I hope we can find a solution to this that keeps an excellent service operating locally, rather than centralising in Plymouth”.

Alan Johnson Secretary of State for Health in Exeter April 2008

“The same solution needs to be implemented in Cornwall”

Keep Cancer Care in Cornwall Campaign May 2008

RCHT CANCER PATIENTS AND CARERS GROUP

**REPORT ON TRAVELLING OUT OF CORNWALL TO
DERRIFORD HOSPITAL, PLYMOUTH BY PUBLIC TRANSPORT**

1. Travel by train

- (a) Patient and carer have to travel from their home to the station in Cornwall from which they are to commence their journey. If they cannot afford a taxi, this will have to be by bus and, of course, there are still some places in Cornwall that do not have a regular bus service. Some bus journeys will necessitate a change for the patient and carer, which involves humping luggage on and off buses.
- (b) The journey from Penzance to Plymouth is 2 hours; from Truro is 1 hour and 10 minutes and St Austell just under an hour. These, of course, only hold good if the train is not delayed and First Great Western have the worst record for time-keeping of any train operator in the United Kingdom! A cancer patient does not have good balance and the trains move quite fast and do not ride well, making it extremely difficult for the patient to get up to use the toilet and indeed to 'stretch their legs'. It should also be remembered that from May to the end of September is the holiday season when the trains get very crowded. The patient and carer need, therefore, to book **RESERVED SEATS** on the trains for both journeys. APEX seats will probably be of no assistance to them as these usually specify one particular train outward and return journeys and, of course, whether they can keep to the times given, particularly on the return journey, will depend upon what time they can leave Derriford. There is also the added problem of whether or not the patient is wheelchair bound. If this is the case, assistance will be required for boarding and alighting from the train and wheelchair accommodation and assistance needs to be booked well in advance.
- (c) From Plymouth the patient and their carer again need either a taxi or to travel by bus. From Plymouth the bus journey necessitates a bus into the centre of Plymouth, getting off at Royal Parade. From Royal Parade there is a Citybus that goes to Derriford, which is quite a long way from the City Centre.
- (d) All this is very tiring for the patient and puts a strain on the carer, who worries about how the patient is going to withstand the journey and what problems they will encounter.

- (e) Problems can also arise for the carer in that they have to see the patient settled into the ward at Derriford and then make their way home if there is a train that can get them back into Cornwall that day. Problems can also arise in that when they get back into Cornwall they may not be in time for a bus to take them back to their home and so they are forced to take a taxi. If there is no train back into Cornwall at the time they need, they will have no alternative but to stay in Plymouth overnight.
- (f) There is also the question of food and drink on the journey. This would mean finding somewhere to eat in the centre of Plymouth or taking food with them. On many of the trains catering does not start until the train reaches Plymouth.
- (g) Train times from Penzance to Plymouth and return are:

Dep. Penzance	Arr. Plymouth	Dep. Plymouth	Arr. Penzance
05.42	07.44	14.41	16.36
06.43	08.49	15.10	17.10
08.45	10.38	17.22	19.22

- (h) Train times from Truro to Plymouth and return are:

Dep. Truro	Arr. Plymouth	Dep. Plymouth	Arr. Truro
06.20	07.44	14.41	15.54
06.43	07.27	15.10	16.22
09.26	10.38	17.22	18.38

- (i) Train times from St Austell and return are:

Dep. St Austell	Arr. Plymouth	Dep. Plymouth	Arr. St Austell
06.37	07.44	14.41	15.37
06.43	07.44	15.10	16.05
09.47	10.38	17.22	18.21

- (j) Fares, all based on an standard open return and upon the patient needing to stay in Plymouth for more than one day are:

Penzance to Plymouth	£26.00
Truro to Plymouth	£23.20
St Austell to Plymouth	£21.80
Penzance to Exeter	£67.80
Truro to Exeter	£60.80
St Austell to Exeter	£50.30

If the patient has a Senior Railcard or a Disabled Railcard they get 34% discount. It would be possible for the carer to do it on the basis of a Day Return if they do not need to stay with the patient overnight, which would be cheaper.

The times given are from the current timetable but a new timetable is due out in May and there may be changes to times. They are to illustrate journey times. The times also depend upon the train not being delayed and First Great

Western have the reputation of being the worst train operator for late-running trains!

It should be remembered that the journey times will be longer where patients have to make a train journey on a branch line in order to join the mainline service, e.g. from St Ives, Falmouth. The train times from Bodmin Parkway have not been listed but these are shorter journeys than from St Austell. There is a direct train service from Newquay to Plymouth.

2. Journey by National Express

For a patient to do the journey by National Express is not recommended as the journey from Penzance takes three hours and 70 minutes, from Camborne three hours and thirty eight minutes, from Redruth three hours and ten minutes, from Truro takes two hours and thirty-five minutes and that from St Austell takes two hours. This is a lot of sitting without being able to move about and very tiring for the patient. This journey would be very awkward, if not impossible, for a wheelchair patient. Comfort stops can also be a problem. Again the question of food arises. The National Express coaches go into Plymouth Bretonside bus station and again the patient and carer would have to either take a taxi or get a bus on to Derriford Hospital.

3. Journey by ordinary bus

This is absolutely out of the question since, on the journey from Newquay to Plymouth alone; the passenger is required to do three changes of bus as the new regulations that have just come into force state that this has to be done to prevent driver fatigue.

4. To sum up, it is felt that to ask patients to make journeys of this sort to go for cancer treatment is very unreasonable. It is tiring, not good for them because they have to sit around and can, therefore, run the risk of DVT's, and many cancer patients are already taking medication that makes them feel nauseated and often sick. Also there are many people who suffer from travel sickness and the last thing any cancer patient needs when they are going into hospital is to spend the journey in misery.

5. There is another factor that must be borne in mind. Someone has to pay the cost of the patient and their carer's journey to Plymouth or Exeter. If the County Council, Primary Care Trust and Strategic Health Authority want to move cancer care out of Cornwall, are they prepared to pay the travelling expenses for the patient and their carer? It is totally unreasonable to expect patients to pay for transport to Plymouth or Exeter to have an operation that has previously been performed in Cornwall. If not, this is another case of discrimination against cancer sufferers from Cornwall.

**Compiled by:
Eric and Rhoda Kirman
18th April 2008**

APPENDIX 2

AA route distances: Cornwall/Devon

<u>Exeter</u>	to	<u>Derriford</u>	<u>45.04 miles</u>
<u>Bude</u>	to	<u>Derriford</u>	<u>49.10 miles</u>
<u>Bude</u>	to	<u>Treliske</u>	<u>54.30 miles</u>
<u>Bude</u>	to	<u>Exeter</u>	<u>56.10 miles</u>
<u>Liskeard</u>	to	<u>Derriford</u>	<u>19.20 miles</u>
<u>Liskeard</u>	to	<u>Treliske</u>	<u>36.90 miles</u>
<u>Liskeard</u>	to	<u>Exeter</u>	<u>60.90 miles</u>
<u>Bodmin</u>	to	<u>Derriford</u>	<u>31.07 miles</u>
<u>Bodmin</u>	to	<u>Treliske</u>	<u>27.00 miles</u>
<u>Bodmin</u>	to	<u>Exeter</u>	<u>68.00 miles</u>
<u>Launceston</u>	to	<u>Derriford</u>	<u>25.20 miles</u>
<u>Launceston</u>	to	<u>Treliske</u>	<u>49.30 miles</u>
<u>Launceston</u>	to	<u>Exeter</u>	<u>42.70 miles</u>
<u>St. Austell</u>	to	<u>Derriford</u>	<u>39.30 miles</u>
<u>St. Austell</u>	to	<u>Treliske</u>	<u>16.70 miles</u>
<u>St. Austell</u>	to	<u>Exeter</u>	<u>76.00 miles</u>
<u>Truro</u>	to	<u>Derriford</u>	<u>52.90 miles</u>
<u>Truro Centre</u>	to	<u>Treliske</u>	<u>3.00 miles</u>
<u>Truro</u>	to	<u>Exeter</u>	<u>88.50 miles</u>
<u>Penzance</u>	to	<u>Derriford</u>	<u>77.50 miles</u>
<u>Penzance</u>	to	<u>Treliske</u>	<u>24.80 miles</u>
<u>Penzance</u>	to	<u>Exeter</u>	<u>111.00 miles</u>
<u>St. Just</u>	to	<u>Derriford</u>	<u>85.10 miles</u>
<u>St. Just</u>	to	<u>Treliske</u>	<u>32.50 miles</u>
<u>St. Just</u>	to	<u>Exeter</u>	<u>118.60 miles</u>

When does guidance become a command? The dangers of moving from the general to the specific.

D.P.Blight.

The proposal by the PCT to implement an interpretation of the Calman-Hine report despite the doubts of a large segment of the population of Cornwall, prompts a consideration of the background and intention of that report.

The report is dated April 1995, and claims to be “Guidance for purchasers and providers of Cancer services.” Since then the national Cancer Reform Strategy has been published, which, while nodding in passing at Calman-Hine, places much importance on the delivery of care locally, to maximise patient convenience. This is, presumably, also a guidance document, but the importance of local care, easily accessible to patient and family, has been ignored. In an earlier paper* the writer outlined some of the problems of access to a remote hospital on the far extreme of the area concerned.

The intentions of the authors of the Calman-Hine Report would be most readily understood by asking them directly. However, there seems to be a reluctance to do this, and, instead, the intentions can be deduced from a study of the papers appended to the report. Many, but not all, of these can be obtained from the Internet, either in complete or in resume form. Others can be read as later versions of the original paper with additional material. Of the documents listed in Section 7, the bibliography to the main report, only Stiller was available. This paper claims, modestly enough, “Centralised referral or entry to trials was frequently associated with a higher survival rate, particularly for the less common cancers, and was never found to be associated with a lower survival rate.” The other documents in the bibliography appear to be generalised, not research, reports.

Calman-Hine proposes a three tier structure for cancer services: -

1. Primary care.
2. Designated Cancer Units at district general hospital level supporting teams capable of managing the commoner cancers.
3. Designated Cancer Centres managing all cancers, including common cancers within their immediate geographical vicinity, and less common cancers by referral from cancer units. The Centres will provide radiotherapy. However, radiotherapy may be continued in some hospitals because of their distance from a Cancer Centre (5.2)

The report also indicates that services should be planned to minimise travelling times whilst maintaining the highest standards of specialist care, using local expertise and agreed protocols. The point at issue is the translation of the

* Blight, D.P: Proposal to make Derriford the sole centre for certain cancer operations in the Southwest. Note prepared for Cornwall and Isles of Scilly Cancer Patient and Carers Group. 2008

general principles governing Cancer Centres outlined in the report, to the specific requirements of a scattered and isolated community.

The first point to arise from a study of the research reports is the thin and rather vague nature of the evidence. Some authors' names appear on several papers, suggesting some over-influence. The publication lists of others show interests in a wide variety of topics. A list of the papers studied, together with an opinion on their relevance to the question of specialist Cancer Centres is given in the appendix to this paper. Many of the papers seem to have little or no relevance to the topic under discussion. One shows that patients carrying health insurance have better outcomes than those without because they present earlier. With the delays inherent in the NHS, this might argue against the Centres. Other papers show that the better educated and the wealthier have better outcomes than do the poor and ill-educated. One investigates the effect of marital status on the outcome (it had no effect). Other papers conclude that outcomes are marginally better in larger hospitals than in smaller ones (size not specified, but one Scandinavian survey refers to surgeons performing one to three resections in a two-year period).

The definition of a specialist surgeon is itself obscure, being attempted only in papers published after Calman-Hine. One of these defines a specialist as one who sets up a dedicated clinic, has a defined association with pathologists and oncologists, and organises and facilitates clinical trials as well as maintaining a separate records system of all cancer patients in his unit's care. Another describes a specialist as one who performs six or more resections in a year. However, it is clear from the papers selected that Calman-Hine were anxious that cancer operations should not just be another task for the general surgeon, along with appendectomy, hernia, etc., but should be undertaken by specialist surgeons. They suggest that a specialist centre should serve a population of no less than about 660,000. This is the general proposal. The implementation of the recommendations (note: not "instructions") is given in Section 5 of the report. This states quite clearly (5.1) that "decisions will have to be taken forward in the light of local circumstances and take account of the views of patients and their carers as well as the professionals involved... Account should be taken of geographical constraints."

In applying the Calman-Hine principles (formulated 13 years ago), with the strengthening of the National Cancer Reform Strategy's requirement for care to be provided near to the home when possible, the geographic conditions presented by Cornwall demand careful study. Travel is a particular concern. Cancers are particularly likely to strike the elderly. Their spouses, also elderly, will probably have health problems of their own, making travelling any distance a daunting prospect. Younger patients may have children, with attendant problems of childcare, maintaining schooling, even seeking temporary accommodation for them during operation and convalescence.

Discussion has recently opened on the undesirable side effects of applying "guidelines" strictly, in cases of hypertension and of type 2 diabetes. It is argued that the patient could be harmed if treatment were pursued to meet all the 'markers' which the guidelines demand. This opens up a wider discussion into the translation of general principles outlined in guidelines, to specific applications. The lazy way would be to apply the letter of the guidelines to any circumstance and try to rely on the

excuse that that was what was prescribed. It is unlikely that this will always be in the best interests of the patient, and, indeed, in the extreme case of Cornwall, will certainly act against the interests of the patient by adding extra worry, and the expense of extra travelling and accommodation, unless the patient is left to survive or die on his own because other arrangements were not possible, or too expensive. The concept of a Centre having specialist teams is unexceptional, but there needs to be flexibility in the arrangements made, or the distress caused to patients, spouses, family and carers alike will far outweigh the unquantified advantages of remote centralised treatment.

This analysis, both of the original Calman-Hine report and the research on which it is based, suggests that the concept of a “Centre of Excellence”, otherwise a Cancer Centre, with emphasis on specialist treatment, has been inflated by those concerned with its implementation, beyond the original intention. The staffing and costs of the proposed centre, however, seem not to have been publicised. The argument against making Treliske a Cancer Centre might be the size of the ‘catchment area’. With a population of over 500,000, Cornwall is close to the lower limit proposed by Calman-Hine, and this paper urges some flexibility in this number, proposed originally by the Royal College of Radiologists. Once a number is written down it becomes vested with almost magical powers, irrespective of the arbitrary manner in which it was originally obtained. If numbers become inflexible, it would be easier for patients to travel from Plymouth to Truro, than from central or west Cornwall to Plymouth.

There is the further point as to whether Derriford can take on extra work. It has been reported that in February 2008 146 operations were cancelled within 24 hours of being due to go into theatre. Over 86 percent of operations were rescheduled for treatment within 28 days. Failure on this scale will take much time to put right. To transfer life-threatening work to such an organisation from one which can currently deal with it is alarming.

It is clear from examination of the papers on which the Calman-Hine report is based that the intention of the authors was to take cancer surgery away from a branch of general surgery and into the hands of specialists. There is no intention of a ‘gold-plated’ service with elaborate organisation. The report also provides for developments to be fully evaluated in their first few years to ensure that they are effective.

The lack of the degree of consultation recommended by the report, and the lack of consideration of the particular geographic constraints of Cornwall together with the briefing paper, which could be considered inadequate, circulated to the overview and scrutiny committees, suggest that inadequate thought and attention has been given to this matter. No figures are given of the likely improvement in outcomes to be expected from the proposals, nor even an outline of the size and staffing of the proposed centre. The guidelines are being treated as an instruction.

In the whole of this exercise the difficult problems have been side-stepped. Guidelines represent the ideal solution in an ideal world. In a less than ideal world it is necessary to make compromises to suit particular conditions. Guidelines are a basis for thought and discussion, not a substitute for them. For critics to be assured that the best interests of patients and carers are served, evidence is necessary of a much closer scrutiny than has been provided, of the impact on patients, spouses, families, and

carers, of the difficulties, worries and the expense, both to families and PCT, of requiring the transport of sick people to a relatively remote hospital.

Appendix.

Analysis of some of the papers appended as references to the Calman-Hine report, and indicating the topics dealt with. Authors' names are given for the identification of the paper under consideration. The full reference is found in the Calman-Hine report.

1. Insured breast cancer patients present earlier than non-insured patients and thus have a better survival rate. The relevance of this to the current NHS debate is difficult to establish, unless it leads to a conclusion that the delays encountered in NHS treatment put patients at greater risk than insured patients. (Ayanian, Kohler, Abe. Et.al.)
2. Race (white vs. non-white) was not a significant predictor of survival time, but income and education and education were. Again, the relevance to the current debate is unclear. (Cella, Orav, Kornblith, et al.)
3. Participants in prospective randomised clinical trials for re-sected non-small cell lung cancer have improved survival compared with non-participants. This, presumably, argues in favour of having enough patients for such a trial (Davis, Wright, Schulman.)
4. The mortality rate for pancreas re-section in American University Centres 1989-90 did not correlate with caseload. Surgeons performing one to three resections in the two-year period had significantly more complications than those performing four or more over the same period. This can scarcely be considered a heavy load, and is surely irrelevant to the current discussion. (Pancreatic cancer resection outcome in American University Centres 1989-90)
5. The paper on the selection of oesophagectomy and postoperative outcome in a defined population (Gulliford, Barton, Bourne) does not deal with treatment in specialist centres, and is thus not of relevance here.
6. "Hospital variables associated with quality of care for breast cancer patients" concludes "The findings suggest that there is a group of urban hospitals, generally small and marginally reimbursed, where comprehensive diagnoses and treatment of breast cancer are not obtained." This, surely, applies to community-type hospitals, and not those the size we are considering here. (Hand, Sener, Imperato et al.)
7. A study of patients with multiple myeloma in Finland concluded that the results favour a systematic treatment schedule in preference to a schedule determined by a free choice of a clinician. Again, it seems aimed against a community-sized hospital in favour of a larger hospital. Not relevant to the current discussion. (Karjalainen, Palva.)
8. Colorectal surgeons in district general hospitals produce similar survival outcomes to their teaching hospital colleagues. Presumably the district general hospitals were large; this argues against the siphoning-off of patients to other centres. (Kingston, Walsh, Jeacock)
9. Patients living at a distance from a specialised health care centre were diagnosed at a later stage, and survival was poorer. This suggests that easier access to the centre would have had a better outcome. (Launoy, Le Coutour, Gignoux, et al.)
10. The paper on the impact of variability among surgeons on post-operative morbidity and mortality was not available. However, a later paper by the one of

the authors argues in favour of specialist surgeons. This does not affect the current argument. (McArdle, Hole)

11. One paper aimed “to investigate whether the survival of women with cancer of the uterine cervix is associated with their marital status and social class”. This is scarcely relevant to the current discussion. (Murphy, Goldblatt, Thornton-Jones, et al.)
12. “It is recommended that patients are referred to units with an interest in breast cancer rather than to general surgical out-patients.” This is not an argument for taking away patients from a hospital that has such a unit. (Sainsbury, Rider, Smith, et al.)
13. The cited papers by Gillis and Gillis and Hole were not available. However, a later paper by Gillis and Hole: Survival outcome of care by specialist surgeons in breast cancer: a study of 3786 patients in the west of Scotland BMJ 1996; 312: 145-148 (20 January) argues in favour of specialists, but hesitates in defining a specialist. Ultimately they decide that specialists are “characterised by their setting up dedicated breast clinics, having a defined association with pathologists and oncologists, and organising and facilitating clinical trials as well as maintaining a separate records’ system of all breast cancer patients in their unit’s care.”
14. An indication of the definition of Specialisation” may be obtained from Weil; Munday: Letters BMJ 1994; 308: 1103 (23 April) A ‘Frequent Operator’ is defined as one who performs six or more oesophageal cancer resections in a year.

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Cancer Funding for Cornwall

'Pants Matters' - Gynae Support Group

'Let's do lunch' Head & Neck Cancer Support Group

The Keep Cancer Care in Cornwall Campaign is supported by

Glyn White	Chair	Mayor's Parlour Campaign Team
Caroline Rowe	Chair	LOF West Cornwall & Poltair Hospitals

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