Mount Vernon Cancer Centre

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Mount Vernon Cancer Centre Review Update – Nov 2020

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NHS England and NHS Improvement

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Welcome

- We want to hear your views, experiences and suggestions. Please tell us and don't leave here wishing you had said something.
- We have a note taker in the room but it is difficult to write quickly enough to capture everything so we are also recording this session so the note taker can check they have got all of your views. There is no other reason and it will not be made public.
- We have about an hour and a half for this session.
- If you've not used video conferencing before, don't worry, we'll try and help you. We've kept these focus groups quite small so we can help support you so you can take part fully
- To avoid talking at once and hearing no one, there is a hands up function that we will use. Put your hand up and we will make sure you get the chance to speak. Don't forget to put your hand back down afterwards though!
- If there is any noise in the background where you are, please can you put your microphone on mute when you are not speaking so that it is easier to hear the person who is.
- If you need a comfort break, please take one. If you are using a mobile device, please don't take it with you!

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Today’s Session

- What is the Mount Vernon Cancer Centre Review
- Why do we need to make changes?
- What has happened so far?
- Who is overseeing the review?
- What is happening now?
- What happens next?
- Timescale
- Our biggest challenges
- Questions and Answers

What is the Mount Vernon Cancer Centre Review?

- The review is looking at all of the cancer services provided by Mount Vernon Cancer Centre and thinking about how they might need to change in the future.
- This includes outpatient chemotherapy, nuclear medicine, brachytherapy and haematology, provided by the Mount Vernon team, as well as radiotherapy and inpatient services.
- These services are provided at Mount Vernon but oncologists from Mount Vernon also run outpatient clinics at many local hospitals in the areas patients come from.
- Patients generally come from Hertfordshire, Bedfordshire, North West London, North Central London, Berkshire and Buckinghamshire, as well as a few from further away.
- An independent clinical team from a major cancer centre in a different part of the country, has made some recommendations about changes that are needed in the short, medium and long term.

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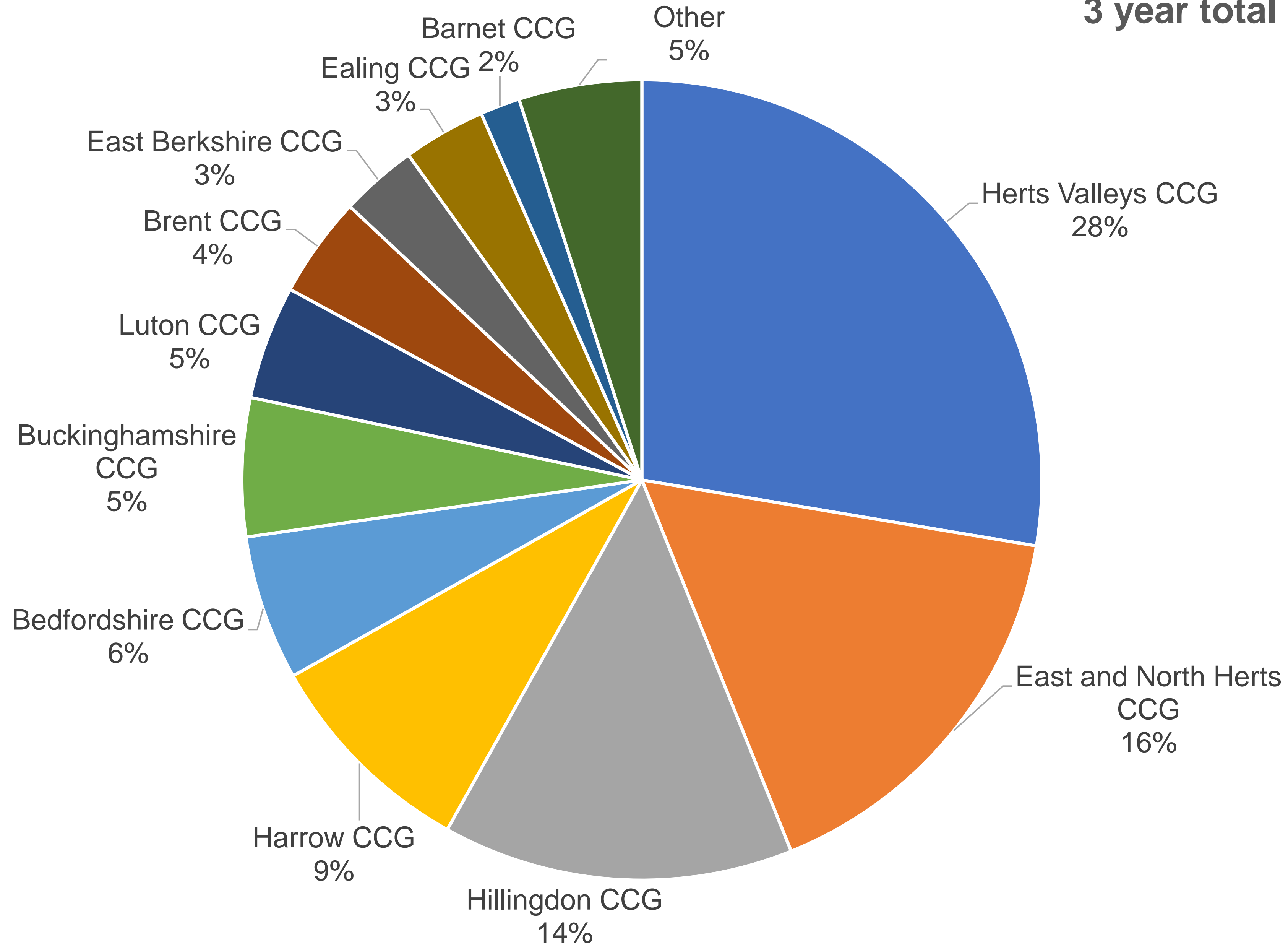
Geographical Distribution of Patients

CCG	2017-18	2018-19	2019-20	3 year total	%
Herts Valleys CCG	3,515	3,375	3,364	10,254	28%
East and North Herts CCG	1,612	2,215	2,212	6,039	16%
Hillingdon CCG	1,804	1,753	1,702	5,259	14%
Harrow CCG	1,099	1,075	1,080	3,254	9%
Bedfordshire CCG	661	714	800	2,175	6%
Buckinghamshire CCG	733	625	715	2,073	6%
Luton CCG	550	543	612	1,705	5%
Brent CCG	508	491	512	1,511	4%
East Berkshire CCG	394	374	385	1,153	3%
Ealing CCG	388	397	454	1,239	3%
Barnet CCG	246	214	137	597	2%
Other	527	714	603	1,844	5%



3 year total

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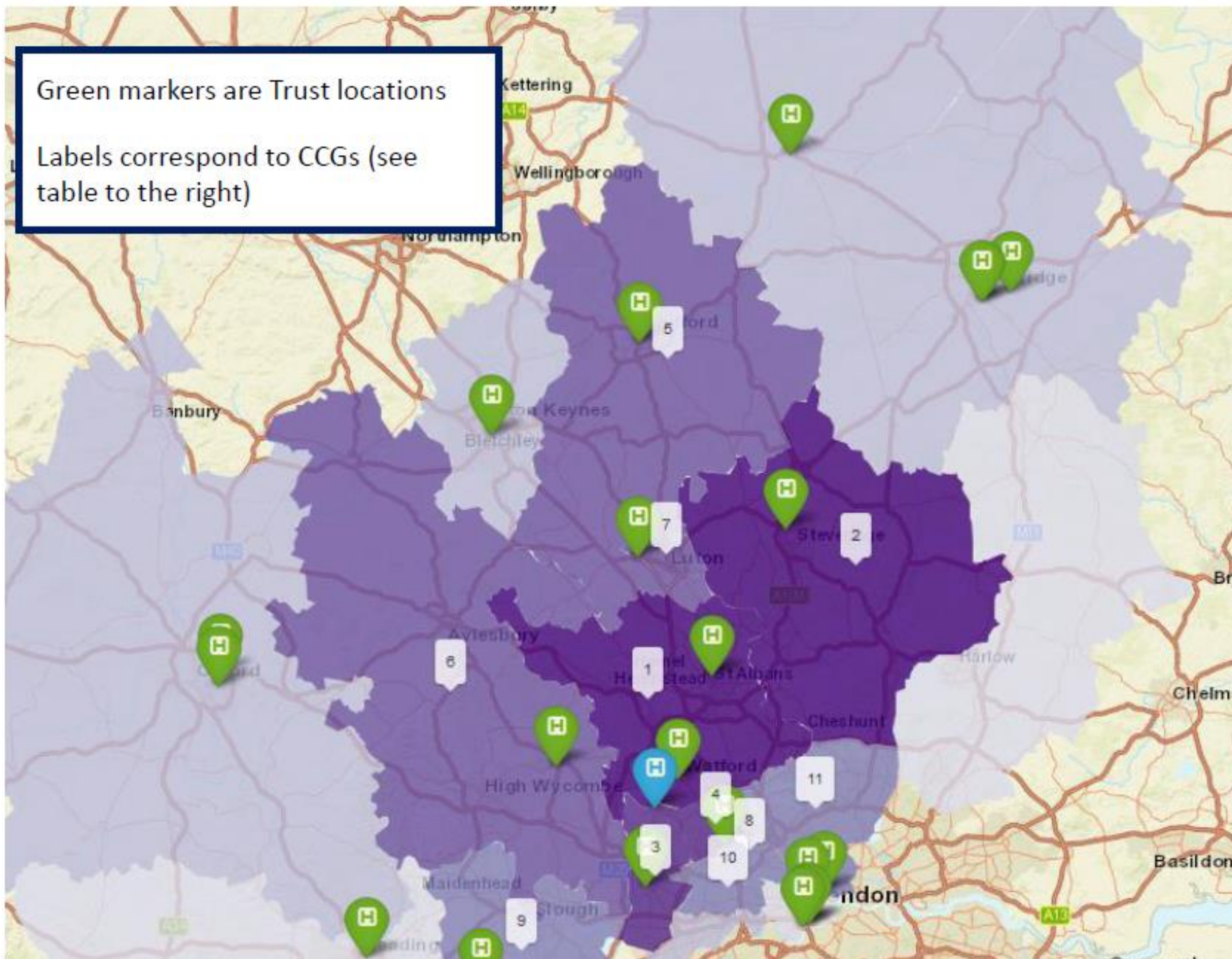
MVCC Catchment – patients attending MVCC 2019



Label	CCG	Unique Patients
1	NHS Herts Valleys CCG	3,056
2	NHS East and North Hertfordshire CCG	2,155
3	NHS Hillingdon CCG	1,550
4	NHS Harrow CCG	1,036
5	NHS Bedfordshire CCG	747
6	NHS Buckinghamshire CCG	645
7	NHS Luton CCG	616
8	NHS Brent CCG	394
9	NHS East Berkshire CCG	381
10	NHS Ealing CCG	346
11	NHS North Central London CCG	196

* Only CCGs with >100 patients are labelled

EDGE

DRAFT - Confidential

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Why do we need to make changes?

- There have been a lot of reviews of Mount Vernon over the last 40 years, but it has always been difficult to find the right answer.

"The future of Mount Vernon Hospital has been a concern since I was first elected in 1979"

John Wilkinson MP

"I am sure that we shall achieve a reconfiguration for Mount Vernon Hospital that is clinically coherent and financially viable"

Paul Boateng, Under Secretary of State for Health

Hansard 1998

- As a result, the buildings are in a bad state, staff aren't always able to provide the care and treatment they would like, and patients care is sometimes split across different hospitals. This cannot continue.

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Why do we need to make changes?

- Many of the buildings are not in a good state of repair, and concerns have been raised in relation to the long-term clinical sustainability of the Cancer Centre.
- Limited support facilities on site (for example intensive care)
- Some newer treatments and research trials have high levels of toxicity. Without services such as high dependency or intensive care, patients will not have access to the latest treatments.

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Why do we need to move to a hospital site?

- There is limited support infrastructure on the existing site which limits the team's ability to deliver complex oncology care. For example:
  - At MVCC there is no cardiology on site so anything required in diagnostics or treatment relies on arrangements with other hospitals.
  - During the first covid peak, Hillingdon had to move all anaesthetists back to Hillingdon Hospital so there was even more limited anaesthetic support on site than normal. Theatre services have had to be temporarily re-provided by Bishop's Wood because there was no support available from Hillingdon. This could put the brachytherapy service at risk.
  - MVCC has no input into decisions made by other organisations, even when they affect MVCC services.
  - Support currently comes from different hospitals for different things which is complex and fractures the patient pathway. For example, Pathology (NWL), histopathology, medical and surgical back-up, anaesthetics (Hillingdon), cardiology (Harefield)
  - Patient care at the moment is "sub optimal" because patients who have an acute need are being transferred out of MVCC or signposted to their local hospital where the Acute Oncology Service can provide support through A&E but oncology expertise beyond that isn't on site. Clinicians want to provide better quality service than we do at the moment.
  - Because we don't have the infrastructure to treat patients – some are travelling long distance to London, or going to their local hospital without the specialist expertise
  - There is not the right support on site to treat patients whose condition worsens. For example, a patient who collapses on site needs to be transferred to another hospital.

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Why do we need to move to a hospital site?

- Some newer treatments and research trials have high levels of toxicity. Without services such as high dependency or intensive care, patients will not have access to the latest treatments. Immunotherapies and other cancer treatments are becoming increasingly complex and there are already treatments that can't take place at MVCC – this gap will increase in future. For example:
    - MVCC cannot treat much haematological malignancy at the moment – many patients are going to UCLH.
- As people live longer, more people with cancer are also living with other illnesses or conditions which require treatment alongside their cancer treatment. This cannot be done at MVCC.
- Staff have done a good job, despite the conditions, in providing high quality treatment and ensuring patient safety. Patient feedback regularly shows that most patients are happy with the services they receive. However, a more permanent solution needs to be found to ensure the sustainability of the services in the long term.
- Staff want to be able to treat more complex patients to develop their skills and become experts in their field and there is a risk that Mount Vernon will not be able to recruit and retain staff if a long term solution is not agreed.
- We want to organise services in ways that provide the best modern care for patients, including access to research trials and new technology and treatments, from good quality facilities.

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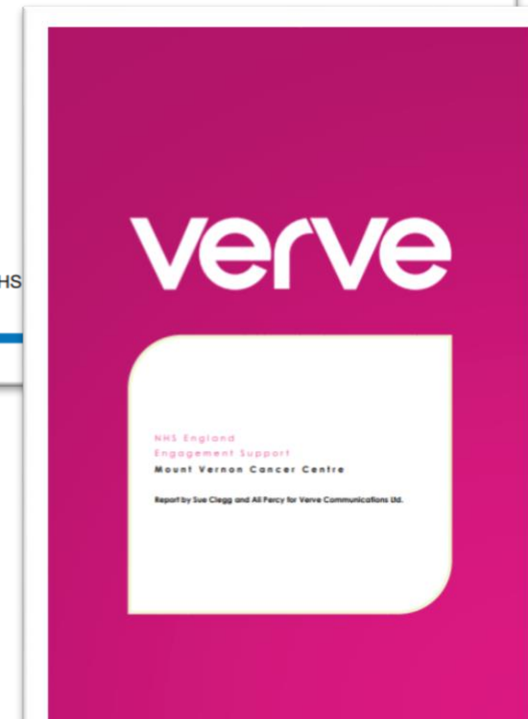
What are the options?

- **Do minimum** – this would most likely mean re-locating all inpatient care and some associated services, including brachytherapy and radiotherapy to an acute site, with outpatients, radio pharmacy and diagnostics and potentially some chemotherapy remaining on site. Radiotherapy could possibly be moved in phases, with some being retained on the MVCC site until the Linear Accelerators reached the end of their life.
- **Dispersal** – patients care would become the responsibility of another cancer centre – i.e. London, Cambridge or Oxford, with satellite and outreach facilities as determined by that centre. This is not considered acceptable by East of England commissioners.
- **Full re-provision** – this would mean a relocation of all MVCC current services onto an acute site, with the possible addition of services patients currently have to travel into London for because of the limitations of the existing site and facilities.
- **Re-provision with ambulatory hub** – this would mean a smaller specialist centre on an acute site, with a day hospital facility on another hospital site
- **Satellite radiotherapy** in North Hertfordshire or South Bedfordshire could be considered in most options. However, in the ambulatory hub option, it is likely to be necessary for the satellite radiotherapy centre and ambulatory hub to be on the same site, and the do minimum option may mean a new satellite radiotherapy service is developed only as the service moves off the MVCC site as the service is not large enough to spread across three sites.

What has happened so far?

- Reviewing of data (for example to improve understanding of where patients are referred from, for what services, how often they attend Mount Vernon)
- Interviews with clinical staff, stakeholders and patients
- Review of existing patient experience information
- Patient workshops, survey and interviews with groups representing protected characteristics to inform early thinking and criteria
- Independent Clinical Review
- Response to short term recommendations
  - Planning to transfer management of service to specialist provider (subject to due diligence)
  - New appointments and funding of additional staff (for example in the acute oncology service)
  - New policies (for example on admission criteria)
  - Increased ward rounds
  - Reviews of patients transferred to other hospitals



Who is overseeing the review?

- The review is run by a Programme Board which is led by the Regional Director of Specialised Commissioning for NHS England in the East of England. Other members include:
  - Commissioners from NHS England in the East of England who commission the service, and from NHS England in London
  - Healthwatch Hertfordshire and Healthwatch Hillingdon
  - Cancer Alliances: East of England Cancer Alliance, North Central and East London Cancer Alliance, RM Partners West London Cancer Alliance
  - Local systems: Hertfordshire and West Essex ICS, North West London STP, Bedford, Luton and Milton Keynes ICS, Buckinghamshire Oxford and Berkshire West ICS / Thames Valley Cancer Alliance
  - CCGs: Bedfordshire CCG, Buckinghamshire CCG, East and North Herts CCG, Harrow CCG, Herts Valleys CCG, Hillingdon CCG, Luton CCG
  - London Radiotherapy Network
  - East and North Hertfordshire NHS Trust who runs the service now
  - UCLH who is providing leadership support and is the preferred specialist provider to run the centre in the future
  - Hillingdon Hospitals NHS Trust who own the land the centre is on
  - Paul Strickland Scanner Centre

What is happening now?

- Discussions / workshops with each health system (x 6 – Hertfordshire and West Essex; North West London; Bedford, Luton and Milton Keynes; North Central London; Frimley Health and Care; Buckinghamshire, Oxfordshire and Berkshire West)
- More detailed analysis of travel times
- Patient Engagement programme
  - 5 x General Update Events, 30 x Patient Focus Groups, 4 x Feedback workshops
  - Survey – paper based and online (October and November)
  - Launch of interactive website using animations, polls, stories etc. (November)
  - Patient Reference Group workshop with Clinical Working Group to assess how fee – patient representation from Healthwatch and Cancer Alliances (December)
  - Work with Learning Disability and Autism Groups (November – December)
  - Non- digital programme of engagement developed with Healthwatch, including marginalised and disadvantaged communities (November and December)
  - Staff engagement (October and November)

What happens next?

- The independent clinical team recommended two different models for future Mount Vernon cancer services.
- Feedback from the staff and patient events will be discussed by the clinicians who are looking at the future clinical model of the services – this includes whether there is a single new cancer centre, or whether there is also a day hospital (ambulatory centre) on a second site, or even if there is a variation of one of those.
- There are pros and cons of both options and the feedback from patients and staff will help the clinical team work out which is the best model to plan services from.
- The clinical team is going to make a recommendation in December. They are not looking at the location of the services.

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What happens next?

- The clinical team will also start to think about whether any individual pathways would benefit from changes to improve outcomes and experiences for patients. Pathways are the way patients access treatment for different cancers from the moment they are referred to Mount Vernon to the end of their treatment and follow-up.
- The independent clinical team said that many of the services needed to be on a main hospital site that had intensive care and other facilities. In December the programme board will agree which hospitals within the existing area that patients come from will be considered. To be considered, hospitals will need to have the right facilities, space for a cancer centre to be built, and not make travel times worse for patients.
- From January, more detailed work will take place to develop detailed proposal for all the hospital sites that are shortlisted, and on the clinical model, to come up with a preferred option or options. We expect we will run a public consultation in June next year.

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October – December 2020	• Patient, public and staff engagement • Patient Reference Group
December 2020	• Options for the clinical model developed • Shortlist of site options agreed (based on geographical access for patients, and clinical criteria)
March 2021	• Shortlisted options developed in full and tested against criteria agreed by the Programme Board after patient and public input into the criteria, to create a preferred option / options
April 2021	•UCLH Board decision on transfer
May 2021	• Assessment of plans
June 2021	• Likely date for public consultation to begin
October 2021	• Earliest decision on outcome of business case and public consultation
November 2021	• Planning for new cancer centre begins
April 2022	• UCLH takes on responsibility for the management of the service at MVCC (subject to April 2021 Board approval)

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Our biggest challenges

- Making sure we can find the money that we will need to build the new hospital
- Making sure we understand the future cancer needs of all the areas the cancer centre covers and come up with the right plan for patients
- Making sure we hear from a wide range of patients and carers with different experiences of Mount Vernon Cancer Centre and from different areas, especially as we cannot meet face to face

Some questions we have been asked…

- Is this a foregone conclusion?
  - No – the Programme Board honestly do not know what the recommendations will be in December and in March. Logically it makes sense that moving the hospital a long way will not be an option.
- Given no other review has resulted in change, will this really happen?
  - Yes – as long as we can get together the capital money we will need.
- Will the transfer to UCLH mean the service is moving to Central London?
  - Definitely not. There are no plans to move any patients to Central London unless they would need to go there anyway. In fact, UCLH would like to explore the possibility of some patients currently being treated in central London, being treated at Mount Vernon instead, if the right clinical facilities were available.
- Why can't you mend the current buildings?
  - It is more cost effective to build a new hospital than bring the current buildings up to the right standard. And improving the current buildings will not deal with the clinical issues on the site.
- Why can't intensive care services come on to the existing Mount Vernon site?
  - Mount Vernon needs access to intensive care beds, but not too many. To build such a small intensive care unit would not be safe. It would be extremely difficult to staff and it would be very expensive to run which would divert resources from elsewhere.

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Your Questions

- Thank you for your time. Over to you.