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

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Declared competing interests of authors: Naomi J Fulop is a National Institute for Health and Care Research (NIHR) (formerly the National Institute for Health Research) senior investigator and was a member of the following: NIHR Health and Social Care Delivery Research (HSDR) Programme Funding Committee (2013–18) and HSDR Evidence Synthesis Sub Board (2016). In addition, Naomi J Fulop is a trustee of the charity Health Services Research UK (London, UK) and is the University College London (London, UK)-nominated non-executive director for Whittington Health NHS Trust (London, UK) (2018–22). Finally, Naomi J Fulop was, in part, supported by the NIHR Collaboration for Leadership in Applied Health Research and Care (CLAHRC) North Thames at Bart's Health NHS Trust. Catherine Perry was partly supported by the NIHR CLAHRC Greater Manchester. Cecilia Vindrola-Padros was, in part, supported by the NIHR CLAHRC North Thames at Bart's Health NHS Trust. Angus IG Ramsay was an associate member of the HSDR Commissioned Board (2014–15) and an associate member of the HSDR Board (2015–18), and is a trustee of the charity Health Services Research UK. Ruth Boaden was a member of the HSDR Funding Committee (2014–19), HSDR Researcher-Led Board (2014–16) and the Dissemination Centre Advisory Group (2015–19). In addition, Ruth Boaden was partly supported by the NIHR CLAHRC Greater Manchester. Kathy Pritchard-Jones was funded by UCLPartners Academic Health Science Network (London, UK) as cancer programme director and as chief medical officer of London Cancer (London, UK) from 2011 to 2016 (when the latter funding reverted to the National Cancer Vanguard programme held locally by the University College London Hospitals Cancer Collaborative on behalf of all acute provider trusts in North Central and North East London and West Essex). London Cancer received funding from NHS England (London, UK). The National Cancer Vanguard receives funding from the NHS England new care models programme. John Hines was urology pathway lead for London Cancer and, therefore, has an interest in the successful implementation of major system change (MSC). Claire Levermore was a pathway manager on the London Cancer centralisations and, therefore, has an interest in the successful implementation of MSC. Muntzer M Mughal was director of the Oesophago-gastric Cancer Pathway Board (later joint Chief Medical Officer) for London Cancer and was a consultant upper gastrointestinal surgeon at University College London Hospitals. David Shackley is the director of Greater Manchester Cancer (Manchester, UK) and clinical lead. David Shackley was involved in the engagement and design aspects of the Greater Manchester proposals Working for Commissioners. Steve Morris was a member of the NIHR HSDR Funding Board (2016–19), the NIHR HSDR Commissioning Board (2014–16), the NIHR HSDR Evidence Synthesis Sub-board (2016), the NIHR HSDR Unmet Need Sub-board (2015), the NIHR Health Technology Assessment (HTA) Clinical Evaluation and Trials Board (2007–9), the NIHR HTA Commissioning Board (2009–13), the NIHR Public Health Research Funding Board (2011–17) and the NIHR Programme Grants for Applied Research Expert Sub-panel (2015–19). In addition, Steve Morris was, in part, supported by the NIHR CLAHRC North Thames at Bart's Health NHS Trust.

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

Published February 2023
DOI: 10.3310/QFGT2379

Plain English summary

The RESPECT-21 mixed-methods evaluation

Health and Social Care Delivery Research 2023; Vol. 11: No. 2
DOI: 10.3310/QFGT2379

NIHR Journals Library www.journalslibrary.nihr.ac.uk

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.

Health and Social Care Delivery Research

ISSN 2755-0060 (Print)

ISSN 2755-0079 (Online)

Health and Social Care Delivery Research (HSDR) was launched in 2013 and is indexed by Europe PMC, DOAJ, INAHTA, Ulrichsweb™ (ProQuest LLC, Ann Arbor, MI, USA) and NCBI Bookshelf.

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Editorial contact: journals.library@nihr.ac.uk

This journal was previously published as *Health Services and Delivery Research* (Volumes 1–9); ISSN 2050-4349 (print), ISSN 2050-4357 (online)

The full HSDR archive is freely available to view online at www.journalslibrary.nihr.ac.uk/hsdr.

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This report

The research reported in this issue of the journal was funded by the HSDR programme or one of its preceding programmes as project number 14/46/19. The contractual start date was in September 2015. The final report began editorial review in June 2021 and was accepted for publication in December 2021. The authors have been wholly responsible for all data collection, analysis and interpretation, and for writing up their work. The HSDR editors and production house have tried to ensure the accuracy of the authors' report and would like to thank the reviewers for their constructive comments on the final report document. However, they do not accept liability for damages or losses arising from material published in this report.

This report presents independent research funded by the National Institute for Health and Care Research (NIHR). The views and opinions expressed by authors in this publication are those of the authors and do not necessarily reflect those of the NHS, the NIHR, the HSDR programme or the Department of Health and Social Care. If there are verbatim quotations included in this publication the views and opinions expressed by the interviewees are those of the interviewees and do not necessarily reflect those of the authors, those of the NHS, the NIHR, the HSDR programme or the Department of Health and Social Care.

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