

Report to PCT Boards on the gynaecological cancer review

Board meeting:

Agenda item:

Summary

1. This paper sets out a recommendation to the Board on the future organisation of specialist surgical services for gynaecological cancer to ensure women locally receive the best care. The model of care proposed will provide women living in the four Avon PCT areas and parts of Wiltshire and Somerset with a service which fully complies with national clinical best practice. This recommends specialisation and centralisation of the most complex surgery to achieve improved care and improved survival for women, as set out in Improving Outcomes Guidance (IOG).
2. A review of these services, currently provided by the University Hospitals Bristol NHS Foundation Trust (UHB) and the Royal United Hospitals, Bath NHS Trust (RUH), led by NHS Bath and North East Somerset, has been undertaken to develop a service model of care which is compliant with the IOG and to recommend the location of services.
3. A steering group has overseen the review including representatives of service users and carers together with clinical advisors. Emphasis has been given to listening to the views of those who use and work in the services.
4. The service model was developed by the ASWCS Cancer Network Site-Specific Group for gynaecological cancer care (acting as a clinical advisory group) and in brief, is as follows:
 - Complex surgical and some radiotherapy procedures for specified types of cancer will be undertaken in one centre for the population. This amounts to about half of the present total workload – some 300 cases each year.
 - The diagnosis and investigation of all potential gynaecological cancer patients will be managed in both of the current hospitals as before together with the management of less complex surgery and all chemotherapy, most radiotherapy and all follow up care.

- The intention is to manage as much of the care of patients as close to home as possible whilst providing specialist, largely surgical care in a centre where this is of benefit.
5. The unanimous view of Primary Care Trust commissioning representatives is that specialist gynaecological oncology surgery should be provided at a Gynaecological Cancer Centre provided by the University Hospitals Bristol NHS Foundation Trust. This development will mean that specialist surgery for about 100 women that would have been undertaken at the Royal United Hospital, Bath under present circumstances will be provided in Bristol in future although all other aspects of their care will remain in Bath.
 6. The Board is asked to support this recommendation which is being considered by all six ASWCS PCTs in November 2009. PCTs will then undertake further work with their local populations and advise Overview and Scrutiny Committees of their recommendation.

Benefits of the proposed change

7. Best practice in the field of cancer care in England is defined by the National Cancer Action Team and the 'Improving Outcomes Guidance' which it has published over the years for nearly all types of cancer. These IOGs are based on research based evidence where this is available and expert opinion at a national level. The gynaecological cancer IOG was first published in 1999 and has been reinforced by the same national team in its standards (published in 2008) for use in the peer review process which is routine for all cancer care in all Cancer Networks.
8. A key feature of many IOGs is the requirement to consolidate the care of patients with uncommon cancers and the scarce resources which are needed for them, be they specialist staff, equipment or facilities. The proposed model of care for gynaecological cancer does this for patients who need this specialist, largely surgical care whilst enabling the rest of treatment to be given in local hospitals. Another important feature is that all patients presenting with possible cancer must be reviewed by a multidisciplinary team (MDT) made up of all clinicians whose opinion as to care is relevant.
9. The main aim of the proposed change is to secure the best outcome for all women with gynaecological cancer. Survival after diagnosis locally is good in general but does not yet match the best elsewhere in England and in the rest of Europe.
10. In brief, the proposals and the associated anticipated benefits are:

- The development of a **Gynaecology Cancer Centre** for the West of England at St Michael's Hospital, Bristol. This centre will provide specialist surgical treatment and cervical brachytherapy for the catchment area for a defined range of cases. Anticipated benefits arising from this are:
 - greater sub-specialisation by surgeons, clinical oncologists, specialist nurses and other clinicians with the corresponding development of greater expertise; improvement in terms of survival and intermediate outcomes such as post operative complication can be expected and will be monitored (see Appendix x for a draft list of outcome measures to be monitored).
 - improved organisation and participation in research and development, in particular in randomised controlled treatment trials
 - improved organisation of audit with the associated development of better professional standards
 - the development of a sub-regional hub for training and innovation among the key clinical professions
 - improved management of the MDT with better documentation and record keeping and better decision making
 - the creation of a more robust and resilient specialist team which is capable of coping with fluctuating workload, staff leave and all that goes with the development of a centre of excellence; equally, consolidation of resources can be expected to reduce the risk, which exists with the present configuration, of service breakdown if key members of staff become unavailable
- **Localised care** for patients who do not need Centre level care and for those who have already been treated at the Centre. A substantial service will remain at the RUH which meets the needs of not only the inpatients which are the subject of this proposal but also the many women who are referred to the hospital and are treated as out-patients. The service can focus on key parts of the patients' care pathway which tend to be overshadowed by the intensive aspects of care. Improvements will be made in:
 - earlier diagnosis and rapid access to diagnostic tests for people with 'red flag' symptoms
 - long term follow up and treatment, with better communication between specialists and clinicians in the community

11. A survey of residents aged 16+ living in the South West by Ipsos MORI carried out as part of a baseline survey into public perceptions of the NHS asked residents about willingness to travel for different kinds of treatment. Residents were asked “how much time would you be prepared to spend travelling by car from your home to access each of the following services”. This found that across the South West, the average number of minutes travelled by car was 77.91 for highly complex surgery/specialist hospital treatment. In BaNES the time travelling by car for highly complex surgery/specialist hospital treatment was 82 minutes. Table 1 shows median travel time to UHB and RUH by ASWCS and PCT population for gynaecological cancer centre level patients treated 2002-2006, .

	Travel time to UHB (mins)		
	Median	(Interquartile range)	Count
Avon, Somerset and Wiltshire Cancer Network	25.1	(14–38.4)	1325
BaNES PCT	28.6	(24.1–32.8)	184
Bristol PCT	11.2	(8.4–13.7)	349
North Somerset PCT	30.5	(25.6–34.9)	157
Somerset PCT	54	(44.8–68.8)	157
S Glouc PCT	16.2	(14.2–21.9)	252
Wiltshire PCT*	44.3	(36.9–51.2)	226

Source: South West Public Health Observatory Cancer Registry

* Part of Wiltshire PCT in ASWCS only.

Table 1 shows median travel time to UHB and RUH by ASWCS and PCT population for gynaecological cancer centre level patients treated 2002-2006.

Background

12. The gynaecological cancer IOG was published in 1999, setting out recommendations for service delivery to improve outcomes for patients. The IOG made a number of recommendations including multi-disciplinary team working and the centralisation of the most complex surgery in specialist centres with a catchment population of approximately 1 million people. The IOG standards for centralisation cover specialist treatments only. Diagnostics, surgery for less complex cancers, chemotherapy, most radiotherapy and palliative care would continue to be provided locally.

13. Delivery of IOGs has been supported in the Cancer Plan, Cancer Reform Strategy and NHS Operating Framework on the basis that compliant services will deliver the best outcomes for patients locally.

14. In 2004 the Cancer Action Team requested action plans from all cancer networks setting out plans for delivering IOG compliant services, including compliance with the gynaecological cancer IOG. ASWCS carried out a review of gynaecological cancer services with a view to implementing the IOG in 2004 supported by Professor Henry Kitchener as independent clinical advisor from outside the area. This recommended that two centres be established in ASWCS – one in Taunton and one in Bristol at UHB to support the Avon and Wiltshire population. The service in Taunton was implemented. However, proposals for the establishment of the centre in Bristol were not implemented and in 2007 the BaNES Overview and Scrutiny Committee raised concerns about the review process and outcomes.
15. On review it was found that the 2004 appraisal did not meet current standards of patients and public engagement and ASWCS recommended a further review be conducted for the Avon population, led by NHS Bath and North East Somerset on behalf of the six ASWCS PCTs and the ASWCS network.

Listening to patients and clinicians

16. The review has had a strong focus on the views of both those using and working in the service. The review was launched with a Stakeholder Event in September 2008 to which all Avon, Somerset and Wiltshire area Local Involvement Networks, Overview and Scrutiny Committee representatives, service user groups, public and patient representatives and Trust clinicians and leaders were invited to discuss the review, ask any questions about the process and sign up to be involved in the process. Annex A sets out the key issues raised at the event, commitments given by NHS BaNES in response and action taken since to deliver those. Annex B sets out the structure of the review with the Steering Group supported by a Service User Group, Clinical Advisory Group and External Clinical Panel.
17. As well as the establishment of a Service User Group, the launch was followed up by regular briefings to stakeholders, updates and review paperwork published on PCT websites and briefings to local and joint Overview and Scrutiny Committees as well as a questionnaire for patients and the public handed out to all patients in the Trusts and published in the local media.

18. Representatives from user groups at all the organisations involved and from local involvement networks sat on a Service User Group that supported the review and were represented on the Steering Group, along with lead clinicians and Medical Directors. The Service User Group has met 6 times, supported by independent facilitation including the Centre for Public Scrutiny to ensure all members of the group, including current patients, were supported to make their views heard with an equal opportunity for everyone to contribute. Five representatives from the Service User Group were voting members of the Steering Group and all other members of the Service User Group were invited to attend the final meeting of the Steering Group as observers.
19. At the request of service users, two joint workshops were arranged for clinicians and the Service User Group so that all patients and users had the opportunity to discuss the review, the evidence behind the IOG recommendations, the potential benefits and disbenefits of centralisation and impact of any changes with clinicians including the lead clinicians and Medical Directors from both the Royal United Hospital Bath and University Hospitals Bristol NHS Foundation Trust. These sessions were welcomed by a number of the users as an opportunity for in-depth discussion with clinicians and managers.
20. This programme of engagement throughout the process has given the review clear feedback on the views and preferences of patients and services users. There has not been one view from service users but the review has allowed a range of strongly held views to be expressed, ranging from support for the proposals to criticism of the review and recommendations. The range of views reported and fed back at the final Steering Group meeting include “We request and expect the highest possible quality service to be specified”, “what is important is what is best for the majority of patients and the patient experience for the majority of patients”, “if I was a patient my priority would be to be alive”, “my personal view would be to support a one site option on the basis that a specialist site would offer more options to all patients”, “I found the evidence pack comprehensive and easy to understand”, “NHS BANES is threatening to decommission and move to a location that will cause women physical and psychological harm for no demonstrable or quantifiable benefit”.
21. Although the review made every effort to involve service users throughout the process, using independent facilitators including the Centre for Public Scrutiny to support the Service User Group meetings to ensure all users we supported to contribute, some members felt their views on the process were not listened to and there has been sustained criticism from three of the nine members of the group. Service user group members of the Steering Group who were involved in the decision making have been invited to review this Board paper and given the opportunity to make statements to the Board. These are attached at annex C.

22. The Avon, Somerset and Wiltshire gynaecological cancer site specialist group, incorporating clinicians from all Trusts across the region, acted as the Clinical Advisory Group. This group provided advice to the Steering Group on the model of service that would deliver best practice, developing and agreeing a detailed clinical service specification for the future delivery of services (table 2 below). The group also met with service users to discuss the model of services and describe the patient pathway and the impact of the proposed model of services on the patient pathway.

23. In addition, external clinical advice was provided to the Steering group by an External Clinical Panel:

- Andy Nordin, National Clinical Lead for Gynaecology and lead clinician for gynaecological cancer at East Kent University Hospitals NHS Trust
- Professor John Green from the University of Liverpool and Clatterbridge Centre for Oncology. Medical Oncologist and Secretary of the British Gynaecological Cancer Society
- Professor David Luesley, Professor of Gynaecological Oncology and surgical gynaecological oncologist. President of the British Gynaecological Cancer Society
- Juliette Sim, Clinical Nurse Specialist, UCLH. Representing the Gynaecological Oncology Nurse Forum

24. The External Panel was asked to review the service proposals developed by RUH and UHB and comment on specific clinical criteria including service quality, including safety and outcomes; compliance with national and best practice clinical guidance on cancer services; impact on other gynaecological services and support for research and development. The panel were asked to identify any risks and issues and provide assurance that the proposed centres would be able to provide high quality clinical care. The key conclusions from the panel:

- either option, if implemented fully would be compliant with the IOG and best practice
- the main issue relating to service configuration was ITU provision at UHB. The Panel advised that it would be essential to provide “enhanced care” on the inpatient ward at St Michaels if UHB wished to continue to provide a gynaecology oncology service and reduce planned transfers to HDU/ITU, but they noted that this did not mean there were any safety concerns about the current service
- there would be advantages to co-locating the centralised service with both external beam radiotherapy and brachytherapy. Currently

brachytherapy is only available at UHB. The review, and proposed changes, will not change the provision of radiotherapy services which will continue to be provided as now with the bulk of services available locally.

- both Trusts needed to do further work on capacity planning, including job planning, bed and theatre capacity and deliverability. Implementation timetables from both Trusts appeared unrealistic
- there should be a clear commitment to the centre with surgeons contractually committed to the specialist centre rather than using a visiting surgeon model
- the removal of the specialist surgical service from either site should not adversely impact on remaining general gynaecology services or unit level gynaecological oncology services
- the Panel was assured by both teams that seamless patient-centred care could be delivered.

Current services

25. Currently services in Avon are delivered by both RUH and UHB. MDT working is being developed within and between the two Trusts but neither site is fully IOG compliant with RUH operating significantly below the IOG population catchment and without the two gynae-oncology subspecialists specified in Gynaecological cancer Peer Review measures. The RUH service is led by a consultant gynae-oncology surgeon. The UHB service operates with a catchment population slightly below the 1 million recommended by the IOG and is led by 3 surgeons, including two RCOG subspecialty trained surgical gynaecological oncologists, and 1 senior trainee. Both services achieve good outcomes and are well supported by the public and patients and within the Trusts.

26. Following the identification of risks during the Peer Review process (a regular review of standards of care which applies to all cancer services in all cancer networks), surgical services at North Bristol Trust were transferred to UHB in 2007. This was a recommendation of the peer review process which was subsequently agreed by North Bristol Trust. Within ASWCS centre level gynaecological cancer services are also provided at Taunton and Somerset NHS Foundation Trust but those services are outside the scope of this review.

27. A workload analysis based on review of all patients from 2006, agreed with lead clinicians as representative of Trust workload, separated total gynaecological cancer surgery into those that would be centralised at the specialist centre (centre level) and those less complex procedures that would continue to be provided at the patient's local hospital (unit level). This analysis identified the following gynaecological cancer cases for Bristol and Bath from the ASWCS PCTs (Bristol cases include NBT and UHB, consolidated at UHB from 2007)

Table 1: unit level episodes that would continue to be provided at the local hospital (source SWCIS)

PCT	Bristol	Bath
BaNES	2	34
Bristol	75	1
North Somerset	32	-
Somerset	3	13
South Gloucestershire	57	2
Wiltshire	3	48
TOTAL	172	98

Table 2: centre/specialist episodes that would be provided at the specialist centre (source SWCIS)

PCT	Bristol	Bath
BaNES	1	33
Bristol	87	1
North Somerset	33	-
Somerset	10	13
South Gloucestershire	42	1
Wiltshire	-	48
TOTAL	173	96

28. In total including treatments for non local residents not included in the tables above, the RUH provided 197 surgical episodes in 2006 (98 centre and 98 unit level) and UHB 360 surgical episodes in 2006 (179 centre level episodes and 181 unit level episodes). This analysis of 2006 figures was acknowledged by both Trusts as representative of current workload, however, as part of the due diligence work recently carried out, UHB has identified higher activity suggesting total numbers of centre episodes at UHB would be closer to 260 per year.

29. The review has been conducted in three key stages:

- identifying the service model

- confirming the options to be considered
- appraising the options

Developing the service model

30. The service model was developed by the Clinical Group taking into account the specification set out in the IOG and recent clinical developments and advice, see table 2 below.

31. In summary, the model sets out that the centre would treat all ovarian, vulval and vaginal cancers and review all cases of diagnosed cervical and endometrial cases with lower risk cervical and endometrial cancers treated and managed locally following the Specialist MDT review. Emergencies would be referred straight to the centre or transferred there after stabilisation at the initial receiving hospital. Relapse surgery, germ cell tumours, and metastatic sarcomas would be managed at the centre while local MDTs would treat and manage pelvic masses as well as low risk cervical and endometrial cancers.

Table 3: summary of clinical service specification drawn up by review Clinical Advisory Group

	Gynaecological cancer surgical unit	Gynaecological cancer surgical centre
Cervical	lower risk cases (approx 10% of total cervical workload)	intermediate and high risk cases (approx 90% of total cervical workload)
Endometrial	lower risk cases (approx 45% of total endometrial workload)	intermediate and high risk cases (approx 55% of total endometrial workload)
Ovarian	refer to specialist centre for treatment	all ovarian cancers
Vulval	refer to specialist centre for treatment	all vulval cancers
Vaginal	refer to specialist centre for treatment	all vaginal cancers
Estimated total surgical episodes for RUH/UHB populations	270	269

32. Following concerns from the Service User Group that the document was technical and inaccessible, a narrative summary was produced for the service user group and a joint session with clinicians was organised to allow discussion between services users and clinicians about the specification and how it would work in practice.
33. Service Users were involved in the work on the service model, attending a joint workshop with the Clinical Group and drawing up a document setting out key issues from a service user perspective that was used as part of the appraisal documentation against which Trusts developed their service proposals.

Confirming the options to be considered

34. The Steering Group was asked to consider whether a two site option, with specialist surgery provided at both RUH and UHB, would be considered viable. This was the preferred model for a number of service users and had been specifically raised by the BaNES OSC and was a question raised at the initial Stakeholder Event when NHS BaNES gave a commitment to work with the Cancer Action Team to confirm the constraints and freedoms.
35. As part of the review process, NHS Bath and North East Somerset wrote to the Cancer Action Team to ask whether a two site option with specialist surgery performed across two sites by one specialist MDT would be viewed as compliant with the IOG. The Cancer Action Team replied saying that such a two site cancer centre would not be seen as acceptable and this was supported by detailed measures in the Gynaecological Cancer Peer Review standards, revised and reissued in November 2008, which say:

“another important principle, underlying current IOG for uncommon or ‘intermediate’ cancers is the principle of ensuring that the MDT method of working adds its full potential value to patient care. This means not only meeting together to make multidisciplinary decisions, but also that a constant and experienced team performs the major surgical procedures. A practice way of ensuring this in the measures is to require that for radical surgical aspects of specialist care, the surgical operations and immediate post-op care should all be carried out in the same host hospital of the team”

36. The correspondence with the Cancer Action Team was shared with the Service User Group, Steering Group and Clinical Group and widely discussed. The Steering Group took the view that it would be preferable to exclude an option that would not be seen as sustainable or deliverable because it was non-compliant rather than spend time working up an option that would not be acceptable.

37. The Steering Group decided that the review should focus on IOG compliant options only, but given representations about access and travel times, would incorporate travel analyses to assess whether full IOG compliance would have unacceptable consequences locally. If the review found that this was so, PCTs would consider pressing the ASWCS Cancer Network, the South West Strategic Health Authority and the National Cancer Action Team to allow an exception to IOG to be made.

Appraising the options

38. RUH and UHB developed proposals against the agreed service specification and service user perspective. The review team commissioned travel analyses including a public transport analysis as well as a standard travel analysis based on driving times as well as a survey of outpatients on transport to hospital. The evidence also included an outcomes summary prepared by the South West Public Health Observatory and feedback from the expert clinical panel.

39. The expert clinical panel met both teams and reviewed proposals. The panel was not asked to make a recommendation but to provide advice to the Steering Group, in particular on any risks or issues they identified. Key findings from the panel's report were:

- either service, if implemented as proposed, would be compliant with the IOG and other best practice
- although there were no safety concerns about current services at UHB (including arrangements for critical care which are provided in a nearby hospital), provision of augmented care at St Michael's Hospital would be essential for further consolidation
- there were concerns about deliverability and capacity and proposed timescales for implementation. Challenges would be greater for RUH because proportionately greater increases in capacity including staffing would be required
- consultants should be contractually committed to the specialist centre
- removal of specialist services from the unit would not adversely affect remaining services, including oncology or mainstream gynaecology
- high quality research and education could be facilitated by unifying services

Making a recommendation

40. The Steering Group, including five Service User representatives, six PCT and the two Trusts, met to review both Trusts against criteria previously agreed:

- quality
- meets best practice
- patient access
- impact on other services
- research and education
- deliverability
- value for money

41. The summary paper which went to the Steering Group outlining key differences between the proposals is attached at annex B. The Board should note that this formed part of a more detailed evidence pack considered by the Steering Group. It should also note that a number of issues, including capacity planning and financial assumptions have been reviewed in more detail as part of subsequent 'due diligence' work and some of the assumptions have been adjusted accordingly.

42. In its discussions, the Steering Group made a number of recommendations:

- a single centre should be established where centre-level services would be consolidated. This was on the basis that the travel analysis did not suggest that a single centre would have unacceptable consequences for the local population based on travel times to a single centre when compared with travel times to existing providers. This travel analysis showed that currently 10.7 patients travel more than 1 hour to receive treatment, and this would increase by 5.8 if the services were centralised at UHB and 4.8 if services were centralised at RUH. Currently, 0.8 people a year travel more than 80 minutes for treatment and this would increase by 1.6 if services were centralised at UHB and 0.4 if services were centralised at RUH.
- noting that concerns had been raised by the External Clinical Panel about capacity planning, the Steering Group asked PCTs to conduct due diligence on the preferred option to investigate costs, capacity planning and deliverability to ensure services could be delivered as proposed

- should the recommendation be to centralise services at UH Bristol, this would be on the basis that augmented care was provided within the wards at St Michaels; this should aim to reduce the planned use of High Dependency Unit (HDU) facilities off-site. The location of the gynaecological cancer ward and theatres on St Michaels site means an ambulance transfer is necessary for ITU and HDU on the main BRI site when required. Currently approximately 14 patients a year at UHB require planned ITU/HDU, with access planned in advance as part of the patient's treatment plan. In addition to planned access to ITU/HDU there are also occasions where, unexpectedly, during surgery it becomes clear that the patient requires ITU/HDU support for recovery and this is estimated to affect 1 patient a year. At the RUH the ward, theatre and ITU/HDU are all on one site. The impact of ambulance transfers on patient experience and the quality of patient experience has been an issue raised by service users and the provision of augmented care will help to address these concerns and improve the patient experience
- any recommendations from the pathology review currently underway at UHB would be implemented before services were transferred, were UHB to be identified as the preferred site

43. The Steering Group was unable to come up with a majority recommendation on the site of the centre and asked the PCT commissioners to conduct a due diligence exercise, review both proposals against the agreed criteria, take the Steering Group recommendations into account and then recommend a preferred site for the centre.

44. The review conducted further work with both Trusts, looking at theatre and bed capacity, deliverability and planning and finances. Commissioning representatives confirmed that the augmented care model proposed by UHB met the requirements set by the Steering Group and the Expert Clinical Panel. They noted the UHB expectation that the provision of augmented care as planned would lead to a reduction of at least 50% in planned admissions to the High Dependency Unit in the Bristol Royal Infirmary and that the provision of augmented care would lead to an enhanced service for patients on the ward with an expectation that 136 patients would be supported through augmented care each year. As the External Panel noted, the current service model, including the lack of augmented care currently, does mean the services are unsafe. UHB have estimated 136 patients a year will use the augmented care facilities and received enhanced nursing support. Of these, 7.5 would have previously transferred to the HDU facilities in the BRI building.

45. The provision of augmented care facilities will decrease but not remove the need for transfers to BRI for ITU and HDU. Out of 317 patients treated each year there will be an estimated 6 patients requiring planned transfers for ITU each year and 7.5 planned transfers for HDU each year. For these planned cases, patients will be transferred via a private ambulance for their surgery in BRI and moved to ITU/HDU after surgery and transferred back to care on the wards at St Michaels by private ambulance later in their care pathway. In addition, there will be an estimated 1-2 patients a year who require unplanned access to HDU and ITU and who will be stabilised in theatre at St Michaels and transferred to BRI ITU by ambulance.

46. It was noted that current services at UHB were seen as safe and high quality and commissioners saw the provision of augmented care as a significant enhancement in current services and in the patient experience. As part of the due diligence work, UHB has confirmed that this service would be provided and funded entirely by the Trust.

47. Table 4 below shows the number of patients likely to require planned ITU/HDU per year in UH Bristol and the impact of the augmented care model. As set out above, the model of care will not impact on the number of patients requiring unplanned or emergency ITU, estimated at 1- 2 per year

	Existing service model – without augmented care			new service model - with augmented care		
	Existing patients (UHB)	Additional patients (from RUH)	Total	Existing patients (UHB)	Additional patients (from RUH)	Total
ICU	4	2	6	4	2	6
HDU	10	5	15	5	2.5	7.5

48. The group confirmed the position agreed at the Steering Group concerning the ongoing pathology review at UHB.

49. Commissioners noted the patient flows with a minimum of 179 (179 identified in analysis of 2006 workload, 260 identified as part of due diligence work) centre level patients treated in Bristol and 99 treated in Bath. In terms of population flows, the establishment of a centre in Bath would affect more people than would the establishment of a centre in Bristol. The commissioners therefore felt that the centralisation of the service in Bristol would have least impact on patients across the ASWCS health community.

50. Commissioners noted concerns raised by the Steering Group and Clinical Panel about deliverability. The due diligence work by both Trusts outlined capacity planning and explained how both Trusts would meet additional capacity requirements if identified as the centre. The group agreed that the challenge was greater for the RUH because of the additional capacity required including theatre time, in-patient facilities and specialist medical and non-medical workforce.

51. Commissioners agreed that the Trust that was the centre would need to ensure all consultant staff were contracted to the host Trust as recommended by the External Clinical Panel and also collect and publish outcomes data as agreed during the review.

52. In summarising discussions, commissioners agreed that both proposals would be compliant with the IOG and with clinical best practice and both Trusts could provide an excellent service. There were a number of areas where there was little difference between the proposals including IOG compliance, research and training, travel times, and impact on other services. There were other areas where there was a difference between the options and pros and cons to both options. The commissioners agreed that the issue was finely balanced but on the basis that either Trust could provide a good service meeting required clinical standards, as confirmed by the External Clinical Panel, they recommended the service be centralised at UHB because UHB were better placed to deliver a centralised service and centralisation of the service in Bristol would have less impact on patients than centralisation in Bath. Table 3 below sets out the pros and cons of each Trust.

	Pros	Cons
RUH	<ul style="list-style-type: none"> ▪ all services provided on one site, including HDU/ITU with no patient transfers between sites 	<p><u>Risk to deliver because of capacity required</u></p> <ul style="list-style-type: none"> ▪ Significant additional capacity required to deliver with an increase in specialist workload from 112 to 317 patients a year (377 with UHB higher estimated workload). ▪ Recruitment of 4 wte consultant gynae-oncologists, 3.25 additional theatre sessions per week and 3 additional in patient beds ▪ financial position of RUH challenging ▪ 260 patients a year currently treated at UHB would need to travel to Bath with 98 remaining in RUH

<p>UHB</p>	<ul style="list-style-type: none"> ▪ UHB well placed to deliver capacity required for consolidated service because scale of increase required relatively small. 0.5 WTE consultant, 1.6 additional in-patient beds, 2 additional theatre sessions per week ▪ financial position robust with operating surplus delivered and expected in future years ▪ consolidating service at Bristol would affect fewer people than consolidation in Bath – 260 people currently treated in Bristol would remain at UHB with 98 transferring from Bath ▪ augmented care available on ward would provide additional level of care and support for 136 patients a year 	<ul style="list-style-type: none"> ▪ HDU/ITU off site with ambulance transfers required for planned and unplanned care. Even with augmented care available on the ward in St Michaels this will affect 13-14 patients a year who will need ambulance transfers from St Michaels to BRI. Although this does not affect clinical quality or safety it does impact on the patient experience
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53. In conclusion, the group unanimously agreed that the best outcomes for patients across the health community would be served by centralisation at UHB within the augmented care service model proposed.

54. The recommendations of the Group were presented to the Avon, Somerset and Wiltshire Cancer Services Board on 25 September 2009. The Board supported the recommendations, and asked that the Service User Group members of the Steering Group be given an opportunity to review the Board paper and make a statement to the PCT Boards. Feedback has been received from all the service users represented on the Steering Group. The feedback varied, some positive and some critical and key points raised were:

- it would be important to record evidence of the effects of a change to centralised specialist surgery so it can be judged whether outcomes improved or not
- the service should not be transferred until augmented care is fully in place at UHB
- public engagement has been variable
- patients will continue to be transferred between hospital sites, albeit in reduced numbers
- the change should not be implemented until the pathology review is complete
- consideration should be given to additional transport needs for patients travelling from BaNES and Wiltshire

- concerns about the review particularly the IOG and its status, evidence supporting it, the Cancer Action Team role and response and local flexibility to interpret the IOG

Financial impact of proposal

55. Specialist surgical services are covered by the national tariff with a set price for each procedure which includes the procedure and ward stay. The average tariff price is £2,825 including market forces factor although this average covers a number of different procedures and will be affected by case mix. Commissioners are required to pay tariff or less and both Trusts confirmed that they would provide services at tariff price.
56. In addition to the tariff price for the surgical procedure, commissioners pay an additional price for any use of ITU and HDU based on a local tariff per bed day. The reduction in proposed use of HDU, with a planned reduction of 15 bed days, should lead to a slight decrease in charges to commissioners of approximately £25,335 per annum across ASWCS.
57. UH Bristol have confirmed that they will fund the provision of augmented care services, which they anticipate will reduce HDU bed days and ensure 136 patients have access to enhanced care on the wards, by reducing their planned operating surplus. NHS Bristol as co-ordinating commissioner have assured the ASWCS Board that they are confident that the resources can be taken from the planned operating surplus and will not impact on delivery of patient care or destabilise any other commissioned services.
58. The transfer will not lead to any additional costs for commissioners in transferring patients to UHBristol.

Recommendation

59. The recommendation is that services be centralised at University Hospitals Bristol with the following conditions:
- augmented care should be provided on the wards at St Michael's Hospital as proposed to enhance the service available for patients and reduce the numbers of patients requiring critical care. UHB anticipate a 50% reduction in the patients requiring HDU and have confirmed this service will be funded internally without impacting on the gynaecological or oncology services
 - UHB have in the past transferred patients to BRI for surgery to maximise theatre capacity. Patients will only be transferred for surgery at BRI when planned critical care is required, not to maintain theatre lists

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- should the pathology review identify any issues with the pathology service at UHB, these will be put right before the transfer is implemented or the decision will be reviewed
- as part of their contractual arrangements with commissioners, the centre will be required to meet the Clinical Panel's recommendations, on staffing and contractual arrangements to ensure all surgeons are contractually committed to the centre
- as part of their contractual arrangements with commissioners, the centre will be required to collect and provide outcomes information as discussed in the review to demonstrate impact on patient outcomes

Next steps

60. This recommendation is being considered by each PCT in November 2009. At the same time, PCTs are preparing impact assessments for their populations and report to local OSCs who will be asked to support proposed improvements in services. We anticipate considerable interest in BaNES, South Gloucestershire and Wiltshire OSC in the proposals.

61. NHS BaNES and ASWCS will support PCTs in this process and co-ordinate a joint OSC in line with agreed ASWCS processes if required.

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Annex A: issues raised at September 2008 Stakeholder Event

Key issue	NHS BaNES commitment	Action taken
Presumptions about outcomes, particularly the options that would be considered	Work without presumptions	Steering Group considered options at both RUH and UHB. Clear from evidence packs and External Clinical Panel that either could deliver a good, centralised service.
Openness	Be open and transparent	All review meeting papers and key background documents available on PCT website.
Listening to patients and clinicians	Listen to what stakeholders have to say and continue to engage	<p>Service User Group established, independent facilitation brought in to support group to ensure all views heard</p> <p>Clinical Group established</p> <p>Joint workshops for service users and clinicians</p> <p>Summaries and glossaries of key documents produced</p> <p>Public and patient questionnaire</p> <p>Ongoing communications and bulletins to stakeholders at key stages in the process</p>
Keep stakeholders updated during review process	Communicate regularly	<p>Website established with all meeting papers uploaded</p> <p>Regular bulletin to stakeholders</p>
What services and hospitals the review covered	Consider and confirm the scope of the review	<p>Steering Group confirmed at the first meeting, November 2008, the scope was:</p> <ul style="list-style-type: none"> • services provided by Bath and Bristol hospitals • focusing on establishment of gynaecological cancer centre
Role of the Cancer Action	Work with the Cancer	Wrote to the Cancer Action Team in

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<p>Team and whether a two site option would be considered</p>	<p>Action Team to confirm the constraints and freedoms early in the process</p>	<p>January 2009 to ask whether a two site option would be seen as compliant with best practice. Response received in February shared with Steering Group, Service User Group, Clinical Group and communicated with stakeholders and in regular Gynaecological Cancer bulletin.</p>
<p>Availability of supporting information, particularly outcomes data</p>	<p>Work to ensure reliable, high quality information for the review and going forwards</p>	<p>worked with the Cancer Network and clinicians to provide agreed workload analysis</p> <p>worked with the South West Public Health Observatory to collect outcomes data for the Steering Group</p> <p>developed set of future outcomes indicators with clinicians and service users against which future service can be assessed. Collection and monitoring of this will be a contractual requirement</p>

Annex B : scope of the review

The catchment population for the review was confirmed as the population of the six ASWCS PCTs (Bath and North East Somerset, Bristol, North Somerset, Somerset, South Gloucestershire, and Wiltshire) currently served by University Hospitals Bristol and Royal United Hospital Bath. Services provided at Taunton and Somerset NHS Foundation Trusts were outside the scope of the review.

Figure 1 below shows the structure of the review.

