Trust Board Meeting: Thursday 3 May 2012

TB2012.29

<table>
<thead>
<tr>
<th>Title</th>
<th>Relocation of Head &amp; Neck Services</th>
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<td>Status</td>
<td>The Trust Board agreed to suspend the transfer of Head and Neck Services to the Churchill Hospital in July 2011. Following a period of review and consultation this paper sets out a series of recommendations for the future location and provision of Head and Neck Cancer Services.</td>
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<tr>
<td>History</td>
<td>The issues addressed in the paper flow back to 2003 with further reviews in 2007 and 2010.</td>
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<th>Board Lead(s)</th>
<th>Paul Brennan, Director of Clinical Services</th>
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<tr>
<td>Key purpose</td>
<td>Strategy</td>
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Summary

The Trust Board agreed to suspend the transfer of Head and Neck Services to the Churchill Hospital in July 2011. Following a period of review and consultation this paper sets out a series of recommendations for the future location and provision of Head and Neck Cancer Services. The issues addressed in the paper flow back to 2003 with further reviews in 2007 and 2010.
Relocation of Head and Neck Services

Introduction and Overview

1. In July 2011 the Trust Board agreed to suspend the proposed relocation of Head and Neck Cancer Services from the John Radcliffe Hospital to the Churchill Hospital for the following reasons:

   1.1. Available theatre capacity at the Churchill Hospital was insufficient to cope with the additional surgical activity required to deliver the Head and Neck service.

   1.2. Critical Care was operating at full capacity due to the expansion of transplant and complex cancer surgery and could not accommodate the additional complex surgical activity associated with the Head and Neck service.

   1.3. Out of hours services at the Churchill Hospital could not manage the additional activity and specifically handle the complex airway conditions associated with these patients.

   1.4. The additional revenue consequences of transferring the service to the Churchill Hospital were in excess of £1.5m and this was not sustainable in the current financial climate.

2. In addition, concerns were expressed about the clinical gain that will be derived from the relocation of the Head and Neck Service given the excellent outcomes achieved by the Team operating from the John Radcliffe Hospital.

3. The Board subsequently agreed to consider three options for Head and Neck Cancer Services as part of a review into the Neuroscience and Specialist Surgery Divisions existing plan to move Head and Neck Cancer Services from the John Radcliffe Hospital to the Churchill Hospital. The three options considered were:

   3.1. Option A

       This involves an outpatient environment solely for head and neck patients on the lower level of Blenheim within the Churchill Hospital with Inpatients being located above this on an 18 bedded ward. ITU would be provided within Churchill Adult ITU and Inpatients and Day Cases would be treated within Churchill Main Theatres. Blenheim has use of an external garden area and the ward has a separate patient day area (the average length of stay for a complex case is 17 days).

       The option includes moving 4 Max Fax Surgical Emergency Unit Beds (Currently in the main JR) to Blenheim.

   3.2. Option B

       This involves a mixed outpatient environment for head and neck patients (with Plastics, ENT and Audiology) on LG1 Level within the West Wing with Inpatients being located above this on a separate side of specialist surgery inpatient ward (SSIP) which has 37 beds in total. ITU would be provided
within Neuro ITU which is one level above SSIP with Inpatients and Day Cases being treated within West Wing Main Theatres.

The option includes moving 4 Max Fax Surgical Emergency Unit Beds (Currently in the main JR) to SSIP.

3.3. Option C

This involves an outpatient environment solely for head and neck patients on the lower level of Blenheim within the Churchill Hospital with Inpatients being located on L0 Level within the West Wing on a separate side of specialist surgery inpatient ward (SSIP) which has 37 beds in total. ITU would be provided within Neuro ITU which is one level above SSIP with Inpatients and Day Cases being treated within West Wing Main Theatres.

The option includes moving 4 Max Fax Surgical Emergency Unit Beds (Currently in the main JR) to SSIP.

4. The financial implications of the three options were:

<table>
<thead>
<tr>
<th>Description</th>
<th>Option A £’000</th>
<th>Option B £’000</th>
<th>Option C £’000</th>
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<tbody>
<tr>
<td>Additional Revenue Expenditure (Recurrent)</td>
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<td>(395)</td>
<td>(1,533)</td>
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<td>Additional Capital Expenditure (One-Off)</td>
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<td>(1,299)</td>
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<td>Additional RBFT Income (Recurrent)</td>
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<td>677</td>
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<tr>
<td>Additional RBFT Expenditure (Recurrent)</td>
<td>(464)</td>
<td>(236)</td>
<td>(464)</td>
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5. Consultation with stakeholders, staff, the public and service users was undertaken on the three options and this paper:

5.1. Sets the context
5.2. Outlines the outcome of the consultation
5.3. Reviews the clinical case for the service
5.4. Sets out the responses to the key issues raised by the Board
5.5. Considers the constraints and opportunities
5.6. Sets out recommendations and timescales for future options.

Background and Service Overview

6. The Head and Neck Cancer Service was originally located at the Radcliffe Infirmary. The proposal was to move this service to the new facility at the Churchill Hospital; however delays to the building programme at the Churchill resulted in the service
moving to the John Radcliffe Hospitals in 2007. Head and Neck Cancer Services are currently split across the main JR building and the West Wing with oncology Services located at the Churchill Hospital. A review was undertaken in 2010 which concluded that from a clinical and strategic perspective the original plans for Head and Neck Cancer Services to move to the Churchill Hospital should proceed.

7. During late 2010 and early 2011, with the implementation plans underway, a number of issues emerged. Firstly it was discovered that the 2010 review made assumptions around capacity that were inaccurate. The review concluded that Blenheim Ward provided 24 beds and an appropriate configuration of patient and staff accommodation; including high dependency. This capacity was sufficient to meet the needs of the service and provide flexibility for private work which could offset a proportion of the increased revenue costs associated with the relocation. However, this proved to be inaccurate as a subsequent assessment by the Infection Control Team demonstrated, the four bedded bays could not be used as planned, the high dependence area was inadequate and a number of the single rooms were not suitable for use as inpatient accommodation. Changes to the ward configuration and space utilisation were implemented leading to a reduction of six inpatient beds giving a maximum capacity of 18 beds.

8. The available theatre capacity was sufficient at the time of the review, however expansion in other services has resulted in a shortfall of two to four all day lists. Whilst costs associated with accommodating these lists can be partially offset by additional activity the net consequence of the change is an increase in the revenue cost of the relocation.

9. The financial challenges facing the Trust have also grown since the 2010 review with the 2011/12 NHS Operating Framework introducing a number of system changes which placed a greater demand on Acute Trusts. The two most significant factors that adversely impact on the Trust’s financial position, which were unknown at the time of the review, was the introduction of the penalty/non-payment regime for readmissions and the reduction in the Market Forces Factor supplement.

10. Although Head and Neck cancer is a relatively rare form of cancer it does involves significant patient treatment over a long period of time. As a result of the nature and location of the cancer in the head and/or neck, treatment is extensive, often involving combinations of surgery, chemotherapy and radiotherapy; this is extremely arduous and challenging for patients. Diagnosis and explanation of personalised treatment plan options, as well as the treatment itself and postoperative recovery, can be traumatic and patients require a lot of support from family and friends as well as a range of professionals.

11. Treatment is therefore intensive and recovery relatively slow, and stays in hospital can be of several weeks. Treatment frequently involves the use of highly toxic chemicals, with specific chemical hazard handling requirements and safety protocols by trained specialist nurses. Treatment often involves other clinical interventions to bypass the affected area, for example a tracheotomy (to improve the airway) or PEG feeding (a direct feeding tube to the stomach through the abdomen to bypass the
12. Recovering patients require a lot of support to re-establish normal breathing, speaking and eating. Surgery can also affect appearance in both the short and long term and this can cause patients additional suffering and anxiety. It is especially important to maintain privacy, dignity and respect for these patients. Carefully managed palliative care and quick access to it is especially important for patient wellbeing, motivation and recovery. Patients need an integrated specialised care environment with the coordinated input of multiple care specialists for optimal outcome.

13. Like many cancers, but perhaps even more than most, Head and Neck Cancer requires the input and close collaboration of a large multidisciplinary team including Ear Nose and Throat Surgeons, Maxillofacial Surgeons, Plastic Surgeons, Oncologists, Specialist Nurses, Speech and Language Therapists and Dieticians. A patient may require support from any or all of these in an outpatient clinic or on the ward, both pre and post operatively.

**Consultation**

14. A period of consultation was undertaken between 23rd January 2012 and 24th February 2012. Four formal consultation and engagement sessions were arranged; two for staff on 27th January 2012 and 2nd February 2012 and two for stakeholders on 1st February 2012 and 23rd February 2012. In addition, the Director of Clinical Services and the Director of Planning and Information responded to requests for individual meetings or attendance at patient and user group meetings.

15. Staff, stakeholders, patients and the public were also invited to provide views via a template questionnaire.

16. The contribution made by staff, stakeholder, patients and the public was extremely positive and delivered in a very professional, courteous and constructive manner. The overwhelming view expressed by all those who attended the various group sessions was complete support for the original proposal to relocate the service to the Churchill Hospital. These views were expressed at both an emotional level and in well-articulated arguments in favour of the move to the Churchill Hospital for reasons of clinical excellence, interdependence with oncology services, environmental and research and development. The most repeated concern expressed by patients and members of the public related to the current ambulatory/outpatient environment and the major benefits to be derived from providing the service from a dedicated outpatient suite co-located with radiotherapy.

17. Attached as annexes to this report are:
   17.1. Annex A – Consultation Questionnaire
   17.2. Annex B – Notes from the formal consultation sessions
   17.3. Annex C – Summary of responses to the Questionnaire

**Clinical Strategy**
18. The Chief Executive and Director of Clinical Services requested colleagues from the Surgical and Oncology Division and the University Department of Oncology to consider the clinical and research implications associated with the three options and to provide expert advice on the proposals. The emerging themes were:

18.1. Clinical Practice:

The single most important mechanism through which cancer treatment outcomes have improved over the last 20 years has been the development of multidisciplinary approaches fully integrating surgery, radiotherapy and chemotherapy into a personalised treatment plan for each patient. Head and Neck Cancer is the greatest exemplar of this practice as each of these three modalities is used in an integrated way in almost every patient. This is not yet true of all cancers. For several other cancers treatment choices may still be either/or decisions between surgery or radiotherapy (for example in prostate cancer or lung cancer), or in sequential, largely independent, phases of treatment (as in gastrointestinal cancers). However, in Head and Neck Cancer, the disciplines in the best international centres work in a fully integrated fashion. For instance, optimal post-operative care of patients after major surgery during post-operative radiotherapy requires daily surgical oversight. Input of the surgeon into the radiotherapy planning process is essential from their detailed knowledge of the exact site of the cancer and where any margins were of particular concern in the placement of radiation sources for internal brachytherapy.

The drivers towards the fully integrated approach to cancer management are not only to maximise the probability of cure but also to do so at the least possible cost to the patient in terms of morbidity. In Oxford, surgical standards are exceptionally high whereas radiotherapy techniques are not yet of the current highest international standard. As Intensity Modulated Radiotherapy (IMRT) is implemented in the coming months and years, this will swing the balance of efficacy and morbidity in combined modality treatment. At present in Oxford, Surgery is much more frequently used than in other international centres where primary chemoradiotherapy is used more often, especially in patients with HPV positive cancers of the oropharynx where outcomes from this form of treatment are excellent. Working together will enable oncologists practicing state of the art treatment to gradually find the optimal balance of treatment selection between surgery, radiotherapy and chemotherapy as the primary modality allowing increasing use of organ preserving approaches.

18.2 Research:

There are multiple opportunities for increasing research in Head and Neck Cancer as improvements in radiotherapy techniques have been one of the major technological improvements in radiotherapy clinical practice. The emergence of HPV induced oropharyngeal cancers as a newly identified and rapidly increasing subtype is changing practice in international leading centres. Establishing the causation of Head and Neck Cancer will become routine in the near future through p16 immunohistochemistry or more precise genetic measures. Patients with these tumours are being extensively entered in
research studies elsewhere. Oxford is not a centre where external research leaders seek collaboration because of our current treatment practices. Developing an integrated and co-located service will provide the environment for pursuing research including imaging and biomarker definition of head and neck cancer pre-operatively to improve patient selection; phase 0 trials to evaluate the efficacy of novel treatments with imaging correlates prior to surgical resection. This will pave the way to the development of innovative phase 1 and 2 studies. If the service is relocated is would provide a powerful platform on which service improvements could develop and cutting-edge basic, translational and clinical research would be undertaken seamlessly, closing the loop from bench to bedside at Oxford.

18.3 Strategy:

The strategy of developing a major Cancer Centre on the Churchill Hospital site was a key plank that paved the way for the investment of the University and many external funders to invest in the massive cancer research facilities on the Old Road Campus. Indeed a key reason for the MRC and CR-UK’s investment in the Gray and in Oxford in general to become a CR-UK funded Cancer Research Centre was that it was planned on the same site as the new hospital facilities, which has facilitated recruitment of very high quality clinical and basic researchers in cancer. However, on current activity, less than half of the surgical procedures within the new centre are related to cancer treatment because of the existing case mix of specialties. The move of Head and Neck Cancer Services to the Churchill site would undoubtedly lead to a significant increase in cancer related surgical activity and support the creation of a world leading integrated cancer research and service centre in Oxford.

Compliance, Activity and Finance

19. Prior to receiving recommendations on the future location for Head and Neck Cancer Services the Trust Board required clarification on three key issues as follows:

19.1. The Thames Valley Cancer Network assessment as to which of the three options under consideration were compliant with the Improving Outcomes Guidance.

19.2. The Royal Berkshire NHS Foundation Trust perspective on each of the options and the impact the selected option will have on referral of complex Head and Neck Cancer patients to Oxford.

19.3. Commissioner agreement to proposals to adjust the local tariff for complex surgical procedures to offset the significant additional financial implications of transferring the Head and Neck Service to the Churchill Hospital.

20. The Director of Clinical Services has perused each of the compliance, activity and financial implications of the options under consideration with the following outcome:

20.1. Improving Outcomes Guidance (IOG)

The Cancer Network have confirmed Options A and B are compliant with current guidance. The Network consider Option C to not be compliant as IOG requires surgical provision to be on a single site.
It should be noted that whilst the Cancer Network confirmed Options A and B were IOG compliant the Network felt that Option A (Churchill Hospital) provides the best strategic choice, would provide co-terminus chemotherapy, radiotherapy and surgical services which would foster more efficient MDT working with an opportunity for greater involvement in translational research and would provide the best quality service and environment for Head and Neck patients.

The Thames Valley Cancer Network assessment was confirmed in writing on 24th February 2012.

20.2. Transfer of activity from the Royal Berkshire NHS Foundation Trust (RBHFT)

The Trust has confirmed that Option A will satisfy their clinical and quality requirements and that if this option was implemented the Trust would send their remaining patients to Oxford for surgery once the move had settled and there was confirmation of adequate capacity. Colleagues at RBHFT believe the transfer should take place two months following the move subject to clinical confirmation the service could cope with the additional activity.

Royal Berkshire NHS Foundation Trust acknowledge that Option B is IOG compliant, however regard the separation of surgical and oncology teams to be a major barrier to service improvement and development. The Trust have indicated that if Option B or C were implemented the remaining surgical patients would not be referred to Oxford and they would look to develop links within East Berkshire and consider moving all Head and Neck cancer patients away from Oxford.

The Royal Berkshire NHS Foundation Trust position was confirmed in writing, by the Chief Executive, on 16th March 2012.

20.3. Local Tariff

Following discussions with Oxfordshire PCT agreement has been reached to increase the locally agreed tariff from £22,650 to £33,230 for complex surgery. Oxfordshire PCT, as lead Commissioner for the OUH Contract, has agreed the new tariff and confirmed the revised tariff will apply to all Commissioners.

The agreement to the new tariff was confirmed, in writing, on 30th March 2012.

Constraints

21. As highlighted in section 1 above the major constraints to the relocation of Head and Neck Cancer Services to the Churchill Hospital relate to theatre and critical care capacity and the depth of the out of hours service to accommodate complex airway patients. These constraints remain and are a barrier to the service transfer, however, options have been developed to address the capacity issues.

22. The theatre schedule for the Churchill alternates on a weekly basis with week 1 operating with spare capacity for seven all day lists and week 2 with five all day lists. In addition, during the period June to October 2012 these sessions will be brought into operation as a key component of the Trust’s plan to meet the new 18 week RTT standards which require 90% performance to be achieved at specialty rather than Trust level. The additional theatre capacity required to accommodate the Head and
Neck service, at a date after 31st October 2012, can be created by implementing six day operating at the Churchill Hospital. This approach is supported by the Director of Clinical Services and the Divisional Director for Surgery and Oncology.

23. Analysis of critical care activity at the Churchill indicates a requirement for a high dependency unit that would both accommodate post-operative surgical patients direct and act as a step down unit from the existing critical care unit to release intensive care capacity. A number of proposals to create a high dependence unit have been considered and the preferred approach is to develop a unit within theatre recovery. Further work is required to enable a detailed plan to be developed, however utilising the theatre recovery area will minimise capital work requirements.

24. A review of out of hours acute support linked to proposals to relocate respiratory and ID services to the John Radcliffe Hospital is being undertaken and this will incorporate the service infrastructure required to support Head and Neck patients.

Opportunity Implications of Options A, B and C

25. The Trust is currently reviewing the portfolio of services provided across the hospital sites taking account of the interdependency of clinical services whilst seeking to maximise the utilisation of high cost assets and relocate services from areas where environmental conditions are sub-standard for modern day health care. The interdependency of acute care together with environmental standards of some of the older accommodation at the Churchill Hospital has been identified as a priority. Currently the Trust is assessing the potential to relocate respiratory inpatient and day case, urology inpatient, infectious diseases inpatient and renal inpatient services to improve clinical adjacencies and the environment that services are delivered.

26. Strategically the Trust needs to work in close collaboration with partnership hospitals to enhance and secure acute services across a network of acute hospitals. The Oxford University Hospitals Trust aspires to work in partnership with acute Trusts to create a network of provider organisations that delivers mutual benefit to all partners. A component of this approach is to ascertain the extent to which partner Trusts will consider the Oxford University Trust as their main provider of tertiary services as the current population base served by the Trust is limited at around two million. Working with colleagues across the Thames Valley, Wiltshire, Gloucestershire and Central England regions we aim to create a partnership providing clinical services to a population in excess of five million.

27. It is essential that any future investment programme and/or service development compliments these dual aims in the context of a challenging financial environment and demand from patients and their representatives for excellent care provided from modern day facilities.

28. The main opportunities presented by the three options are as follows:

28.1. Option A will release theatre and inpatient facilities at the John Radcliffe Hospital which creates the potential to support the development of the Trust’s designation as a Major Trauma and Vascular Centre. The released theatre
capacity may also support the review currently being undertaken to release the JR 2 theatre complex which is in need of major refurbishment.

28.2. Option B will leave the Blenheim complex free for alternative use and this could enable the renal inpatient unit to be relocated from the old Churchill building stock and also presents an opportunity to house other ambulatory/outpatient services currently located on the site. In addition seven/five all day lists will remain unallocated in the Churchill theatre complex and this provides the potential for expansion of surgical and transplantation services.

28.3. Option C creates the potential to relocate an inpatient unit to the ward area within the Blenheim complex and will release some outpatient capacity on the John Radcliffe site.

**Recommendations:**

**The Trust Board is asked:**

29. To **approve** the relocation of Head and Neck Cancer services to the Churchill Hospital. The Board is asked to note the views expressed by stakeholders as outlined in paragraphs 14 to 16; the clinical and research benefits articulated in paragraph 18 and the answers to the three specific issues on IOG compliance, transfer of additional activity and the confirmation of commissioner agreement to the revised tariff as detailed in paragraphs 19 and 20.

30. To **agree** that the full transfer of the Head and Neck service cannot commence until the 1st November 2012 due to the requirement to undertake additional surgical activity at the Churchill Hospital in order for the Trust to comply with the revised national 18 week Referral to Treatment standard for the NHS. A phased approach to the earlier transfer of non-surgical activity to be the subject of consultation with stakeholders.

31. To **agree** to confirm the actual date for the transfer of Head and Neck Cancer services at the Board meeting on 5th July, following completion of the development planning referred to in paragraphs 21 to 23.

32. To **note** that the Director of Clinical Services will bring forward proposals to create additional theatre and critical care capacity to the July 2012 Trust Board.

33. To **note** that the Director of Clinical Services will bring forward proposals for enhancing the provision of out of hours services at the Churchill Hospital to the September 2012 Trust Board.

34. To ask the Director of Clinical Services to consult on options for service reconfiguration that would strengthen strategic, research and environmental issues associated with the current configuration of services across the John Radcliffe and Churchill Hospital sites and bring proposals to the Trust Board in October 2012.

*Mr Paul Brennan*

**Director of Clinical Services**

*April 2012*
Annex A - Consultation Questionnaire

Questions:

1) Please tell us which PCT you are based in.

2) Please tell us if you are a clinician or a member of the public.

3) Please tell us which hospital trust you work for.

4) Do you agree that OUH should develop and expand head and neck cancer services?

5) Which option do you consider gives the best quality environment for head and neck patients?

6) Which option do you consider represents the best value for head and neck patients?

7) Which option do you consider represents the best value for all OUH patients?

8) Please prioritise the options - 1 most desirable and 3 least desirable.

   1
   2
   3

9) Which option(s) do you consider meets the needs of commissioners (who purchase healthcare)?

10) Please make any other comments in relation to these options below:
Thank you for taking the time to complete this questionnaire, your views are valuable to us and will be included in the final options appraisal in a summarised format.

Annex B - Notes from the formal consultation sessions

**Head and Neck Staff Consultation Meeting Minutes**  
**Friday 27 January 2012 – 12.00 pm – 1.30 pm**

| Present: | Alice Freebain, Consultant Clinical Oncologist, Royal Berks Hospital  
Andrew Stevens, Director of Planning and Information, Oxford University Hospitals  
Graham Cox, Consultant ENT Surgeon, Oxford University Hospitals  
Jacky Rawlings, Head and Neck Clinical Nurse Specialist, Oxford University Hospitals  
Neil Cowan, General Manager, Oxford University Hospitals  
Paul Brennan, Director of Clinical Services, Oxford University Hospitals  
Stewart Winter, Consultant ENT Surgeon, Oxford University Hospitals  
Vanessa Linton, Head and Neck Clinical Nurse Specialist, Oxford University Hospitals |
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<tr>
<td>2701:01</td>
<td>Paul Brennan gave an overview of the Trust's financial position, ongoing costs savings programme and future strategic direction.</td>
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**Royal Berkshire Foundation Trust income**  
It was noted that the West Berks Major Head and Neck income was dependent on the Oxfordshire service being compliant.

**East Berkshire PCT work**  
It was understood that an additional bi-weekly cancer operating list was starting imminently within Heatherwood and Wexham Park which may move more Head and Neck work towards this area and into London.

**IOG Compliance**  
It was noted that the 2010 quality update does mention a consolidated service.

It was also noted that the 2004 IOG guidance did not specifically comment on a consolidated service.

**Thyroid Service**  
It was commented that previous peer reviews of the thyroid service were less than satisfactory.

It was stated that to deliver a compliant thyroid service would be contingent on the outcome of the Trust’s Board’s decision in relation to Option A and B.

**Outpatient Service within the West Wing**  
It was noted that in the current configuration there is a mixed environment including some children in the outpatient environment.

**Joint head and neck clinic**  
This was requested to be weekly instead of fortnightly. It was noted that this was not covered in either Option A, B or C.

**Clinical Nurse Specialists/Rooms**  
It was noted in the current outpatient configuration within the West Wing these were not a sole use or permanent arrangement.
Further it was noted that in relation to the transfer of patients requiring radiotherapy - which had been 4 patients for a six week period in the previous 12 months - there was a potential loss of income as Clinical Nurse Specialists were not available to see patients on the ward and provide an outpatient service when they were travelling backwards and forwards.

**Increasing Incidence**
It was noted that a recent BBC3 documentary noted an 11% increase in HPV over each year coming. Hence a potential doubling in Head and Neck cancer treatments required over the next 8 years.

**Strategy**
It was noted that having a fully compliant service would strategically lead to more work transferring to Oxford University Hospitals as other Centres are/will reduce the complexity of cases including those with Head and Neck Cancer. It was also noted that currently laser patients could only be done within the West Wing and that further being close to the Oncology Ward (As In Option A) may give additional benefits.

**Tariff**
It was then noted that Head and Neck Cancer services are out of tariff.

It was commented that as part of the Division’s commissioning intentions for 2012/13 it had been requested to increase the tariff by £1.2M overall in line with tariff charged by some other acute hospitals.

Further it was noted that there might be PCT support for this

**Main Document**
Comments were then made in relation to the tables within the main document in terms of what might and might not be both a “yes” or a “no”. It was noted that parts of this in order to have a fully compliant MDT – all specialties and sub-specialties need to be linked to Oncology which is on the Churchill site.

Comments were then made in relation to having under Option B a Specialist Ward. It was confirmed that the intention was to have a separate area within SSIP Ward which will be run as a sole use Head and Neck Cancer Ward.

Comments were then made in relation to the transfer of elective activity from High Wycombe. A previously agreed Business Case was contingent on the release of a Wednesday all day operating list following the potential transfer of Head and Neck Cancer Services to the Churchill Site.

It was noted that under Option A this would be deliverable and under Option B it would require further work as the current offering from the end of February was a bi-weekly Monday list – half day.

Comments were then made in relation to the presentation of the expenditure...
linked to the Royal Berks Foundation Trust income. It was noted that additional expenditure under Option A was linked to the fact that additional staffing was required to support the previously agreed business case in 2009 as there had not been adequate staffing budget allocated.

Comments were then made from the Clinical Nurse Specialist Team that the OUH were dealing with some of the most complex patients and that a split site model would not be appropriate or in the interest of patient care.

Those who had attended the meeting were thanked for their time.

| Date of Next Meeting | 1 February 2012  
|                      | 12.00 pm – 1.00 pm |
| Venue               | Boardroom Level 3 JRH |
Head and Neck Public Consultation Meeting Minutes  
1 February 2012 – 12.00 pm – 1.25 pm

Present:
Andrew Stevens (AS) – Director of Planning & Information - Oxford University Hospitals
Chandi Ratnaratunga – Head of Clinical Networks – Oxford University Hospitals
Christine Perrin (CP) – Public Stakeholder
Clive Perrin (CP) – Public Stakeholder (Laryngectomy club)
Hilary Mullins (HM) – Public Stakeholder
Neil Cowan (NC) - General Manager - Oxford University Hospitals
Paul Brennan (PB) – Director of Clinical Services - Oxford University Hospitals
Paul McGough (PMc) – Head and Neck Cancer Patient and Patient Advocate
Jane Gould (Minutes) – Divisional PA – Oxford University Hospitals

0102:01 Paul Brennan gave an overview of the Trust’s financial position, ongoing costs, savings programme and future strategic direction for the future of Head and Neck services at the Oxford University Hospitals.

In particular:

PB commented that he had recently attended a Cancer patient panel.

PB highlighted that a Service and Compliance document was reviewed in the summer of 2011 in light of the Improving Outcome Guidance. PB highlighted that this document is non-specific.

Tariffs

PB commented that the current Head and Neck service operates under a local tariff/pricing with the Commissioners. PB stated that Oxford University Hospitals (OUH) is paid below that received by other hospital Trusts.

PB confirmed that commissioners had been asked to support an increased tariff.

Background to Head and Neck Move

PB gave a timeline of the original Head and Neck Cancer Services relocation. The services were due to move from the Radcliffe Infirmary in 2007 to the Churchill site.

Head and Neck Services moved to West Wing on the John Radcliffe site when the West Wing opened in January 2007.

The OUH Cancer Centre opened in 2009.

In 2010 an external review was carried out in relation to head and neck cancer services.

In July 2010 the first step to implement the Head and Neck Services move to Blenheim Ward were due to begin and scheduled to end by April 2011.
PB commented that the Blenheim Ward did have a 24-bed capacity.

Some facilities were deemed not suitable for high dependency patients – namely the 4-bedded bays. Some of the single rooms were also too small for clinical reasons – namely resuscitation facilities would not be able to be used in these rooms.

PB said that the revised maximum capacity of Blenheim Ward was 18 beds - including the use of the pain relief area.

PB commented that since the opening of the Cancer Centre in 2009, there had been an expansion of other services and this had impacted on theatre capacity on the Churchill site.

The provision of an “out of hours” on-call service would need to be provided by the Infectious Disease Unit and the Respiratory Service. PB commented that clinically these two specialties would not be able to cope with the needs of a high dependency patients-base.

In the Summer of 2011 – PB recommended to the OUH Board to further investigate these above issues. Thereby the Trust Board put any imminent move to the Churchill site on hold.

PB also commented that other specialties eg - Infectious Diseases, Renal and Respiratory which are currently on the Churchill site, may move to the John Radcliffe site.

**Consultation Document**

PB briefly went through the three current options for the Head and Neck Cancer relocation:

Option A – To relocate all Head and Neck Services to the Churchill Site.

Option B – To relocate Head and Neck Services to the West Wing on the John Radcliffe Site.

Option C – To incorporate a split model for Head and Neck Services with Inpatients at the John Radcliffe and Outpatients at the Churchill.

PB highlighted that the document addresses compliance, improving patient safety and the financial implications for the OUH Trust.

**Costs**

PB highlighted the relevant costs for the Head and Neck relocation.

Potential lost income from the Royal Berkshire Hospitals Trust for treating 24 patients...
is - £700K pa.

The associated costs for the moves:

- Including additional theatre lists and out of hours cover - £1.6M.
- £400K – for West Wing relocation.
- £1.1M – for the split model between the John Radcliffe and the Churchill
- £650K – Additional Churchill building works.
- £1.3M – Additional costs for conversion of West Wing.

PB highlighted the potential running costs of the move namely:

- £400K – John Radcliffe site
- £1.6M – Churchill site (£1.2M extra)
- There are also one-off costs for the West Wing.

PB said that the OUH Trust will have to bear the cost of any of the agreed Options.

PB commented that Option A could free up space for the Major Trauma Centre on the John Radcliffe Site and also for the Vascular Unit.

PB commented that Option B, Blenheim Ward could be utilized for other Departments to move to on the Churchill Site.

Decision

PB said that the OUH Trust Board would provide the final decision on the Head and Neck Cancer Services on 1 March 2012.

PMcG commented that PB had spoken for approximately 25 minutes and hoped that equal time would be allocated to all the stakeholders.

AS commented that the Blenheim Ward design had not met current specifications for infection control eg, MRSA and CDiff. This was due to the original business case and plans dating back to 2003.

CIP wanted clarification regarding the £11K raised for equipment for the Blenheim Ward at the Churchill.

CIP also wanted clarification on whether the a part of the unit be it at the Churchill or John Radcliffe Site would still be named after a benefactor.

AS confirmed that whichever Option was agreed upon, OUH would guarantee to either refund £11K, which had been already spent on equipment for Blenheim Ward, or use the equipment in situ.
CIP wanted clarification that the use of the late Ken Rilev would still be used to name a part of the unit. Both PB and AS confirmed that any commitments made in the past would be honoured.

HIM asked for clarification regarding the Royal Berkshire Hospital (RBH) patients.

PB confirmed that RBH currently had a single ENT ward and as such some major head and neck surgical cases (~24 per year) are carried out there, and that as part of the consultation it was intended to seek a definitive decision from RBH as to which options would mean the movement of patients from RBH to OUH for their major surgery.

HIM commented that there were no radiotherapy facilities on the John Radcliffe site.

It was confirmed that Option A would mean all outpatient and inpatients would receive this treatment on the Churchill site.

If Option B were undertaken then inpatient would need to be transferred from the John Radcliffe to the Churchill site. It was estimated that this would affect about 4 patients per year, for a six week period.

NC commented that there was no plaster room currently on the Churchill site and Option A would mean patients being transferred to the John Radcliffe site. It was estimated that this would affect about 5 patients per year as a single journey.

PMc discussed a document of which copies were kindly given out during the meeting.

PMc has experienced first hand treatment of radiotherapy and said that patients' wellbeing and care should be first not financial/operational issues.

PMc said that he had a copy of the Outcomes Guidance Folder. He highlighted relevant information on:

- Key recommendations on page 8
- Structures on page 38
- Treatments on page 78

PMc also commented on Research evidence issued by National Institute of Health and Clinical Excellence

PMc said that the OUH should be about excellence and not just compliance and should be achieving the best for its patients.

PMc also expressed his commented regarding the Department of Health guidelines which had been issued regarding cancer patients.
PMc commented that early diagnosis and early intervention is critical when it is concerning cancer patients.

The Single Quality Scheme Document 2009 – 2012 highlights certain discriminations – this is mainly aimed at race and sex but PMc said that it was also extremely important not to discriminate against cancer patients and the OUH should be aware of this.

PMc gave a brief history of how he viewed the Head and Neck Cancer Move:

- March 2001 - Feasibility study.
- October 2002 – PFI tenders were agreed.
- March 2004 – Bidders approval agreed.
- October 2004 – Full business case written.
- March 2009 – Cancer Centre completed at a cost £109M.
- February 2011 – No Head and Neck patients at the Cancer Centre.

PMc reiterated that patients would be included in all decisions about their care as per Government Policy. The Inclusive Cancer Centre of excellence vision with Head and Neck Services based at the Churchill would be fulfilled.

PMc also commented from a document – flexible in future – NHS changing. PMc said that he felt strongly that the OUH should be flexible, enduring and have sustainable value.

PMc also commented that the Head and Neck move should deliver the best prospect and return of public and private investments to enhance health, wellbeing and quality of life and increase survival strategies.

PMc said that long term cost savings would benefit from early intervention.

PMc said that costs are not the only thing that is relevant when comparing options and that Health Economic consideration rather than purely cost considerations are an essential part of the evaluation.

PMc reiterated that for best clinical reasons that Option A should be agreed.

PMc said that more (translational) research would be carried out on the Churchill Hospital Site and as such Option A lent itself to this.

PMc stated that if Option A were followed that there would be closer links with Primary Care, GPs and DGHs.

PMc confirmed that for clinical safety to Head and Neck patients that all oncologists should be based in the same hospital – Option A.
PMc quoted from Annexe F - Vision for Head and Neck Cancer. This provided information on the current thinking about Head and Neck cancer treatment vision over the next few years.

The patients' best interest and their medical care should be paramount to reduce their time spent in hospital.

PMc quoted from the NICE guidelines – which state patient safety is important regarding their care and referred to life threatening airway problems.

PMc reiterated that it should be MDT teams that decided on the best Options for the patients.

PMc further quoted from his document to say that the Option decided should be for best practice, patient experience, reassurance, dignity and equality.

PMc also asked what the best option would be for the University.

PMc thanked OUH for his own treatment and care which had been shown during his treatment.

PMc confirmed to PB that he would be making a further written submission.

PMc commented that he felt disappointed with the way the whole Head and Neck consultation process had been handled by the OUH.

PMc said that he had spoken to a broad spectrum of patients and they all favoured Option A.

PMc said that the staff need to be motivated, inspired and feel involved.

PMc likened the Options to:
iPad/IMac - A
Dell Desktop - B
Sinclair Spectrum - C

PMc requested a further face-to-face meeting with PB and AS, which was agreed.

AS reiterated to the meeting that the option which is chosen would be the one that is best for the Head and Neck patients. AS said that it also needed to take into account what the impact is on other services and patients within the OUH.

PMc asked whether any other patient services had been reviewed to the same degree.

PMc said that any move to the West Wing (Option B) would “devalue the OUH brand”.

CIP commented that any other Option would incur costs which would also
OCR suggests some issues with the balance of the content. The text seems to be part of a formal document, possibly related to a meeting or decision-making process. Here is the text transcribed with some adjustments for readability:

Epatate.

CIP commented that OUH means excellence.

PB encouraged everyone to complete the questionnaire and return so that staff and patient views are recorded.

PMc said that it is important not to discriminate against any patients.

PMc commented that he thought it was misrepresenting Head and Neck services by stating “Integrated services” in the West Wing.

PMc also commented that he thought that Head and Neck cancer patients should not be treated alongside children in clinical areas as this was not providing privacy and dignity.

PB thanked everyone for their attendance and closed the meeting.

<table>
<thead>
<tr>
<th>Date of Next Meeting</th>
<th>2 February 2012</th>
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<tr>
<td>Time</td>
<td>5.00 pm – 6.00 pm</td>
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| Venue                | SSIP Seminar Room, Level 0, JRH |
# Head and Neck Staff Consultation Meeting Minutes

**Thursday 2 February 2012 – 5.00 pm – 6.00 pm**

<table>
<thead>
<tr>
<th>Present:</th>
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<tbody>
<tr>
<td>(All CUH Staff)</td>
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<tr>
<td>Amanda Salisbury - Consultant Clinical Oncologist - Head and Neck MDT Chair</td>
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<tr>
<td>Andrew Stevens - Director of Planning and Information</td>
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<td>Carol Harris - Principal Speech and Language Therapist</td>
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<td>Caroline Fraser - Principal Speech and Language Therapist</td>
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<td>Chris Alcock - Oncologist and Former PPI Steering Group Member</td>
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<td>Heather Talbot - Sister - Head and Neck Services</td>
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<td>Jennifer Wylie — OMFS Consultant and Head and Neck Surgeon</td>
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<td>Kunmi Fasanmade — OMFS Consultant and Head and Neck Surgeon</td>
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<tr>
<td>Neil Cowan - General Manager</td>
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<tr>
<td>Paul Brennan - Director of Clinical Services</td>
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<td>Rebecca Turner – Matron Specialist Surgery</td>
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<tr>
<td>Rupal Shah – Head and Neck Dietician</td>
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<tr>
<td>Sandle Popat – Restorative Consultant</td>
</tr>
<tr>
<td>Steve Watt-Smith – OMFS Consultant and Head and Neck Surgeon</td>
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**0202:01**

PB gave an overview of the Trust’s financial position, ongoing costs savings programme and future strategic direction.

PB gave an overview that this was the second of two staff meetings and the first public meeting had been held – with the second one planned for 23 February 2012.

PB also mentioned that he attended a Patient and Carer Cancer Panel meeting earlier in the week.

PB clarified that issues in relation to a potential increase in tariff and the designation of the centre via Thames Valley Clinical Network and income from Royal Berkshire Foundation Trust would all be clarified as part of the period of consultation.

SWS stated that he felt the RBFT income was questionable as he was unsure what major head and neck activity was being completed on this site.

NC stated that activity data was available via the National Audit for Head and Neck Cancer which showed these patients were treated there.

SWS also stated that the PP income assumptions were questionable and then NC confirmed that there were no PP income targets within any of the options or in the 2009 Business Case.

CA stated that there was a strategic potential to increase income within the service and in particular for complex/major case income as other centres will begin to close in the future.

SWS stated that the service would not work on multiple sites.
CA stated that in 2001 it had been thought that BNT would move onto the Cancer Site. However, other issues in the service had meant that this was not possible.

RT asked what would happen if this service did not move into the West Wing in relation to the Cancer Network as she understood they favoured a one-site option (A).

It was confirmed that as part of the consultation period, the question in relation to designation of the services of major Head and Neck Cancer specialists in Option B and C would be confirmed.

CA stated that some of the accommodation at the Churchill was indeed poor and that he had mentioned this to other clinical colleagues back in 2002 when the Head and Neck service began planning its move to Blenheim Ward, though he did not witness action taken with the traction of that in head and neck cancer.

CA also stated that there would be more opportunity for translational research and charitable monies with the Head and Neck service under Option A on the Churchill site.

JW stated that in relation to the Tuesday clinics – they are currently using 7 rooms and currently within Option B only 3 rooms would be provided.

AS asked the members of staff present in relation to Head and Services which they thought would be the major quality issues.

The group felt that airway cover needed to be paramount in everyone’s mind and it was further stated that tracheostomies were now performed by the OMFS team – who have to go the Churchill on a much more frequent basis following an increase in service delivered at this site and in particular transplant services.

It was also noted that patients with Head and Neck cancer need to focus on quality of life issues, particularly longer term.

The MDT chair stated that the Head and Neck team are a fantastic team including SALT and Dietetics and that many people were motivated towards a move to the Churchill under Option A and that any other decision would have a significant negative impact on morale.

JW stated that she understood, that as part of her appointment Option A, would be the one that was implemented.

PB stated that the Head and Neck service was indeed an excellent service with great outcomes and reminded everyone present that the Cost Improvement Programme target for OUH in 2012/13 was £49M. As such any significant investment decisions needed to be considered in a greater amount of detail – hence the consultation period.
CA stated that the service of Head and Neck cancer should have a weekly clinics not bi-weekly ones. It was confirmed this had been raised in a previous meeting and further was not presented as a solution specifically in any of the three options.

KF stated that he thought that three of the rooms within Option B outpatient environment would not be big enough for patients and their relatives.

It was confirmed by all parties present in the room that Option C – a split site option – would not be achievable and therefore was not supported by a single individual in the room.

The Dietetic Lead stated that she felt that the accommodation being proposed under Option B did not sound like it would work.

It was stated that the Board was there to make a long term decision and further that an external peer review in 2012 in relation to Head and Neck Cancer Services was going to be completed and the MDT Chair reminded those present that the Head and Neck Cancer Service only passed this Peer Review with the condition of Option A being implemented last time around.

It was restated that as part of the consultation period it would be determined if the service would be compliant under ICG prior to closure of the consultation period.

Those present were thanked for their attendance.

| Date of Next Meeting | 23 February 2012 5.30 pm – 6.30 pm | Venue | Conference Room Level 3 JRH |
Public Head and Neck Consultation Meeting Minutes
Thursday 23 February 2012 – 5.30 pm – 7.05 pm

Present:
Andrew Stevens – Director of Planning and Information, OUH
Neil Cowan - General Manager, OUH
Paul Brennan - Director of Clinical Services, OUH
Angie Bryant – Heads2Together
Ian Barker – Heads2Together
Michael Ocock – Patient
Matthew Covill – Director of Business Planning, OUH
Steve Cander – Thames Valley Cancer Network
Pay Haye – Thames Valley Cancer Network
Bernadette Laverty – Thames Valley Cancer Network
Ralph Goodson – Heads2Together
Nick Crowson-Towers – Heads2Together
Helen Baker – Planned Care Manager/Cancer Commissioning, NHS Oxon/Bucks
Marcus Lapthorn – Chair – OUH Cancer Fund
Oliver Cassell – Consultant – Plastic Surgeon, Chair of Relocation, OUH
Ted Baker – Medical Director, OUH

2302:01
Paul Brennan began an overview of the Trust’s financial position, ongoing costs, savings programme and future strategic direction

RG asked the meeting whether the whole process was real.

PB stated that this was a full consultation process and that this was the fourth of four consultation meetings to be held.

RG quoted a letter from Sir Jonathan Michael dated 27 March 2011 in relation to the proposed move to the Churchill and then asked what happened last summer?

AS confirmed that this would be covered by PB, and also stated that this was a full consultation process and that this was the fourth of four consultation meetings to be held.

PB confirmed that all minutes from the first three meetings were uploaded to the internet for information and these minutes would also be uploaded.

PB gave a timeline of the original Head and Neck Cancer Services relocation. The services were due to move from the Radcliffe Infirmary in 2007 to the Churchill site.

Head and Neck Services moved to West Wing on the John Radcliffe site when the West Wing opened in January 2007.

The OUH Cancer Centre opened in 2009.

In 2010 an external review was carried out in relation to head and neck cancer services.
In July 2010 the first step to implement the Head and Neck Services move to Blenheim Ward were due to begin and scheduled to end by April 2011.

PB commented that the Blenheim Ward was planned to have a 24-bed capacity.

Some facilities were deemed not suitable for high dependency patients – namely the 4-bedded bays. There were issues with compliance with most recent control of infection requirements. Some of the single rooms were also too small for clinical reasons – namely resuscitation facilities would not be able to be used in these rooms.

PB said that the revised maximum capacity of Blenheim Ward was 18 beds - including the use of the pain relief area.

PB commented that since the opening of the Cancer Centre in 2009, there had been an expansion of other services and this had impacted on theatre capacity on the Churchill site.

The provision of an “out of hours” on-call service would need to be provided by the Infectious Disease Unit and the Respiratory Service. PB commented that clinically these two specialities would not be able to cope with the needs of a high dependency patients-base.

In the Summer of 2011 – PB recommended to the OUH Board to further investigate these above issues. Thereby the Trust Board put any imminent move to the Churchill site on hold.

PB briefly went through the three current options for the Head and Neck Cancer relocation

Option A – To relocate all Head and Neck Services to the Churchill Site.

Option B – To relocate Head and Neck Services to the West Wing on the John Radcliffe Site.

Option C – To incorporate a split model for Head and Neck Services with Inpatients at the John Radcliffe and Outpatients at the Churchill.

PB highlighted that the document addresses IOG compliance, improving patient safety and the financial implications for the OUH Trust.

PB commented that some services on the Churchill site are in inadequate accommodation.

It was commented and agreed by those present that issues would now be discussed by those present.

MO read out a letter which he stated would also be sent to Trust Board on 24
February 2012.

A member present asked about the questionnaire style and PB confirmed that the questionnaire was similar to that recently used by SHA as part of their public consultation in relation to Major Trauma and Vascular Services.

AS reminded those present that the questionnaire and consultations meetings are everyone’s opportunity to say what is important to them, in order that their views can be taken into consideration.

PH said that she was keen to see an IOG compliant service. PH stated from TVCN’s perspective, Option A provides the best strategic fit and qualitative benefits.

TVZN also recommended talking to commissioners urgently about the tariff.

PB clarified that this had been put in writing to the lead commissioner.

BL stated that quality was very important and that she had some clinical concerns. TB asked BL to explain these.

BL stated that Option C was not compliant. Option A was compliant and that Option B was compliant but not integrated. BL outlined that she felt this was due to:

- Radiotherapy transfers from JR to CH
- Split site working
- That staff were awaiting a decision and this was impacting negatively on morale
- That clinical oncologists had to travel to JR site
- IMRT therapy was likely to become optimal therapy long term and this is/would be on CH site
- Staff retention
- That TSSG may have a view on the potential transfer of RBFT activity under this option

TVZN recommended Option A, they stated they could live with Option B and considered Option C non-compliant. TVZN confirmed their submission had been made formally just prior to the meeting.

ML asked whether under Option A there would be the additional tariff.

ML stated that there had been an issue with Head and Neck since 2009. It was queried about the strategic direction of Head and Neck and whether Head and Neck was a key service.

PB clarified that all services are key services.

ML said that within another five years there might be the same problem again if option A was not implemented, and that there may be issues for 2012 peer review.
PB confirmed that the Trust Board needs to make an informed decision regarding compliance and as such had asked for TVCNs formal response on the compliance issue.

OC commented that at the Peer Review, a lack of thyroid integration had been noted.

RG asked which patients are treated on Jane Ashley/Paediatric Centre

AS confirmed these are Women/Children

RG asked which patients are treated in the cancer center

PB confirmed that the majority of patients in the new facilities at the Churchill are not cancer patients.

RG stated that he feels the public should discriminate against cancer patients in the cancer center.

RG read from an issue of OUH news in relation to the building and implementation of the cancer center.

AS confirmed that a public apology was made in the AGM in relation to the comments made and further clarified that money raised from cancer charities would be and was spent on cancer.

RG said that he does not understand why Head and Neck is not moving to the Cancer Centre.

AS confirmed that the Trust had to decide what was best for all patients. AS said that the new facilities at the Churchill were for 2 primary developments – the Cancer Centre and a Surgery and Diagnostic Centre.

BL stated that University and research should be on the same site.

PB stated that whichever option is chosen would make clinical colleagues work closely together.

RG stated that in 2010/12 there was small surplus of £1.3M which was deemed small. Therefore Option A should be deemed small.

RG asked was there extra capacity in theatres planned on the CH site in the future

PB clarified there was currently debate over 6/7 day working including theatres and support services, but that there was no current plan.

RG queries about the unused theatres on the Churchill site. It was confirmed that 3 out 5 do not fit new criteria and 2 out of 5 could be reconfigured but at a cost of
millions for capital/building works.
ML asked about the potential loss of £2.5M income in Julia Clark’s report if OUH was potentially de-designated. PB confirmed that income goes up as well as down due to the tariffs changing across OUH.

ML said that Peer Review was a very serious issue if OUH are to get potentially two qualified external peer review reports.

IB said that everyone agrees that Option A is the best, Option B is compliant for now but what happens longer term, IB said that Option A is a longer term more strategic option.

RG queried with regard to the guidelines/compliance and commented that Head and Neck patients are still being seen and that all present would do well to remember this at all times.

PB said that there were three key pieces of information needed to reach a decision.
1 TVCN response (received)
2 PCT Tariff response
3 RBFT response in relation to transfer of activity under what Option(s)

ML asked whether the deadline would be extended.

PB confirmed that the board would need the three items (listed above) to make an informed decision, and that a communication would follow once the deadline period had closed in relation to this.

ML asked whether OUH envisages selling estate on the Churchill site.

PB confirmed that there were no current plans for land disposal.

AS confirmed the workings of a public trust board meeting and board papers following a question from OC.

PB and AS thanked everyone for their attendance and closed the meeting.
Annex C - Summary of responses to the Questionnaire

1) Please tell us which PCT you are based in.

![Pie chart showing the distribution of responses by PCT.]

- Did not say: 1
- East Berks: 5
- Oxon/Bucks: 2
- Swindon: 1
- West Berks: 69

2) Please tell us if you are a clinician or a member of the public.

![Pie chart showing the distribution of responses by role.]

- Public: 15
- Clinician: 63
3) Please tell us which hospital trust you work for.

![Pie chart showing hospital trusts](image)

4) Do you agree that OUH should develop and expand head and neck cancer services?

![Graph showing agreement](image)
5) Which option do you consider gives the best quality environment for head and neck patients?

![Pie chart showing the distribution of responses to option A, B, C, and did not say.]

6) Which option do you consider represents the best value for head and neck patients?

![Pie chart showing the distribution of responses to option A, B, C, and did not say.]
7) Which option do you consider represents the best value for all OUH patients?

8) Please prioritise the options - 1 most desirable and 3 least desirable.

1 – Most Desirable:
2 – Next Desirable:

3 – Least Desirable:
9) Which option(s) do you consider meets the needs of commissioners (who purchase healthcare)?

![Pie chart showing options and their counts]

Comments:

B and C are unworkable
Been a long time coming
Better to have treatment and outpatients in the same place
Considers best option for patients and staff
For A to work head and neck needs to be recognised as a separate entity
For the best interest of the head and neck patients
Getting the unit together properly will mean the most efficient and effective service
Having attend public meeting at JR - I am more convinced than before that Option A is the best choice
Head and Neck cancer patients having PEGs fitted are much better cared for at the Churchill
Head and Neck cancer treatment on cancer site makes complete sense
How can you have a cancer hospital in Oxford with head and neck cancer patients not being part of it
I feel it would make far more sense for Head and Neck to be relocated to the Churchill
I strongly feel Head and Neck Cancer services should be located at the Churchill
Is OUh really using its assets to maximal affect
It is vital that the Head and Neck service is consolidated on the Churchill Site
It would be a travesty to not see the plans for the cancer centre to come to fruition
It would be a travesty to not see the plans for the cancer centre to come to fruition
Links with University - much better conducted on Churchill Site next to imaging centre
Making head and neck treatment part of the single site cancer hospital is the only logical way forward
Mentions benefits of being on one site
More integration of services
Must beneficial for all patients to be seen on one site
No question - Option A serves Head and Neck cancer now and in the future
Option B and C are impractical
Option A fulfils the Trust vision of a cancer centre
Option A is better as care overall is not just about cost
Option A is the choice of patients and staff
Option A is the only option that meets the requirements of the service
Option A is the only option which will provide sustainable, consolidated integrated care
Option A offers the most economic and efficient management of head and neck patients
Option A only which allow for a future expansion
Option A provide truly integrated service
Option A provides a higher standard of care for complex patients
Option A provides the best environment for the patient
Option A provides the best patient care facility to make Oxford nationally and internationally reknown
Option A will allow development of first class unit
Option A will complete the cancer centre transition
Option A will fulfil the Trust’s original signed treatment to offer cancer services under one roof
Option A will only work if support services receive sufficient funding
Option A would be the best option for head and neck patients
Option A would provide a much better quality environment
Option B and C result in split site working which is not peer review complaint
Option B and C would not be supported by FBT sending patients to OUH
Option C and B not viable - no room in West Wing to relocate MaxFax
Option C is not practical
Option C is not viable
Option C looks entirely unworkable
Possibilities of closer working with plastics to streamline cancer services
Reference to OUH Trust Board - Thames Valley Cancer Network and Julie Clark report
Relocate staff to one site removing the requirement to move between sites during the normal working day
Service needs to be sustainable and fully integrated
Terrible shame a good plan was not implemented
The need for a unified head and neck service is vital to OUH remaining a viable cancer network
The option to divide in and outpatient services would result in fragmentation in care
The proposal to accommodate MaxFax in the West Wing just does not make sense
The service currently provides a very high standard of clinical care to its patients
There are lots of reasons why the Head and Neck service should move to the Churchill
There is no more capacity for patients to be seen in the present West Wing clinics
This document is riddled with errors
This service must be underguard by a robust support structure
To provide a world class competitive service - all services need to be on one site
We must invest on this for the future
We work very hard to achieve our excellent outcomes and we simply cannot work across multiple sites
When the Department left the RI it was in anticipation of coming to the Churchill