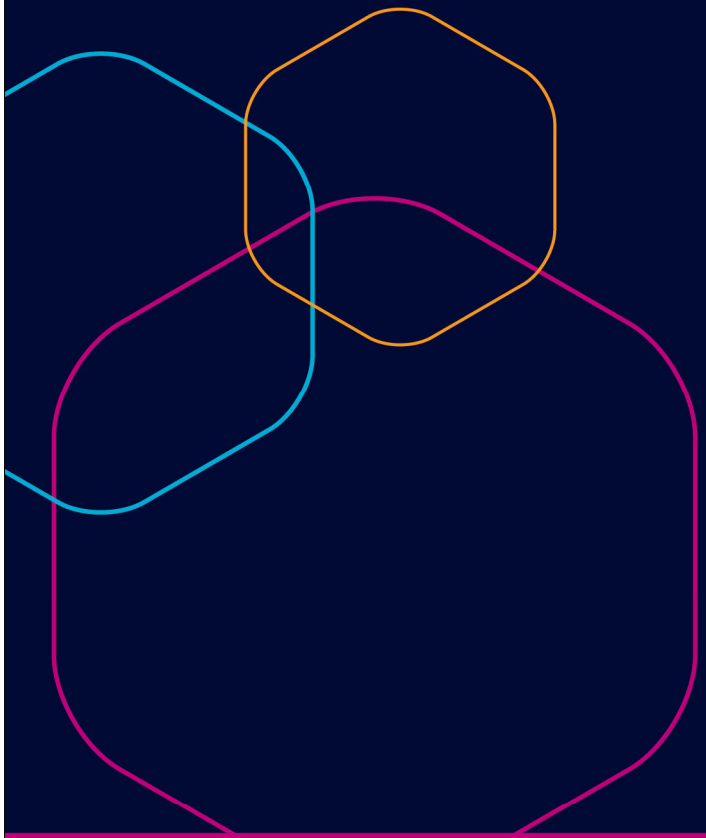
NHS

Commissioning Support
for London

A proposed model of care for London cardiovascular services



Providing clinical and business support to London's NHS

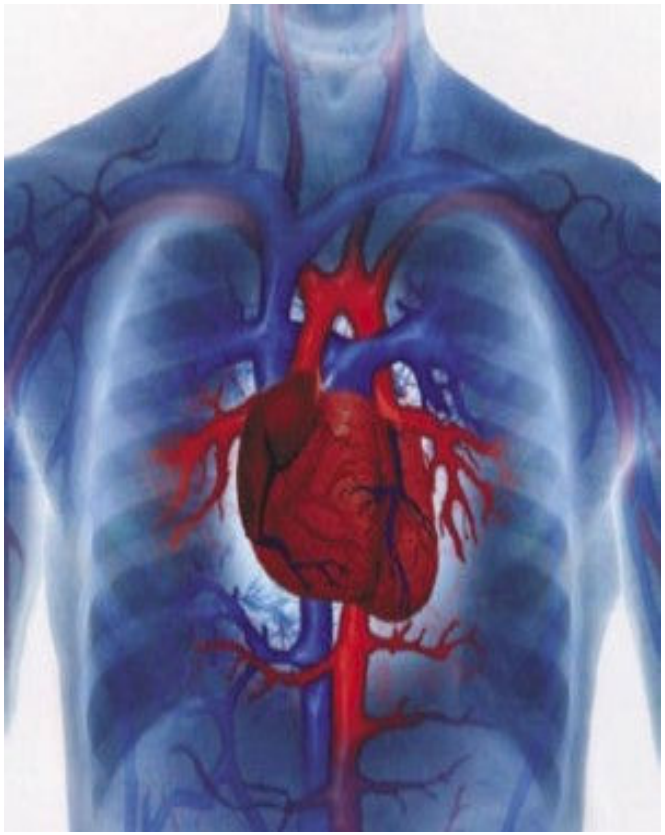
Project structure

Focus on emergency and complex hospital care

Vascular surgery
Surgery on veins and arteries

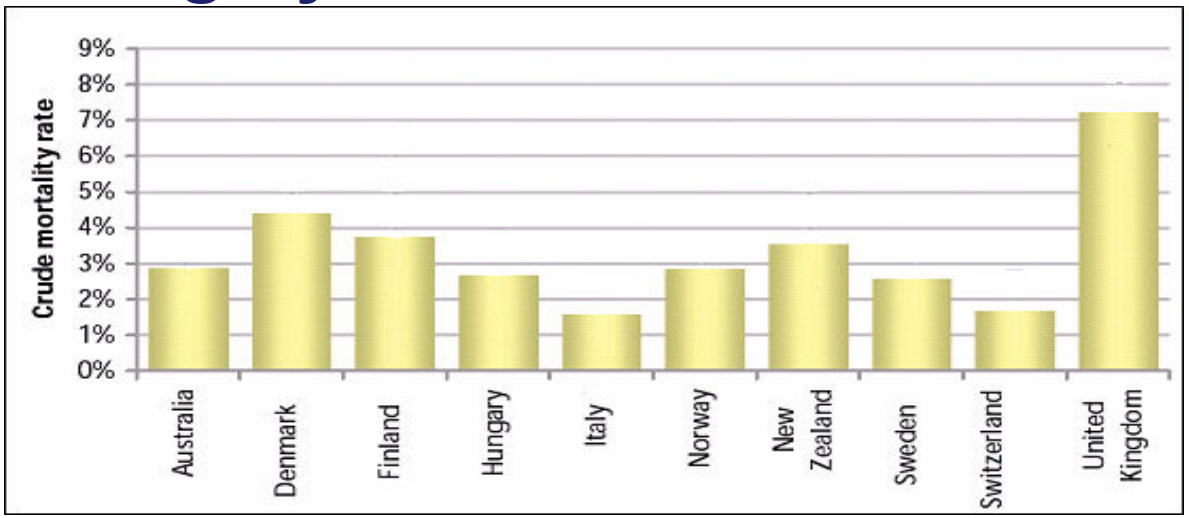
Cardiac surgery
Surgery on the heart

Cardiology
Less invasive procedures on heart



Project led by:
- clinical expert panel for each area
- patient panel

Vascular surgery



Case for change

UK has the poorest outcomes for complex vascular surgery in Europe

In London, 75% of complex vascular surgery takes place in six hospitals, 25% is spread across 13 sites

Medical evidence shows higher volume hospitals & the experience of surgeon gives better outcomes – practice makes perfect

Model of care

All emergency and elective complex vascular surgery should be centralised into high volume hospitals

Local hospitals will continue to deliver the bulk of the vascular service:

- Outpatients & diagnostics
- Varicose vein surgery

Cardiac surgery

Case for change

Pathway length for urgent heart bypass surgery in London varies from 18 to 52 days

- 14 days in the United States
- 20-25 days in the rest of the UK

Medical evidence shows mitral valve repair gives better outcomes than mitral valve replacement

Proportion of patients having mitral valve repair over replacement is low

Model of care

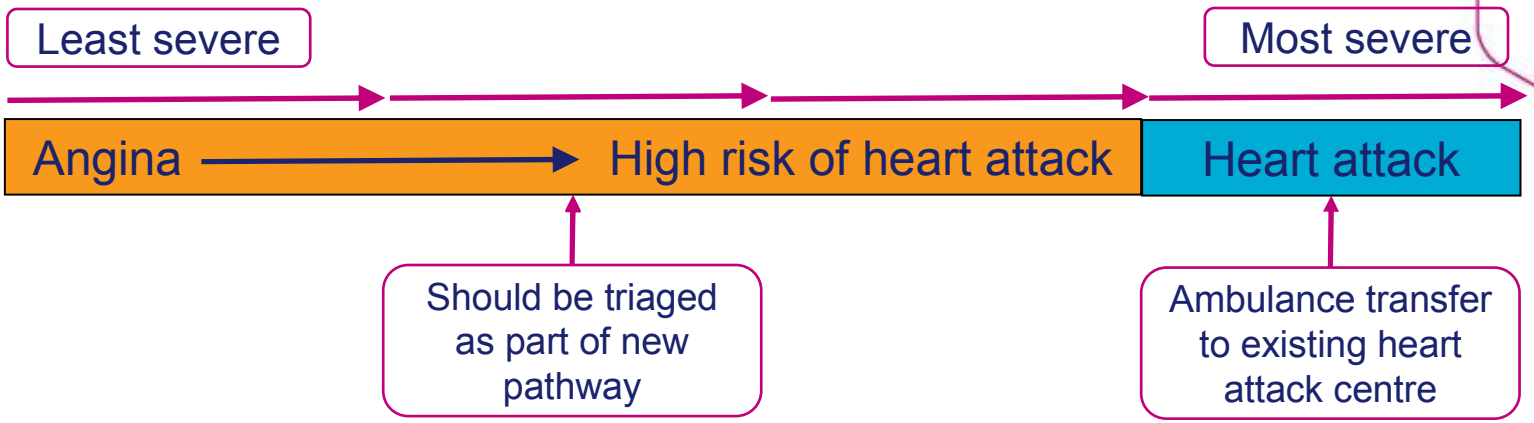
No changes to **where** heart bypass surgery is provided, changes to **how** cardiac surgery is organised

Recommendations to improve urgent cardiac surgery

- Use of electronic referral system
- Standardised method of assessing the urgency of each patient

Concentrate expertise of surgeons and teams performing mitral valve surgery

Cardiology



Case for change

Patients at high risk of having a heart attack who are given an early angiogram have improved outcomes
- NICE guidance, March 2010

The UK implants fewer corrective heart rhythm devices than European comparators

There is huge variation across London PCTs

Model of care

Patients should be risk assessed at local A&E departments

High risk patients should be transferred to a centre for an angiogram within 24 hours

Hospitals organise into electrophysiology networks

Local hospitals should implant simple devices and link to specialist sites for complex care

Scale of change

Vascular surgery

- Approx 2,500 arterial procedures per year
- Approx 75% of cases already performed in six Trusts

Centralisation likely to affect less than 700 cases per year

Cardiac surgery

- Approx 3,000 non-elective cases per year (increasing)
- Approx 1,000 mitral valve procedures per year

Changes in working practices will benefit thousands of patients

Cardiology

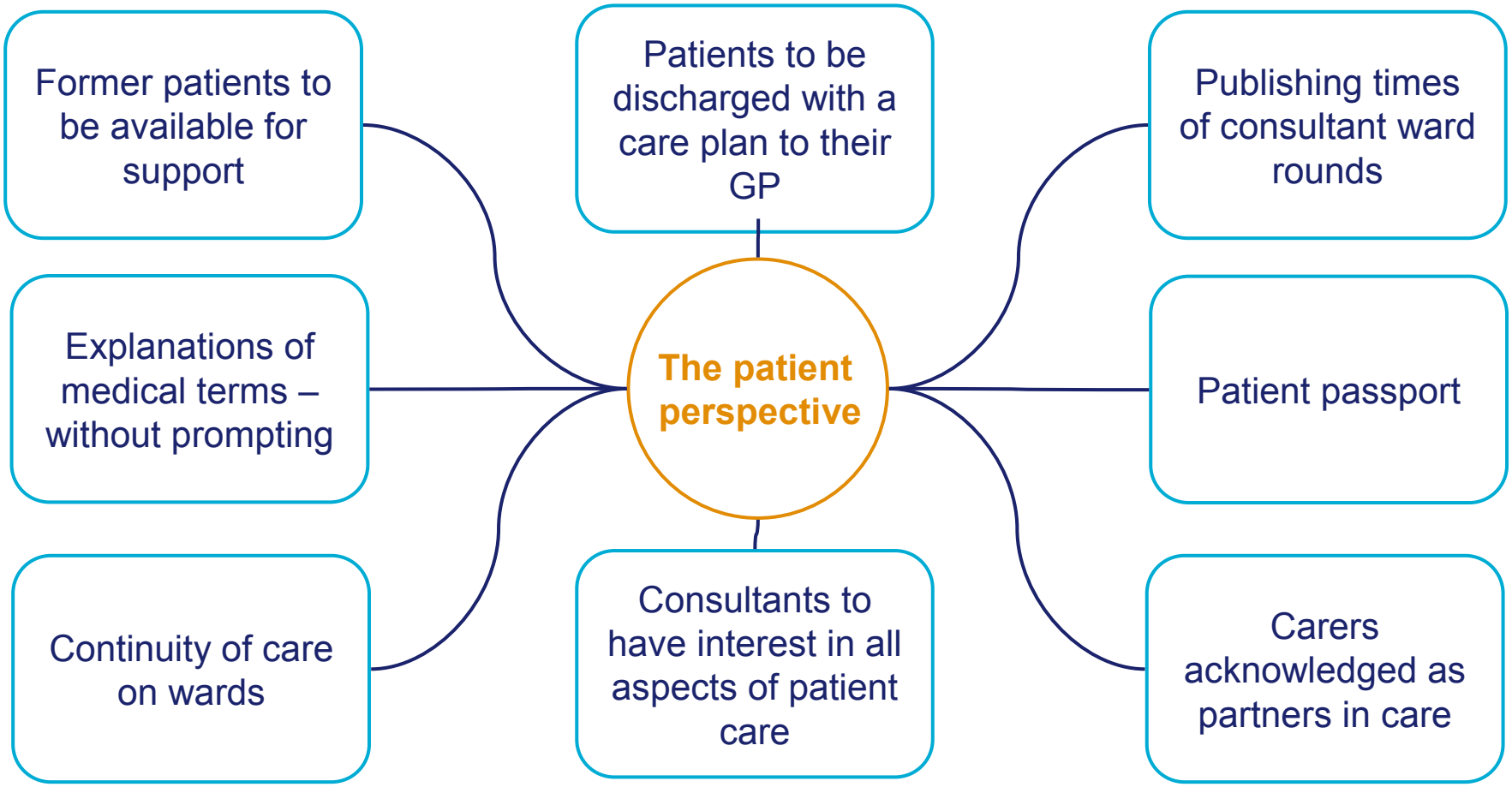
- Ambulance service called out to 60,000 “chest pain” patients per year
- Increase in heart rhythm device implants likely to affect hundreds of patients

Changes to pathways will benefit thousands of patients

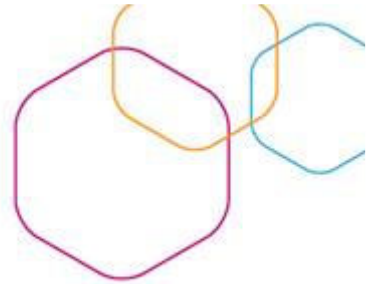
The Patient Perspective

The patient panel fully support the project – it will improve quality, reduce deaths and give people better lives

In addition patients would also benefit from improvements in the following areas:



Engagement plans



www.csl.nhs.uk
Click on “cancer and cardiovascular models of care”

All project documents published on the internet

Online questionnaire available – PLEASE COMPLETE

Speaking to patient, local authority and GP groups across London

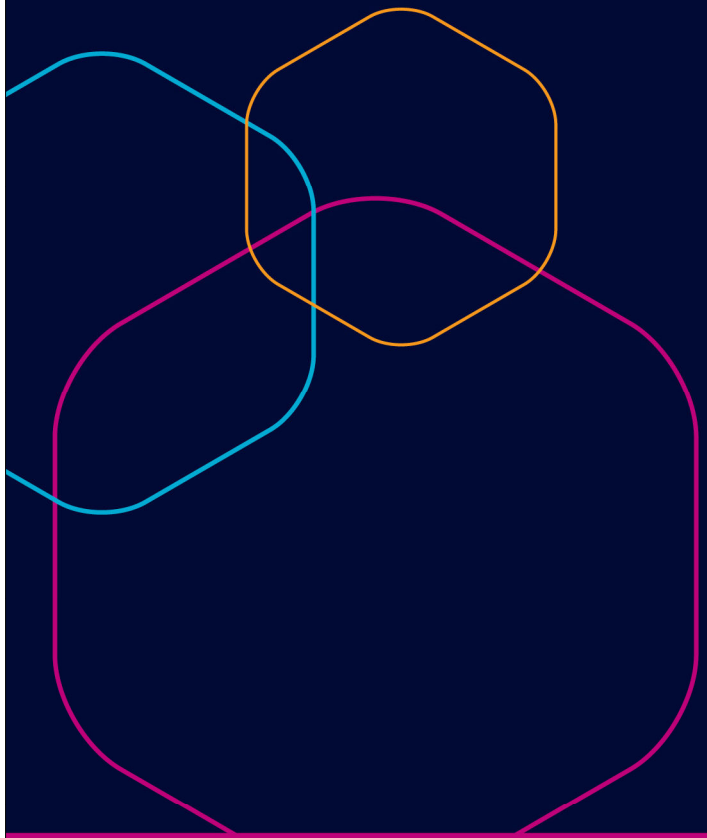
Engagement events to be held in September

Hand over finalised work to commissioners in Autumn 2010

NHS

Commissioning Support
for London

A proposed model of care for London cancer services



Providing clinical and business support to London's NHS

Developing the proposals

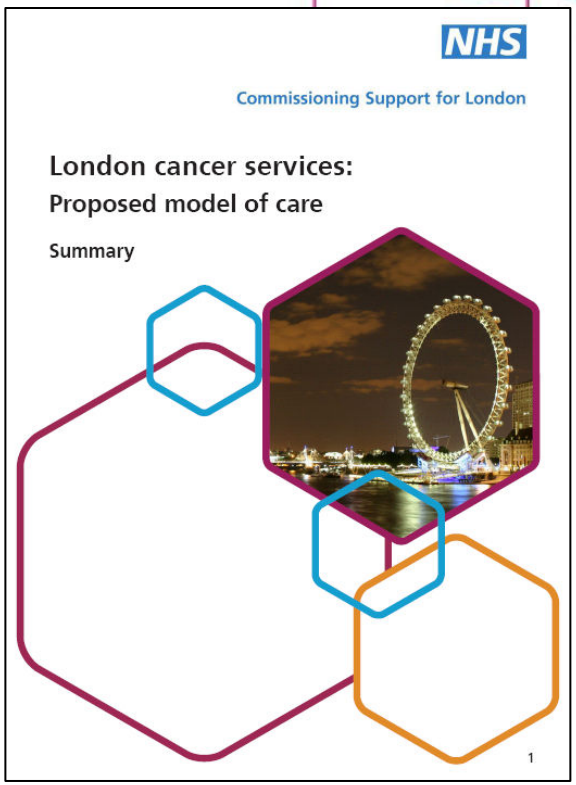
Clinically-led

Three work areas:

- Early diagnosis
- Common cancers and general care
- Rarer cancers and specialist care

Project board informed by:

- An expert reference group for each work area
- An overarching expert reference panel
- A patient panel
- Out of London experts

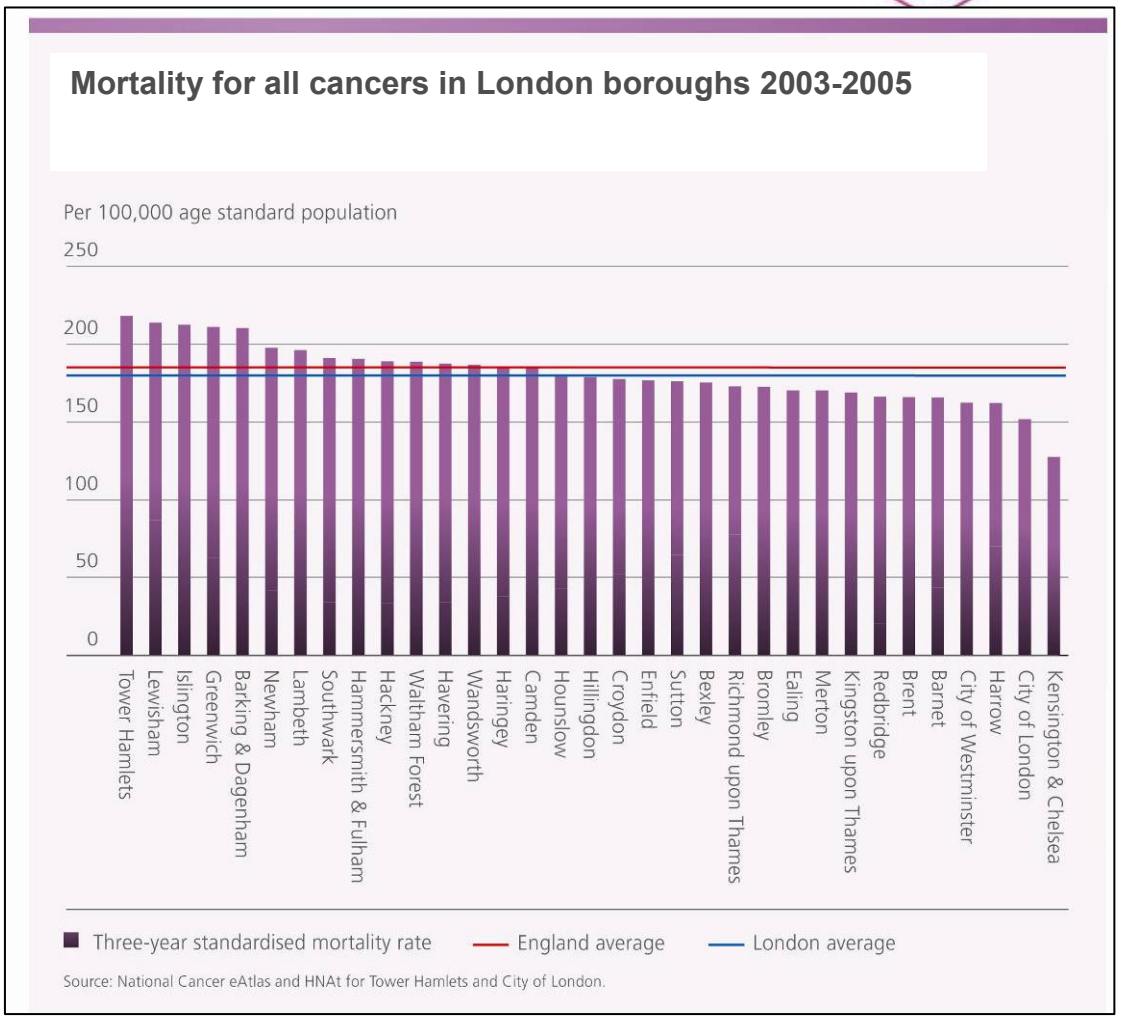


Case for change

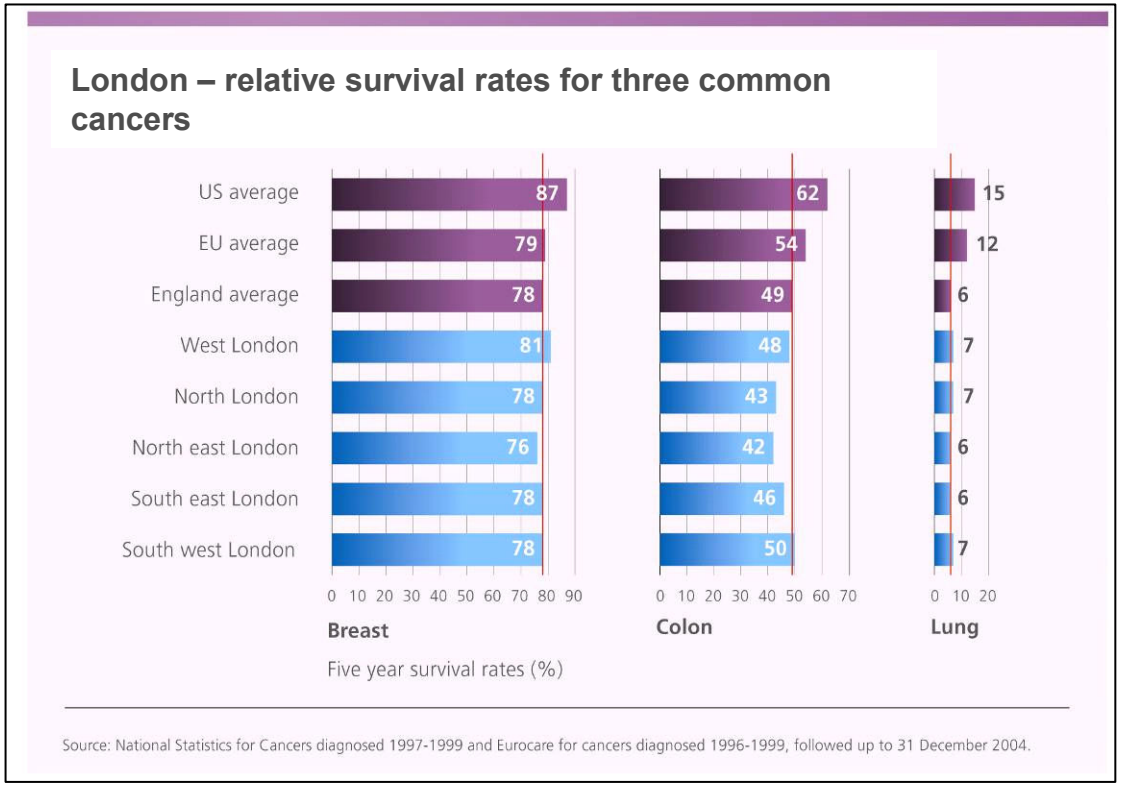
There are areas of excellence in London but significant inequalities in access and outcomes

Learning and best practice should be shared

Treatment and care (such as type of surgery and length of stay) should be standardised



Case for change

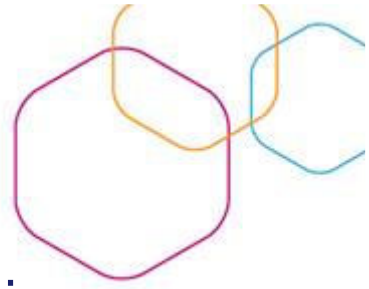


Later diagnosis has been a major factor in causing poorer relative survival rates

Specialist surgery should be centralised: common treatments and surgery should be localised where possible

Strong commissioning of high-quality comprehensive care pathways is necessary; organisational boundaries should not be a barrier

Cancer networks

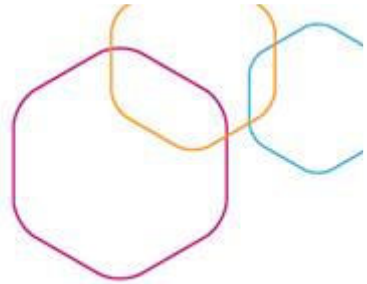


Existing five cancer network teams should focus on giving expert commissioning advice as **cancer commissioning networks**

To ensure that standardised care pathways can be delivered a small number of **provider networks** should be developed

Configuration and number of networks will be driven by implementation of model of care recommendations

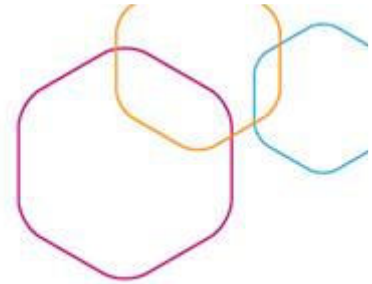
Early diagnosis



Recommendations include:

- Implement recommendations of National Awareness and Early Detection Initiative (NAEDI)
- Direct access to some diagnostic investigations from primary care
- Increase uptake rates of screening programmes
- Understand and address inequalities to increase awareness and reduce late presentation

Common cancers and general care



Recommendations include:

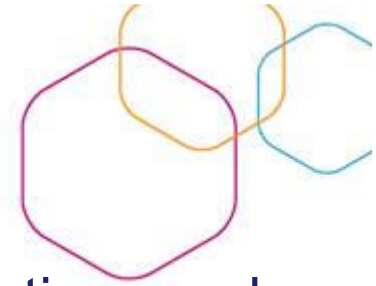
- Centralisation of some surgical services, localisation of others
- Standardised best practice (day case breast surgery, laparoscopic colorectal surgery, enhanced recovery programmes to minimise lengths of stay)
- High quality, safe local delivery of chemotherapy
- Acute oncology services in emergency departments
- Complement traditional follow-up with bespoke follow-up based on survivorship model

Rarer cancers and specialist care

Recommendations include:

- Concentration of some rarer cancer services beyond minimum NICE requirements to help ensure high quality experience and outcomes
- Minimum caseloads for specialist oncologists for each rarer tumour type to maintain their specialist expertise
- Consider centralised commissioning of all radiotherapy (to include specialist radiotherapy) to ensure equal access to treatment for all Londoners

The patient perspective



The cancer patient panel fully support the recommendations and contribute a foreword to the model of care

The key themes that emerged from the panel's discussions were:

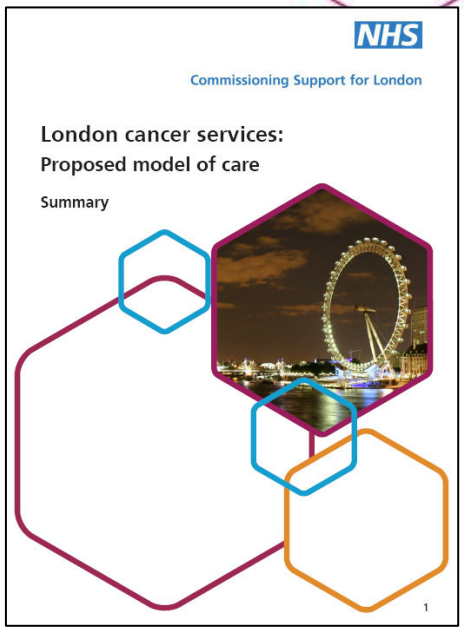
- An increased emphasis on public awareness and problems associated with delays in diagnosis
- The need to have transport considered when patients travel further for the best specialist care
- The need for joined-up pathways of care with designated keyworkers available for all patients
- A holistic approach to patients with carers acknowledged as partners in care

Gathering support

Full clinical model of care was published as a *proposed* model in August 2010

It was released alongside a more accessible summary of the entire review process and its findings

Visit the website to see the **summary** and to give your views via the online **questionnaire**.



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Click on “cancer and cardiovascular models of care”