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JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE AGENDA

3.30 pm	Thursday 13 March 2014	Redbridge Town Hall, Council Chamber

COUNCILLORS:

LONDON BOROUGH OF BARKING & DAGENHAM

Councillor Sanchia Alasia
Councillor Syed Ahammad
Councillor Tariq Saeed

LONDON BOROUGH OF WALTHAM FOREST

Councillor Khevyn Limbajee
Councillor Sheree Rackham
Councillor Richard Sweden

LONDON BOROUGH OF HAVERING

Councillor Wendy Brice-Thompson
Councillor Nic Dodin
Councillor Pam Light

ESSEX COUNTY COUNCIL

Councillor Chris Pond

LONDON BOROUGH OF REDBRIDGE

Councillor Stuart Bellwood
Councillor Mrs Vanessa Cole (Chairman)
Councillor Hugh Cleaver/
Councillor Filly Maravala

CO-OPTED MEMBERS:

Mike New, Healthwatch Redbridge
Ian Buckmaster, Healthwatch Havering
Richard Vann, Healthwatch Barking & Dagenham
Jaime Walsh, Healthwatch Waltham Forest

For information about the meeting please contact:
Anthony Clements (Tel: 01708 433065)
anthony.clements@havering.gov.uk

Joint Health Overview & Scrutiny Committee, 13 March 2014

Essex County Council

Havering
LONDON BOROUGH

NOTES ABOUT THE MEETING

1. HEALTH AND SAFETY

The Joint Committee is committed to protecting the health and safety of everyone who attends its meetings.

At the beginning of the meeting, there will be an announcement about what you should do if there is an emergency during its course. **For your own safety and that of others at the meeting, please comply with any instructions given to you about evacuation of the building, or any other safety related matters.**

2. MOBILE COMMUNICATIONS DEVICES

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3. CONDUCT AT THE MEETING

Although members of the public are welcome to attend meetings of the Joint Committee, they have no right to speak at them. Seating for the public is, however, limited and the Joint Committee cannot guarantee that everyone who wants to be present in the meeting room can be accommodated. When it is known in advance that there is likely to be particular public interest in an item the Joint Committee will endeavour to provide an overspill room in which, by use of television links, members of the public will be able to see and hear most of the proceedings.

The Chairman of the meeting has discretion, however, to invite members of the public to ask questions or to respond to points raised by Members. Those who wish to do that may find it helpful to advise the Clerk before the meeting so that the Chairman is aware that someone wishes to ask a question.

PLEASE REMEMBER THAT THE CHAIRMAN MAY REQUIRE ANYONE WHO ACTS IN A DISRUPTIVE MANNER TO LEAVE THE MEETING AND THAT THE MEETING MAY BE ADJOURNED IF NECESSARY WHILE THAT IS ARRANGED.

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AGENDA ITEMS

1 CHAIRMAN'S ANNOUNCEMENTS (Pages 1 - 2)

The Chairman will announce details of the arrangements in case of fire or other events that might require the meeting room or building's evacuation.

2 APOLOGIES FOR ABSENCE AND ANNOUNCEMENT OF SUBSTITUTE MEMBERS (IF ANY) - RECEIVE.

3 DISCLOSURE OF PECUNIARY INTERESTS

Members are invited to disclose any interests in any of the items on the agenda at this point of the meeting. Members may still declare an interest in an item at any point prior to the consideration of the matter.

4 MINUTES OF PREVIOUS MEETING (Pages 3 - 10)

To agree as a correct record the minutes of the meeting held on 7 January 2014 (attached).

5 CANCER AND CARDIO-VASCULAR PROPOSALS (Pages 11 - 32)

1. To receive an update from North East London Commissioning Support Unit officers on the current review of proposals for services for prostate cancer (presentation attached).

2. To discuss the open letter from clinicians concerning aspects of the proposals (attached with response letter from Sir David Nicholson, Chief Executive, NHS England).

6 BARTS HEALTH - RESPONSE TO CQC REPORT

To receive an update from Trust officers on how the Trust is responding to a recent report on its services by the Care Quality Commission.

7 BHRUT - RESPONSE TO CQC REPORT

To receive an update from officers of Barking, Havering and Redbridge University Hospitals NHS Trust on how the Trust is responding to a recent Care Quality Commission report on its services.

8 MOORFIELDS EYE HOSPITAL NHS FOUNDATION TRUST - PROPOSED CHANGE OF LOCATION (Pages 33 - 34)

To agree the Committee's response to a proposed change of location for Moorfields Eye Hospital (draft letter attached).

9 URGENT BUSINESS

To consider any other item of which the Chairman is of the opinion, by means of specific circumstances which shall be specified in the minutes, that the item shall be considered as a matter of urgency.

Anthony Clements
Clerk to the Joint Committee

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London Borough of Redbridge

Map of LB Redbridge Town Hall
128-142 High Road, Ilford, Essex 1G1 2DD

<u>**Meeting rooms**</u>

Please report to reception on arrival

The Council Chamber and Committee Rooms 1 & 2 are on the 1st Floor

Rooms 42, 43 and 49 are on the 2nd Floor

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MINUTES OF A MEETING OF THE
JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE
Redbridge Town Hall
7 January 2014 (3.30 - 5.50 pm)

Present:

COUNCILLORS

Barking & Dagenham	Sanchia Alasia
Essex	Chris Pond
Havering	Wendy Brice-Thompson, Nic Dodin and Pam Light (Chairman)
Redbridge	Stuart Bellwood and Filly Maravala
Waltham Forest	Richard Sweden

Councillors Mrs Joyce Ryan and Mrs Vanessa Cole (Redbridge) were also present.

Healthwatch representatives present:
Richard Vann, Healthwatch Barking & Dagenham
Ian Buckmaster, Healthwatch Havering
Mike New, Healthwatch Redbridge

Scrutiny officers present:

Glen Oldfield – Barking and Dagenham
Anthony Clements – Havering
Jon Owen and Jilly Szymanski – Redbridge
Corrina Young – Waltham Forest

Health officers present:
North East London Commissioning Support Unit – Neil Kennet-Brown, David Fish, Nadine House, Steve Jupp
Barts Health – Jo Carter, Lynne Hinton, Clare Morrell
BHRUT – James Hebdon
Partnership of East London Cooperatives – Chris Brody, Jacqui Niner, Remi Xander

Four members of the public were present.

All decisions were taken with no votes against.

The Chairman reminded Members of the action to be taken in an emergency.

26 CHAIRMAN'S ANNOUNCEMENTS

The Chairman of gave details of action in the event of fire or other event that might require the evacuation of the meeting room.

27 APOLOGIES FOR ABSENCE AND ANNOUNCEMENT OF SUBSTITUTE MEMBERS (IF ANY) - RECEIVE.

Apologies were received from Councillors Syed Ahammad, Barking & Dagenham and Khevyn Limbajee, Waltham Forest. Apologies were also received from Jaime Walsh, Healthwatch Waltham Forest.

28 CHANGE OF COMMITTEE MEMBERSHIP

The Committee noted that Councillor Mrs Joyce Ryan from London Borough of Redbridge had now left the Committee and that, subject to confirmation, Councillor Mrs Ryan would be replaced by Councillor Mrs Vanessa Cole.

It was agreed that Councillor Pam Light from Havering should chair the meeting on this occasion.

29 DISCLOSURE OF PECUNIARY INTERESTS

There were no disclosures of pecuniary interests.

30 MINUTES OF PREVIOUS MEETING

It was noted that the fourth paragraph, second line of page 7M of the minutes of the 8 October meeting should reads ‘offices’ rather than as stated. Some minor amendments to job titles of the NHS officers present were also noted.

Other than the amendments shown above, the minutes of the meetings held on 8 October and 20 November 2013 were agreed as a correct record.

31 ACUTE TRUST EMERGENCY PLANNING

1. Barking, Havering and Redbridge University Hospitals NHS Trust (BHRUT)

   BHRUT covered two acute sites at Queen’s and King George Hospitals. It was noted however that King George was not a receiving hospital for major incidents.

The Trust used a series of emergency manuals and an on-call system that was the same as that used by the Local Authority. There was also an emergency planning and business continuity system in place at Queen's.

In case of a major incident, a series of hospitals (usually four) were nominated by the London Ambulance Service to respond to an incident. A nominated hospital would assess the impact of an incident and decide if this was a major incident that required a more coordinated response. Specific stocks of burns treatments dressings and other equipment were carried in case of a major incident.

If there was a major incident, discharges from Queen's Hospital would be accelerated but this would be done in conjunction with NELFT or North East London Community Services (NELCS). Some existing patients could also be transferred to King George if necessary.

In cases of e.g. severe weather, guidance was sought from the Met Office in the same way as Councils did. There were also plans to deal with industrial action or fuel shortages. Should there be an incident on a hospital site, evacuation plans were available.

Other health links used in emergency planning included NHS England (who would coordinate responses to a major incident) primary care and Council adult social care departments.

2. Barts Health NHS Trust

Barts Health was the largest Hospital Trust in the country, controlling six hospitals including Newham and Whipps Cross. For external incidents, the Trust would be informed by London Ambulance Service or NHS England. In internal incidents, the Trust itself would advise doctors and nurses in the relevant hospital.

Incident response saw staff alerts cascaded down and this covered approximately 250 staff at Barts. Additional doctors could be alerted to come in to assist the discharge of existing patients would also be accelerated. Some elective surgery would also be cancelled in order to free up space for emergency surgery. Arriving relatives would be looked after and hospital staff would also be supported. Support would by Barts and the London Chest Hospital in case of a major incident.

There would also need to be a recovery period following an incident. In the case of the July 2005 London bombings, all casualties were received within a three hour period but the recovery period while victims continued to be treated lasted for around three months.

The Trust also had a number of event-specific plans to cover issues such as the decontamination of patients or an influenza pandemic. There was also a hospital evacuation plan in case of an incident such as the fire at the Royal Marsden Hospital. Plans were also available to deal with fuel disruption, extreme weather etc. Business continuity plans would deal with situations such as the loss of key staff or the non-availability of utilities.

All emergency plans underwent a cycle of audit and review. Barts Health also planned its responses in conjunction with the wider environment such as Local authorities and other emergency services.

A recent incident had seen the trauma centre at the Royal London Hospital put on standby for the building collapse at the Apollo Theatre. The Trust also planned the health response for large scale events such as the Olympic Games and London Marathon.

3. Questions and Discussion

In the case of a major incident occurring in the West Essex area, hospitals would be nominated by the East of England Ambulance service. Notifications would also be received from the Essex or East of England health resilience structure.

If multiple hospitals were required to respond to an incident, NHS England would lead on coordinating the response. Hospitals would advise NHS England if e.g. their emergency department had become full and could not take any further admissions. The grading of incidents was based upon a four-stage scale set up by NHS England:

0 – Incidents affects the Trust only
1 – Incident dealt with within normal major incident procedures
2 – All hospitals in the area respond
3 - All hospitals in the region respond

High levels of A&E patient activity could be managed by the Trusts and A&E departments worked closely on this with the London Ambulance Service. Confirmation had recently been received of funding levels to deal with winter pressures on hospitals.

Barts Health confirmed that accelerated discharge would be planned with Councils and discharge people into community settings would also be supported.

The Committee **NOTED** the presentations.

32 CHANGES TO CANCER AND CARSDIOVASCULAR SERVICES

NHS officers explained that the prostate surgery proposals were now being reviewed externally by the London Clinical Senate. A hybrid option was being considered where bladder cancer surgery would take place at UCLH with radical non-robotic prostatectomies carried out at BHRUT. Findings of the review would be communicated to the Committee. The outcomes of the review were expected to be known by the end of February and it was **AGREED** that these should be scrutinised at a special meeting of the Committee.

A two-site option for stomach and gullet cancer involving BHRUT and UCLH had been recommended for the medium term. Any move to a single site would be subject to a separate review in 3-5 years. There would also be a to clarify the future of the smaller centre undertaking operations of this kind in Chelmsford.

There had been five public drop-in sessions for people to discuss the proposals and the sessions had been run in a similar way to those for other major consultations such as Crossrail or the HS2 rail link. Patients had been involved in an options appraisal workshop and videos and Twitter had also been used as part of the engagement.

Health officers had met with the Chairmen of the three Joint Overview and Scrutiny Committees in December 2013 and felt it would be useful if the Committee could scrutinise planning for the implementation of the proposals such as for example travel issues. Officers were also happy to attend future meetings as required.

A recent issue that had been raised was the impact of the changes on the ocular oncology service but officers felt there was still sufficient capacity for the service at Barts Hospital.

In the new structure, renal surgeons from, for example, BHRUT would also be able to carry out operations at the Royal Free Hospital, thus reaching a sufficient of operations per surgeon to improve skills.

A Member felt that the consultation events had been held in the wrong place and had been too London-centric. Officers pointed out that events had been held at different times of the day. The Commissioning Support Unit officers would have been happy to present in for example Loughton but had not been asked too. The proposals had also been advertised in local newspapers covering Harlow, Epping Forest and surrounding areas.

There were 79 radical prostatectomies that took place in the sector last year and this was less than 20% of all prostate work. This was also less than 3% of cancer in-patient activity. It was emphasised that there were no plans to move any other prostate treatments from BHRUT.

A representative of a local prostate patients support group felt that not enough weight had been given to patients' views during the options appraisal. They also felt that the consultation outside London had been inadequate and that the proposals should be subject to formal s. 244 consultation. Officers responded that the weighting given to patient experience had increased from 20 % to 25% at the expense of clinical outcomes.

It was confirmed that BHRUT would remain a neurology service and continue to offer services for leukaemia and oesophago-gastric cancer. Only partial nephrectomy for renal cancer (approximately 60 patients per year) and prostate cancer surgery (around 80 patients per year) would move from BHRUT.

The Committee considered whether formal s. 244 consultation was required but noted that to do so, a Joint Committee would need to be formed from the three existing Joint OSCs. Members would be free to scrutinise the issues further in the future, even if formal consultation was not invoked. Members felt that it was essential that further engagement took place on the proposals as they were developed, even if formal consultation was not considered necessary. Members also felt that the proposals would improve services overall, even if they did constitute a substantial variation.

The Committee **AGREED** that the draft response letter concerning the cancer and cardiac proposals should be sent to the appropriate health officer, subject to the addition that further engagement and consultation on the proposals should take place. The Committee further **AGREED** that formal consultation under section 244 of the National Health Service Act 2006 was not required on this occasion.

33 **PATIENT EXPERIENCE - BARTS HEALTH**

Barts Health officers emphasised that the Trust was committed to getting patient experience right. A number of initiatives had recently been introduced in this area including the successful presenting of a patient story at each Trust board meeting.

Patient panels and fora were moving forward and there were hospital directors for each site. The Trust also worked closely with Age UK as regards older people's wards. Reports on Patient Advice and Liaison Service (PALS) contacts and complaints were shared with local Healthwatch organisations. The main concerns reported to PALS related to appointments difficulties, staff attitudes and treatments.

Surveys were carried out with in-patients and the friends and family survey was now also carried in maternity and out-patients with plans to also introduce this for children's services. Improved e-mail and telephone access for PALS had also been introduced.

It was confirmed that the PALS service had closed at Whipps Cross but the Trust was looking to restart services at the Whipps Cross site. Appointments could still be made to meet a PALS officer at the Whipps Cross site. Officers noted that there was no textphone for the PALS service.

The Trust worked very closely with the local advocacy service and could also offer support of for example English was not a patient's first language. Officers were also happy to involve Essex Healthwatch in patient experience work.

Members felt that patient feedback should be standardised across Trusts and that should e.g. be one definition of staff attitude issues. The Committee **AGREED** to recommend that patient experience data should be shared between Barts Health and BHRUT.

34 **NHS 111 UPDATE**

The NHS 111 service had commenced operation in February 2013. Officers were keen to secure more support for the service moving forward from the Commissioning Support Unit. The service was provided by the Partnership of East London Cooperatives (PELC).

In March 2013, the service had received calls from 8,000 patients per month but this had risen to 15,000 per month by November 2013. Approximately 1,200 calls per day had been received over the Christmas period.

There had been no complaints recorded directly against PELC. Complaints were sometimes received by NHS 111 but these mainly related to providers.

The software used by the service was the same across London although officers would take back observations that for example chest pain should be asked about at an earlier stage. While someone saying they could not breathe would be advised appropriately, it was also important to avoid unnecessary referrals to A&E.

It was confirmed that NHS 111 staff were aware of the weekend GP opening service that had recently commenced in Havering. Health facilities were e-mailed by NHS 111 staff if a patient was referred to them but it remained up to providers to ensure that these e-mails were checked regularly.

NHS 111 services were required to be able to meet surges in demand. A staff bank could be called upon to provide additional operatives at times of high demand. Neighbouring NHS 111 services could also assist if required without impacting on the quality of the service. A reserve site in Harlow was

also now available. The facilities at Becketts House had now been expanded and could handle calls from more areas.

Feedback to GPs had now improved and consultation was ongoing with GPs on a revised format for this.

Members thanked the PELC officer for her presentation and for arranging the recent visit to the NHS 111 offices at Becketts House in Ilford. It was felt that it may be useful to arrange another visit for Members after the Council election.

The Committee **NOTED** the update.

35 **URGENT BUSINESS**

It was **AGREED** that a special meeting of the Committee should be held in March to consider the response of Barts Health and BHRUT to the recent CQC reports on the Trusts as well as the outcome of the London Clinical Senate Review of the prostate proposals.

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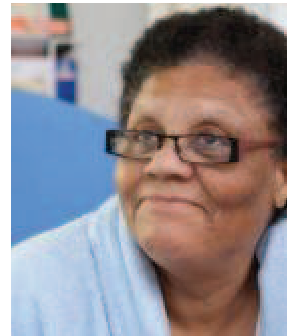
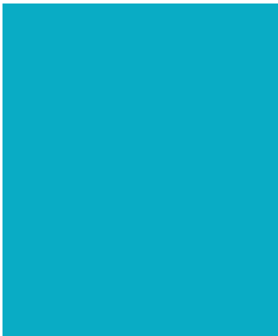
Chairman

Cancer and cardiovascular services





About the programme

- Local services are not organised in a way that gives patients the best care
- Currently our specialists, technology and research are spread across too many hospitals
- To address this, clinicians have recommended:
  - Specialist cardiovascular services at The London Chest, The Heart Hospital and St Bartholomew's Hospital are consolidated to create an integrated cardiovascular centre at St Bartholomew's
  - For specialist cancer care, the proposal is to consolidate only some of the specialist elements of five cancers
- The majority of care would continue to be provided locally.

Specialist cancer services: scope

Clinical scope	Approx impact of the proposed changes
Brain cancer surgery	97 of 831 procedures
Head and neck cancer surgery	241 of 394 procedures
Complex prostate cancer surgery (radical prostatectomies)	93 of 275 procedures
Complex kidney cancer surgery (partial and full nephrectomies)	145 of 239 procedures
Complex bladder cancer surgery	32 of 71 procedures
Acute myeloid leukaemia (level 2b) treatment	18 of 118 patients
Haematopoietic stem cell transplantation (level 3b) treatment	53 of 274 procedures
OG (stomach or throat) cancer surgery	53 of 131 procedures

Programme update

- The majority of CCGs have submitted formal support for the proposals
- London Clinical Senate independent clinical assurance underway
- Initial business case expected to be published in April 2014

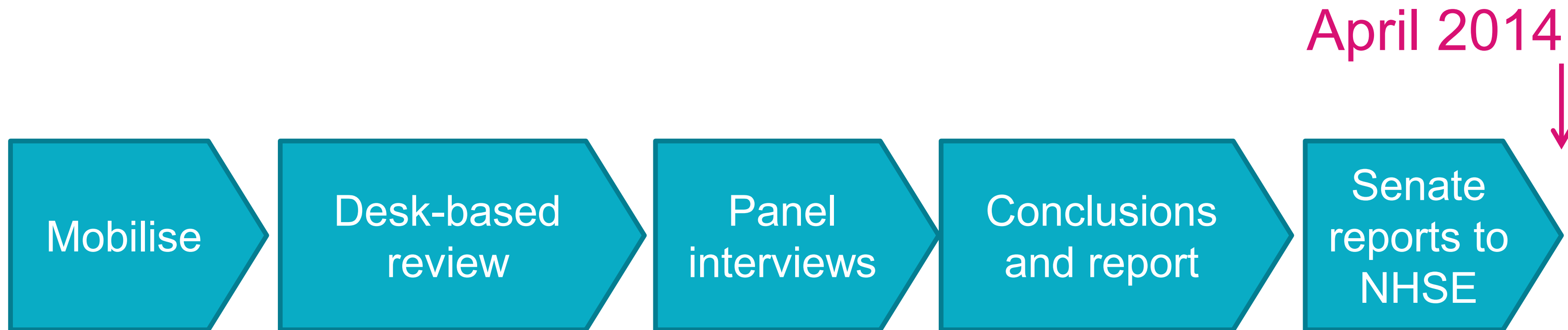
London Clinical Senate review: scope

- Advise on robustness of clinical process to arrive at recommended options, and depth of clinical involvement and support
- Advise on the future model and location(s) of radical prostatectomies, specifically:
  - A comparative analysis of current outcomes data
  - Which outcome measures should be used to compare radical prostatectomy performance
  - Implications of recently published NICE prostate guidance
- Professor Chris Harrison, Clinical Senate Council Vice-Chair, leading the process

Expert reference groups

Expert reference group (programme-wide)	Expert reference group (prostate)
• One clinician with expertise in cancer services and one with expertise in cardiac services • Two London Clinical Senate Lay Members • A GP • Director of Nursing and Medical Director (both drawn from the London Clinical Senate Council or Forum) • A member of another Clinical Senate	• Consultant Urologist/Andrologist, London Clinical Senate Council Member • Director, Centre for Clinical Practice, NICE or nominee • Chair of the Specialised Urology Clinical Reference Group or nominee • Clinical Audit Lead, British Association of Urological Surgeons (BAUS)

Clinical Senate assurance review: plan



Programme-wide clinical review

Prostate review

Initial business case approval

- A Commissioner Programme Board will have final approval of the initial business case
- The board will comprise NHS England and six CCGs who are majority commissioners for the proposed changes:
  - For **specialist cardiovascular** 59% of activity is CCG commissioned. Of this, 70% is commissioned by Haringey, City and Hackney, Enfield, Islington, Camden and Barnet CCGs
  - For **specialised cancer care** all the services are commissioned by NHS England, except acute myeloid leukaemia. This would particularly impact Enfield, Barnet, Haringey and Camden CCGs due to the proposed transfer of services to ULCH from other locations

Planning for implementation

	ROLE	MECHANISMS
Commissioners	• Ensuring plans meet the standards and requirements identified in engagement (eg management of co-dependencies, meeting volumes, deliverable in a safe and timely manner) • Ensuring system-wide benefits are identified and the overall change programme will deliver these benefits • Ensuring a framework is in place to assure the ongoing implementation • Deciding whether to proceed to implementation	NHS England: • Specialised Commissioning • Ops and Delivery CCGs Common Commissioner Board
Clinicians	• Signing-off clinical service models from a pathway perspective • Developing proposals for a individual pathways	• Pathway Boards • UCL Partners • Provider Clinical Directors
Providers	• Developing robust implementation plans and service models • Providing confidence to clinicians and commissioners that the plans and models are deliverable • Mobilising their own delivery programmes	• Provider programmes
TDA / DH/HMT	• Approving Barts Health OBC and FBC	TDA Board DH/HMT process

Planning for implementation: major trauma

- Meeting held with clinicians on 16 December to help shape workshop to identify and address issues
- Full day clinically-led workshop on 16 January with over 45 representatives from across the system
- Presentations from national clinical director for trauma care, Barts Health's trauma lead and a Barts Health trauma and vascular surgery consultant
- Recognition of the excellence of the current trauma service, and its significant improvements that it has made
- Clear commitment to maintain services and work collaboratively between trusts

Workshop outcomes

- Opportunity to breakdown walls between institutions and move away from silo working, with a collaborative focus on improving outcomes for all patient groups
- Key issues highlighted:
  - Importance of culture and interpersonal relationships to deliver excellent trauma services
  - Training, working across organisational boundaries, recognition that significant changes underway
  - Trauma services require many different specialties, skills and support services, which must continue to be available through effective collaborative working
  - All four pathways (upper GI, head and neck, urology and neuro-oncology) need to work through the specific issues raised, with potential solutions

Major trauma: next steps

- Programme of work underway between trusts, UCLPartners and commissioners to mitigate risks
- This element of work will form part of the wider planning for implementation phase of the programme
- Commissioner and provider assurance and oversight frameworks to be established and completed prior to implementation, if approved

Phase two engagement approach

- Approach discussed with patient advisory groups and meeting scheduled to discuss approach with local Healthwatch groups
- Engagement period commence following approval of initial business case
- Plain English summary leaflet of proposals distributed to all stakeholders
- Information available online and cascaded via trusts, CCGs and stakeholders
- Engagement events:
  - 1x prostate discussion event in outer north east London
  - 3x stakeholder advisory group meetings covering travel, whole pathway integration, and service impacts
  - Open offer to attend meetings

Next steps

- Following endorsement of the recommendations in the initial business case, phase two of the programme will commence including:
  - Phase two engagement
  - Planning for implementation
  - Development of commissioner assurance and oversight frameworks
  - Development of decision-making business case
- The above will support final decision-making expected in June 2014

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Sir David Nicholson
Chief Executive,
NHS England,
PO Box 167380
Redditch0
B97 9PT

CC Mr Simon Stevens,
Dr Anne Rainsberry, Regional Director NHS England, London.

15th January 2014.

Dear Sir David.

This open letter arises from an unprecedented coming together at an emergency open meeting on the 11th December 2014 of around 60 doctors to discuss plans by NHS England to move some cancer services from Barts Health Trust to University College Hospital London. The majority of attendees were consultants, cancer specialists and their colleagues, working in Barts Health. There were also junior hospital doctors and GPs from the local area and CCG. Senior representatives from NHSE involved in developing cancer services were present.

The meeting expressed concern that the proposal to move five specialist cancer services from Barts Health to UCLH, as set out in "Improving Specialist Cancer and Cardiovascular Services in North and East London and West Essex", would lead to a number of unintended consequences which have not been properly considered and will not, as they stand, be in the interest of the generality of patients in North East London and West Essex. The clear consensus of the doctors at the meeting (many of whom had not been consulted about the proposals) was that, as presented, the proposals were unacceptable and needed to be re-examined with the help of all staff grades and types; there was also a need for a wider public discussion.

Barts Health Trust, comprising Whipps Cross, Newham General, The London Chest, The Royal London, Barts and Mile End hospitals and Tower Hamlets Community Health Services, serves one of the most deprived and multi-ethnic populations in the UK. Services to meet the special needs of this population have been built up over many years by staff teams in these hospitals.

The concerns expressed at the meeting can be summarized under six main headings:

ACUTE SERVICES AT BARTS HEALTH

There was particular concern that the move could destabilize The Royal London as the major trauma and acute centre for East London and beyond.

For example, the victim of a road traffic accident who has incurred a brain injury or ruptured internal organ may need the specialist skills of the cancer neurosurgeon or

upper GI cancer surgeon: such staff are of course trained in acute surgical care and serve on emergency cover rotas. Emergency rotas in neurosurgery and general surgery at Barts Health rely heavily on cancer as well as non-cancer surgeons, and it is unclear who would perform these emergency procedures at Barts Health if these surgeons were no longer there.

RETENTION AND RECRUITMENT OF KEY STAFF AT BARTS HEALTH

Nursing and other key operating theatre, anaesthetic and ITU staff would lose skill if they were not regularly involved in the care of patients with the complexity of surgery which cancer sufferers often require and currently undergo at Barts Health; it was feared that many would leave Barts Health to obtain such experience elsewhere in London, jeopardizing the care of all patients throughout the Trust and threatening the training of students and staff. Furthermore, losing these cancer services would be likely to impact negatively on the recruitment of doctors, nurses and theatre staff throughout Barts Health.

CURRENT CANCER OUTCOMES AT BARTS HEALTH

It was a concern that the information on which NHSE had made these decisions might not accurately reflect the excellent outcomes, on an international scale, of the relevant cancer services at Barts Health, or their large patient throughputs; nor was it felt that the decisions made by NHSE took adequate account of the contributions of the surgical cancer specialists to more comfortable palliative care for those for whom curative treatment is not possible.

MULTIPLE MORBIDITIES OF BARTS HEALTH PATIENTS

The East End of London has a greater concentration of deprivation than most of the rest of London, is multi ethnic and its population has higher rates of multiple health problems including diabetes, TB and heart disease. Cancer patients often suffer from other conditions such as heart and lung disease (and cardiac patients from cancer), so centralisation may disadvantage patients who have more than one medical condition. Patients from East London and West Essex would be adversely affected if Barts Health no longer house, mainly under one roof, all relevant specialists; conversely UCLH cancer patients with cardiac problems would not have access to the full range of cardiac services, including surgery, should they need them.

INTERHOSPITAL TRAVEL AND TRANSFERS FOR BARTS HEALTH PATIENTS

Many patients, particularly those for whom English is not a first language, have difficulty travelling within the Barts Health area, let alone into central London. Sharing patients in two different mega-trusts invites confusion and problems in communication, risking patients becoming lost in the system and further compromising patient care. Consultants working across trusts reported that they had already had this experience with between-hospital referrals. Clearly, continuity of care for cancer patients diagnosed in Barts Health and sent to UCLH for surgery would be undermined. Hospital records would easily be lost, and multidisciplinary team meetings (MDTs) between carers at the different hospitals would be impracticable and/or expensive. There would also be a risk of pre-operative investigations being expensively reduplicated after inter-hospital transfers.

FEARS THAT OTHER SERVICES WILL BE TRANSFERRED IN THE FUTURE

Finally, there were concerns that this proposal heralds further centralization of other services in the future, threatening care closer to home for the people of North East London and West Essex, and therefore patient choice, quality and cost of care.

CONCLUSIONS OF MEETING

In summary, the meeting was clear that the proposals had unintended consequences and would introduce problems that had not been adequately thought through; it was concluded that the plans were unacceptable as drafted. The meeting called on you as Chief Executive of NHS England to reconsider the re-organisation of specialist cancer and cardiac services in central and east London and Essex.

Yours sincerely:

Dr Jackie Applebee GP Tower Hamlets.
Dr Lynne Barrass, Consultant, Barts Health.
Dr Kambiz Boomla, GP Tower Hamlets.
Dr Joanne ChinAleong, Consultant Histopathologist, Barts Health
Dr Simon Coppack, Consultant Physician, Barts Health.
Mr Michael Dilkes, Consultant ENT Surgeon, Barts Health.
Dr Helen Drewery, Consultant, Barts Health
Mr Khalid Ghufoor, Consultant ENT Surgeon, Barts Health.
Dr Julia Hadley, Consultant in ICU and Anaesthesia, Barts Health.
Dr Ben Hart GP Tower Hamlets
Ms Frances Hughes, Consultant Upper GI Surgeon, Barts Health
Dr Daniel Kennedy, Consultant in ICU and Anaesthetics, Barts Health.
Dr Louise Langmead, Consultant Gastroenterologist, Barts Health.
Dr Anna Livingstone, GP Tower Hamlets
Dr Satheesh Matthew, Chair Medical Staff Committee, Newham General Hospital.
Dr Lisa Mears, Consultant Histopathologist, Barts Health.
Dr Edward McKintosh, Consultant Neurosurgeon, Barts Health
Dr Louise McWhirter, ITU Consultant, Barts Health
Dr David Rampton, Consultant Gastroenterologist, Barts Health.
Ms Kay Seymour, Consultant ENT Surgeon, Barts Health.
Dr Ron Singer, GP.
Dr Jeremy Steel, Consultant Barts Health
Dr Hafiz Syed, Consultant, Barts Health
Mr Michael Waring, Consultant ENT Surgeon, Barts Health.
Ms Semma Yalamanchili, ENT Surgeon, Barts Health.

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Dr Jackie Applebee
Chair of Tower Hamlets BMA Division
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E3 4QJ

By email to:
jackie.turner@jackieapp.demon.co.uk

17 February 2014

Dear Dr Applebee

Thank you for your letter of 15 January 2014, regarding the proposed consolidation of specialist services for five cancer pathways in north and east London and west Essex. I understand some of your members have raised concerns about the future of the major trauma centre at The Royal London Hospital, staffing and travel for patients within the Barts Health area.

The development of the proposals, as outlined in the case for change document Improving specialist cancer and cardiovascular services in north and east London and west Essex, are at an early stage and further work with clinicians and the public will inform the development of a business case.

The proposals, if approved, aim to replicate the success of major trauma centres and stroke units by ensuring the small number of cancer and cardiovascular patients who require specialised treatment receive world-class care.

The importance of The Royal London as a major trauma centre and ensuring it continues to provide high-quality acute care is recognised by all who are working on these proposals. Work is already underway to ensure any potential impacts of these proposals on other parts of the health service are fully considered and mitigated. This work will continue as the business case is developed and as part of planning for implementation.

We are committed to involving clinicians and the public in changes to health service. The initial engagement period was widely publicised with letters issued to over 540 stakeholders accompanied by a copy of the case for change and a link to information about relevant engagement events on NHS England's website. Tower Hamlets Clinical Commissioning Group (CCG) advertised the engagement to members and the public via its GP bulletin and website, and the proposals were discussed at the CCG's Governing Body meeting in public on 5 November 2013. Five staff events were held during the 38-day period with over 90 clinicians and staff attending the event at Barts Health. In addition, advertisements were

placed in 14 papers across the area and UCLPartners tweeted details of the events to 700 plus followers each time any new information was added to their website, as well as the day before and the day of the event. NHS provider trusts were encouraged to publicise the dates on their websites and via other means such as Twitter.

Overall engagement showed broad clinical and public support for the proposals and the need to improve outcomes across the area.

As commissioners, we share the aims of clinicians and other health partners of tackling the health challenges present in the unique population of east London. These proposals have potential to help improve the survival and outcomes of cancer and heart disease patients, which accounts for two-thirds of premature deaths in London. The programme is also undertaking an equalities impact assessment, which will be included as part of the business case.

As previously mentioned, work is continuing with GP partners and clinicians to understand their opinions. On 16 December 2013 Barts Health, supported by commissioners, held a meeting with clinicians who had raised some questions about the proposals. The purpose of the meeting was to get their input into a workshop to identify and explore the issues surrounding the impact of the proposed cancer changes on major trauma and acute services at the Royal London Hospital. This all-day workshop, held on 16 January 2014, involved 45 participants and was facilitated by Barts Health Medical Director, Steve Ryan, and National Clinical Director for Trauma, Chris Moran.

I understand that this proved very useful in providing an opportunity to discuss how the major trauma centre can continue its lifesaving work without compromise. Mitigation measures, to be achieved through collaborative work across organisations and sites were also discussed. The notes from this meeting are now being drawn up and I understand that a copy of these will be sent to Tower Hamlets BMA Division for your information. I also understand that additional meetings are currently being arranged to ensure all stakeholders have the chance to talk through the issues with commissioners.

We recognise there is still further work to do and believe that communication and collaboration across providers will strengthen joint working and training opportunities. Major trauma centres and stroke units already collaborate between departments and providers and we believe similar joint working arrangements with the proposed specialist cancer centres could enhance this system. We will continue to work with clinicians at Barts Health as the proposals are developed and in any planning for implementation.

If the proposals are approved we would also be establishing provider and commissioner assurance and oversight before implementation to ensure the integrity of the trauma service at The Royal London is maintained.

With regards to the points raised around travel for patients living in the Barts Health area, this is one of the areas in which work is ongoing to assess the current quality and provision of hospital travel arrangements and appropriate mitigation measures. Another key area which will be examined as part of the planning for implementation is that of safe and efficient transfer of patient records and data between hospitals and liaison with primary care.

The vision for cancer and cardiovascular care in north and east London and west Essex is to create an integrated system of care. As an essential part of this system Barts Health would remain a leading cancer care provider, particularly for colorectal, breast, uro-oncology and haemato-oncology.

I want to reassure you that these proposals are for specialist services for five types of cancer and specialist cardiovascular services only. The majority of care would continue to be provided locally and any other service changes would be subject to separate and appropriate engagement.

I trust this letter is helpful.

Yours sincerely

Sir David Nicholson
Chief Executive

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Essex County Council

Anthony Clements
Principal Committee Officer

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DRAFT

TO:

Rob Elek
Programme Director – Transformational
Director of Strategy and Business Development
Moorfields Eye Hospital NHS Foundation Trust
162 City Road
London
EC1V 2PD

Date: 13 March 2014

Your Reference:
Our Reference: **AC**

Dear Rob

Views of Outer North East London Joint Health Overview and Scrutiny Committee (JHOSC) on Proposed Move of Hospital Location

As the current Chairman of the Outer North East London JHOSC, I am writing to confirm the overall views of the Committee on the above proposals. A group of JHOSC Members recently visited the existing City Road site and, having discussed the matter at the Committee's meeting on 13 March 2014, the Committee is of the view that these proposals do not require formal consultation under section 244 of the National Health Service Act 2006. The Committee therefore feels that the changes should proceed, subject to the comments shown below.

A group of JHOSC members and officers recently visited the existing City Road site and I would like to record my thanks to Moorfields officers for facilitating this. The visit showed clearly how cramped the existing building now is and that this is a hindrance, if not to good clinical care, then certainly to the patient experience received. The Committee therefore is in support of your plans to move the hospital to more fit for purpose premises.

The Committee has noted the Trust's assurances that no services will change as a result of the proposals which are solely for a move of location and is therefore of the view that the proposals

The Joint Health Overview and Scrutiny Committee is exercising its powers as conferred under the NHS Act 2006, section 245 (as amended by the Health and Social Care Act 2012). This is distinct from and separate to those powers exercised by the Executive of the constituent Councils.

do not constitute a service variation of the type that would require formal consultation of the kind mentioned in the legislation referred to above. Clearly, the Committee would plan to scrutinise the situation in the coming years in order to establish that no services are reduced or impacted as a result of the move of location.

The Joint Committee feels it is essential that a robust programme of engagement continues with both itself and other all other stakeholders including the relevant Local Healthwatch organisations as the plans are developed and the move of location takes place. Specifically, the Committee would like Moorfields officers to appear before it on at least an annual basis in order to update plans for the move of hospital site. It is also recommended that Moorfields pass any written updates or publications concerning the move to the Clerk to the Committee, as they are published, in order that these can be distributed to Committee Members without delay.

In conclusion, the Committee understands the reasons why Moorfields wishes to move to a new site and supports the Trust's plans to do so. The Committee looks forward to engagement on the plans continuing over the coming years and to further scrutinising the proposals as they are developed in more detail.

Yours sincerely

Councillor Mrs Vanessa Cole
Chairman, Outer North East London Joint Health Overview and Scrutiny Committee

This letter has been copied to:

All Members and Supporting Officers, Outer North East London Joint Health Overview and Scrutiny Committee
Luke Byron-Davies, Clerk, Inner North East London Joint Health Overview and Scrutiny Committee
Rob Mack, Clerk, North Central London Joint Health Overview and Scrutiny Committee

DRAFT

The Joint Health Overview and Scrutiny Committee is exercising its powers as conferred under the NHS Act 2006 section 245 (as amended by the Health and Social Care Act 2012). This is distinct from and separate to those powers exercised by the Executive of the constituent Councils.