Oncology, Radiotherapy and Chemotherapy provision in West, North & East Cumbria

PCBC Financial Outline Specialised Services

Financial Context

In 2014/15 NHS England expenditure on specialised services for the Cumbria CCG population totalled £109m.

The exact split between South and West, North & East Cumbria is not available; however we can broadly estimate that of this £65m was incurred on acute specialised services for West, North & East Cumbria, plus a further £6.7m on specialised Mental Health.

Of the £65m acute, £21m was spent within the West, North & East Cumbria economy, (North Cumbria University Hospitals NHS Trust and Cumbria Partnership NHS FT), the remainder outside the economy, chiefly with The Newcastle Upon Tyne Hospitals who are the main tertiary provider for this population.

No Mental Health Specialised services are provided within the economy; all of the £6.7m is incurred with other Mental Health providers.

This all equates to an approximate spend of around £222 per capita.

Currently Specialised Commissioning within the North is in financial balance and has submitted a five-year balanced plan.

Background

The due diligence process undertaken by The Newcastle Upon Tyne Hospitals to establish a new model for oncology services has identified on the one hand additional resource requirement and higher costs associated with providing the service in the Cumbria location, and on the other scope for efficiencies in smoothing the pathway and changing ways of working.

Consequently, although the full impact for this and other specialised services is not yet known, the five year plan for Specialised Commissioning factors in both growth in expenditure to ensure quality and access, and a year on year QIPP assumption of 2.4% to achieve financial balance.

The current model of provider-based commissioning has allowed NHS England Specialised Commissioners to factor in specific growth in spend associated with the potential new Cancer facility in Carlisle; due diligence at this stage prevents disclosure of exact amount, but we would at least expect to have ability to fund revenue consequences of the scheme, plus a phased implementation of lead provider model with additional costs arising from TUPE and clinical leadership.

It is evident that with radiotherapy activity currently requiring 1.4 LINACS there will always be diseconomies of scale; however the latest modelling, taking into account both growth in incidence and changes in fractionations the net requirement in 2017/18 will be 1.6 LINAC machines.

Capital investment is critical to securing radiotherapy and associated oncology/chemotherapy services in the locality. Commissioners cannot provide capital and no single provider is willing to

make the investment at the expense of their own capital programme and financial balance. This is evidenced throughout the robust process undertaken to secure a lead provider.

The overall cost of capital is c£35m, of which c£27m relates to a new build. This is a maximum cost and would be subject to scrutiny with a view to reduction, but as a ball park figure to establish principle, we feel it is appropriate to quote the maximum at this stage.

There is an element of the above which relates to an interim improvement which would be feasible should a long term sustainable plan be agreed; a single LINAC replacement would provide immediate assurance on continuity of the service, which is the urgent and pressing need. This would enable IMRT to be delivered to the population by 2017.

Consideration should also be given as to prioritisation with the national replacement programme.

Should the service not be secured in the locality there will be; financial, quality and patient safety risks, services would be fragmented as no single provider has sufficient spare capacity. There would be a need for investment within those other provider/centres to attain that capacity (likely to be at least two LINACS and associated accommodation) and excessive patient travel to access radiotherapy centres.

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