Briefing Paper for Chiltern CCG on the proposals by Dr Phillip Lee MP, for a 'Royal Thames Valley Hospital'

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1 Purpose of this report

In May 2012, Dr Phillip Lee, MP for Bracknell, wrote and circulated a report on proposals for a Royal Thames Valley Hospital (RTVH), to be situated in Berkshire, to the south west of Maidenhead. In the report, Dr Lee suggested that the new hospital would serve a significant population from south Buckinghamshire. Wexham Park, Wycombe and Stoke Mandeville Hospitals currently provide for this population.

At Chiltern Clinical Commissioning Group (CCG), as the new clinically led commissioning organisation serving a population of over 320,000 in Amersham, Wycombe, and across South Buckinghamshire, we were interested in exploring the impact of this proposal on our population in more detail and on reviewing the possible benefits/disadvantages for our patients,

We therefore commissioned a report from 'Healthplanning Ltd' to provide a briefing on the proposal in more detail, and to identify the issues for Chiltern CCG, and the population of Amersham, Wycombe and South Buckinghamshire.

It should be said at the outset that whilst a number of significant concerns about RTVH are raised in our report, Dr Lee's proposals are a serious contribution to what is a necessary debate about the future direction of Health Services in the area, and we welcome the opportunity to engage in this debate.

This report is in three parts.

- Part 1 outlines the recent background to the current pattern of hospital services across the area, and describes the Chiltern CCG population

- Part 2 summarises the key proposals from Dr Lee's report particularly in relation to Chiltern CCG population, and indicates the key arguments he advances.

- Part 3 of this report identifies the impact of the new hospital on Chiltern CCG and the population for which health services are commissioned and suggests the approach the CCG should take to Dr Lee's proposal,

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PART 1 – Current pattern of hospital services and a description of the Chiltern CCG population

1.1 Recent changes to Hospital services

It is important to first set Dr Lee's report in the context of changes currently taking place in local acute hospital services, and the Chiltern CCG population and localities.

The current configuration of hospital services in Buckinghamshire, and across the Thames Valley has experienced a number of changes in recent years, and is still continuing to change. The challenge for the Health Economy across Thames Valley is of providing services to diverse populations where there is no single dominant town or city. The current NHS response to this has been to move towards networks of acute services which can provide clinical critical mass whilst still serving local populations.

In 2010, 'Care for the Future' recommended that Stoke Mandeville, Wexham Park and Royal Berkshire Hospitals should be the main acute sites for local people. It also proposed that having a substantial local population, Wycombe Hospital should continue to provide a range of general services and further develop its specialist services, whilst Amersham should continue to provide a range of local health services.

In 2012, in Buckinghamshire, these recommendations were taken forward after consultation, in the 'Better Healthcare in Buckinghamshire' changes which altered services between Stoke Mandeville, Wycombe, and Wexham Park Hospital.

Since October 2012, East Berkshire has also been consulting on changes to acute services ('Shaping the Future'), proposing to move the Minor Injuries Unit at Heatherwood to the planned new Urgent Care Centre at Brants Bridge in Bracknell, to move rehabilitation services to Wexham Park and the community, and to close the Ascot Birth Centre at Heatherwood.

1.2 Chiltern CCG's population

Chiltern CCG's population is mainly served by the following two acute hospital providers:

- *Buckinghamshire Healthcare Trust (BHT)*. This is the main acute Trust commissioned by Chiltern CCG to provide services from its three sites at Stoke Mandeville, Wycombe, and Amersham Hospitals (the Trust also provides the local community hospitals).

- *Heatherwood and Wexham Park.* This is the acute main Trust serving East Berkshire, from its two sites at Heatherwood and Wexham Park Hospitals, but it also serves parts of Chiltern CCG's population.

Chiltern CCG's population of 320,000 is split into four localities – Wycombe (87,000), Woburn Green (87,100), Amersham and Chesham (72,877), and the Southern Locality (87,500). For each locality the pattern of use of acute services is as follows:

- *Wycombe locality* is served mainly by Buckinghamshire Healthcare Trust (BHT), and has Wycombe Hospital in the locality. Trauma and emergency care is provided at Stoke Mandeville in Aylesbury. Some patients from the South and East of the locality do travel to Wexham Park on the outskirts of Slough.

- *Wooburn Green locality* is also served by BHT, but a greater number of patients use Wexham Park.

- *Amersham and Chesham locality* patients mainly use BHT (Amersham / Wycombe and Stoke Mandeville)

- The *Southern locality* borders onto the Wexham Park Hospital site and most patients go there, although some patients use Wycombe.

In summary, the population in the Wycombe, and Amersham and Chesham localities are major users of Buckinghamshire Healthcare Trust, whilst the Wooburn Green and Southern locality population are major users of Heatherwood and Wexham Park Trust.
Other hospitals which serve Chiltern CCG's population are Oxford University Hospitals, mainly for tertiary services, and Watford and Hillingdon Hospitals, mainly for minor cross border flows.

Royal Berkshire and Frimley Hospital are two Foundation Trusts which do not normally serve Chiltern CCG residents, but are part of the regional health economy which would be impacted by any changes in hospital services in Berkshire.

PART 2 – Key proposals from Dr Lee's report

2.1 The RTVH proposal

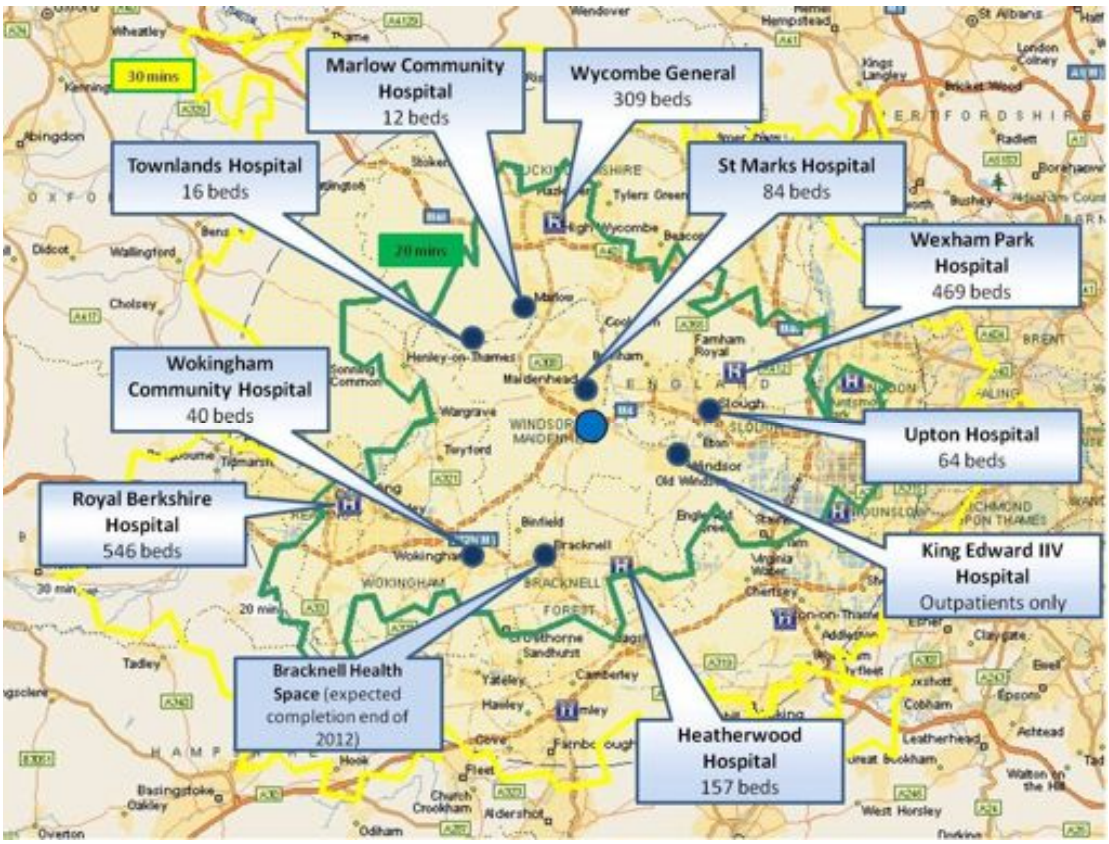
In May 2012, Dr Phillip Lee, MP for Bracknell, published a report entitled *'The Royal Thames Valley Hospital - 21st Century Patient Care: Challenges & Opportunities - A Vision Of A Sustainable Healthcare Plan For The Thames Valley'.* He argues his case in the report (and in the subsequent public meetings) on the basis of his clinical background:

> *As the only practicing GP in the House of Commons and having worked in around 50 practices situated throughout the Thames Valley region, I have….. argued vociferously for a 'rethink' of the healthcare strategy for the Berkshire, South Buckinghamshire and South East Oxfordshire areas.*

In relation to the future pattern of provision of healthcare he adds that:

> *The stark reality is that healthcare provision in the future will require a real need for consolidation of acute and emergency services in fewer locations and an increase in the provision of chronic care in the community through locally-based clinics.*

In his analysis of the problems he includes the following map:



He states that:

> *It is apparent that many small community hospitals and clinics are scattered across the region and larger hospitals are mostly found on the outskirts, hardly within easy reach. Also, linkage between inter-departmental services is made considerably more difficult by this disparity in location. Access to the only 'proper' acute hospital, Wexham Park, is severely restricted by its geographic positioning in the north-east of the region. Hence, access to services is difficult and time consuming.*

He states the risks as:

> *It becomes obvious that with the current hospital landscape, effectively dealing with the challenges of greater efficiency and improving patient experience are at risk. These challenges may become insurmountable for the Trusts in the near future.*

2.2 Proposed new hospital (RTVH)

His long-term solution is therefore

> *My vision is for a major, acute emergency hospital providing the very best care to a large region. This would act as a hub from which a series of 'arterial routes' to community hospitals would emanate…... On this basis, a regional hospital situated along the M4 would be the most cost effective and efficient solution to tackle future healthcare demands in the region.*

He proposes to locate the new hospital, which he calls Royal Thames Valley Hospital, at Junction 8/9 of the M4, to the south west of Maidenhead:

> *'Thereby allowing a quick and easy access for patients and emergency services from all directions. The location would enable a broadening of the catchment area by strategically placing the hospital in close proximity to the most important motorway link in the region.*

2.3 Population to be served by RTVH

What does this 'broadening of the catchment area' mean? In his proposal Dr Lee analyses the population of Berkshire, South East Oxfordshire and South Buckinghamshire. Some of his analysis is variable (I have assumed that what he refers to as 'East Berkshire' is in fact 'West Berkshire'), but I have used my best judgement to tease out his intentions.

He states that the proposed hospital will serve an ageing population in excess of 650,000 people living in the local authority areas of South East Oxfordshire, South Buckinghamshire, Bracknell Forest, Windsor & Maidenhead, and Slough as follows:

	2011	2022
South East Oxfordshire	133,000	138,000
South Buckinghamshire	68,000	71,000
Bracknell Forest	112,000	130,000
Windsor & Maidenhead	139,000	141,000
Slough	129,000	137,000
Total	581,000	617,000
Other population	?	?

He therefore assumes that the new hospital will serve all of the population of Bracknell Forest, Slough, Windsor and Maidenhead, and 30,000 of the population from Henley on Thames. I assume the balance is made up from patients in the Wycombe area.

His assumptions for **South Buckinghamshire** are that:

> *This area includes the towns of Beaconsfield, Gerrards Cross, High Wycombe and Marlow. It also would involve the larger villages of Bourne End, Flackwell Heath and Wooburn Green. The population in the area is in excess of 150,000. High Wycombe and the immediate surrounding area alone has a population of over 120,000. All of the towns would expect to have their acute care provided by the new hospital with the exception of Gerrards Cross, which would in future have their care provided by Hillingdon Hospital*

2.4 Services to be included in RTVH

The proposed plan states that RTVH would be a ‘state of art’ 1016 bed, acute hospital providing the following services:

- Full A&E
- Critical care (Intensive Care Unit, Medical and Surgical High Dependency Units, and Coronary Care Unit)
- Major trauma centre
- 20 operating theatres
- Diagnostic services
- '24/7' hyper acute stroke services
- Ophthalmology services
- Neurosurgery services
- In-patient care
- Medical day care services
- Children’s care unit
- Maternity unit with obstetrician ‘24 hour cover’
- Outpatient clinics serving the local population.

2.5 Services in surrounding hospitals

Marlow Community Hospital, Townlands Hospital, King Edward VII Hospital and Upton would serve as community hospitals offering:

- Elective care surgery
- Secondary out-patient care.
- Rehabilitation services.

Wycombe Hospital would be ‘reduced in size to reflect its changed status’.

St Mark's and Wexham Park hospitals would be closed.

Heatherwood Hospital would be closed, although Dr Lee includes the caveat that he would not support closing Heatherwood and relocating services to a new centre in Bracknell unless the whole plan outlined in his document was implemented.

2.6 Benefits of the proposal

Dr Lee’s report claims that the design for the new facility would achieve the following benefits:

- Provide acute and specialist services on a single site and accessible to a larger population
- Provide ‘state-of-the-art’ facilities and buildings that are fit for purpose
- Improve the efficiency and effectiveness of services and facilities thereby improving patient flows and care
- Improve financial profitability by concentrating core clinical services onto fewer sites
- Improve access to diagnostic services such as laboratory and imaging services
- Use staff to their full potential by optimising departmental and functional relationships
- Improve the safety and sustainability of future healthcare
- Achieve the lowest carbon footprint for a hospital in the UK in a truly sustainable way

2.7 The cost of the new hospital

In his report Dr Lee looks at a number of new hospital schemes in the last decade, and concludes that the total capital cost for the new hospital and other associated community sites would be in the region of £750 million.

To fund this cost, Dr Lee proposes that the most favourable funding option for this £750 million is a 'capital resale of current assets model'. This would raise funding for the new hospital from the sale of existing hospital sites as follows:

- Wexham, Heatherwood and St Mark's Hospital would be completely sold for development
- Upton, King Edward and Wokingham Hospitals would be partially sold
- Wycombe Hospital would be reduced in size to meet its new requirements, and partially sold.

The following table, based on that in his report, summarises his assumptions for land values that could be recovered from the sale of each site. They are based on the assumption of residential development on 70 per cent of the total site area (Option 1), or residential development on the current building footprint (Option 2).

This gives a total potential sale value of all the sites of between £511m and £1,843m

	Site area (ha)	Sell off	Area sold (ha)	Option 1	Option 2
Upton Hospital	1.67	65%	1.02	22.3	32.6
Heatherwood Hospital +Aggregate Site	17.73	65%	11.52	82.1	537.8
Wexham Park Hospital	24.4	100%	24.4	240.8	976
Wokingham Community	1.85	65%	1.2	10.8	44.1
St Marks Hospital	1.41	100%	1.41	29.6	61.1
King Edward IIV Hospital	0.8	50%	0.4	8.3	17.3
Wycombe General	6.7	65%	4.3	117.5	174.2
Total potential sale value				**511.4**	**1,843.1**

Dr Lee also suggests that:

> *Even if additional capital was required from central government, I believe that this would be more than justified for two reasons:*
>
> *1) the projected local increase in population over the coming decades would support a viable business plan within any future regional health economy*
>
> *2) the relative under-funding (when compared to other parts of the country) of the region's healthcare spending over the last decade*

PART 3 - Impact of the new hospital on Chiltern CCG and its population

It is possible to distinguish between the wider impact of the hospital on Chiltern CCG, and the wider health economy it sits within, and then identify the impact on each of the four localities

3.1 Impact on other hospitals

Because of its scale, RTVH would have a significant impact on acute hospitals beyond East Berkshire, and would have a potentially dramatic impact on services in Buckinghamshire.

The shift of the Wycombe population to RTVH would obviously reduce significantly the level of acute hospital services provided locally at Wycombe Hospital, requiring those patients who live north of High Wycombe to travel further for routine care.

Even more significantly, by reducing the population served by BHT by up to 50% it would certainly make that Trust unviable in its current form, and probably require a merger of Stoke Mandeville with Oxford. This would in turn undermine the critical mass for acute services in Aylesbury, and lead to a dramatic reduction in services to that population. This would be in effect a 'domino effect', that has been seen elsewhere (for example in London).

The effect would be to leave Buckinghamshire with the threat of having no acute services, or at best a limited range, whilst Berkshire would have two acute hospitals within its boundaries, and a further two (Hillingdon and Frimley Park) nearby. The effect on Chiltern CCG's population would be very significant.

This pattern does not seem a rational approach when looked at from a Thames Valley regional view.

In terms of the analysis of the clinical pressures driving the NHS there is much common ground between the 'Care for the Future / Better Healthcare in Buckinghamshire' analysis, and Dr Lee's proposals. Where there is a sharp difference however, is in the proposed solution. The local NHS vision across Buckinghamshire and Berkshire is based on a carefully constructed network of acute hospital services, concentrated to reflect clinical need, but co-ordinated across a number of sites to ensure local populations are still served.

The local NHS vision is driven particularly by the geography and population of the area, with a few large cities, and a series of smaller or larger towns. This is in contrast to areas where a regional city serves a wide geographical area (e.g. Cambridge or Norwich). In this context 'superhospitals' in the UK tend to be teaching hospitals in large urban areas or hospitals serving a wide geographical area.

This point was made in a recent parliamentary debate where Steve Baker, MP

for Wycombe commented on Dr Lee's proposals, stating that:

> *A number of NHS professionals, managerial and clinical, differ with him and think that a network of hospitals is an effective and incremental way forward.*

Where Dr Lee's vision fails, I believe, is because it is really a response to the problems of acute service provision in East Berkshire. East Berkshire failed to rationalise hospitals in the late 1980's and early 1990's when other health economies (e.g. West Berkshire) were beginning to address these issues. For example, Dr Lee's proposal, whilst rationalising hospital stock in East Berkshire, still leaves King Edward VII (in Windsor) functioning as a hospital.

To create a critical mass for the RTVH, Dr Lee's vision has to take the population of Wycombe too, the loss of which is then enough to undermine BHT. He also assumes repatriating East Berkshire residents who go to Frimley and Royal Berkshire hospitals, which would also undermine the viability of these hospitals.

The time for this solution was in the 1990's. Events have now moved too far to make the RTVH vision sustainable. With the current pressures facing all trusts, it has been recognised that further reconfigurations and mergers are inevitable. I believe this is recognised by the four trusts involved (Royal Berkshire, Berkshire Healthcare Trust, Heatherwood and Wexham Park and Frimley Park).

I expect the situation over the next five years to be one of further developments of the network model. There will undoubtedly be difficult decisions in some areas, but I would not expect towns the size of Wycombe and Aylesbury to be left without acute services, even if they are not necessarily able to support all services. Innovative methods of staffing and skill mix will need to be found. I believe the recent Buckinghamshire changes showed what can be achieved, and a new hospital would undermine this approach. Reducing the physical size of Wycombe Hospital to 65% of the current 'footprint' would be unlikely to enable the current range of services provided at Wycombe, post Better Healthcare in Bucks, to be sustained.

Changes on this scale will require national support. Indeed in an interview with the Health Service Journal on 15th January 2013, David Nicholson stated that:

> *the commissioning board – as commissioner of primary care as well as specialist services would be actively involved in nearly all discussions about service change…: "We are a player on the pitch. It's hard to imagine a service change that's going to take place over the next few years that the commissioning board is not directly involved in".*

He added that:

> *clinical commissioning groups would often be leading changes, where they focused on general hospital and community care, but the board would*

> *"convene, help and facilitate it ….We can start to have a much more strategic view about the pattern of services across the country in a way nobody's really been able to do before."*

Dr Lee, in his most recent Public meeting expressed frustration over lack of national leadership of strategic change. Whilst I would argue in Buckinghamshire (and in Berkshire) we have tried to grapple with this (which Dr Lee does not acknowledge), it does now look like a regional approach will overtake Dr Lee's proposal at some point.

Therefore there is the likelihood that whilst the debate is necessary, and the drivers Dr Lee identities are real, his solution, whilst seeming superficially attractive to some residents who would benefit from it the most (e.g. Marlow), it is much more likely to prove a diversion from the solutions we need over the next ten tears.

I quote Steve Baker again;

> *Dr Lee's ideas remain a controversial contribution to debate. Coming so soon after the Better Healthcare in Bucks changes, it remains to be seen whether they will be helpful*

3.2 Funding

There are real issues over the affordability and practicality of RTVH. Dr Lee quotes a number of hospitals, particularly Norfolk and Norwich. However I think a more recent example may be Southmead Hospital in Bristol.

This is a PFI scheme due to for completion in 2014. It has a capital cost of £430million. It includes 800 beds, 24 theatres and the full range of services for a population of 400,000 people.

The Hospital is being developed between Carillion and Lloyds Bank in a contract worth £600m over a period of 35 years and 4 months (including the construction phase), which constitutes £430m of construction services and £170m of facilities management and maintenance services. It includes the procurement, purchase, supply and installation of all medical equipment.

So, on the face of it, there are recent developments that are similar to Dr Lee's £750m proposal. However to fund this from land sales alone assumes substantial development on all the vacant sites. I think this is highly optimistic bearing in mind that many of the sites have complex planning histories and are therefore unlikely to get the premium prices required to cover all the development costs involved.

More likely, there would be significant additional funding required, either from local commissioners (CCGs and NCB) or by direct government funding. It is difficult to see this happening in this decade, given the Chancellors recent statements about expenditure until 2017 and beyond, so it would be at least ten years before development could begin.

There is also a significant issue regarding existing assets and PFI. The closure of Wexham, and parts of Wycombe in particular, would involve the write off of considerable assets that still have a significant life. In the past the Treasury has been reluctant to accept this, and indeed this was one of the major reasons for stopping 'superhospital' proposals in Berkshire in the early 1990's in favour of the redevelopment of Royal Berkshire Hospital.

There are also significant PFI schemes in Buckinghamshire at BHT sites in Wycombe, Stoke Mandeville and Amersham. These costs all still have at least 20 – 30 years to run, so any new hospital would have to absorb these costs. These costs are substantial and would continue even if the services on any of these sites cease. I believe that this factor alone could make the business case for a new hospital uneconomic, unless it does not serve Buckinghamshire.

This takes us back to the situation that a new hospital is not viable without the Buckinghamshire population, particularly that in the south of the county, but that the costs that come with them are unaffordable.

3.3 Services for Older People and the shift to services closer to home

With the rising population of older people in England, there is widespread recognition that providing effective, sensitive and efficient services for older people is the biggest challenge facing the NHS over the coming decades.

As Dr Lee states in his report:

> *No amount of tweaking the system will address the pressures of rising demand in the coming decades. If we don't take this issue seriously, the system will collapse under the weight of demand and it is the truly vulnerable who will suffer……. An ageing population will place additional constraints on the current provision of care in the region.*

The current NHS strategy of networked services is responding to this challenge by reducing the size of its acute hospitals, and shifting more services closer to home. At the same time it is developing appropriate services (for example Rehabilitation services) in local hospitals and in people's own homes

Dr Lee does acknowledge the need for community services, and indeed sees considerable services remaining in them, but the impact of such movements does not seem to have been robustly factored into his vision.

It is difficult to see how this shift of services could take place, if RTVH is built. The likelihood must be that in the face of a superhospital (particularly one serving only East Berkshire and South Buckinghamshire), most services would have to be pulled from community hospitals in Marlow, Wycombe and elsewhere in East Berkshire. There are many examples in the NHS in the past where this has happened. Whilst I recognise this is not an easy balance to get right, the network model does try to sustain local services by not concentrating

all services in one place.

Dr Lee also suggests that Wycombe Hospital (and indeed Marlow, Townlands, King Edward VII and Upton Hospital) serve as community hospitals offering elective care surgery. This not only makes no sense in terms of the numbers required for efficient and safe surgery, but is also inconsistent with the RTVH bed numbers needing to be as high as 1,016 beds for a population of 650,000.

I also therefore do not see how this model empowers local GPs or CCGs in developing local services,, to respond to the needs of Older people..

3.4 New Hospital location problems

Almost any new site can be expected to generate fierce controversy in the surrounding area. Whilst this is outside the scope of this report, it is already clear that the RTVH proposal will generate strong opposition from some Maidenhead residents already worried about the shortcomings of the local transport infrastructure and other environmental issues. This is inevitable for any new site, but again will do nothing to make the proposal easier to progress.

The location at Junction 8/9 does make sense, but only if it is trying to serve South Bucks as well as East Berkshire. To serve East Berkshire alone a site between Maidenhead and Slough would be far preferable, and indeed has been identified and discussed in the past.

The risk is therefore, that the site is not actually in the optimal place to serve the population in the greatest need.

3.5 Impact on localities

The impact of the new hospital will vary in each of the four localities:

- *Amersham and Chesham locality* patients who mainly use BHT (Amersham / Wycombe and Stoke Mandeville), would not transfer to RTVH as the journey times would be much longer than to Aylesbury. They would however, be significantly affected if the services at Stoke Mandeville were compromised and would be remote from acute health services.

Wycombe locality. All Wycombe patients would be greatly impacted by the loss of acute services from Wycombe Hospital. Patients to the north of High Wycombe would also be significantly affected by any diminution of services at Stoke Mandeville, and would have extended journey times to RTVH.

Patients to the south of High Wycombe would also lose the acute services, and have to travel further to RTVH, although the journey could be easier than their current journey to Stoke Mandeville.

Comparing access and travel times from High Wycombe to Stoke Mandeville, with High Wycombe to RVTH, the position is more complex than the map

would suggest. The distance by car from High Wycombe to RVTH is 11 miles, and to Stoke Mandeville 15 miles. Google maps suggests off peak car travel times of 25 minutes to RVTH and 30 minutes to Stoke Mandeville. In peak hours both these times would be worse, although with the notorious peak hour congestion at Handy Cross, Bisham and J8/9 roundabouts, peak hour journeys to RVTH would probably be worse.

Public transport journeys would be significantly worse to RVTH from High Wycombe. Currently there are four buses per hour from High Wycombe to Stoke Mandeville taking 45 minutes, with buses until 22.00. There is only one bus an hour to Maidenhead, taking 60 minutes with the last bus at 17.30. To serve RVTH, these services would have to be extended a further 3 miles south of Maidenhead into a lightly populated area, which would require considerable public subsidy.

Wooburn Green locality. All Wooburn Green locality patients would be impacted by the loss of acute services from Wycombe Hospital. Stokenchurch patients would be significantly affected if the services at Stoke Mandeville were threatened and would probably have to travel to Oxford.

Beaconsfield patients who currently use Wexham Park would have longer journeys to RTVH. Marlow patients would be the clear beneficiaries amongst the CCG's population with easier journeys (at least in respect of car journeys during non peak hours).

The *Southern locality* patients would all face longer journey times to the new hospital, compared to their current journeys to Wexham Park. This does indicate that, although the current location of Wexham Park is often criticised due to its poor road access, a location in the west of the area is worse for the South Bucks (and indeed Slough) populations.

The report suggests that *Gerrards Cross* patients would in future have their care provided by Hillingdon Hospital. Dr Lee's report justifies this on the grounds that the travelling time for Gerrards Cross residents would still be less than that currently experienced by the majority of South Buckinghamshire people who now have to travel to Stoke Mandeville in Aylesbury. This argument is likely to be very unpopular with residents in the area who have some of the highest car ownership rates in England and will be asked to swap a drive through relatively quiet country roads for a drive through Uxbridge to get to Hillingdon which would be lengthy, particularly during peak hours.

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