Thames Valley Clinical Senate

“What could be the impact of the acquisition of Heatherwood and Wexham Park Hospital NHS Foundation Trust by Frimley Park Hospital NHS Foundation Trust on clinical pathways for specialised services and other volume sensitive services (including stroke and cancer pathways)”

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1. Executive Summary

Health care systems and their commissioners, in partnership with providers and the public, are required to ensure that clinical services are sustainable, accessible, of a high quality and give the patient a good experience of care.

The improvement of services to achieve these outcomes happens on a daily basis and many of these improvements occur within an existing configuration of services. However, there are times when changes occur as part of a reconfiguration and this requires teams and organisations to work together to ensure that change results in higher quality care and more sustainable services for patients.

A reconfiguration proposal was developed in 2014/15 for Frimley Park Hospital, in Camberley, Surrey, to acquire Heatherwood and Wexham Park Hospital (HWP), Slough by means of a financial merger. The proposal was seen as an opportunity to help secure the sustainability of both hospitals and to improve the quality at HWP and was strongly supported by the Department of Health, Monitor and the local Clinical Commissioning Groups (CCGs).

The proposal did not specify detailed plans for service pathway changes but there was a stated ambition to develop the services available at HWP and to repatriate local patients from other hospitals. It was recognised that this would improve the viability of the hospital, which was important for the local population, but it gave rise to the potential for it to impact on patient pathways and services delivered elsewhere in the Thames Valley. The Senate process brought out an agreement that any such future service developments would not be taken forward at the cost of the wider population.

A strategic view of the impact of the acquisition across a wider geography was needed with an assessment of the effect on individual service pathways and the sustainability of those pathways. NHS England South, South Central, sought evidence based clinical advice from the Thames Valley Clinical Senate which would support commissioners in future local discussions and planning. The remit of the work was to review such proposals as were known and identify potential impact across the geography on those service pathways and any interdependent clinical services. Putting the patient as the focus of the pathways meant that the review was not restricted to the Thames Valley geography but extended to hospitals on the Thames Valley boundaries whose services were accessed by Thames Valley patients.

The work was led by the Thames Valley Clinical Senate Council with advice and input from the Clinical Directors of the Thames Valley Strategic Clinical Networks, the Thames Valley Senate Assembly and four Clinical Stakeholder Forums.

The business case for the acquisition stated an intention to maintain a District General Hospital (DGH) on both sites meaning that most general services would continue to be available to patients within their local geography. The Senate therefore rationalized the

review to focus on specific services which, whilst small, had the potential to impact a significant change to patient flows. The services were:

- Primary Percutaneous Coronary Intervention (PPCI)
- Vascular surgery
- Stroke services
- Specialised cancer pathways

Each of these clinical areas corresponds with one of the Thames Valley Strategic Clinical Networks (SCNs) and the Senate worked in partnership with the SCNs and their Clinical Directors to deliver this piece of work.

A Senate Assembly event was held in July 2014 where a high level clinical vision for the acquisition was shared with attendees including patients and the public, third sector organisations and NHS clinicians and managers. Responses collected at the event informed the structure for the subsequent clinical stakeholder forums.

Four clinical stakeholder forums were held in January and February 2015, one per clinical area. The services were reviewed in detail and information was shared with delegates both before and during the forums. The clinical ambition of the new Trust, with regard to each of these services, was shared and clinical consensus was achieved with respect to the possible risks and benefits. These are shown in full in Appendices 1 – 4.

At all times the needs of patients were considered above the needs of individual organisations, but in considering individual pathways, there was a need to consider the co-dependency of services and possible wider implications for hospitals where change may have been indicated. The Senate referred to the work undertaken by the South East Coast Clinical Senate 'The Clinical Co-Dependencies of Acute Hospital Services' to inform this work.

The Senate recognised the opportunities which could arise from the acquisition and did not seek to restrict those benefits. The recommendations relate to the impact of the proposals shared with the Senate by the new Trust.

PPCI – full details of these recommendations are in section 8 on page 22

- Frimley Health stated an ambition to develop the currently non-compliant PPCI service at Wexham Park Hospital, into a compliant 24/7 PPCI centre. Due to inconsistencies with available data, it was not possible to be comprehensively assured regarding future activity volume, but the Senate supported the proposal on the basis of: population need, the benefit to the broader cardiology service and on the assurance that Frimley Health would not run the unit at Wexham if it did not meet the minimum specification.

- The PPCI Centre at Buckinghamshire Healthcare NHS Trust (BHT) in High Wycombe is currently not compliant with the National Service Specification, as it is not 24/7, but provides a high performing service. The Trust does not currently have an ambition to make this a 24/7 service but the work undertaken by the Senate indicates that the Centre is an important one for the Buckinghamshire population and has therefore agreed to take positive steps to address this with CCG commissioners and with the NHS England Specialised Commissioners
- It was recognised that there are likely to be potentially poorer outcomes for patients requiring a secondary transfer and that these transfers could be avoided by appropriate direct admission to a PPCI Unit. The Senate therefore recommends that clear clinical protocols and governance arrangements for clinicians and ambulance staff are agreed
- The Senate recommends that Frimley Health participates in the Thames Valley Cardio Vascular Disease SCN.
- The Senate recommends that work is undertaken to ensure that patients from the Milton Keynes area are getting equivalent access to high quality PPCI services.

Vascular Services – full details of these recommendations are in section 8, page 23

- The Senate was assured that the Thames Valley Vascular Strategic Clinical Network (TV Vascular SCN) is leading the work to include Buckinghamshire in the Thames Valley Network.
- The vascular networks are currently focussed around the specialised vascular services and the Senate recommends that work is undertaken to ensure that sufficient vascular consultant support is available at the non arterial centres to ensure appropriate patient care.
- The Senate recommends that Frimley Health ensures that its connections, pathways and relationships between the vascular centre and local services in East Berkshire are reviewed and addressed where/if necessary to facilitate safe and trusted transfer, particularly for rehabilitation.
- The Senate recommends that Frimley Health participates in the Thames Valley Vascular SCN.
- The Senate recommends that work is undertaken to ensure that patients from the Milton Keynes area are getting equivalent access to high quality vascular services.

Stroke Services – full details of these recommendations are in section 8, page 25

- The Senate recognised the robust evidence base for the London model and agreed that the evidence could be applied to the Thames Valley. It therefore supported the recommendation from the Thames Valley Stroke SCN to move Thames Valley stroke services to the London model with the John Radcliffe Hospital (JR), Royal Berkshire Hospital (RBH), Frimley Park (Camberley) and Buckinghamshire Healthcare NHS Trust (Wycombe) identified as the hyper acute stroke units subject to Clinical Reviews being undertaken to assess the impact of individual CCG proposals in line with NHS England guidelines

- To help mitigate unintended consequences on patient access and ambulance performance of the move to the London model, the Senate recommends that a modelling exercise is carried out with the Ambulance Service
- The Senate has reviewed reports regarding the management of patients with stroke mimic and found that the Wycombe Hyper Acute Stroke Unit (HASU) is able to meet the needs of these patients and recommends that it continues as a hyper-acute centre.
- The Senate recommends that work is carried out to review the stroke rehabilitation models and pathways to ensure that there is sufficient post-acute care capacity and provision.
- The Senate noted that the Milton Keynes area does not currently follow the London model and recommends that the TV Stroke SCN reviews the options for developing a high quality stroke service for patients in Milton Keynes.

Cancer Services – full details of these recommendations are in section 8, page 26

- The Senate supported the proposal to simplify pathways in line with the Improving Outcomes guidance.
- The Senate recommends that patients are treated in accordance with compliant pathways and that irrespective of where complex cancer treatment is delivered, other cancer treatments including radiotherapy and chemotherapy, where appropriate, should be delivered locally.
- The Senate recommends that commissioners should endorse the work undertaken by the Thames Valley Cancer SCN with regard to the urology cancer surgery pathway.
- The Senate did not feel that a case had been made for a single cancer centre relationship for east Berkshire patients but will review in light of the pathway work described.
- The Senate found that there is an opportunity to plan and increase local radiotherapy provision within a distributed model and recommends that a refresh of the Radiotherapy Strategy is carried out focussing initially on areas of specific need to include Slough and mid and north Buckinghamshire.

The Senate reached its conclusions through the review of clinical and activity data, the outcome of the consultation at the Assembly event and clinical consensus. The Senate did not have access to any financial information and the financial case for change was considered elsewhere. It is acknowledged that clinical consensus of any kind is open to bias on a range of fronts, is not cast in stone and is challengeable. However, this independent, clinical report aims to provide both the Thames Valley and Specialised Commissioners with information to inform their commissioning decisions.

2. Introduction and Background

In 2104/15, a proposal for Frimley Park Hospital NHS Foundation Trust to acquire Heatherwood and Wexham Park Hospital NHS Foundation Trust through a financial transaction was being progressed.

NB: The Senate recognizes that in a strict accounting sense, the agreement between Frimley Park Hospital and Wexham Park Hospital would be described as a merger. However, this document refers to it as an 'acquisition' to reflect the terminology widely used within the Thames Valley to describe the process.

Frimley Park Hospital NHS Foundation Trust is a district general hospital (DGH) located in Surrey, close to North East Hampshire and East Berkshire borders with a current catchment population of 400,000-500,000 *(source: FPH FBC July 2014).* The Trust provides a full range of DGH services for the population of North East Hampshire and West Surrey. FPH is outside of the Thames Valley geography and sits within the South East Coast Clinical Senate and Strategic Clinical Network (SCN).

Heatherwood and Wexham Park Hospital NHS Foundation Trust is a DGH located in East Berkshire, with a current catchment population of 463,00,000 *(source: HWP website Sep 2014)* serving the population of East Berkshire (Slough, Bracknell, Windsor, Ascot, Maidenhead) and South Buckinghamshire. The Trust delivers its services from two main sites; Heatherwood Hospital in Ascot and Wexham Park Hospital in Slough. HWP sits within the Thames Valley and the Thames Valley Clinical Senate and SCN.
The proposal was signed off by both Boards and completed on 1st October 2014. The new combined Trust is known as Frimley Health NHS Foundation Trust (Frimley Health).

In October 2014, Frimley Park Hospital was awarded an outstanding rating by the CQC – the first hospital in England to achieve this rating.

The Thames Valley Clinical Senate

The Thames Valley Clinical Senate is a non-statutory body which has been formed to support Clinical Commissioning Groups (CCGs), Health and Wellbeing Boards and NHS England to make the best decisions about healthcare for their populations.

Its main function is to provide a forum for health and care professionals and patients to debate matters of strategic importance to the Thames Valley, develop a shared understanding of issues and build consensus on proposals for reconfiguration and improvement.

The independence of the Senate is a core principle of its way of working and its focus is to provide impartial clinical advice which is in the best interests of patients, not of individual organisations or professional interests.

The topic was accepted by the Clinical Senate in May 2014 and it agreed to provide a response in September 2014 which was anticipated to coincide with the completion of the acquisition. The complexity of the topic and its further ramifications meant that the Senate submitted an interim report in September but continued working on elements of the topic until September 2015.

2 Acknowledgements

We are very grateful to all those who have contributed to the development of this work including:

- those who attended the Senate Assembly event in July 2014
- the clinicians and patients who attended the four Clinical Stakeholder Forums in January and February 2015
- the Thames Valley Strategic Clinical Network Directors and Clinical Leads who supported the work with clinical advice and gave their leadership to the Clinical Stakeholder Forums
- the Thames Valley Strategic Clinical Network Managers who have supported the work within individual clinical areas and who will be leading pieces of work arising from this topic
- Frimley Health, who early on engaged with and supported this piece of work and have committed themselves to partnership working with the organisations within the Thames Valley.

4. The Topic

The acquisition was a financial agreement and as such, did not specify proposals for clinical service pathway changes. However, the business case stated an ambition to develop specialised services and repatriate work from other 'external' Trusts. External Trusts could be external to or sited within the Thames Valley.

It was recognized that Frimley Health would need to make changes in order to improve the viability of the Wexham site but this gave rise to the potential for there to be an impact on patient pathways delivered elsewhere in the Thames Valley, especially those which rely on population numbers to ensure quality and continuity of service.

The acquisition was addressed from a financial perspective by a number of partners including the CCGs in Berkshire East, Buckinghamshire (Chiltern CCG), West Surrey and North Hampshire. None of these bodies had the responsibility to consider the acquisition from a wider, whole system perspective.

The Thames Valley Clinical Senate was therefore asked to give an objective clinical perspective on the potential opportunities and impact of the acquisition on the sustainability of pathways across the Thames Valley.

In setting the question, it was noted that the business case stated an intention to maintain a District General Hospital (DGH) on both the Camberley and Wexham sites. It was therefore agreed that the Clinical Senate's focus would be on specialised services and where there were current quality concerns.

The question was agreed as follows:

"What could be the impact of the acquisition of HWP by FPH on clinical pathways for specialised services and other volume sensitive services (including stroke, and cancer pathways)"

It was agreed that, at the discretion of the Area Team, there may be a need for a second question once the clinical vision begins to emerge and this was drafted as below.

"How does the NHS provide high quality, accessible and sustainable services beyond the acquisition of HWP by FPH?"

This was not considered as part of the initial review but in its Interim Report to NHS England South, South Central, the Senate recommended this should be addressed by four Clinical Stakeholder Forums. This was subsequently agreed and the outcome of these Forums is included within this paper.

4.1 The Business Case for the Acquisition

The Full Business Case (FBC), issued in June 2014, made a case for the acquisition based on:

- Ongoing financial challenge
- Increasing quality expectations
- Doubts over the sustainability of smaller Acute Trusts

Whilst the Business Case did not include a specific and detailed clinical vision, it did state an ambition to:

- repatriate work from external Trusts
- develop services within key clinical areas (see Section 4.4)
- increase volume and protect services that may otherwise be lost to secondary specialist providers.

4.2 Potential Catchment

Within the FBC, Frimley Health identified an enlarged catchment area of 800,000 – 1 million people. This was based on current GP referral patterns to the two hospitals and a 30 minute drive time.

The identified catchment spans a significant portion of Berkshire and Buckinghamshire and overlaps with catchments also identified by the Royal Berkshire Hospital Reading, and Buckinghamshire Healthcare NHS Trust, High Wycombe – both of whom have catchments which already overlap with each other.

There is currently no agreed methodology for how the population catchment of a provider is defined but the identification of the catchment is a key issue in relation to the commissioning of specialised services which are population dependent.

Regardless of which population falls within which hospital catchment, it is important that patients should not be restricted in their choice of where they receive their treatment.

An independent study of the 30 and 45 minute drive time, commissioned by the Senate, and based on the ONS mid 2012 mid-year population estimates, shows that the size of the Thames Valley population catchment and the overlap between hospitals population is as follows:

Thames Valley population with access to hospital sites

Total Thames Valley Population 2,043,418

	Average Driving Times			
	30 minutes		45 minutes	
	Number	%	Number	%
Access to all 5 Hospitals	1,562,285	76.5%	1,943,939	95.1%
Individual Hospital Access				
Frimley Park Hospital NHS FT	166,682	8.2%	650,684	31.8%
Heatherwood & Wexham Park Hospital NHS FT	557,007	27.3%	978,320	47.9%
Royal Berkshire Hospital NHS FT	527,125	25.8%	1,096,823	53.7%
Buckinghamshire Hospitals NHS FT	415,522	20.3%	774,268	37.9%
Oxford University Hospitals NHS FT	367,343	18.0%	836,423	40.9%
Overlapping Areas				
Royal Berkshire / Heatherwood	142,706	7.0%	150,761	7.4%
Buckinghamshire / Heatherwood	54,846	2.7%	28,257	1.4%
Frimley Park / Heatherwood	86,614	4.2%		
Royal Berkshire / Oxford			79,656	3.9%
Oxford / Buckinghamshire			182,989	9.0%
Royal Berkshire / Heatherwood / Frimley Park	80,068	3.9%	358,807	17.6%
Royal Berkshire / Oxford / Buckinghamshire			19,204	0.9%
Royal Berkshire / Oxford / Heatherwood			14,426	0.7%
Oxford / Buckinghamshire / Heatherwood			3,829	0.2%
Buckinghamshire / Frimley / Heatherwood			41,363	2.0%
Royal Berkshire / Buckinghamshire / Heatherwood			47,249	2.3%
Royal Berkshire / Oxford / Buckinghamshire / Heatherwood			68,320	3.3%
Royal Berkshire / Buckinghamshire / Frimley / Heatherwood			247,201	12.1%
Oxford / Buckinghamshire / Frimley / Heatherwood			1,878	0.1%

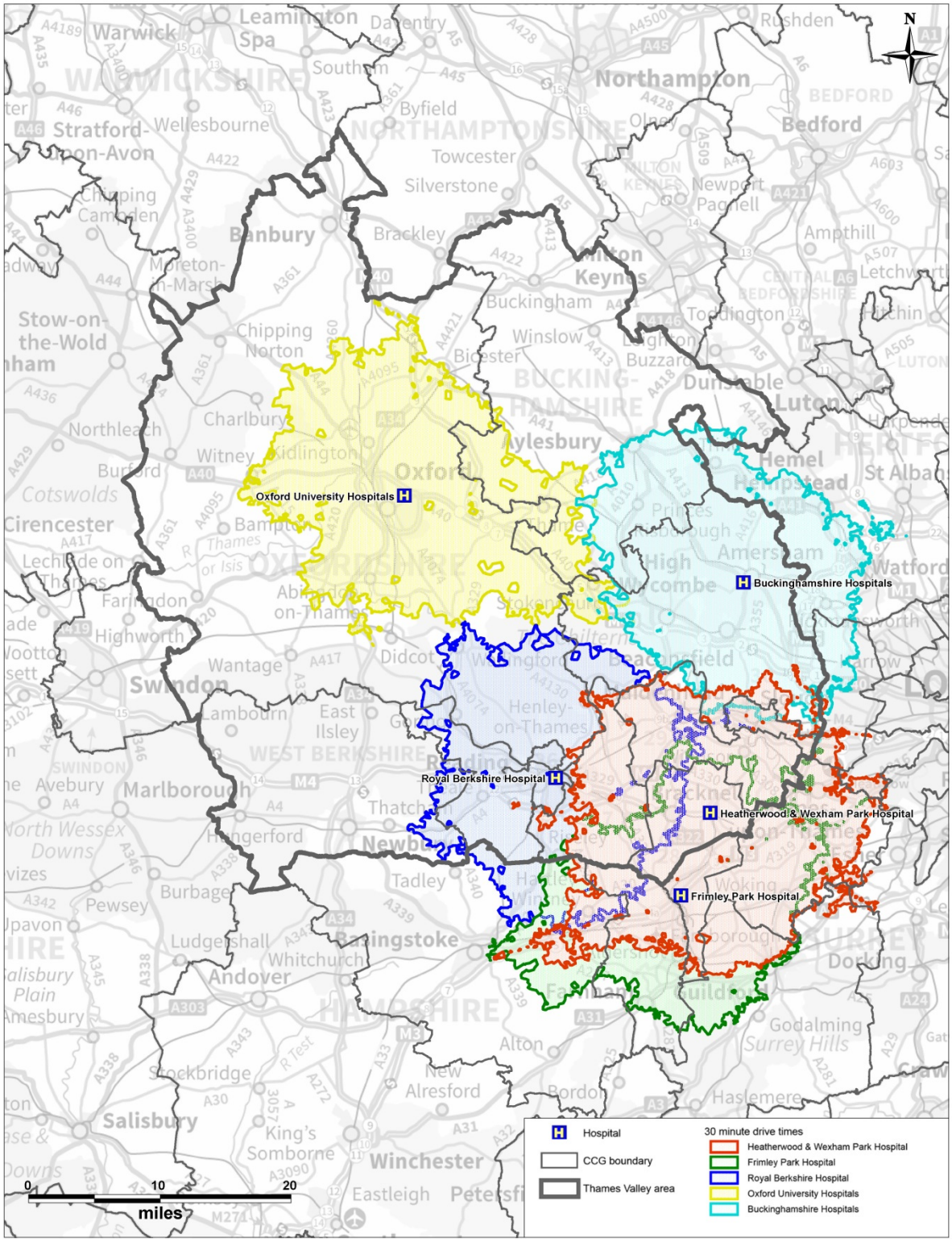
The chart shows that 76.5% of the Thames Valley population could access one of the five Trusts within a 30 minute drive time and this increases to 95.1% when the drive time is increased to 45 minutes.

The overlap population in each of these drive times is:

30 minutes: 364,234 (17.8%)

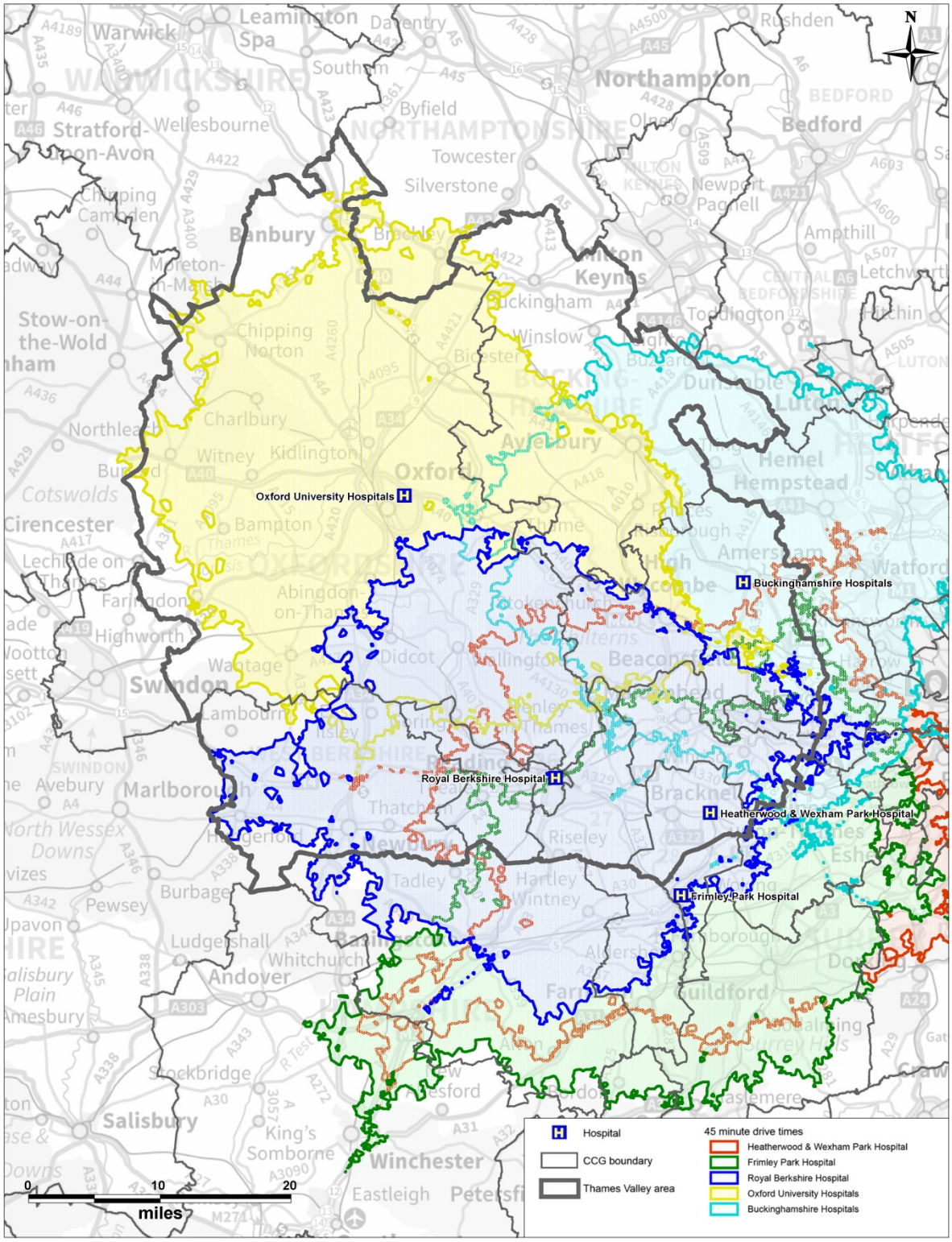
45 minutes: 1,243,940 (61%)

Fig 2: 30 minute average drive time (private vehicle) to the 5 hospital sites (showing overlap)



Thames Valley Clinical Senate	South West Commissioning Support NHS Kathryn Wright - 19 September 2014 © Crown copyright and database rights 2014 Ordnance Survey 100050537. Contains Royal Mail data © Royal Mail copyright and database right 2014. X:\Clinical Senate\Thames Valley\Workspaces\Avg_Drive_30mins.wor
30 minute average drive times (private vehicle) to 5 hospital sites	

Fig 3: **45 minute average drive time (private vehicle) to the 5 hospital sites (showing overlap)**



4.3 Clinical Ambition

Due to the distance between the two main sites of Camberley and Wexham (24 miles) and the difficulty with transport links, Frimley Health stated that all 3 hospital sites (Camberley, Wexham and Heatherwood) would be retained and that the Camberley and Wexham sites would continue to offer full DGH services.

Frimley Health stated that it would like to position itself to be one of the 40 - 70 specialist emergency centres though it is noted that the national process for these to be identified had not yet been agreed. It plans to develop an elective surgery unit on the Heatherwood site which would support this ambition. The nomination of specialist emergency centres is outside the scope of this topic and the Senate has not therefore commented on this.

The new Trust would also like to be recognised as a Centre of Excellence for a number of specialised services and states that the enlarged Trust population gives it the opportunity to try and achieve this. (see population catchment above)

4.4 Clinical Vision / Service Developments

The following information has been provided by Frimley Health by way of documentation and presentation to inform the Senate debate:

Frimley Health believed that the following amalgamations could be readily achieved: anaesthetics, endoscopy, radiology, maternity, gastro-enterology, palliative care, stroke, pathology and haematology.

In a presentation to the Senate Council in July 2014, FPH identified the priorities as:

- Vascular – Development of a joint department with a vascular centre at Frimley and local services at Wexham
- Cancer – Identification of a single cancer centre and to secure a local radiotherapy service and enhanced chemotherapy service on the Wexham site.
- Stroke services – Sustain the hyper acute service (HASU) at Frimley by increasing scale with the intention to deliver a hyper acute service (HASU) at Wexham (NB it was subsequently decided not to proceed with the proposal for a hyper acute service at Wexham)
- PPCI – intention to deliver a 24/7 Primary Percutaneous Corononary Intervention (PPCI) service at Wexham. The current service at Wexham is 8am – 6pm Monday to Friday

Other potential developments were identified as:

- Maternity – Service development for enhanced uro – gynaecology service and joint fertility service.
- Cardiology - Develop a centralised complex devices service and seven day angiography. Develop sub-specialisation of cardio-vascular services.

- Radiology – Build up interventional radiology service at HWP with shared on-call rota between FPH/Royal Surrey County Hospital/Hampshire Hospitals.
- Neurological Services – Develop an enhanced neuro rehabilitation service.
- General surgery – Building up of complementary surgical services such as colorectal, upper GI and breast surgery with plastic reconstruction.
- Urology – Treatment of HWP lithotripsy patients at FPH.
- Elective care – the Heatherwood site would be developed in to a new hospital with the development of a number of one stop services for urology, orthopaedics and hepatology. There would also be an enhanced recovery facility.
- Respiratory medicine – Extend cystic fibrosis service to Wexham. Develop interventional bronchoscopy service at HWP site. Also develop sleep apnoea, combined allergy and asthma services.

A series of services are targeted for expansion or repatriation and these are: :

- Obstetrics;
- Oncology – chemotherapy;
- Hepatology – viral hepatitis and liver failure support – potential identified to develop a liver service;
- Orthopaedics – complex revision joint replacement surgery, spinal cord stimulation studies;
- Plastics – development of the HWP service and enabling repatriation of patients from London;
- Haematology – bone marrow transplant.

5. Senate Assembly Response to the acquisition

The Senate Assembly is the wider multi-professional group which provides the Council with ready access to experts from a broad range of health and care professions. Membership encompasses the whole patient pathway across all care settings and includes patients and the public, health professionals and public health and social care professionals.

The inaugural Senate Assembly event was held in July 2014, based around the Frimley Health topic.

The Frimley Health ambition was shared with the Senate Assembly which was asked to consider the question

From what you have heard or what you have not heard but are concerned about, what may be the impact of the acquisition (positive and negative) on –

- *Your role*
- *The services you provide*
- *The patient experience*

There were 221 responses to the question, 75% of which reflected concerns. The responses were categorised into six groupings:

1. Service design
2. Perceived risk to existing Thames Valley services
3. Patient perception
4. Travel / Access
5. Interagency working
6. Others.

In summary, the Assembly response reflected that:

- the acquisition presented an opportunity to develop or re-design pathways with a request that this should be done on a system wide collaborative basis to ensure that it was done for the benefit of patients rather than individual providers.
- the acquisition presented an opportunity to improve quality at HWP
- there were concerns that the acquisition could affect the sustainability and viability of existing Thames Valley pathways and that there was a need for whole system engagement in future service planning
- there were concerns about the possible impact on existing specialised centres such at Mount Vernon and Harefield Hospitals
- patients were concerned that the acquisition was financial rather than patient centred and that there was a risk of losing local services
- there were concerns about potentially longer travel times for patients and their families and difficulties of using public transport from East Berkshire to Camberley were identified

- there were concerns about how Frimley Health would develop new relationships with community and third sector providers in Berkshire and this was felt to be especially important when considering respite, outreach and rehabilitation services
- there were concerns about how Frimley Health would engage with GPs and whether practices would be well informed by the new Trust so that they could advise their patients appropriately

These points were fed back to the Thames Valley Clinical Senate Council and were shared in the discussions at the Clinical Stakeholder Forums (see section 7) which were held in January and February 2015.

6. Key Clinical Areas

The information shared by Frimley Health helped to identify that the key areas for initial review were:

- Cancer Services
- Stroke Services
- Primary Percutaneous Coronary Intervention (PPCI)
- Vascular Services

The response to the early clinical ambition shared by Frimley Health is as follows and formed the basis of the Clinical Stakeholder Forums.

6.1 Cancer

For the common cancers, most patients have all their care provided in the local DGH and there is no suggestion that this would change. However, most specialist cancer work is volume sensitive and the impact on rarer cancers would need to be worked through to assess whether any change of referral pathways would make current services unsustainable.

Specialist surgery areas that are noted for repatriation are Urology, Upper GI, HPB(Hepato-biliary) and Gynae

The TV Cancer Strategic Clinical Network (SCN) has led a piece of work to repatriate urology work from HWP to RBH to ensure that the current Thames Valley service is compliant with national requirements. If, in the future, the HWP activity and population catchment was repatriated to FPH, there is a risk that the current pathway would no longer be compliant.

Potential changes to the other cancer pathways identified are unlikely to present a risk to sustainable services within the TV, either because volume is very low or cases are already referred outside of the TV.

Ambition to develop a radiotherapy service on the Wexham site

Most of the patients from HWP requiring radiotherapy are currently referred into either the RBH or the Mount Vernon Hospital. If HWP developed a radiotherapy service on its it site, this would not reduce the ability of RBH to offer a full range of radiotherapy, either in Reading or at its satellite in Bracknell.

However, the Bracknell radiotherapy facility is only nine miles from the proposed development on the Wexham site and the sustainability of both should be reviewed.

Intention to link with a single (or maximum two) cancer centres

The TV cancer pathways are currently within a network of multiple cancer centres ensuring minimum travel times for patients.

FPH expressed governance concerns regarding the number of cancer centres with which HWP is currently linked and has stated an intention to link to one, or possibly two, cancer centres reducing the number of Multi-Disciplinary Teams (MDT) involved. Its current link is with the Royal Surrey County Hospital in Guildford and this link is proposed to continue. The Senate Assembly voiced concern about increased travel time for patients and maintaining their right to choice of provider will be essential.

6.2 Vascular

FPH stated an intention to repatriate some of the specialised work which has moved away from the Trust and to develop specialised services. Particular drivers are the PPCI, Vascular and Stroke services.

The previously agreed (c 2012) Thames Valley "solution" for vascular surgery consists of a Surgical Centre "Hub" at the John Radcliffe Hospital, Oxford, and "Spoke" services Wycombe, Wexham and Reading. The network is not yet functioning to the desired level across all aspects of the service and a new Thames Valley Vascular Network has been established to review the current provision and implement revisions to ensure compliance. This network does not yet include FPH.

FPH is a stand-alone Vascular "Hub" catering for the Surrey area, a small amount of North Hampshire, and a significant proportion of East Berkshire. Other East Berkshire patients travel to Oxford or Wycombe for vascular surgery and OUH provides an in-reach service to HWP. The ambition to further develop the vascular Hub at FPH would likely steer the majority of East Berkshire patients towards FPH and would reduce volume in OUH. The impact of this on the viability of the compliant vascular services in Thames Valley was not expected to be significant.

6.3 Stroke Services

The FBC stated an intention to sustain FPH's hyper acute service by increasing scale and to deliver a HASU at HWP.

If a HASU was to be developed at WPH it would mean that the A&E is supported by an on-site hyper acute stroke service.

However the volume of admissions would be relatively low, and certainly well below 600 patients annually. Some repatriation from Wycombe would be possible but these numbers would be insufficient to bring the service up to the 600 admissions required. There is a risk that the impact on Wycombe of losing these cases would mean this service also fell below the national requirement and could affect the sustainability of this service affecting patients in Buckinghamshire who are not covered by the OUH service.

6.4 Primary Percutaneous Coronary Intervention (PPCI)

FPH has stated an intention to develop a fully compliant PPCI service at WPH.

Within the Thames Valley, PPCI services are currently provided at the JR, RBH, WPH and BHT. It is estimated that c730 PPCI patients are treated each year in the Thames Valley, with c75% being treated at either the OUH or the RBH.

HWP currently has only a small amount of PPCI activity, with most patients living nearby being treated elsewhere, including a small number treated at FPH. The total number of patients affected is likely to be less than 80.

The national service specification indicates that there should be one 24/7 PPCI centre for every 600,000 to 1 million people. The Thames Valley population could therefore support two (or possibly three) units. In line with the FPH intention, a second catheter laboratory is under construction on the WPH site. BHT is also constructing a second catheter laboratory with the risk that Thames Valley has potential over provision.

This is a specialised commissioning service.

6.5 Specialised Commissioning

The FBC states an ambition for the new Trust to develop its specialised services and to repatriate activity from other Trusts.

There are currently 113 specialised services delivered across the Thames Valley with the majority being delivered by the OUH. WPH currently holds contracts for 14 specialised services.

A comparison of specialised services delivered at FPH but not HWP identified 26 services which the new Trust could potentially seek to expand and / or repatriate.

A national major review of specialised commissioning is currently being undertaken and could impact the new Trust's ambitions.

7. Clinical Stakeholder Forums

The Senate's interim report to the NHS England South, South Central Local Team stated that on the evidence available, it had established that this was a complex situation which presented both opportunities and potential risks for existing pathways and services within the Thames Valley.

To maximise the opportunities and to understand and mitigate against potential risks, the Senate recommended further engagement and dialogue across patient pathways and geography. As an impartial body in this scenario, the Senate recommended that it should continue to lead the work to further understand the impact of the acquisition.

The Senate recommended that further detailed work was required to:

1. obtain sufficiently detailed information to inform its final recommendations and
2. to enable it to provide clinical leadership to CCG commissioners by informing them of the wider implications of individual commissioning decisions and providing the clinical evidence base.

In order to gather the clinical views and evidence to inform the response, Clinical Stakeholder Forums, for each of the four clinical areas under review, were held during January and February 2015. The purpose of the Forums was to consider the potential impact of service proposals on a whole system basis to ensure that across the geography:

- services would be sustainable
- services would be accessible and of a high quality enhancing the patient experience
- any proposed service change clearly articulates the benefits to patients

The focus of the Forums was to consider each clinical area from four different perspectives:

- Patient experience
- Accessibility
- Quality
- Sustainability

An output report from each of the Clinical Stakeholder Forums is included in Sections 11-14.

8. Senate Recommendations

The question posed to the Thames Valley Clinical Senate by the NHS England South, South Central was:

What could be the impact of the acquisition of Heatherwood and Wexham Park by Frimley Park Hospital on clinical pathways for specialised services and other volume sensitive services?

From the outset, it was clear, from both the NHS England Local Team and CCG perspective, that the acquisition presented an opportunity to address both the quality and sustainability issues at Wexham Park Hospital (WPH). Frimley Park Hospital has achieved an outstanding CQC rating, the first Trust in England to do so, and has stated its intention to bring this rigour and passion to WPH.

It was not within the remit of the Senate to consider the acquisition itself or to debate the value or otherwise of the transaction. Its task was to consider the potential impact on the existing configuration of patient pathways.

Whilst recognising the opportunities, and not seeking to restrict the benefits which could arise from the acquisition, the Clinical Senate was asked to identify the impact of the transaction on clinical pathways and services.

From its initial reviews, the Clinical Senate identified that the immediate priorities for review were the service pathways for Primary Percutaneous Coronary Intervention (PPCI), vascular surgery, stroke and cancer.

The Senate Council met on 17th March 2015 to review the output of its work on this topic and to evaluate whether it had sufficient evidence to inform a formal response. The Senate was presented with the evidence compiled for the Clinical Stakeholder Forums and the subsequent output and considered the options this presented. It also had reference to the output of the Senate Assembly discussion and the work of the Thames Valley Strategic Clinical Network Clinical Directors.

The Senate felt that it was able to conclude some aspects of the topic but some new issues had been identified which required additional modelling and subsequent consideration to provide assurance that patients in and around Thames Valley were being best served by the proposals. Further work was undertaken between April and September 2015 and this is reflected in the recommendations below:

Senate Response

8.1 Primary Percutaneous Coronary Intervention (PPCI) Services

Frimley Health would like to provide a 24/7 PPCI Centre on the Wexham site. It has built a 2nd catheter laboratory and is recruiting additional consultant cover to facilitate this.

The National Service Specification indicates that there should be one 24/7 PPCI Centre for every 600,000 to 1 million people. This is a general estimate which does not take into account the demographic structure of the population or other factors influencing levels of need.

The Thames Valley population is circa 2.4 million and on the basis of the specification could therefore support a minimum of 2 and a maximum of 4 PPCI centres. Evidence favours a shorter time to procedure.

There are currently two compliant PPCI centres sited within the Thames Valley and they are at the John Radcliffe Hospital, Oxford (JR), and the Royal Berkshire Hospital (RBH) in Reading. Compliant PPCI centres on the Thames Valley borders which also treat Thames Valley patients are Frimley Park Hospital and the Royal Brompton and Harefield Hospital. Two further PPCI centres are located at Buckinghamshire Healthcare Trust (BHT) at High Wycombe, and Wexham Park Hospital, Slough. Neither of these services are currently compliant with the National Service Specification as they do not achieve the minimum caseload of 100 PPCI cases per annum and do not provide a 24/7 service. Both have a networked service with Harefield for out of hours cover.

Whilst supportive of the principle of the additional 24/7 centre at Wexham, the Senate was not assured, in the absence of modelling data, that that the numbers of PPCI cases that would go to Wexham Park would be sufficient to meet the minimum requirement of 100 PPCI cases. This view was based on the current activity level at Wexham of 44 cases pa (2012) and the evidence that the rates of cardiovascular problems are decreasing. The Senate therefore commissioned 2 additional pieces of work to:

- model patient flows and volume assuming the new centre was to proceed and
- to model population growth and demographics in relation to the changing disease incidence and the impact on existing centres.

The additional information was discussed at the Senate Council meeting in September 2015.

Recommendations:

1. The Senate supported the Frimley Health proposal to provide a 24/7 PPCI on the Wexham site on the following basis:
    - population need
    - that the centre would not destabilise other PPCI units
    - the benefit to the broader cardiology service at Wexham Park
    - on the assurance from Frimley Health that the unit would not be run if it did not meet the minimum specification.

2. The PPCI Centre at Buckinghamshire Healthcare Trust in High Wycombe is currently not compliant with the National Service Specification but provides a high performing service. The Trust does not currently have an ambition to make this a 24/7 service and proposes the continuation of the existing networked model with Harefield. Work undertaken by the Senate indicates that the centre is an important one for the Buckinghamshire population and has therefore agreed to take positive steps to address this with CCG commissioners and with the NHS England Specialised Commissioners

3. It was recognised that there are likely to be potentially poorer outcomes for patients requiring a secondary transfer and that these transfers could be avoided by appropriate direct admission to a PPCI Unit. The Senate recommends that the TV CVD SCN leads a piece of work to agree clear clinical protocols for clinicians and ambulance staff and governance arrangements for:
    - Patients presenting in-hours, to non PPCI centres where cath labs are available on site
    - Patients presenting to A&E at non-cardiac sites (Milton Keynes, Stoke Mandeville and Banbury). Further work is required to understand the scale of this issue.

    The Senate will have a watching brief on these pieces of work and will update its recommendations as a result of the work undertaken.

4. The Senate recommends that Frimley Health participates in the TV CVD SCN to promote links between services to benefit the Thames Valley population and particularly those in East Berkshire.

5. The Senate recommends that the TV CVD SCN undertakes work to ensure that patients from the Milton Keynes area are getting equivalent access to high quality PPCI services as patients in the rest of the Thames Valley.

8.2 Vascular Services

As part of the acquisition of Heatherwood and Wexham Park Hospital by Frimley Park Hospital, it was agreed that the new organisation, Frimley Health, would provide

vascular services to patients in East Berkshire from its vascular centre at Frimley Park with effect from 1st April 2015 creating a viable vascular network.

There is currently a compliant vascular network in place for Oxfordshire and Berkshire and work is underway for Buckinghamshire to join this network. Once this is complete, there will be two compliant vascular networks in place within the Thames Valley – one centred around the OUH and the other centred around Frimley Park. Activity at the OUH will be impacted by the change as some emergency activity will be repatriated to Frimley Health.

Recommendations:

6. The Senate was assured that the Thames Valley Vascular Strategic Clinical Network (TV Vascular SCN) is leading the work to include Buckinghamshire in the Thames Valley Network. The Senate carried out a clinical sense check of the proposals arising from this work in September 2015 and supported the proposal to progress with a vascular hub at the JR with spoke services being provided at RBH and BHT subject to:
    - the development of contingency plans
    - the provision of sufficient vascular support at the non-arterial centres to be agreed to ensure appropriate patient care (see point 7 below)
    - discussion with the Buckinghamshire HASC to agree the process for wider consultation

7. The Stakeholder Forums found that vascular networks are currently focussed around the specialised vascular services and the Senate recommends that work is undertaken to ensure that sufficient vascular consultant support is available at the non arterial centres to ensure appropriate patient care. This should include:
    - development of common standards and responsibilities for day to day support for local hospitals to improve access, experience and outcomes for patients.
    - agreement on which procedures could and should be carried out in local services and which in the vascular centre
    - agreement on how sustainable interventional radiology cover can be provided both for vascular services and local hospitals need for interventional radiology support across a broader range of clinical services

8. The Senate recommends that Frimley Health ensures that its connections, pathways and relationships between the vascular centre and local services in east Berkshire will facilitate safe and trusted transfer, particularly for rehabilitation.

9. The Senate recommends that Frimley Health participates in the TV Vascular SCN to promote links between services to benefit the Thames Valley population and particularly those in East Berkshire.

10. The Senate recommends that the TV Vascular SCN undertakes work to ensure that patients from the Milton Keynes area are getting equivalent access to high quality Vascular services as the patients in the rest of the Thames Valley.

8.3 Stroke Services

Within the information which Frimley Health originally shared with the Senate, it identified a clinical ambition to provide a hyper acute stroke service at Wexham. However FH revised its ambition during the course of this work and advised that Wexham will become a stroke rehabilitation facility with the Camberley site continuing as a hyper acute stroke centre.

There are currently six sites within Thames Valley providing stroke services to the Thames Valley population and these are at the JR, RBH, BHT, Horton General, WPH and Milton Keynes General. (There are a further three hospitals on the Thames Valley borders which also provide a stroke service to the Thames valley population and they are the Great Western (Swindon), Luton and Dunstable and Frimley Park. Of these nine hospitals, six are hyper acute stroke units (HASUs) (JR, RBH, BHT, Great Western, Luton and Dunstable and Frimley Park (Frimley Park is currently designated as a HASU and this is likely to be confirmed as part of the Surrey Stroke Review.)) The remaining three hospitals, the Horton, WPH and Milton Keynes provide acute stroke services (ASUs).

The Thames Valley Stroke Strategic Clinical Network (TV Stroke SCN) has recommended that the Thames Valley move from the 'Manchester' model of stroke services, where only those patients presenting within 4 hours of stroke onset are directed to a HASU, to the 'London' model meaning that all stroke patients would have direct admission to the closest HASU. The majority of the Thames Valley population lives in the catchment of a HASU but 500-600 patients each year are currently admitted to one of the ASUs.

Recommendations

11. The Senate recognised the robust evidence base for the London model and agreed that the evidence could be applied to the Thames Valley. It has supported the recommendation from the TV Stroke SCN to move stroke services from the Manchester to the London model of delivery with the John Radcliffe Hospital, Royal Berkshire Hospital, Frimley Park (Camberley) and Buckinghamshire Healthcare NHS Trust (Wycombe) identified as the hyper acute stroke units. The Senate supports the principle of the TV Stroke SCN recommendation but was unable to assess the impact of the pathway changes as local plans were not available. The Senate therefore recommends that, in line with the NHS England assurance guidelines,

individual CCG proposals should be subject to a Clinical Review prior to implementation.

12. To help mitigate unintended consequences on patient access and ambulance performance of the move to the London model, the Senate recommends that the TV Stroke SCN undertakes a modelling exercise with the South Central Ambulance Service to assess the impact of the proposed move including potentially increased ambulance times for some patients. The Senate will have a watching brief on this work.

13. It is known that circa 40% of patients with suspected stroke are likely to be 'stroke mimics' and the Senate sought assurance that the needs of these patients can be met at each of the HASUs. This is particularly relevant to the Wycombe HASU which does not have, on site, all of the services which are identified as co-dependencies. The Senate has reviewed reports regarding the management of patients with stroke mimic and found that the Wycombe HASU is able to meet the needs of these patients and recommends that it continues as a hyper acute stroke unit.

14. The Senate recommends that the TV Stroke SCN works with the Thames Valley CCGs to carry out a review of the stroke rehabilitation models and pathways to ensure that there is sufficient provision to facilitate continued patient recovery. The Senate will have a watching brief on this work.

15. The Senate noted that the Milton Keynes area does not currently follow the London model and recommends that the TV Stroke SCN reviews the options for the optimal service for patients in Milton Keynes.

8.4 Cancer Services

Frimley Health is keen to ensure as clear and simple as possible set of compliant cancer pathways. It currently links to the Royal Surrey County Hospital for its Surrey population and would ideally like to have a relationship with a single cancer centre partner for the East Berkshire population or, as a compromise, one centre per cancer type. It would like radiotherapy provision on the Wexham site provided by a cancer centre.

The OUH and the RBH are currently Thames Valley cancer centres. Services are compliant with the exception of urological cancer surgery which is not compliant with the Improving Outcomes Guidance. A new national Service Specification is awaited and compliance cannot be addressed until this is available but it was noted that the choice of centre covering the east Berkshire population could have a significant impact on access for the population of West Berkshire.

Radiotherapy for the Thames Valley population is provided at four main centres; the OUH, RBH (Reading and Bracknell) Mount Vernon Hospital and the Royal Surrey

Hospital. In line with the Radiotherapy Strategy, there are plans for radiotherapy provision at Milton Keynes and the Great Western Hospital (Swindon) and an additional LINAC at the Bracknell site.

Recommendations

16. The Senate supported the proposal to simplify pathways in line with the Improving Outcomes Guidance. This will give patients and clinicians clarity about where treatment will be provided. The Senate recommends that the Thames Valley Cancer Strategic Clinical Network (TV Cancer SCN) produces a patient flow map of the existing services and pathways to inform discussions.

17. The Senate recommends that patients are treated in accordance with compliant pathways with radiotherapy provision as close to home as clinically feasible. Subject to the production of the map identified in '16', the Senate recommends that Trusts, CCG commissioners and Network Clinical Groups monitor the patient flows to ensure that pathways are being applied on a local level.

18. The Senate recommends that commissioners should endorse the work undertaken by the TV Cancer SCN with regard to the Urology Cancer Surgery pathway.

19. The Senate did not feel that a case had been made for a single cancer relationship for east Berkshire patients but will review in light of the pathway work described.

20. The Senate found that there is an opportunity to plan and increase local radiotherapy provision within a distributed model and recommends that a refresh of the Radiotherapy Strategy is carried out focussing initially on areas of specific need to include Slough and mid and north Buckinghamshire. The refresh should take into account the Five Year Forward View, cost implications of running individual machines and staffing issues. It is noted that national guidance is still awaited. The work should be reported to a future Senate Council meeting.

9. References and Data Sources

1. NHS England Thames Valley Strategic Clinical Network 'Review of Primary Percutaneous Coronary Intervention (PPCI).' Ruth Barnes. November 2014.

2. NHS England Thames Valley Strategic Clinical Network 'Review of specialised vascular services (adults) in the Thames Valley' Dr Giok Ong. June 2014.

3. Department of Health. Radiotherapy Services in England 2012 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213151/Radiotherapy-Services-in-England-2012.pdf

4. The Clinical Co-dependencies of Acute Hospital Services: A Clinical Senate Review. South East Coast Senate. http://www.secsenate.nhs.uk/clinical-senate-advice/published-advice-and-recommendations/clinical-co-dependencies-acute-hospital-services-clinical-senate-review/

5. Cancer Research UK and NHS England. Vision for Radiotherapy 2014-2024. Radiotherapy: our vision for the next ten years - Cancer Research UK - Science blog

6. NHS England. Five Year Forward View NHS England » The NHS Five Year Forward View

7. Myocardial Ischaemia National Audit Project (MINAP)
   2012 MINAP Analyses 2012 - Datasets
   2013 MINAP Analyses 2013 - Datasets

8. British Cardiovascular Intervention Society.

9. Vascular Service Quality Improvement Programme

10. Association of Upper Gastro-intestinal Surgeons of Great Britain and Ireland. AUGIS outcome data. http://www.augis.org/outcomes-data/

11. Sentinel Stroke National Audits (SSNAP) 2013/14

12. Hospital Episode Statistics 2013/14

10. Thames Valley Clinical Senate Council

Membership of the Senate Council is as follows:

Dr Jane Barrett	Chair, Thames Valley Clinical Senate, Consultant Oncologist
Dr Michael Bannon	Dean, Health Education Thames Valley
Dr Lindsey Barker	Medical Director, Royal Berkshire Hospital NHS Trust
Stuart Bell	CEO, Oxford Health
James Drury	Director of Finance, NHS England, South, South Central
Prof Gary Ford	CEO, Oxford AHSN, Consultant Stroke Physician
Jan Fowler	Director of Nursing, NHS England, South, South Central
Dr Hugh Gillies	General Practitioner, Oxfordshire
Dr Abid Irfan	Chair, Newbury and District CCG, General Practitioner
Dr Lise Llewellyn	Director of Public Health, Berkshire
Helen Mackenzie	Director of Nursing, Berkshire Healthcare Trust
Karen Maskell	Patient/lay member
Dr Jackie McGlynn	Medical Director, Bracknell and Ascot CCG, General Practitioner
Dr Chris Morris	General Practitioner, Berkshire
Dr Jane O'Grady	Director of Public Health, Buckinghamshire
Dr Geoff Payne	Medical Director, NHS England, South, South Central
Mark Stone	Patient/lay member
David Williams	Director of Strategy, Buckinghamshire Healthcare NHS Trust

In attendance

Dr Aarti Chapman	Associate Director of SCN & Senate, NHS England South, South Central
Wendy McClure	Senate Manager, NHS England South, South Central

11. Appendix 1 – PPCI Clinical Stakeholder Forum

Primary Percutaneous Coronary Intervention (PPCI)

The PPCI CSF workshop was held on 30 January 2015. The question posed to the Forum was:

How do we provide heart attack (PPCI) services to the Thames Valley population and where would the PPCI centres be sited?

National Guidance

The key National standards for Primary Percutaneous Coronary Intervention (PPCI) are set out in the National Service Specification and include:

- Over 100 PPCI cases per hospital per annum and over 75 cases per operator per annum. The latter include planned PCI / angioplasty cases as well as unplanned/emergency PPCI cases.
- < 150 minutes 'Call to balloon time' (120 minutes as locally set standard) and < 90 minutes 'Door to balloon time.'
- PPCI centres should operate 24/7 and 365 days per year.
- Full resuscitation and other back up should be immediately available.
- Configuration: The national service specification indicates that there should be one 24/7 PPCI centre for every 600,000 to 1 million people. This is a general estimate which does not take into account the demographic structure of the population or other factors influencing levels of need.
- Across the Thames Valley with a population of approximately 2.4 million, we would therefore expect to have between two and at most four PPCI 24/7 centres.

The table below summarises national requirements:

Service specification key requirements	Service specification additional requirements
PPCI centres should operate 24/7 (24 hours a day, seven days a week) and 365 days per year	A PPCI centre should have two or more cardiac catheter laboratories
Each centre should perform a minimum of 100 PPCI procedures per year	There should be contingency planning in case of service reduction or withdrawal
Full resuscitation and other back up should be immediately accessible	A dedicated multidisciplinary team should be in place
A minimum of 75 PCI procedures per operator per year is required to maintain competence as an independent operator	There should be support from other disciplines such as anaesthetics and intensive care
Call to balloon time should be 150 minutes or less (120 minutes as a locally set standard)	Cardiac rehabilitation should be available to all patients on discharge
Door to balloon time should be 90 minutes or less.	

What the data says

A review of local Primary Percutaneous Coronary Intervention services is being finalised.[1] The Clinical Stakeholder Forum (CSF) drew from the draft review report and this paper will not seek to duplicate the detail contained within it. In preparation for the Forum data from the 2014 MINAP[2] report was reviewed. This was cross-referenced with BCIS[3] and Hospital Episode Statistics (HES data) where appropriate.

Current Pattern of Service:

- Six hospitals provide care for the Thames Valley population. They are Frimley Park, John Radcliffe, Harefield, Royal Berkshire, Wycombe and Wexham Park.
- Frimley Park, John Radcliffe, Harefield and Royal Berkshire provide 24/7 PPCI centres
- Wycombe and Wexham Park hospitals currently run PPCI services between 8.00am and 6.00pm Both have Out of Hours cover provided by the Royal Brompton and Harefield NHS Trust (Harefield).
- The national call to balloon target time is 150 minutes though the locally set target time is 120 mins. All six hospitals performed better against the 120 minute target call to balloon time and the 90 minute door to balloon time target than the England wide performance.

The data review shows:

- Frimley Park, John Radcliffe, Harefield and Royal Berkshire meet the 100 case requirement.
- Wycombe and Wexham Park hospitals did not meet the 100 case requirement:
- From historical 2012 data, three hospitals did not appear to meet the 75 cases per operator requirement: Harefield (for 7/13 operators) John Radcliffe (for 3/7 operators) and Frimley Park (for 1/7 operators). However the data presented at the workshop, while the best available was known to be out of date and did not take account of staff turnover during the years in question.
- The call to balloon time in <120 minutes performance has reduced in all but Royal Berkshire during 2013/14.
- Median call to balloon time for South Central Ambulance Service in 2013/14 was 97 minutes compared to 112 minutes nationally.
- 30 day unadjusted mortality rates for STEMI patients admitted to hospital between 2011 and 2014 were within expected rates for all primary PCI capable centres. As this data involves small numbers and does not reflect case mix, it is not generally regarded as valuable.

The updated data pack used to inform the CSF is attached as appendix XX.

[1] NHS England Thames Valley Strategic Clinical Network 'Review of Primary Percutaneous Coronary Intervention (PPCI).' Ruth Barnes. August 2014.

[2] Myocardial Ischaemia National Audit Project

[3] British Cardiovascular Intervention Society audit

Known plans

National guidance indicates there should be one 24/7 PPCI centre for every 600,000 to 1 million people. The Thames Valley population is approximately 2.4 million which suggests the population base in Thames Valley would support an additional 24/7 PPCI centre.

The main proposals for change across and around the Thames Valley were summarised at the CSF as follows:

- Frimley Health propose to develop 24/7 PPCI with a second catheter laboratory and sufficient consultant cover at Wexham Park Hospital. This would create three PPCI 24/7 centres immediately within the Thames Valley with Harefield and Frimley Park also providing some cover
- Buckinghamshire Healthcare is developing a second catheter laboratory at Wycombe but does not aspire to provide 24/7 cover as this is provided through a networked approach with Harefield Hospital.
- It was noted that Basingstoke currently provides a 24/7 service which is proposed to be relocating to a new acute treatment centre further down the M3 but with a very small anticipated change in travel times and hence minimal impact on flows.
- Swindon currently provides a daytime only service.

Opportunities and Risks - Output from Opportunity and risk Assessments

The CSF identified a number of key themes and issues.

Improving the patient experience

- The greatest risk to a good outcome for patients is time and there is a need for more public education to inform patients what to do when they have chest pain and the importance of getting the right treatment as quickly as possible - to reduce avoidable self-presentation at A&E or a non PPCI centre.
- Provide additional training for staff in non PPCI centres and A&E's without a PPCI centre, on heart attack symptoms and the importance of timeliness to enable them to respond to these patients appropriately and get them to the right place quickly for the correct intervention.
- A review of hospital processes from A&E to PPCI centre should be carried out to ensure that it is slick and that there are no delays in the pathway.
- Provide additional training for primary care to improve transfers and reduce avoidable presentations at an A&E without a PPCI centre.
- There is an opportunity to improve the quality of transfer to hospital for PPCI. Inform the patient of what is happening – during the transfer and the treatment
- The evidence of speed to balloon is compelling and supports the argument for a 3rd 24/7 PPCI centre

Improving patient access

- Additional mapping of patient flows required to identify where the Buckinghamshire patients would go if Wycombe was unable to continue as a networked PPCI centre.
- Need a national push on patient education – similar to the stroke campaign – to advise patients to call for help early.
- Secondary transfers are a risk to good outcomes. Data collection required to identify how many patients this affects (MINAP/BCIS could provide). Also look at how many patients are transferred from the non 24/7 service at Wexham in and out of area.
- Modelling impact of any proposed re-provision of services on ambulance flows will be required.
- Design a future proof system.

Clinical Quality

This group specifically considered the proposal for a 24/7 service at Wexham.

- Opportunities arising from the proposal were identified as:
  - 24/7 coverage closer to a high risk population
  - The sustainability of the PCI service at Wexham
  - Releasing ambulance crews from transferring patients out of area – though the numbers of patients were not known and needs to be collected.

- Risks were identified as
  - the development would probably add to net provider costs within Thames Valley, though should not increase commissioner costs. The business case for any such development was also likely to include cardiology elective flows.
  - Confidence in data accuracy and whether the centre would meet national minimum volume recommendations which would impact on its general sustainability – additional modelling required.
  - The proposal does not support the need in the north of the patch

- Overall, there was support for the development of a further 24/7 PPCI centre at Wexham Park but there was a recognition that we need to be designing for the future and need to recognise the future service specification for PPCI. There is also a need to obtain the numbers of people from the Wexham area going to other centres out of hours.

Clinical sustainability.

- There is a risk of establishing a third 24/7 centre in Wexham to Wycombe and its acute cardiac unit (ACU).

- Further data is required to be sure of predicted activity as current numbers at Wexham are small for a 24/7 economy. There is a need to understand patient flows, out of hours transfers and elective and non-elective balance.
- The provision of PPCI and indeed all cardiology requires a broad skilled clinical team in the pre-hospital, hospital and post-acute rehabilitation environments. There were some particular recruitment difficulties especially around cardiac physiologists. The importance of support from radiology was also recognised.
- A third centre at Wexham would not address the issues in the north of the patch and the question was asked whether Aylesbury would be an option to cover Milton Keynes? It was noted that previous modelling showed no better population coverage from this option.

Conclusions from the PPCI Clinical Stakeholder Forum

The following was agreed at the Clinical Stakeholder Forum:

1. The CSF supported a third 24/7 PPCI centre in the Thames Valley and felt that the most appropriate location would be Slough subject to:
   - confidence in data accuracy and whether the centre would meet national minimum volume recommendations which would impact on its general sustainability – additional modelling required.
   - additional modelling to map the anticipated revised patients flows for PPCI by centre across Thames Valley
   - provision of public health modelling for future populations – design a future proof system
   - commissioner review of the anticipated impacts on local patient flows and costs
   - the new centre must meet the national specification

2 It was recognised that there are likely to be poorer outcomes for any patients requiring secondary transfer. This potentially involves Thames Valley patients presenting at Stoke Mandeville, Milton Keynes and the Horton where there is an A&E but no facility for PPCI. Further work is required to understand the scale of this issue and what could be done to mitigate the risks. Clear protocols for decision-making are needed for ambulance and A&E clinicians.

3 Buckinghamshire Healthcare stated that the Wycombe cardiology service is sustainable as a cardiology service without 24/7 but assurance needs to be sought.

4 Further work is required to consider governance and protocols for patients presenting at a non 24/7 centre:
   - For patients who require immediate PPCI presenting in hours to non-24/7 centres where catheter laboratories are available on site for limited hours.
   - For patients presenting to non-cardiac sites and requiring secondary transfer.

5 Workforce shortages already exist – further consideration and modelling will be required

6 Opportunity and need for patient education
- For vulnerable communities – such as Slough
- For wider communities – recognising symptoms and acting appropriately

12. Appendix 2 – Vascular Stakeholder Forum

Vascular Services

The Vascular CSF workshop was held on 30 January 2015. The question posed to the Forum was:

How do we provide networked provision for specialised and non specialised vascular services for the Thames Valley population?

National Guidance

The key national standards covering vascular services only cover specialised services and do not cover critical aspects of vascular services such as support for local outpatient clinics and inpatient opinions, for instance for diabetics and patients with compromised legs.

The 'core standards' section of the 2013/14 NHS Standard Contract for Specialised Vascular Services (adults) is summarised below. This incorporates a wide range of other standards including NICE, VSGBI and NCEPOD[4].

Activity Volumes	Organisation of services
• Arterial centres, o Six surgeons, each with ±10 AAA[5] procedures per year would equate to 60 AAA procedures per centre. o A commensurate number of lower limb procedures. o A minimum number of 50 CEAs[6]. • Endovascular aneurysm repair (EVAR) will only be performed in specialist centres by clinical teams experienced in the management of AAAs.	• Separation of vascular and general surgery • Patients with a vascular emergency will have immediate access to a specialist vascular team at the arterial centre with on-site vascular surgery and interventional vascular radiology

It should be emphasised that vascular services are delivered by a wide and skilled clinical team including interventional radiologists, specialist nurses, anaesthetists and vascular surgeons. A number of these staff including interventional radiologists have critical roles supporting other clinical services.

[5] Abdominal Aortic Aneurism
[6] Carotid Endarterectomy

What the data says

A review of local specialised vascular services has recently been completed.[7] The Clinical Stakeholder Forum drew from this and this paper will not seek to duplicate the detail contained within it. In preparation for the Forum data from the latest VSQIP[8] report was reviewed. This was cross-referenced with hospital episode statistics (HES data) where appropriate.

The data review was limited to specialised vascular procedures including abdominal aortic aneurysm repair (AAA); carotid endarterectomy (CEA) and lower limb amputation.

Vascular activity is 70% elective, 30% non-elective.

Current pattern of Service:
As at January 2015, the pattern of service for Thames Valley residents is:

- Compliant vascular network in place for Oxfordshire and Berkshire
- Elective and non-elective AAA service provided by Oxford University Hospitals (OUH)
- CEA service provided by OUH for Oxfordshire and West Berkshire
- Buckinghamshire Healthcare currently joining the network service for non-elective AAA and major elective service. Previously BHT had provided an AA and CEA service for Buckinghamshire and East Berkshire.
- From April 2015, East Berkshire will join the vascular network, centred on Frimley, with transfer of elective and non-elective vascular activity from Oxford into this network.

The 2013/14 AAA activity data by Trust indicates:

- Frimley Park and OUH exceeded the recommended 60 procedures per year (combined urgent and elective/planned activity).
- Buckinghamshire Healthcare falls below the 60 procedure threshold (circa 30)

The CEA activity data for 2013/14 by Trust indicates:

- Buckinghamshire Healthcare, OUH and Frimley Park CEA rates met the minimum rate of 50 procedures in 2013/14 (combined urgent and planned activity).

[7] 'External review of specialised vascular services (adults) in the Thames Valley are' by Dr Giok Ong. for NHS England Thames Valley, June 2014.

8 VSQIP – Vascular Service Quality Improvement Programme

Known plans

The main proposals for change across and around the Thames Valley were summarised at the CSF.

- Frimley vascular network will cover Wexham Park from 1st April
- Implementation of the Thames Valley Review proposals are in progress. Buckinghamshire Healthcare NHS Trust (BHT) is joining the Thames Valley / Oxford network. Discussions are ongoing around the working of the Thames Valley network including rota arrangements for Buckinghamshire HT surgeons and local hospital vascular cover for RBH & BHT and a revised repatriation policy.

- These changes will need operational protocol changes with the South Central Ambulance Service.

Opportunities and Risks - Output from Opportunity and risk Assessments

The CSF identified a number of key themes and issues.

Improving the patient experience

- Berkshire and South Buckinghamshire patients being referred to the Frimley Park arterial centre will need to have timely rehabilitation provided close to home. Frimley Park will need to develop new links with community hospitals and services in Berkshire/South Buckinghamshire to ensure safe and trusted transfers. This is an opportunity to look at new models of care.
- In relation to AAA / CEA MDTs it was considered there needed to be improvements in making the appropriate offer through improved engagement with patients regarding major surgery. Robust data and other options open to patients should be shared to inform choice and quality of life.
- In non-arterial centres, there will not always be a vascular surgeon on site to assist or advise on surgery that unexpectedly requires vascular input. This could be managed by greater consideration given to risk rating them and scheduling operations for when there would be a vascular presence.
- There is a need for a daily presence of consultants and specialists at non arterial sites to support patients requiring non-specialised treatment. For example: diabetic foot care and care for frail elderly patients.

Improving patient access

- There is acceptance that outcomes for patients in high risk interventions such as AAA and CEA are improved in high volume centres, but this needs to be balanced by developing the network based around the patient pathway.

- Support and maximise opportunities in primary care for early intervention and prevention to reduce the number of patients requiring the services in the arterial centres.
- Consideration of how the vascular centres best provide local support needs to include a focus on a patient centred pathway and clear communications, underpinned by consistent agreed service levels and clear yet flexible protocols.

Clinical quality

- Re-iteration of the need for post-operative rehabilitation close to home and the difficulties of obtaining this when surgery has taken place in an arterial centre
- Networks need to consider how sustainable interventional radiology cover can be provided for both vascular services and local hospitals' need for interventional radiology support across a broader range of clinical services.
- Trainees and students in arterial centres will have greater opportunities for quality and quantity of training, which has to be balanced by the reality that trainees and students in non-arterial centres would miss opportunistic training experiences if patients are not coming to their centre.
- Review ambulance protocols in light of the revised network.

Clinical sustainability

- Re-iteration of the issues regarding interventional radiology cover
- Centralisation into fewer centres with greater clinical volumes creates opportunities for:
  - High quality sustainable training programmes
  - Capital investment and high tech kit
  - Sustainable on-call rotas 1:6 -> 1:8
  - Clearer care pathways and patient flows

Conclusions from the Vascular Clinical Stakeholder Forum

The following conclusions were agreed:

1. There was a widespread view that previous reviews of vascular services had been overly focussed on specialised services, which was necessary but not sufficient to ensure good patient experience across the network. Future work should encompass the whole patient pathway and be focussed on the patient.

2. It was noted that there are now two clear vascular service networks based around Oxford and Frimley. It was agreed that these could deliver learning and training opportunities for all vascular team members with on call 7/7 cover for vascular services.

3. There is a risk that the vascular network system is designed to serve the low numbers of high risk patients at the expense of the majority of patients with vascular compromise. There is a need therefore to design the system around the patient

pathway and to agree common standards around daily support to local hospitals and health systems for non-specialised vascular services.

4. It was suggested there would be value in both vascular networks developing and sharing common standards for local service provision. This needs to include agreement about which procedures could and should be carried out in local hospitals, and which in the vascular centre, in order to support patient pathways, local service integration, protect the vascular centre's capacity and continue to improve outcomes.

5. There was agreement that arrangements need to be in place for the provision of post-operative rehabilitation services for patients and that this will require the development of new relationships for the Frimley arterial centre. Rehabilitation should ideally be provided by community providers rather than hospitals and there is an opportunity to look at new models of provision.

6. Networks need to consider how sustainable interventional radiology cover can be provided both for both vascular services and local hospitals' need for interventional radiology support across a broader range of clinical services.

7. Support and maximise opportunities in primary care for early intervention and prevention to reduce the number of patients requiring the services in the arterial centres.

13. Appendix 3 – Stroke Clinical Stakeholder Forum

The Stroke CSF workshop was held on 10th February 2015. The question posed to the Forum was:

How should stroke services be provided to the Thames Valley* population, following the London model, and where would the hyper-acute services be sited?

A hyper acute stroke unit (or HASU) is where there is a stroke triage system, expert clinical assessment, timely imaging with expert interpretation, the opinion of a consultant stroke specialist and where the ability to deliver intravenous thrombolysis are available throughout a 24-hour period.

National Guidance

The **National Stroke Strategy (2007**) 'Markers of a quality service' include:

Stroke

- All patients with suspected acute stroke are immediately transferred by ambulance to a receiving hospital providing hyper-acute stroke services for at least the first 72 hours of their care.
- Patients with suspected acute stroke receive an immediate structured clinical assessment from the right clinicians.
- Patients requiring urgent brain imaging are scanned in the next scan slot within usual working hours, and within 60 minutes of request out of hours with skilled radiological and clinical interpretation being available 24 hours a day.
- Patients diagnosed with stroke receive early multidisciplinary assessment – to include swallow screening (within 24 hours) and identification of cognitive and perceptive problems.
- All stroke patients have prompt access to an acute stroke unit and spend the majority of their time at hospital in a stroke unit with high-quality stroke specialist care.
- Specialist nursing is available to monitor patients.
- Appropriately qualified clinicians are available to address respiratory, swallowing, dietary and communication issues.

Transient ischaemic attack (TIA) and minor stroke

- Immediate referral for appropriately urgent specialist assessment and investigation is considered in all patients presenting with a recent TIA or minor stroke.
- A system which identifies as urgent those with early risk of potentially preventable full stroke – to be assessed within 24 hours in high-risk cases; all other cases are assessed within seven days.
- Provision to enable brain imaging within 24 hours and carotid intervention, echocardiography and ECG within 48 hours where clinically indicated.

The CSF noted that no formal national advice was given on other services or specialities to support a HASU and stroke services. Dr Matthew Burn, local SCN stroke lead, however stated that there needed to be 24/7 on site medical and ITU teams.

What the data says

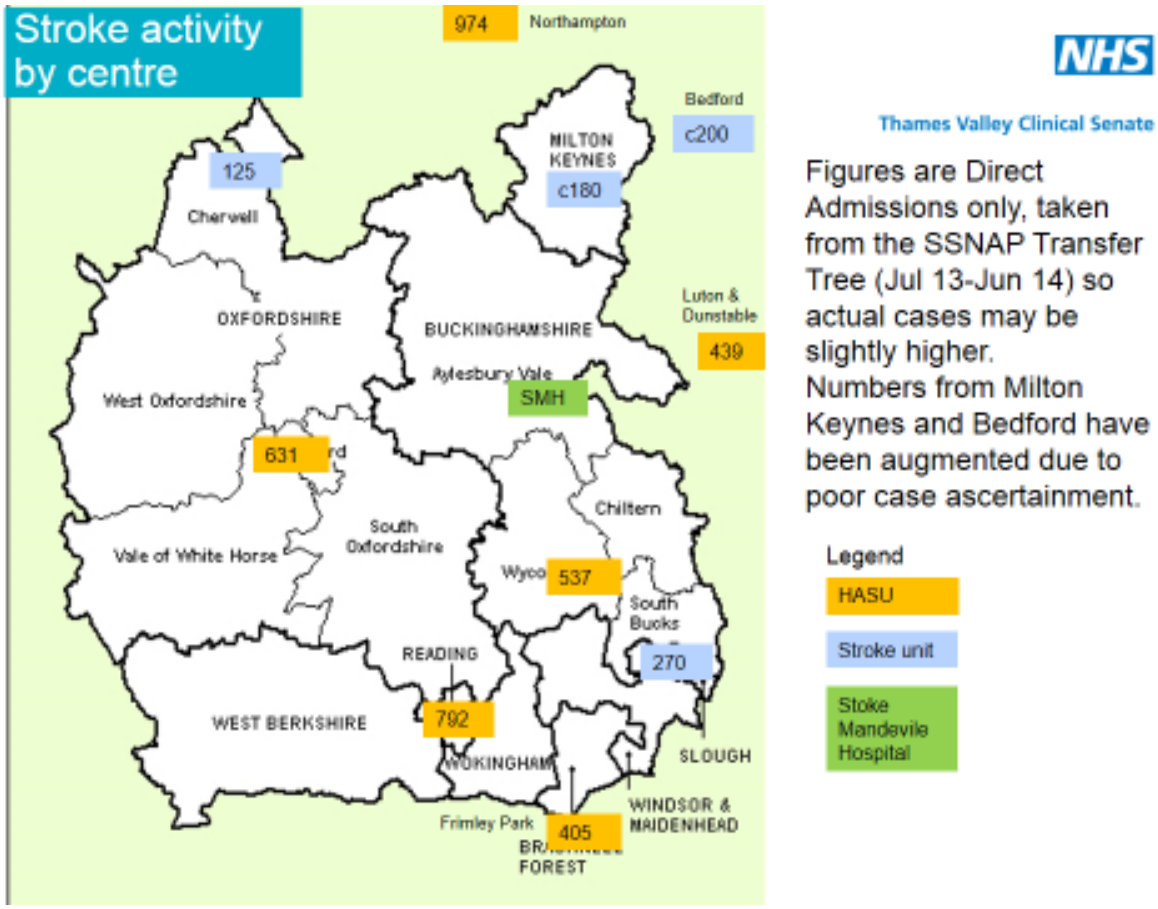
In preparation for the Clinical Stakeholder Forum (CSF) the recent work of the Strategic Clinical Network (SCN) and data from the Sentinel-Stroke-National-Audit-Programme (SSNAP) and Hospital Episode Statistics (HES data) was reviewed. These are both data sources submitted by hospital providers with SSNAP recording detailed information about the care of individual patients by clinical team and across their whole pathway.

Current Pattern of Service

At present, Thames Valley follows the Manchester model for stroke care but with an intention to move towards the London model. The Thames Valley population is currently served by the following stroke services:

- Six hyper acute stroke units (HASUs) at Frimley Park Hospital, Great Western Hospital, John Radcliffe Hospital, Royal Berkshire Hospital, Wycombe Hospital and Luton and Dunstable, each of which admit over 400 stroke cases per annum.
- Three stroke units at Horton Hospital, Milton Keynes Hospital and Wexham Park Hospital, which admit between 121 – 245 stroke patients per annum.

This is summarised in the map below



Key findings from the data review were:

- In 2013/14 2,822 patients were admitted to hospital for stroke from the Thames Valley CCGs.
- For every 100 patients attending a hospital with suspected stroke approximately 60 will have stroke confirmed and 40 will be 'stroke mimics' with other conditions (such as seizures, syncope, migraine, sepsis and functional illness) which also often require specialist care. This is likely to be well provided by the sort of clinical team available in a HASU.
- The 2013/14 Stroke Standardised Mortality Ratio was within the expected range for all Thames Valley CCGs.
- There is some evidence that care processes are better at HASUs, for example percentage of patients scanned within one hour, percentage of patients on a stroke unit in under four hours, and percentage seen by a stroke consultant in under 24 hours.
- Length of stay is generally shorter in HASUs than in smaller stroke units
- Performance against the nationally identified key core processes has been tracked using SSNAP data for the units serving Thames Valley. This shows a general improvement trend across all units but with some wide variations in current performance. According to this data, local HASUs were performing well in general with the exception of Luton and Dunstable.
- Nationally, and locally, 40% of patients with stroke have a known time of onset and arrive at hospital within four hours of this time. Thrombolysis for eligible patients is much more effective within four hours. However, in Thames Valley 11% of this cohort are taken to non-HASUs. This is approximately 100 patients per year according to the SSNAP data. 20% of stroke patients arriving at non-HASUs arrive there within four hours of a known time of onset

Known plans

The main proposals for change across and around the Thames Valley were summarised as:

- The intent of the Thames Valley SCN to move from the 'Manchester model' for stroke care towards the 'London model.'
- The forum also considered the implications of the West Surrey Stroke Review, the likely designation of Frimley as a HASU and the potential development of further HASU sites for Surrey.

The 'Manchester Model'

This is the model Thames Valley has had since 2011 when commissioners and the SCN undertook a process to designate a number of local HASUs and stroke units (as described above). In this 'Manchester' model, patients go to a HASU *if they present within the four hour* 'thrombolysis window', but otherwise will go to their local stroke unit. Most patients in the catchment of a hospital with a stroke unit but not a HASU will never go to a HASU.

In practice, the majority of the population of Thames Valley live in the catchment of a HASU rather than a standard stroke unit, and 75-80% of patients are directly admitted to a HASU. This leaves 500-600 patients a year admitted directly to standard stroke units.

The 'London Model'
In this model, a HASU is defined as a unit that takes all patients with stroke for the first 72 hours of their care, regardless of whether they can receive thrombolysis. One feature of such units is a high volume of patients. This is associated with effective processes of care, and allows investment in augmented levels of staffing. A national consensus is emerging that if possible all patients should be admitted to these units, seeing between 600-1500 patients a year.

Chiltern CCG has already changed its commissioning arrangements for hyper acute stroke care from Wexham to Wycombe for all South Buckinghamshire residents with acute stroke, regardless of whether they are in the 'thrombolysis window'. Other Thames Valley CCGs are also considering consulting on this move to a 'London model' in Oxfordshire and East Berkshire.

There are no proposals to change the designation of any specific units within Thames Valley. However Surrey CCGs are undertaking a collaborative stroke review. This is highly likely to designate Frimley Park as the HASU for West Surrey. There is a potential development of a HASU at St Peters Hospital in Chertsey, as one of three possible central Surrey sites.

It was also noted that North Hampshire Hospitals NHS FT is planning to develop a critical treatment centre off the M3 south of Basingstoke, which would give rise to the possible relocation of it's existing HASU from Winchester.

Opportunities and Risks - Output from Opportunity and risk Assessments

The CSF identified a number of key themes and issues.

Improving Patient Experience.

- There is an opportunity to site units so that the greatest number of patients get timely access to the HASU and so that each centre has sufficient number of patients to be viable – 600 minimum
- Patient experience is influenced by softer skills such as the care delivery measures shown in SSNAP.
- Stroke mimics – each unit needs to have capacity and expertise to handle these patients.

- There is a risk with the proposed move to the London model if patients and the public are not supportive of the 'best outcome' versus 'nearest possible site' debate.
- There was recognition that the current patient flow from East Berkshire is to High Wycombe, Reading and Frimley.
- As is the case with any service reconfiguration, commissioning decisions must be influenced and shaped by the views of patients, families, carers and the third sector. It was noted that the Stroke Association's patient experience led survey had provided useful insights.

Patient accessibility.

- The 'London' model with all patients going to HASUs enables one clear ambulance pathway reducing the need for secondary transfers. This has the potential to increase the number of patients with a stroke mimic being taken to a HASU and a question was raised as to whether Wycombe unit has the capacity and capability to handle these patients.
- There is a benefit in a one tier service with all stroke patients receiving HASU care.
- Opportunity for clarity and rationale for consultation on patient pathway.
- The London model would result in longer ambulance travel times with more patients exceeding the call to door time target of 60 minutes.
- There is a potential staffing risk regarding recruitment and retention at acute stroke units
- There is a risk that it may be harder to repatriate patients within the London model and so there needs to be assurance that there is sufficient capacity and staff to provide stroke rehabilitation. Review rehabilitation pathway: HASU–> Community or HASU –> ASU –> Community? Look at providing Stroke rehabilitation and Neuro rehabilitation on one site.
- Need to ensure that there is sufficient capacity and ITU and medical support for stroke mimic patients.
- There was a concern that the north of Thames Valley was not getting an equivalent service and this requires further work.

Clinical quality

- A single clear 'London' model with all patients going to HASUs makes it clearer for the ambulance service. Defined HASUs remove ambiguity of pathways and drive up the potential outcomes for patients.
- HASUs should be co-located with Emergency Department/district general hospital services to include those patients who self-present or have ambiguous symptoms. Additional data is required as follows:
    - outcome data from Wycombe re Stroke patients who are secondary transfers into Wycombe.

    - Outcome data from Wycombe re outcomes and need for secondary transfer for stroke mimics.
    - Review of evidence for co-location of stroke unit with an Emergency Department
- Appropriate rehabilitation facilities to maintain the flow for HASU and end to end quality of service for patients – commissioners will need accountability for addressing poor performing services.
- A more resilient workforce will result in improved consistency of performance across standards.
- There needs to be more focus on outcome measures and less on proxy targets such as time, which are challenging for some geographic locations and a potential distraction from best outcomes.
- The group supported the continuation of the HASUs at RBH, Frimley, and OUH but had some concerns about the long term sustainability of the Wycombe HASU.

Clinical sustainability

- Opportunity for commissioners to commission so that funding is available to support a patient-led service. Use the flexibility of co-commissioning and the Five Year Forward View to do things differently.
- With more patients going directly to HASUs, there is a need and opportunity to improve repatriation and stronger links to associated services including social services for early supported discharge – this is an opportunity to try new models.
- There is a need for a simple model – 'if it looks like a stroke the ambulance should go to the nearest HASU'.
- Wycombe HASU operates without an on-site acute medical unit. Assurance will be needed to endorse it for the future – particularly regarding rehabilitation which needs stroke team support, impact of secondary transfers and care being designed around integrated services rather than geography.

Conclusions from the Stroke Clinical Stakeholder Forum

The following was agreed at the Clinical Stakeholder Forum:

1. The Forum supported the proposed move to a 'London model' of stroke care with direct admission for all stroke patients to HASUs.

2. Continued use of the designated current HASUs:
    - Reading
    - Wycombe
    - Frimley
    - Oxford

3. Given the intention to move to the London model, the long term sustainability of the Wycombe HASU and the required supporting clinical services for a HASU should be reviewed. An independent review of the operation, performance and sustainability of the unit has already been commissioned by Buckinghamshire Healthcare and will be made available, by the Trust to support the review.

4. Further work to be undertaken to review the numbers of:
   - patients currently presenting at non HASUs and their onward pathway
   - patients with stroke mimic presenting, their care needs and how these patients are currently being managed.

5. Further feasibility review and planning required:
   - Modelling work with the ambulance service to assess the impact of the proposed introduction of the London model – increased travel times and impact on wider service.
   - Working with providers and commissioners to understand the needs, care pathway and capacity requirements of stroke mimic patients.

6. There is a need to work with providers and commissioners to review local stroke rehabilitation models and pathways and ensure that repatriation policies are clear and have sufficient capacity provided to meet the needs of stroke and stroke mimic patients. Improve links with social services. Commissioners to be accountable for ensuring that patient flow from HASU to rehabilitation is timely.

7. To provide continuing support to CCGs in articulating the case to the public for the 'London model'.

8. In terms of performance monitoring, there needs to be more focus on outcome measures and less on proxy targets like time, which are challenging for some geographic locations and a potential distraction from best outcomes.

9. To consider the issues of recruitment and retention at acute stroke units

10. To raise with Milton Keynes and Aylesbury Vale CCG issues around access and performance of HASU(s) serving their population.

11. Further work is required to embed patient experience feedback including support for families and carers into the local commissioning of stroke services.

14. Appendix 4: Cancer Clinical Stakeholder Forum

The Cancer Services CSF workshop was held on 10 February 2015. The question posed to the Forum was:

'How should we provide cancer services to the Thames Valley* population?'

The CSF focussed on, the provision of radiotherapy, which is a common part of many patients' treatment, and some of the specific cancers which may require surgical and other treatment at a specialist centre, including urology, upper GI and gynaecology. It also considered Frimley Health's intention to simplify and clarify cancer centre partnership arrangements for the Thames Valley population receiving their treatment at Heatherwood and Wexham Park Hospitals.

The CSF did not focus on the provision of services for common cancers, such as breast, colo-rectal and lung, as these are mainly treated in local acute hospitals.

National Guidance

The current guidance around the provision of cancer services has been developed over the last ten years, by national clinical reference groups using the best available evidence and professional judgement. A series of national standards have been produced in 'Improving Outcomes Guidance' (IOG) or 'National Service Specifications.' These describe the services and processes required to diagnose, treat and care for people with particular cancer types. Where specialist surgery is likely to be required for less common cancers, specific guidance around volumes and population sizes have been developed. This primarily relates to volumes of surgery per Trust or per operator and these were summarised for the CSF. Some National Service Specifications are currently under review by Clinical Reference Groups, with uncertain timescales for publication.

Radiotherapy is a key treatment used in most types of cancer. It is usually given to patients with cancer using a linear accelerator (LINAC) for external beam radiation treatments. The linear accelerator is used to treat all parts/organs of the body. It delivers high-energy x-rays to the region of the patient's tumour.

Radiotherapy provision in England has recently been reviewed, following previous reports, and the findings of the review are currently being implemented.[9] The report has recommended planning for an increase in radiotherapy delivered to meet the needs of an ageing population. This in turn will require more linear accelerators (LINACs), more productive use of existing machines and a corresponding development of the workforce. In addition, the adoption of latest technology is recommended with a move to a future technical standard for radical treatment which allows better treatment of tumours[10]. At present, only about half of LINACs nationally have the appropriate technical capability. Intensity Modulated Radiotherapy (IMRT) is used in conjunction with this more sophisticated technology. A national best practice target has been set of 33% of all

[9]https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213151/Radiotherapy-Services-in-England-2012.pdf

[10] Four-dimensional adaptive radiotherapy (4D ART)

radical fractions delivered with IMRT. Progress towards this across the country when reviewed in 2012 was slow.

What the data says

In preparation for the Clinical Stakeholder Forum (CSF) the recent work of the Strategic Clinical Network (SCN) was reviewed along with data from: the National Radiotherapy Review; Hospital Episode Statistics (HES) around total Trust activity and patients from Thames Valley CCG's treated in hospitals outside the Thames Valley, such as London teaching hospitals. In addition, the National Peer Review 2013 and 2014 scores, 2014 National Cancer Patient Survey and catchment populations for cancer centres using national/strategic clinical network analysis were reviewed.

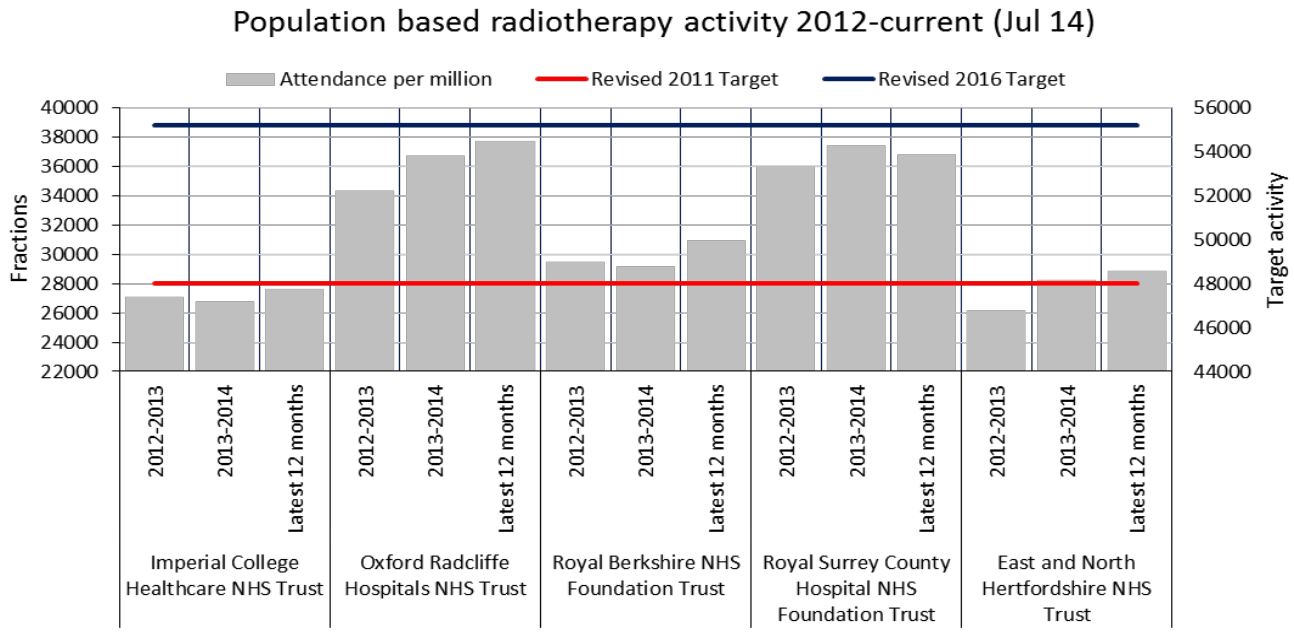
Current service provision:

- Specialist gynaecology cancer surgery: Compliant services are provided by Oxford University Hospital covering most Thames Valley CCGs; Hammersmith (part of Imperial College FT) serving East Berkshire and Royal Surrey County Hospital.
- Specialist upper gastro-intestinal cancer surgery: Compliant services are provided by Oxford University Hospital and Royal Surrey County Hospital, both of which meet the national professional (AUGIS)[11] recommendation of 60 oesophageal and gastric resections per centre per year.
- Specialist urology cancer surgery: Urology in Thames Valley is not compliant with IOG guidance. A Thames Valley Strategic Network project (now including Frimley Health) is addressing this but work is on hold awaiting the anticipated revised National Service Specification.
- Radiotherapy for Thames Valley residents is provided in four main centres with catchments ranging from 1.4 million for Oxford, c1.2 million for Royal Surrey, 800K for Royal Berkshire to just under 2 million for Mount Vernon (part of East and North Hertfordshire NHS Trust).
- Previously (2009) agreed local Trust/commissioner plans for Radiotherapy services include LINACs at Milton Keynes (in planning with interim use of local private facility) and Great Western Hospital sites by the Oxford University Hospitals [in planning] and a LINAC in Bracknell provided by the RBH [operational].

Key findings from the data review were:

- In 2013/14, 83% of urology, gynaecology and upper GI cancer patients received specialist surgery within the Thames Valley, with a complex variety of patient flows to other tertiary centres in London, Bristol, Surrey and Northampton
- Overall radiotherapy activity for Thames Valley is currently below national target levels but is on course to meet 2016 targets. All centres have shown considerable increases in productivity and activity over the last three years as shown in the figure below and have met or nearly met the IMRT target.

[11] Association of Upper Gastro-intestinal Surgeons of Great Britain and Ireland. AUGIS also collects and publishes outcomes data. http://www.augis.org/outcomes-data/



Known plans

The main proposals for change across and around the Thames Valley were summarised as:

- Cancer Centre support arrangements for common and specialist cancer treatment across Thames Valley CCGs are generally clear. As noted above these are generally compliant with national guidance except in specialist urology cancer surgery.
- East Berkshire has a complex series of flows and a distributed model of support from multiple cancer centres including Oxford, Reading, London and Mount Vernon.
- Frimley Health is keen to ensure a clear and as simple as possible set of compliant patient pathways with ideally a single cancer centre partner, as a compromise at least per cancer type.
- Specialist gynaecology and upper GI cancer surgery are both compliant for the Thames Valley population at present and should remain so, at least in regards to catchment populations, regardless of where the East Berkshire population flows in future. Oxford is currently the main surgical centre for both areas for Thames Valley (with some East Berkshire flows to London).
- Specialist urology cancer surgery is not currently compliant in Thames Valley with resolution awaiting national CRG guidance. The choice of the main centre covering East Berkshire would have significant impact on the sustainability of the previously agreed Thames Valley South Cancer Centre.
- Radiotherapy provision across Thames Valley is being increased by plans for new LINACs provided by:

  - Oxford University Hospitals at Milton Keynes (in planning with interim use of local private facility) and the Great Western Hospital site [business case approved].
  - Royal Berkshire FT plans for a second machine at RB Bracknell.
- Frimley Health has an aspiration for local provision of radiotherapy in Slough provided by an appropriate Cancer Centre.
- It was also noted that North Hampshire Hospitals FT, which is not a cancer centre, operates a LINAC at Basingstoke providing a limited range of mainly palliative treatments. North Hampshire Hospitals FT and Southampton Universities Hospitals FT work together through a Joint Radiotherapy Board, ensuring common treatment protocols and joined up patient pathways.

Opportunities and Risks - Output from Opportunity and risk Assessments

The CSF identified a number of key themes and issues.

Patient Experience and Accessibility – Specialist Cancer Surgery

- There is an opportunity to improve the experience for patients with less common cancers needing surgery if they can access a specialist centre properly geared for their care. The Royal Berkshire cystectomy service was cited as a good example.
- The majority of care, such as radiotherapy, can be delivered locally (80:20 rule) with good communication and record sharing. There is an opportunity to increase local provision.
- Ensuring continuity of care is important, especially when non-local specialist teams are involved. Appropriate support for local clinic services are important although it was recognised that this might be difficult in some highly specialised areas where numbers are very small.
- A concern was expressed about over-reliance on IT solutions within networked models. A plea was made for more use of patient held records.
- There is a value in reducing the complexity of the pathways as it will make referral into the service more streamlined but needs to be balanced with patient choice.
- Need to consider the impact of centralisation on the Cancer Centre in Reading which could be undermined.

Clinical quality and Sustainability - Specialist Cancer Surgery

- A two million population would give a future proof opportunity to move to a single Thames Valley cancer centre for specialist cancer surgical services with single pathways linked into local ones and linked to DXT/chemo but not at the detriment of other common cancer services.
- There could be a risk to the sustainability of centres that would no longer carry out specialist cancer services but it was noted that there could be reciprocity in

agreeing alternative services which those hospitals could carry out. Bariatric and upper GI cancer surgery were cited as examples.

- A risk of moving to a single cancer centre was cited as workforce –training needs to take account of the increasing central need of specialist work but also the requirements at peripheral sites.
- More work would be required to assess the single cancer centre proposal to ensure that it would not decrease the quality of care to non-cancer patients.
- An opportunity was identified to maximise existing capacity and technology optimally such as robotic surgery
- Supporting services are needed in cancer centres but also in local hospitals where patients may wish to be treated

Patient Experience and Accessibility – Radiotherapy

- A Wexham based LINAC could serve South Buckinghamshire and Slough (which has a more deprived younger community) and it would enable patients to have continuity of treatment on the same site. It was recognised that travel to Bracknell for the Slough population is difficult.
- However, there was concern that a LINAC at Wexham could negatively impact Royal Berkshire's Bracknell LINAC with reduced activity and potential de-staffing at both units. Additional modelling would be required to assess this and it is likely that this would need to be done on a regional basis.
- There are existing staff recruitment and retention problems at Wexham and the intention would be to work with an existing cancer centre to provide the LINAC facility. It was noted that it would be important to select a suitable and sustainable partner.
- Despite the benefits to the Slough population, looking at the geography of existing LINACs, questions were asked as to whether Wexham would be the best location for new machines
- CNS support is available when there is local provision of deep X-ray treatment which would improve the patient experience

Clinical quality and Sustainability - Radiotherapy

- The group felt that the current geography makes it difficult to have a single provider link for a cancer centre and questioned the risk associated with commissioning a single provider. However, it was recognised that multiple relationships with many cancer centres can result in duplicated structures and wasted resources.
- It was noted some centres had difficulty recruiting therapeutic radiographers and physicists. More staff are needed in models with distributed provision - with associated cost. It was felt that recruitment and retention was best if limited to a large centre.
- Rationalise patient flows with clear pathways for radiotherapy and other oncology services across East Berks to improve commissioner oversight, and improve quality of patient outcomes/experience.

- Could the Royal Berkshire Hospital and the Oxford University Hospital become a single cancer centre with distributed radiotherapy provision around Thames Valley?
- Modelling on potential patient flows and financial viability would be required before proceeding with a single model.
- It was noted that more local provision in Slough (and elsewhere in Thames valley) could be tied to the replacement of old LINAC machines at existing centres in Oxford, Reading and Mount Vernon.
- There is an opportunity to influence the national agenda for radiotherapy services through the provision of a proposition for Thames Valley.

Conclusions from the Cancer Clinical Stakeholder Forum

The following was agreed at the Clinical Stakeholder Forum:

1. In any planning and commissioning of specialist cancer services, it is vital that communications and relationships are considered as they are key to good patient experience.
    - These include patient relationships with professionals caring for them.
    - Local to specialist centre links need to be good.
    - Both of the above can be enhanced by good IT and patient held records/'Apps'

2 The CSF broadly supported Frimley Health's aspiration for a clearer and simpler set of compliant **patient pathways**.

3 It was noted that Frimley Health would ideally want to identify a single cancer centre partner for East Berkshire patients, or, as a compromise, at least per cancer type. This may be an opportunity to explore with the current providers.

4 Single pathways for specialist cancer surgical services were supported but must join up with local services including common cancer provision. In planning such cancer services across Thames Valley the following should be considered:
- Interdependencies between cancer and non-cancer services.
- Impact on training of clinical staff.
- Risk of destabilising local providers through centralisation.
- Need to optimise use of technology such as robotic surgery.
- Need to ensure scale is still right at two million given emerging national specifications and frequency of cancers.

- An understanding of the available patient specialist cancer pathways that are compliant with national guidance would allow professionals to offer patients choice as appropriate.

5 There is an opportunity to plan and increase local radiotherapy provision and access across Thames Valley with clear and consistent pathways.

- Consider opportunity of planned replacement and expansion in LINAC capacity to develop a distributed model focussing initially on areas of specific need to include Slough and North Buckinghamshire.
- This might best be done by a single alliance of existing TV cancer centre providers developing a joined up offer, which may include specialist cancer surgery pathways too.
- It was important to address issues around staffing, whilst acknowledging that increased provision would be likely to increase costs in direct staffing. These could be offset by patient access and better links with other local services.
- Given the national radiotherapy review, there was an opportunity for the Thames Valley to develop a proposition, in line with the national Five Year Forward View.

-ENDS-