ASHFORD AND ST PETER'S/ROYAL SURREY COUNTY MERGER INQUIRY

Summary of a hearing with The Royal Marsden NHS Foundation Trust held on Thursday 7 May 2015

Background

1. The Royal Marsden NHS Foundation Trust (The Marsden) told us that it was a leading cancer centre specialising in diagnosis, treatment, care, education and research. It had two hospitals: one in Chelsea in London, and another in Sutton, Surrey. It also had a chemotherapy day care unit at Kingston Hospital and it provided community services in the London boroughs of Sutton and Merton. Its lead commissioner was NHS England.

Cancer services

2. The Marsden said that prior to the Calman-Hine report of 1995, which examined cancer services in the UK, survival rates and the structure of cancer care varied across the UK. At this time there were areas of good practice in specialist centres, such as The Marsden, but there were also hospitals that did not have the right level of support structures leading to clinicians often making decisions without the view of the full multidisciplinary team.

3. The Marsden said that, as a result of the Calman-Hine report hospitals such as itself were designated as cancer centres and took a leadership role in ensuring that the cancer units with which it worked had the appropriate level of clinical input. Clear cancer referral pathways were agreed and documented, of which general practitioners (GPs) were advised. The cancer networks that were formed to oversee the development of cancer services provided by the centres were initially part of the health authorities before being hosted by Primary Care Trusts. The cancer networks no longer existed but were key in overseeing improvements to clinical pathways both in terms of speed and ensuring clinical guidelines were agreed across the network.

Patient choice

4. The Marsden said that when patient choice was introduced competition was excluded from cancer services. Patients were generally directed to the appropriate hospital by GPs who were influenced by their Clinical Commissioning Group (CCG) guidelines. However, patients might choose

another hospital or hospital trust on the basis of a previous experience or due to travel time. There were well established pathways from cancer units (eg Hillingdon) to specialist centres (eg Imperial) and that once a patient had started on a pathway it was quite difficult for them to specify a different hospital because they were under the care of the multidisciplinary team at a particular trust.

Referrals

5. The Marsden said it competed for referrals on its boundaries. Its access policy included a duty to its local population and its local cancer networks and a much wider responsibility for more specialist cancers. It was working to ensure that patients were treated in the right place, which might be closer to their home. This was to ensure the hospital's capacity was maximised either for patients from the local area, those with rarer cancers or for access to certain clinical trials.

6. The Marsden said that about half of its patients were GP referrals, many of which resulted in benign diagnoses. The remainder came from other hospitals, the latter being referred either with diagnosis and/or more likely with malignancy. It had a range of agreements with other trusts ranging from clear service level agreements to more informal arrangements for the provision of oncology support by the Royal Marsden to the provision of non-cancer clinical care by other trusts for Royal Marsden patients. [✂]

Services

7. The Marsden said that although it was a comprehensive cancer centre it provided a specialist tertiary service for diagnosed patients in addition to a diagnostic service (GP referrals) for some tumour groups. As a specialist cancer service it was commissioned to provide a service for rare conditions. NHS England had developed service specifications for rarer conditions and The Marsden completed a self-assessment against these specifications. It had to ensure that it had the clinical teams in place to provide appropriate cover for rare complicated cancers. It might only treat a small number of these per year in the south-east of England and so did not always benefit from the economies of scale available in other (cancer) areas.

8. The Marsden provided a large second opinion service which it operated without always seeing a patient and for which it did not charge (because there was no tariff). Under its access policy it did not have a duty to take such patients, if they sought to transfer their care, provided the patient was already receiving appropriate treatment locally.

Data analysis

9. The Marsden said it relied upon its own data and that from an independent healthcare planning consultant who conducted analysis of Hospital Episode Statistics data. The only other data sources available were the Cancer Waiting Times Database and the Cancer Outcomes and Services Dataset. Outpatient data suffered from a lack of diagnostic coding that meant it was almost impossible to know how much cancer work was undertaken in the outpatient setting. The way that treatments were counted was also problematic, for example, some trusts recorded chemotherapy as day cases and others as regular day attendances. This was a problem when trying to look at national data sources and understanding cancer excellence.

Payment and tariffs

10. The Marsden understood that the tariff proposed for 2015/16 by NHS England was rejected by the majority of trusts. As a result, providers were given the option of accepting the new tariff or retaining the existing tariff from the previous year, but with the Commissioning for Quality and Innovation funding removed for the year. Its actual commissioning details had not yet been agreed.

11. The Marsden's costs for cancer treatment were not met by the tariff. [✂]. Hospitals undertaking complex cancer treatment were under-resourced financially because the costs exceeded the income.

Community services

12. The Marsden considered the model of taking care into the community was the future but this was difficult to achieve as a result of reduced economies of scale. If it lost a particular specialism, because it was treating insufficient numbers, it believed that the work would be transferred to another cancer centre. NHS England looked at where services were located and could look at reducing the number of surgical cancer centres.

13. The Marsden currently provided general community services in Sutton and Merton. [✂]

Quality

14. The Marsden believed that quality in relation to cancer care was often measured by soft factors. The main measurable outcome was long-term survival.

The parties and the merger

15. [✂]

16. [✂]

17. [✂]

18. The Marsden said that the merger could potentially affect it to a small degree as the merged trust would be competing with certain tumour sites where minimum surgical volumes were part of the NHS England service specifications, however this was dependent on the aspirations of a merged trust. Its current situation would be unaffected if the merger was not to go ahead.