Board of Directors Meeting

Date: 31 October 2007

Agenda item: 7.2 Part 1

Title: Peninsula PCT’s Proposal to Centralise Upper GI cancer Surgery at Plymouth Hospitals NHS Trust

Prepared by: Matthew Bryant, Tawfique Daneshmend, Saj Wajed, Martin Cooper, Richard Berrisford, Angela Pedder

Presented by: Angela Pedder Chief Executive

Action required: The Board is asked to:

- note the proposal made by the Peninsula PCTs
- note RD&E’s response
- endorse the steps that are being taken via the Devon Health Overview and Scrutiny Committee to ensure the proposals are subject to full public consultation
- confirm commitment to continuing to provide Improving Outcomes for Cancer Guidelines compliant Upper GI cancer surgery at the RD&E
- agree to formally challenge the Peninsula PCTs proposals for centralisation

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1. PURPOSE
1.1 The Peninsula PCTs have proposed Upper GI cancer surgery should be centralised at Plymouth Hospital NHS Trust and from 2010 the RD&E should cease to be commissioned to provide this service. This paper sets out the background to the proposal and the reasons why the proposals are not robust, and sets out the implication of the proposals for the care and treatment of patients.

2. BACKGROUND
2.1 The 4 PCTs in the south west peninsula are proposing the centralisation of upper gastrointestinal (GI) cancer surgery services at Plymouth Hospitals NHS Trust. The Royal Devon and Exeter NHS Foundation Trust believe the proposals are flawed and will have a significant detrimental impact on the care and treatment of patients from Exeter, East Devon, Mid Devon and North Devon.

The PCTs have suggested the proposals to centralise upper GI cancer surgery in Plymouth are minor in nature, affecting a small number of patients and consequently there is no requirement to proceed to a full consultation. The RD&E contests this view and believes the potential implications of the proposals are significant for large numbers of patients in the Exeter, East Devon, North Devon and Mid-Devon areas, and are not limited to those patients who are directly referred to the upper GI surgeons offering this type of surgery. The proposal will result in the cessation of the only established total Minimally Invasive Oesophagectomy (MIO) key hole surgery service in the United Kingdom and therefore dismantle a team at the forefront of surgical innovation for patients with upper gastrointestinal cancer. The Royal Devon and Exeter NHS Foundation Trust is wholly committed to providing the highest quality patient care that is in line with available national guidance and standards. We believe that our service is compliant with the national Improving Outcomes Guidance (IOG) for Upper Gastro-intestinal cancer and delivers some of the best outcomes for oesophageal cancer patients of any surgical centre in the United Kingdom, as we shall demonstrate below.

This briefing paper set out the areas of concern that have been raised by the Trust, Appendix 1, and has been developed to assist the Devon Overview and Scrutiny (O&S) committee with its consideration of the proposals to change the service delivery arrangements for this important cancer service.

3. KEY ISSUES
3.1 • There has been no public consultation or engagement process to seek the views of local people on this service change;
• The Exeter centre is fully compliant with the Improving Outcomes Guidance and its clinical outcomes and mortality figures are better than the proposed centre;
• Currently, there is an outstanding unit with an international reputation providing upper gastrointestinal cancer surgery at Exeter;
• If centralisation is to be considered, then this should be on the basis of proven clinical outcomes and compliance with standards;
The Exeter service has a proven track record of clinical innovation and improvement and can offer the very latest surgical techniques. It is the only centre in the UK offering a totally Minimally Invasive Oesophagectomy (MIO) service;

It will be impractical for the MIO service to transfer to Plymouth as the post-operative care for these patients requires the ongoing presence of one of the operating surgeons, and is incompatible with retention of a commitment to provide other surgical services in Exeter;

If the surgeons who have developed this service are made to stop providing upper GI cancer surgery, advances in minimally invasive upper digestive cancer surgery would be set back for the country as a whole;

The RD&E is a centre of clinical excellence for upper digestive cancer surgery and is providing this within national tariff arrangements; there is no financial advantage for the healthcare system in making this change;

There is currently no proven expertise in minimally invasive upper GI cancer surgery within the Peninsula other than in Exeter. Centralisation to a single centre in Plymouth will deprive patients in the Peninsula of a choice to have their cancer removed by minimally invasive operation;

The impact of the arrangements for patients travelling may be considerably larger than acknowledged thus far. This is a real disadvantage to patients and their relatives, who may have to bear the cost of additional travel;

There is no reason why a two-centre solution cannot be commissioned;

If a single site solution is endorsed then Exeter is well placed to provide that service and offers a wider range of treatment options than Plymouth;

The time and cost involved in consultants travelling around the Peninsula is likely to be prohibitive and may create a significant financial risk that has not been accounted for;

The withdrawal of the service from Exeter may have a detrimental impact on other surgical services and in time result in further service rationalisation;

The Royal Devon and Exeter Hospital has a high reputation for innovation, safety, and patient centred care. Commission for Healthcare Improvement and Healthcare Commission annual health checks over the last seven years have consistently rated the quality, service and financial performance of RD&E ahead of those provided by any other acute trust in the southwest peninsula.

4. PROPOSALS

4.1 It is proposed the RD&E should:

- Challenge the decision of the Peninsula PCTs and, via the Devon Overview and Scrutiny Committee, seek to ensure there is full public consultation on the proposals;
- Work with members and local people, specialist local and national patient groups, and GPs, via the local Medical Committee, to oppose the proposal to centralise upper GI cancer surgery in Plymouth.

5. FINANCIAL/OTHER IMPLICATIONS

The financial impact of these proposals cannot be assessed until more detail is provided by the PCTs; the service implications are detailed in the supporting paper.

6. RECOMMENDATIONS

The Board is asked to:

- note the proposal made by the Peninsula PCTs;
- note RD&E’s response;
endorse the steps that are being taken via the Devon Health Overview and Scrutiny Committee to ensure the proposals are subject to full public consultation;
confirm commitment to continuing to provide Improving Outcomes for Cancer Guidelines compliant Upper GI cancer surgery at the RD&E;
agree to formally challenge the Peninsula PCTs proposals for centralisation.
1. INTRODUCTION

The Overview and Scrutiny (O&S) Committee is being asked by Devon PCT to endorse a set of proposals agreed between the 4 PCTs in the southwest peninsula for the centralisation of upper gastrointestinal (GI) cancer surgery services at Plymouth Hospitals NHS Trust. The Royal Devon and Exeter NHS Foundation Trust believe the proposals are flawed and will have a significant detrimental impact on care and treatment of patients from Exeter, East Devon, Mid Devon and North Devon.

The PCTs have suggested the proposals to centralise upper GI cancer surgery in Plymouth are minor in nature, affecting a small number of patients and consequently there is no requirement to proceed to a full consultation. The RD&E contests this view and believes the potential implications of the proposals are significant for large numbers of patients in the Exeter, East Devon, North Devon and Mid-Devon area, and are not limited to those patients who are directly referred to the upper GI surgeons offering this type of surgery. The proposal will result in the cessation of the only established total Minimally Invasive Oesophagectomy (MIO) (key hole surgery) service in the United Kingdom and therefore dismantle a team at the forefront of surgical innovation for patients with upper gastrointestinal cancer. The Royal Devon and Exeter NHS Foundation Trust is wholly committed to providing the highest quality patient care that is in line with available national guidance and standards. We believe that our service is compliant with the national Improving Outcomes Guidance (IOG) for Upper Gastro-intestinal cancer and delivers some of the best outcomes for oesophageal cancer patients of any surgical centre in the United Kingdom as we shall demonstrate below.

This briefing paper has been developed to assist the O&S committee with its consideration of the proposals to change the service delivery arrangements for this important cancer service.

2. WHAT IS UPPER GASTROINTESTINAL CANCER SURGERY?

Upper GI cancer surgery involves operating on peoples’ chest and abdomen with the aim of curing cancer affecting the upper digestive tract. This type of cancer affects the oesophagus (gullet), stomach and pancreas. In the United Kingdom, the number of upper GI cancers of this kind has been rapidly rising over the past three decades. In 1994, the incidence of upper gastro-intestinal cancers was 50 per 100,000 for men and 35 per 100,000 for women, in 1997 upper gastro-intestinal cancers accounted for 13.5% of all cancer deaths.1 These cancers are usually divided into two groups and treated by separate teams which may be based in separate hospitals. Cancers of the oesophagus and stomach are treated together by a specialist oesophago-gastric team; the smaller number of pancreatic cancers are treated by a separate pancreatic team. For simplicity within this document, we will use the term Upper GI cancer to refer to oesophago-gastric cancers and the work of the specialist multi-disciplinary team treating them, and identify pancreatic cancer separately when discussing its treatment and the guidelines associated with it. For an area such as Devon Primary Care Trust (covering a population of around 750,000) this means that there might be

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in the region of 76 new oesophageal cancers and 123 gastric cancers per year.\(^2\) The numbers may actually be higher than this in Devon due to the elderly population being greater than the national average and the increased incidence of cancer in an ageing population. The reasons for the increasing incidence of upper GI cancer are unclear, however, increasing numbers of patients in the South West Peninsula are developing this type of cancer. It affects patients from middle age onwards, many of whom present with surgically curable disease.

Upper GI cancer surgery aims to remove the entire gullet or the part of the stomach affected with cancer in order to achieve a cure. The operations performed include oesophagectomy (removal of the gullet) and gastrectomy (removal of the stomach, either whole or in part). Traditionally these operations are performed through large incisions, using an open surgical approach. More recently, surgeons at the RD&E have pioneered a key-hole (laparoscopic) method of removal of the gullet, with enormous benefits to patients, (this operation is termed Minimally Invasive Oesophagectomy (MIO)). The national average 30-day mortality rate for oesophagectomy surgery is 9%; a peer reviewed study accepted for publication in the British Journal of Surgery confirms the inpatient mortality rate for MIO surgery at the RD&E is 1%.\(^3\)

3. BACKGROUND AND CURRENT CONFIGURATION OF UPPER GI SERVICES IN EXETER

The Royal Devon and Exeter Hospital has a long history of providing upper gastrointestinal surgery, as well as pioneering innovation in the management of these types of cancer. Three decades ago, the RD&E was the first hospital in Britain to establish Selectron for radiotherapy for carcinomas of the gullet. In the late 1980s and early 1990s oesophago-gastric surgery was undertaken by a thoracic surgeon (Mike Pagliero) and an Upper GI surgeon (Martin Cooper). A decision was made at that time to centralise thoracic surgery in Plymouth, but the oesophago-gastric cancer work continued in Exeter with the lung surgery moving to Plymouth. This experience of a centralised thoracic service led to poor standards of care and a failure to deliver timely treatment and support to patients. As a result of this experience a decision was made to re-establish thoracic surgery in Exeter in 1996. This service now provides high quality surgery to the population of Exeter, East Devon, Mid Devon and North Devon and the quality of clinical outcome of the service available has been warmly commended at every Royal College of Surgeon inspection visit since that date.

The upper GI service has continued to develop and following the appointment of Saj Wajed as an additional upper GI surgeon in Exeter in 2004, he and Richard Berrisford have collaborated successfully and pioneered the introduction of keyhole surgery for gullet cancer (MIO) in Britain. The team based at the RD&E is now recognised internationally for these unique surgical skills and the enormous benefit they have brought to patients. The benefits in terms of reduced post-operative mortality from this procedure have already been described above; however, there are significant and even more dramatic benefits in terms of the quality of life of patients after surgery. With open oesophagectomy, and partial key hole surgery, recovery time for patients (of whom a third are on average in their seventies and eighties\(^4\)) is between nine and twelve months; with MIO surgery, patients normally regain a pre-operative quality of life within three months.

The RD&E has led the development of this surgical technique in the United Kingdom, and for the past two years has organised a training course for over sixty surgeons from across the

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\(^2\) Based on incidence per 100,000 described in Improving Outcomes Manual (as above), p. 7

\(^3\) Berrisford RG, Wajed SA, Sanders D, Rucklidge MWM, Early outcomes after total minimally invasive oesophagectomy, British Journal of Surgery 2007 (in press), accepted for publication June 2007

\(^4\) This figure is taken from a study by JS Rahamim, GJ Murphy, Y Awan, M Junemann-Ramirez, The effect of age on the outcome of surgical treatment for carcinoma of the oesophagus and gastric cardia (European journal of cardio-thoracic surgery May 2003, pp. 805-810) which looked at a series of 596 patients undergoing gastro-oesophagectomy in Plymouth between 1979 and 1999, of whom 199 were aged between 71 and 89 years. The 30 day post operative mortality for all patients between 1993 and 1999 was 6%.

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country. The course is recognised by the national Association of Upper Gastro-Intestinal Surgeons (AUGIS), and subsequent mentoring arrangements have been offered to encourage dissemination of MIO surgery to other specialist UK centres in the future.

The RD&E service has been externally assessed by the National Cancer Action Team for the compliance of its upper GI cancer service with the national guidelines set out in the Improving Outcomes Manual, and was found to be 93% compliant with the mandatory national standards (and 90% compliant with the developmental standards). The visiting team praised the “detailed audit and good professional development of the minimally invasive service”\(^5\). In contrast, the Plymouth service achieved a score of 86% for the mandatory standards and 81% for the developmental standards.

In summary therefore, a clinically safe and valued local service for upper digestive cancer has been provided from the Exeter site for many years. The local service has a history of excellent clinical outcomes and has been commended by the Royal College of Surgeons, the Association of Upper GI Surgeons and the Association of Laparoscopic Surgeons. It is valued highly by patients across Exeter, East Devon, Mid-Devon and North Devon. It is also supported by patients who have been referred to the service from further afield including South Devon, Dorset and other parts of the country and by the national Oesophageal Patients’ Association. The service is compliant with the national guidance for the delivery of specialist upper GI cancer surgery, as demonstrated by external assessment; it also has a sufficiently large caseload to be designated as a “high volume centre” for upper GI cancer\(^6\), and based on current workload is one of the largest seven units in England for oesophagectomies.

4. THE WIDER CONTRIBUTION OF UPPER DIGESTIVE CANCER SURGERY TO PATIENT CARE PROVIDED BY THE RD&E

As well as performing a training function for the wider NHS as described above, the upper GI cancer service in the RD&E interacts with and helps to support many other clinical departments. Overall the proposed changes would result in a serious loss of expertise for this patient group. The wider contribution that would be lost if the service is centralised in Plymouth may be summarised as follows:

- The upper GI surgical team provide direct, face-to-face clinical consultation and support to clinical colleagues, as and when needed. This level of support would not be available from a visiting service. Current practice is therefore hugely superior to intermittent visits and telephone consultations visiting consultants would be able to provide;
- The service provides an outpatient service and multi disciplinary team meetings in Exeter and North Devon district hospitals enabling care to be delivered as close to home as possible. It is unlikely a single centre solution would be able to maintain the current links to more geographically isolated areas;
- The skill of the upper GI surgeons enables other invasive investigative procedures and also major operations for benign diseases of the gullet and stomach, for example large hiatus hernias and ruptured oesophagus, to be provided locally. The loss of the cancer surgery will limit the range of operative procedures consultants working in Exeter could perform. As a consequence the RD&E’s ability to retain the current excellent surgical team, who are attracted by the scope of surgical care they can provide, could be compromised;

\(^5\) National cancer Peer Review Peninsula Cancer Network report (February 2007), p. 55

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• The presence of local expertise in radical upper digestive surgery allows the team to provide assistance to their surgical colleagues in other specialties to enhance the quality of surgical care given to patients within the RD&E. Loss of this on-site expertise would be extremely damaging to patient care and frustrating for other clinicians seeking to provide seamless multi disciplinary care for patients;

• Patients admitted with trauma benefit from early review and at times life-saving surgery in our unit. Similarly, intensive care patients often require upper GI reviews and sometimes urgent surgical intervention. As the range of surgical expertise the Exeter surgeons perform declines they will not be able to maintain the skill required to provide this level of intervention. The current level of support will not be available from a surgical centre 45 miles away and therefore the only option will be for critically ill patients to be transferred to the surgical centre;

• The RD&E Thoracic and Upper GI Unit has a major commitment to research in this field, with a full-time research fellow currently undertaking several major studies of critical importance, some in collaboration with other centres. Research expertise and the associated learning will be lost to the Exeter service if surgical care is centralised in Plymouth.

5. NATIONAL PROVISION OF UPPER GASTROINTESTINAL CANCER SURGERY AND THE PLAN TO IMPLEMENT THE IMPROVING OUTCOMES GUIDANCE FOR UPPER GI CANCER SURGERY IN DEVON AND CORNWALL

In England and Wales, the provision of all upper gastro intestinal cancer surgery is subject to the Improving Outcomes Guidance (IOG), issued in 2001, as part of the Improving Outcomes Guidance series stemming from the National Cancer Plan.

The guidance for Upper GI cancer sets out arrangements for the designation of hospitals as diagnostic units or specialist surgical centres in which surgery would be performed for oesophago-gastric and pancreatic malignancies as separate events and by separate surgical teams. Two principles underpin this guidance: firstly outcomes from surgery would be better if care was concentrated into centres treating higher volumes of patients; and, in response to the Improving Outcomes Guidance in 2002, the Peninsula Cancer Network agreed a plan for a one centre pancreatic and two centre oesophago-gastric model for Devon and Cornwall. Both elements of the plan were in line with the recommendations for population catchment areas published in the Improving Outcomes cancer guidance which had been intended to produce sufficient volumes of surgery to make specialist centres viable. Secondly, outcomes and the patient experience of care would be superior if treatment was provided by an integrated multi-disciplinary team. The Royal Devon and Exeter Hospital supports both these principles; the Upper GI service is provided by a comprehensive specialist multi-disciplinary team, and the volume of patients treated means that we are classed as a “high volume” centre, and on 2006 data, we would be among the top seven units in England in terms of volumes of oesophageal surgery.

For the specialist oesophago-gastric cancer team the guidance stated that:

“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)“

and

7 Improving Outcomes Manual (as above), p. 29
“It is anticipated that most Specialist Oesophago-gastric Cancer Teams will be based at Cancer Centres, although some will work in larger hospitals with designated Cancer Units." The guidance also stated that its minimum figures for the population base to be served by each team were intended “to take the diverse geography of Britain into account.” The Peninsula plan for upper GI cancers saw a centre based in Plymouth serving Cornwall and West Devon, and a centre based in Exeter serving South Devon, North Devon, Exeter, Mid Devon and East Devon. Both centres would serve a population of approximately 800,000. The separate specialist pancreatic team would be based in Plymouth and serve a population of 1.6 million.

Both Exeter and Plymouth are designated Cancer Centres and there is no doubt that in the context of the UK, Devon is a comparatively sparsely populated area. The England Rural Development Programme (published in October 2000) described the whole of the South West region as “sparsely populated relative to the rest of the country, with an overall population density of 1.93 persons/ha compared with 3.6 for England”; the document states that the population density for Devon is 1.51 person/ha, significantly below the regional average and only 41.9% of the national average. The report states that the South West has “the highest proportion of its population living in rural districts of any region in England” and “the largest number living in rural localities”. The definition of rurality used is based on that used by the OECD for international comparison (which defines a rural locality as that with a population of 1.5 persons per hectare). Of 112 counties and unitary districts in England, Devon has the 7th lowest population density.

The summary assessment standards subsequently published to guide the peer review assessment of upper GI cancer provision by the National Cancer Team omitted the figure for sparsely populated areas; however, the Improving Outcomes Guidance Manual itself has not been revised and remains the definitive reference point for commissioners; there is no evidence to suggest that its authors ever intended anything else other than to set out a model for the delivery of the highest possible standards of care, but also wished to take into account the “diverse geography” of the UK. Consequently, following the publication of the upper gastro-intestinal assessment standards, the Peninsula plans for oesophago-gastric and pancreatic cancers were agreed and accepted by the National Cancer Team and the two centre oesophago-gastric model was explicitly supported in a letter from Mike Richards (National Cancer Director) to the Cancer Network in October 2004.

In addition to the issue of “sparsely populated areas” described in the Improving Outcomes guidance, it is also recognised that the population of Devon and Cornwall has a higher proportion of elderly people than the national average. This leads to a higher incidence of certain types of cancer, including Upper GI cancer; the South West Cancer Intelligence Service (part of the national network of cancer registries) recognises the peninsulas’ age adjusted cancer population to be equivalent to 2.1 million people, therefore providing a sufficient population base for two oesophago-gastric centres and one pancreatic centre. A further factor is that over the next decade, the population, particularly in East Devon, is forecast to grow.

It is worth noting that it is on the basis of the two reasons set out above – a sparse population and the demographic profile of the local population – that the local Commissioners were able to decide to retain pancreatic cancer surgery in the Peninsula, as the Improving Outcome Guidance Manual states that “Specialist assessment and interventions for patients with pancreatic cancer should be provided by multi-professional teams based at Cancer Centres which draw from catchment areas with populations of two to four million. (The minimum acceptable population size is one million, but this figure is only appropriate for sparsely populated areas).”

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8 As above, p. 29
10 Improving Outcomes Guidance Manual (as above), p. 30

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Prior to the Peninsula plan, oesophago-gastric cancer surgery was carried out in three sites in the Peninsula (Exeter, Plymouth and Truro) and pancreatic surgery in two sites (Exeter and Plymouth). As described above, the Peninsula plan set out arrangements for pancreatic work to centralise in Plymouth and for Upper GI cancer to centralise in Exeter and Plymouth. For Upper GI cancer, the Plymouth service would serve West Devon and Cornwall (approximately half the population of the Peninsula), and the Exeter service would provide surgery for the population of North and South Devon, as well as its usual catchment population of Exeter, East Devon and Mid-Devon. The national upper GI guidance rightly put a great emphasis on the treatment being carried out by specialist multi-disciplinary teams, and the Peninsula plan had the advantage of aligning the new surgical service with the existing specialist oncology provision (providing radiotherapy and chemotherapy treatment) already in place. The hospitals in Exeter, South Devon and North Devon, work together via a number of jointly appointed consultants to provide an integrated specialist oncology service for the population (with the specialist centre being in Exeter). Whist this required some changes to the surgical pathway for Torbay patients, it ensured alignment with the pathway of oncology treatment (therefore delivering genuine multidisciplinary working as envisaged by the Improving Outcomes Manual). For most patients living in the Torbay area the proposed changes offered shorter journey times and improved public transport access to Exeter over the links to Plymouth.

For these two reasons – oncology support and transport access – Exeter is the designated specialist centre for a range of other specialist surgical services for cancer that are also subject to Improving Outcomes guidance. These include urological cancers, head and neck cancer, gynaecological cancer and specialist plastic surgery provision, for the population of Torbay, South Devon and North Devon. The intention of the plan was for Upper GI cancer to fit into this established pattern of service provision.

Following agreement by the National Cancer Director, the plan was discussed at the Peninsula Cancer Network Executive Board and approved by the Chief Executives of all eleven PCTs and 5 acute trusts in Devon and Cornwall in 2002. This plan required four surgeons to change their operative practice; Martin Cooper (upper GI surgeon in Exeter) would transfer his pancreatic cancer practice to Plymouth; Joe Rahamim (thoracic and oesophageal surgeon in Plymouth) would shift from covering the Torbay population to providing a service to Truro, and the two upper GI surgeons in Cornwall would transfer their practice to Plymouth. A further specialist oncological upper GI surgeon would be appointed in Exeter to support provision of the service to North and South Devon.

6. IMPLEMENTATION OF THE PENINSULA PLAN TO DELIVER THE IMPROVING OUTCOMES GUIDANCE QUALITY REQUIREMENTS

Subsequent to the agreement of this plan, the only service changes that were actually implemented by the NHS bodies involved were related to Exeter; Martin Cooper ceased his pancreatic practice and this moved to Plymouth. Exeter also appointed an upper GI surgeon with a specialist interest in cancer surgery in October 2004. The other Primary Care Trusts, as the organisations responsible for commissioning services in line with the nationally approved plan to deliver the Improving Outcomes Guidance, refused to change their commissioning patterns, despite the clear aim of aligning specialist surgical and oncology services, and the need to comply with the Improving Outcomes Manual.

The Exeter pancreatic surgeon (Martin Cooper) changed his practice by giving up pancreatic cancer surgery as both he and the Royal Devon and Exeter hospital recognised the importance of ensuring it should be delivered in the future in line with the Peninsula Cancer Network plan. Surgeons in the other hospitals affected (Truro and Plymouth) declined to change their practice to reflect the national Improving Outcomes Guidance requirements, and appealed directly to the South West Peninsula Strategic Health Authority Chief Executive for an external review of upper GI services to be carried out to assess whether a two centre or 3 centre OG service was most appropriate for Devon and Cornwall. Against the advice of both the Medical Director of the Cancer Network (Martin Cooper) and the Chair of the Cancer Network (Peter Colclough) an external review was commissioned in October
2004. Specifically, the remit was to review upper GI cancer provision in Devon and Cornwall in the context of a debate about whether a three centre OG model (with operating continuing in Truro, Plymouth and Exeter) could be maintained set against the two centre plan which had the approval of the National Cancer Director.

The external review was undertaken by a retired surgeon from London (John Bolton) who initially recommended that the two centre plan should be reinstated and enforced; subsequently he suggested that the two centre plan should be enforced immediately with the view to moving to a single centre in the future. In this final report his five key recommendations were:

1. The original 2002 Peninsula cancer Network action plan should be reinstated and resubmitted to the Cancer Action team
2. Oesophago-gastric resections should cease at Truro and the specialist teams should be consolidated in Plymouth and Exeter
3. The population base should be redistributed to ensure an appropriate population for each team. The realignment of the Torbay oesophago-gastric population base to the specialist team in Exeter would seem logical in the light of other service reconfigurations
4. The two oesophago-gastric teams should work together as part of a full and functional network group, with consideration given to the formation of a joint specialist MDT
5. The above steps should be seen as an interim measure with the intention of moving to a single site when retirements of the non-cardiac thoracic surgeon in Plymouth and the senior upper GI surgeon in Exeter dictate the need for a review of staffing and services

In summary therefore prior to the Bolton report, a plan for upper GI services had been submitted to and signed off by the National Cancer Director. The plan had been implemented for pancreatic cancer (in part due to the agreement of the pancreatic surgeon in Exeter to cease this service); but the plan for Upper GI cancer had not been implemented due to a reluctance to change historic patterns of provision and commissioning by the healthcare organisations involved. This led to a situation where the service for the Peninsula did not comply with national guidance and the surgical service for the population of Torbay was not aligned to the specialist oncology provision, but continued to be based on historic referral patterns. The Bolton report reaffirmed the original Peninsula Cancer Network action plan of a two centre surgical model in Plymouth and Exeter on the basis of realigning services for the Torbay and Truro populations, so that care for these patient groups could be provided by properly constituted multidisciplinary teams organised around the needs of patients and reflecting the pathways of care patients would experience, rather than historical patterns of referral between individual clinicians. Of five key recommendations only one was concerned with a future reconfiguration of provision, and this was firmly focused on a possible response to future retirements.

7. SUBSEQUENT DISCUSSION AND IMPLEMENTATION OF THE BOLTON REPORT RECOMMENDATIONS

Despite the fact that the four main recommendations of the Bolton report dealt with the need to establish a two centre model, discussion focused on creating a single centre in the future around potential retirements although no retirements in the service in either centre are due before 2012. In March 2006, despite objections from the RD&E, the Peninsula Cancer Network focused discussion on the designation of a single centre. Both Plymouth and the RD&E were asked to submit a response to a questionnaire about a providing a single centre for upper GI cancer surgery by 2010.

No agreed criteria or methodology were established for how the responses would be evaluated, but in December 2006 the responses were evaluated by a panel comprising the medical directors of the three acute trusts in Devon and Cornwall not bidding for the service, the Director of Public Health for the Peninsula Strategic Health Authority, and a user
representative. At least two of the panel members had expressed preferences for a single centre solution based in Plymouth prior to the evaluation exercise. The panel was asked independently of each other to evaluate Exeter and Plymouth as potential centres of excellence for Upper GI cancer surgery by assigning scores to a series of twelve measures ranging from clinical outcomes through to financial performance. The result of this evaluation was very close but placed Plymouth ahead of Exeter with a score of 4370 to 4150 (51.3% to 48.7%) No criteria were presented to the assessors to guide their scoring and there was a high degree of variability between the scores assigned by different assessors within each category. Despite this unsatisfactory process, the assessment of Exeter’s clinical outcomes achieved an aggregated score from all five assessors of 460 out of a maximum of 500. This compared to a score of 415 out of 500 for Plymouth. Four out of the five assessors ranked Exeter as a better service in terms of ensuring the highest possible clinical outcomes for patients, and the fifth ranked the ability of both centres to ensure high quality clinical outcomes equal. Taking all measures in total, the user representative on the panel assigned 925 points to Exeter’s submission versus 860 points to that from Plymouth.¹¹

The clinical consensus across the Peninsula Cancer Network supports a two-centre solution, this is confirmed in the minutes of a meeting of the Peninsula Cancer Network upper GI group on 27 April 2007, it was recorded in the minutes that:

“At the previous NSSG meeting (13 October 2006) the group expressed consensus agreement to support the development of a Network oesophago-gastric service to be based on two sites (RDE and PHT) as opposed to a single site as noted in the IOG action plan. It was requested that this preference be relayed to the Network Executive Board.”¹²

The Peninsula Cancer Network upper GI group is composed of senior clinicians working in the upper GI cancer service across Devon and Cornwall set up to offer the Cancer Network and Commissioners advice about the clinical direction of the service. Its advice has been ignored by the PCTs in making their decision to centralise upper GI cancer in Plymouth.

In summary therefore, the originally agreed, nationally approved two upper GI centres plan and the Bolton report recommendations have not been implemented by the Cancer Network or Commissioning bodies. This is despite:

- The Cancer Network’s evaluation exercise to assess the suitability of either Exeter or Plymouth as a single centre of excellence for upper GI cancer surgery placed Exeter above Plymouth in terms of its ability to ensure the highest possible clinical outcomes for patients.

- The sole user representative in this exercise assessed Exeter’s submission to be the single centre of excellence in the Peninsula as stronger than that of Plymouth.

Although the RD&E contends this assessment process was flawed, it was the view of the panel that the Exeter service was most likely to ensure the highest possible outcomes for patients. The Peninsula Cancer Network’s own Network Site Specific Group for upper gastro-intestinal cancers, representing the views of senior clinicians of all professional disciplines from all provider organisations involved in working to deliver a high quality upper GI cancer service across Devon and Cornwall, believe there should be two centres offering oesophago-gastric cancer surgery. This view coincides with the view of the RD&E.

National NHS policy has recently reaffirmed a commitment to health care being patient centred, clinically lead, and focusing on the delivery of clinical excellence, and in the words of Lord Darzi’s NHS Next Stage review Interim report, care should be “localise where

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¹¹ These figures are taken from the Peninsula Network Executive Board Papers (8th December 2006), agenda item 7, D. Chambers, Upper GI Cancer Plan (paper and appendix C)

¹² Minutes of the Peninsula cancer Network Upper GI NSSG, 27th April 2007
possible, centralise where necessary. How is the PCT proposal consistent with this national policy direction?

8. EXTERNAL QUALITY VALIDATION OF THE EXETER SERVICE

Nationally, there is a rolling three year programme to quality assure those cancer sites for which Improving Outcomes Guidance has been published. Via a process of peer review, an external multi-professional team, accountable to the National Cancer Action Team, visits each hospital providing cancer services to assess their compliance with standards based on the service specifications set out in the Improving Outcomes Guidance.

As part of this exercise, in 2006 upper GI cancer services in Devon and Cornwall were peer reviewed. Commenting on the Exeter service the report highlighted the development of Minimally Invasive Oesophagectomy, recording there had been “detailed audit and good professional development of the minimally invasive service”\(^\text{14}\), and in relation the multidisciplinary team in Exeter stated that, “This is a strong, well led team. There is an excellent pathway of care and this is supported by good data collection”.\(^\text{15}\) For Torbay the report observed that “the patient pathway does not incorporate the option of minimally invasive surgery”,\(^\text{16}\) an option which would have been available had the patterns of surgical referral switched in line with the original Peninsula Cancer Network plan and the recommendation of the Bolton report. It also commented that the Plymouth MDT “is not currently functioning as a specialist team. The team does not review OG cases from Truro and Torbay and does not review pancreatic cases from Barnstaple and Exeter.”\(^\text{17}\)

The purpose of including these comments is not to criticise the Plymouth or Torbay teams. It is the RD&E’s belief that the best solution for the population of Devon and Cornwall is to have two oesophago-gastric surgical teams, one in Exeter and one in Plymouth. But the report echoes concerns expressed earlier in this paper; significant service change has taken place for patients in the move of pancreatic surgery away from Exeter and the external assessment is that the change has not delivered the improvements in the processes of multidisciplinary team working that were intended in the Improving Outcomes Manual and the Cancer Networks plan.

The external review also assessed compliance against IOG standards for the two specialist upper GI teams, the results were as follows:

<table>
<thead>
<tr>
<th>Team</th>
<th>Mandatory standards (level 1(^*))</th>
<th>Aspirational standards (Level 1 and 2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exeter</td>
<td>38/41 (93%)</td>
<td>19/21 (90%)</td>
</tr>
<tr>
<td>Plymouth</td>
<td>36/42(^\text{18}) (86%)</td>
<td>17/21 (81%)</td>
</tr>
</tbody>
</table>

The peer review process clearly demonstrates the Exeter service is performing very well against the standards and is fully IOG compliant.

9. THE PROPOSAL FOR THE FUTURE OF UPPER GASTRO INTESTINAL CANCER SURGERY IN THE PENINSULA

The proposal put forward by the Peninsula Primary Care Trusts seeks to reconfigure upper digestive cancer surgery to provide a single centre model. There are a number of questions relating to the proposed changes in the provision of cancer surgery services that have not been answered throughout the process of discussion.

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\(^\text{13}\) Our NHS, Our Future, (NHS Nest Stage Review Interim Report, Department of health, October 2007) p. 32
\(^\text{14}\) National cancer Peer Review Peninsula Cancer Network report (February 2007), p. 18
\(^\text{15}\) As above, p. 55
\(^\text{16}\) As above, p. 80
\(^\text{17}\) As above, p. 29
\(^\text{18}\) The discrepancy between 41 standards applicable to Exeter and 42 to Plymouth is due to Plymouth providing a pancreatic MDT which should be separate and additional to the oesophago-gastric MDT

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Why does the service provided by the RD&E need to change?

No rational answer to this question has been provided. There is no suggestion that patient outcomes at the RD&E are less good than other units, indeed, as already discussed, the unit’s results are currently among the very best in the UK. The RD&E’s service complies with the service specification set out in the Improving Outcomes Guidance Manual, and has been independently assessed against these standards as part of the national process of cancer peer review.

Probably more importantly the Minimally Invasive Oesophagectomy procedure, which has now been performed on over 100 patients with very low mortality and excellent quality of life outcomes, cannot be matched anywhere in the UK. There is no evidence based suggestion that the quality of clinical care and outcome provided now and in the future will be improved for patients by any service change. In addition patients across the South West, and more widely from other parts of the country will lose the opportunity to make the choice between traditional open surgery and Minimally Invasive surgery. If the RD&E can no longer provide upper GI cancer surgery, MIO will only be available to patients who can afford to fund their own treatment abroad.

- **What is the difference between minimally invasive and open surgery?**
  
The operation commonly used today for open oesophagectomy was developed in the 1940s and has changed little since that date. Such surgery is intended to remove the cancer and surrounding tissue, and does this by opening the chest and the abdomen with large incisions (usually well over 30 cms in length), and sometimes removing or breaking ribs to provide access to the diseased area. The level of injury the patient experiences in order for the surgeon to be able to access the area where surgery needs to be carried out is similar to that suffered in a major road traffic accident, and there is often significant blood loss and damage to surrounding organs including the lungs. This means that recovery from this operation is very slow with normal quality of life only returning after 9-12 months. For patients whose disease returns this sometimes means that they never really recover from surgery; overall less than 1 in 5 patients undergoing this traumatic surgery are alive 5 years after their operation.

  Minimally invasive oesophagectomy (MIO) was successfully developed in the United States (in Pittsburgh) in the late 1990s, and seeks to apply some of the major scientific and technological advances that have allowed the development of keyhole surgery in other fields over the past twenty years to oesophageal cancer surgery. Four small cuts are made into the right chest (all about 1cm), a similar number made in the abdomen and a 3-4cm incision in the neck are made, through which, by “keyhole surgery” the operation is completed, and therefore this avoids the major additional trauma associated with the open procedure which is so detrimental to post-operative quality of life and speed of recovery.

  In Exeter, the significant advantages for this operation that our patients have experienced to date are:

  o Much less pain after surgery
  o Normally no requirement for blood transfusion
  o Normally no routine admission to the Intensive Care Unit
  o Reduced complications after surgery
  o Most significantly after patients return home they regain their normal quality of life in weeks rather than months

  Currently our inpatient mortality (chances of dying whilst in hospital after surgery) for MIO is 1% compared to 5% in the very best units in the units in the UK for open oesophagectomy.
How many hospitals in UK offer minimal invasive surgery for upper GI cancer?
As described above, there are no other hospitals in the UK who are routinely offering totally Minimally Invasive Oesophagectomy - and no other hospital in the UK has a published track record for this operation. Some hospitals are offering a keyhole operation in the abdomen, but patients still receive a large open chest operation. Selected RD&E patients are also offered minimally invasive gastrectomy (keyhole removal of the stomach).

Is there a difference in survival rates? Yes, for complex reasons including thorough staging, routine PET scan, and the ability of keyhole surgery to spot unexpected spread of the tumour MIO has a better survival rate than an open procedure; and from our experience so far, our medium term (2 years after surgery) survival rates are superior to open oesophagectomy and are better than any published series for open surgery in the UK. The RD&E survival rate is among the very best in the published literature, worldwide.

What is the operative mortality (survival in hospital) of the unit in Exeter and how does it compare? Exeter has a 1% mortality rate this compares very favourably with other high volume hospitals performing oesophagectomy (removal of the gullet) and a nationwide mortality rate of 9% 30 days after the operation.

How many operations do Exeter and Plymouth carry out annually for gullet cancer? Exeter did 38 totally minimally invasive oesophagectomies in 2006, plus many other procedures for gastric and oesophagogastric cancer. This puts Exeter in a “High Volume” group of Units in the UK. There are only 12 Units in England performing more than 30 oesophagectomies a year; based on current workload, Exeter’s practice will be among the top 7 largest practices in England. Between April 2005 to March 2006 Plymouth carried out 35 oesophagectomies.

Why can't the Minimally Invasive Oesophagectomy service transfer to Plymouth?
This surgery is so specialist and complex that not only does it require two surgeons to carry out the operation itself, but it is essential to have one of the operating surgeons available for the 24-48 hour period after the operation in case there are post-operative complications that mean a patient has to undergo further surgery. In Exeter, the day after surgery, one of the operating consultant surgeons will review the patient two or three times during the day to ensure that post-operative progress is satisfactory. The operating consultant and their team then reviews the patient daily for the next 7-8 days as some of the most serious complications can arise during this period. It would simply not be practical for the surgeons, who also have other commitments to local patients, to be absent from Exeter for two to three days for each MIO operation and travel 90 miles daily to review the patient for the next 4-5 days. Indeed such prolonged absence would have a detrimental effect on other general and specialist surgical care these surgeon offer local patients.

The surgeons in Plymouth are highly competent in open oesophageal surgery but it would not be reasonable to ask them to take responsibility for the complex post-operative care of a group of patients following a surgical procedure in which they are neither trained nor experienced.

Good clinical outcomes for patients depend on effective multidisciplinary working. The surgeons who have developed and provide this surgery in Exeter (Richard Berrisford and Saj Wajed) work closely as members of a specialist multidisciplinary team, including for example, Consultant Anaesthetists, who have been involved in

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the development of this surgical service right from the start. It would obviously be extremely difficult to transfer all aspects of this specialist team into another hospital.

Therefore in the event of Exeter’s oesophago-gastric cancer centre being closed, it is likely that it would become impossible for two of the country’s leading surgeons in the field to continue to operate on cancer patients. This would almost certainly be to the detriment of patients requiring upper GI, general and thoracic surgery in Devon and the South West.

- **How many patients having the operation come from outside of the Peninsula?**
  Such referrals to the RD&E are increasing in number, particularly in view of the excellent outcomes being published. A number of patients have come from Dorset and South Devon, with some from other parts of the country.

- **What effect will losing this centre of excellence have on the RD&E?**
  A very large, highly dedicated multidisciplinary team is involved in delivering outstanding care to all Upper GI cancer patients. They are all involved in making minimally invasive surgery for cancer such a success in Exeter. Clinicians at the RD&E are recruited and encouraged to innovate and seek out new ways of delivering improved care to patients. The loss of this service will undermine confidence for the future that the hard work and dedication clinicians put in to enhancing service quality is valued locally.

  The RD&E’s reputation for excellence and innovation is recognised and this helps attract very good calibre staff. MIO is our most recent flagship service joining other internationally recognised service like our diabetes and orthopaedic services. It is through this encouragement of innovation that local patients benefit from the quality and excellence of the service we provide.

- **How is this proposal consistent with national policy initiatives like CHOICE?**
  It is clear from the recent interim report on the NHS produced by Lord Darzi, NHS Next Stage review Interim report, that the NHS wishes to offer care to patients that is personalised (with choices about types and locations for the delivery of care), and where possible to offer the opportunity to access expert care close to home. Maintaining two IOG compliant upper GI cancer surgery centres in the Peninsula is fully consistent with this policy and offers patients a choice of location and operative procedure. Closure of the services in Exeter denies patients a choice of upper GI cancer surgical centres and the approach to manage their disease. It also removes a local service from a significant number of patients. Most importantly, however, it will deny patients the opportunity of attending a centre offering one of the most up to date surgical techniques for upper GI cancer surgery in the world with excellent clinical outcomes.

- **Does the proposal offer a cost effective solution that maximises the healthcare gain commissioners can achieve for the populations they serve from the resources they have available to them?**
  Financially, this service is as efficient as open surgery as, there is a reduced requirement for blood transfusion and ITU support, the post-operative stay is the same because of the need to carefully monitor the patient for 7-8 days, the complication rate is lower. MIO can therefore be delivered within a national tariff price for this surgery; and there is no financial benefit to NHS Commissioners from switching the service away from Exeter. If the service is centralised in Plymouth increased costs will be borne by patients and their families who will have to travel long distance to access care that is currently available locally.

- **What is the detailed specification for how services will be provided?**
  Currently the commissioners have not produced a service specification; therefore, it is not known how a single centre would continue to offer equity of access, patient...
centred care, and provide the vital links with oncology and other aspects of the multidisciplinary team.

10. THE ROYAL DEVON AND EXETER NHS FOUNDATION TRUST VIEW

The Royal Devon & Exeter NHS Foundation Trust believes the plan put forward in respect of the service for the population of Exeter, East Devon, Mid Devon and North Devon, is unacceptable and inappropriate. The Exeter service is compliant with the national standard for the provision of upper GI cancer surgery and therefore the proposal is ill-founded, detrimental to local patients and may result in a serious under-provision of care. In addition it will result in the loss of the UK’s only centre providing MIO surgery and therefore lead to less choice and poorer outcomes for local patients who otherwise would have benefited from this service, and as it develops for the future.

Our concerns may be summarised as follows:

- There has been no public consultation or an engagement process to seek the view of local people on this service change;

- At present there is an outstanding unit with an international reputation providing upper gastrointestinal cancer surgery at Exeter. If centralisation is to be considered, then this should be on the basis of proven clinical outcomes and compliance with standards. The Exeter centre is fully compliant with the Improving Outcomes Guidance; and if one centre needs to be selected for Devon and Cornwall we believe it should be the centre with the best demonstrable surgical outcomes and one which has a proven track record of clinical innovation and improvement and that can offer the very latest surgical techniques;

- It will be impossible for the Minimally Invasive Oesophagectomy service to transfer to Plymouth as the post-operative care for these patients requires the ongoing presence of one of the operating surgeons and is incompatible with retention of a commitment to provide a other surgical services in Exeter. If the surgeons who have developed this service are made to stop providing upper GI cancer surgery, advances in minimally invasive upper digestive cancer surgery would be set back for the country as a whole. It may take a decade or more to undo the harm that would be caused in this way;

- The RD&E is a centre of clinical excellence for upper digestive cancer surgery and is providing this within national tariff arrangements; there is no financial advantage for the healthcare system in making this change;

- There is currently no proven expertise in minimally invasive upper GI cancer surgery within the Peninsula other than in Exeter. Centralisation to a single centre in Plymouth will deprive patients in the Peninsula of a choice to have their cancer removed safely by minimally invasive operation;

- The impact of the arrangements that have been assumed for patients travelling may be considerably larger than acknowledged thus far. This is a real disadvantage to patients who may have to travel a long way, and for their relatives who may have to make repeated visits. When asked, patients always express a choice for high quality local services. Inevitably, some patients may decide not to undergo surgery as their treatment option;

- There is no reason why a two-centre option cannot be commissioned. If a single site solution is endorsed then Exeter is well placed to provide that service and offers a wider range of treatment options than Plymouth;
• The time and cost involved in consultants travelling around the Peninsula is likely to be prohibitive and create a significant financial risk that has not been accounted for. The withdrawal of the service from Exeter may have a detrimental impact on other surgical services and in time result in further service rationalisation.

• The Royal Devon and Exeter Hospital has a high reputation for innovation, safety, and patient centred care. Commission for Healthcare Improvement and Healthcare Commission annual health checks over the last seven years have consistently rated the quality, service and financial performance of RD&E ahead of those provided by any other acute trust in the southwest peninsula.

11. CONCLUSION

The Royal Devon & Exeter NHS Foundation Trust is committed to providing excellent upper GI cancer surgery services to its population that are in line with national guidelines. We have demonstrated our commitment to this by establishing an internationally recognised centre of excellence and pioneering minimally invasive surgery for gullet and stomach cancer. There is no valid clinical or strategic reason why this should not be sustained and enhanced in the future. As an NHS Foundation Trust the RD&E cannot be instructed to terminate this service unless there are concerns about the quality and standards of the service provided and this is clearly not the case. But if Devon PCT implements the decision to centralise upper GI cancer surgery in a single centre in Plymouth they will remove this element of the service from their contract with the RD&E and thus prevent us from providing a service to our local population, despite its compliance with national standards. In essence the RD&E will have the staff, facilities and expertise to offer this service but the PCT will refuse to fund the treatment of their patients at the RD&E.

The unanimous view of all doctors and surgeons working at the RD&E is that our upper GI surgeons in Exeter provide the best outcomes available to patients; externally validated audit data demonstrates we are one of the top performing units nationally. Dismantling such a centre of excellence risks a significant loss of service and expertise for no demonstrable gain for patient care and quality. It is also the view of senior clinicians working in upper GI cancer services across Devon and Cornwall that a two centre surgical model is appropriate and should be retained; a view that has been supported by the National Director of Cancer Services, Mike Richards, and which is wholly in line with the requirements set out in the Improving Outcomes Guidance, and the comments about the need to reflect the diverse geography of Britain.

The Overview and Scrutiny Committee is being asked by the Devon Primary Care Trust to endorse a set of proposals that are basically flawed and will have a significant impact on local patient care. At this stage the proposals are loosely defined and the potential impact on patients has not been adequately assessed. The Devon Primary Care Trust is requesting the O&S Committee to approve their proposal without the need for public consultation. The Royal Devon and Exeter NHS Foundation Trust would urge the Committee not to agree to this request, to recognise that these proposals have emerged as the result of a flawed and unsatisfactory process, and are unnecessary to support the delivery of high quality clinical care.

The potential implications of these proposals are significant for large numbers of patients in Exeter, East Devon, Mid Devon and North Devon. The Royal Devon and Exeter NHS Foundation Trust would therefore urge the O&S Committee to reject any suggestion that these proposals should be approved. As a minimum we would suggest they should be subjected to full public consultation and that a detailed and fully costed set of proposals be developed to enable the people of Exeter, East Devon, Mid Devon and North Devon to be fully engaged in the debate and decision making process on the future shape of their service.
In conclusion, in the recently published document; Our NHS Our future: NHS Next Stage Review Interim Report October 2007, the Parliamentary Under Secretary of State, Lord Darzi stated “...effective change needs to be animated by the needs and preferences of patients, empowered to make their decisions count within the NHS; with the response to patient needs and choices being led by clinicians, taking account of best evidence”. The RD&E is committed to working in partnership with the population it serves, contributing to the development of evidence and delivering local service based on the best available. The Exeter based upper GI cancer service meets all of these aspirations and the O&S Committee is asked to help ensure the approach outlined by Lord Darzi and due process for consulting on changes in NHS services is followed.