

Centralisation of specialist cancer surgery services in two areas of England: the RESPECT-21 mixed-methods evaluation

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Disclaimer: This report contains transcripts of interviews conducted in the course of the research and contains language that may offend some readers.

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Plain English summary

The RESPECT-21 mixed-methods evaluation

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Plain English summary

Creating fewer, more specialised centres for complex cancer surgery (or ‘centralisation’) means that centres can focus more on cancer surgeries and this may benefit cancer patients.

This study looked at centralisation of specialist surgery for prostate, bladder, renal and oesophago-gastric cancers in two areas of England [i.e. London Cancer (London, UK), which covers north-central London, north-east London and west Essex, and Greater Manchester Cancer (Manchester, UK), which covers Greater Manchester].

The study looked at:

- stakeholder preferences for centralising specialist cancer surgery, by surveying cancer patients, health-care staff and the general public
- the impact of centralising specialist cancer surgery on patient health, quality of care and value for money
- approaches to making changes, whether or not changes happened and what changes made a difference
- how our findings apply to other cancer and non-cancer settings.

The study found the following:

- In response to our survey, patients, clinicians and the public advised that they were willing to travel longer for specialist cancer surgery, but only if it meant that patients had better care and outcomes.
- With regard to impact on health, quality and value for money, only London Cancer’s centralisations happened in time for us to study their impact. Effects were mixed. Surgeons performed more operations, the time spent in hospital decreased and there was no change in death rates (which were already low). There was a good probability (i.e. a 79% chance) that centralising specialist prostate cancer surgery provided better value for money, and, roughly, a 50 : 50 chance that centralising bladder and oesophago-gastric surgery provided better value for money. Changes to renal surgery were not cost-effective.
- Making change happen was helped by consistent clinical leadership (involving staff, patients and the public), communicating progress clearly and learning from previous changes. Following change, some staff reported feelings of loss and concerns about information and care in local services. In Greater Manchester, some changes did not happen because of health-care staff’s concerns.
- At our workshop, it was agreed that lessons from our research seemed relevant to other health-care settings.

We conclude that centralising specialist cancer surgery services improved some parts of care. However, our study was limited because parts of our survey sample were self-selecting and we could not analyse certain aspects of care, patient experience and quality of life.

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