MINUTES OF A MEETING OF THE
JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE

9 April 2013 (3.30 pm – 5.25 pm)

Present:

London Borough of Havering:
Councillors Wendy Brice-Thompson, Nic Dodin and Pam Light

London Borough of Redbridge:
Councillors Hugh Cleaver and Joyce Ryan

London Borough of Waltham Forest:
Councillors Khevyn Limbajee (Chairman) Sheree Rackham and Nicholas Russell

Essex County Council:
Councillor Chris Pond

All decisions were taken with no votes against.

31 **CHAIRMAN'S ANNOUNCEMENTS**

The Chairman gave details of the arrangements in case of fire or other event requiring evacuation of the meeting room.

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

Apologies were received from Councillors Sanchia Alasia, Barking & Dagenham and Stuart Bellwood, Redbridge. Apologies were also received from Jilly Mushington, scrutiny officer, London Borough of Redbridge.

Healthwatch representatives present:
Mike New, Healthwatch Redbridge
Joan Smith, Healthwatch Havering

Health officers present:
John Hine (JH) Consultant Surgeon, Whipps Cross
Neil Kennett-Brown (NKB) London Cancer
Mike Gill (MG) Director of Medicine, Barking, Havering and Redbridge University Hospitals NHS Trust (BHRUT)
Nicole Millane, North East London Commissioning Support Unit

Scrutiny officers present:
Anthony Clements, Havering (notes)
Glen Oldfield, Barking & Dagenham

Corrina Young, Waltham Forest
Farhana Zia, Waltham Forest

Two members of the public were also present.

33 DISCLOSURE OF PECUNIARY INTERESTS

There were no disclosures of interest.

34 MINUTES OF PREVIOUS MEETING

The minutes of the meetings held on 8 January and 13 February 2013 were agreed as a correct record and signed by the Chairman.

35 UROLOGICAL CANCER PROPOSALS

JH explained that he chaired the urology pathway board which aimed to make treatment better for patients in North East and North Central London as well as West Essex. The principal drivers for change were to ensure better outcomes for cancer patients in terms of both survival and patient experience. It was also important to promote more clinical trials in order to improve outcomes for some types of cancer.

The overall proposals were to keep less complex surgery at the existing hospitals while there would be a single centre for complex prostate and bladder cancer surgery and a separate single centre for complex kidney surgery. Diagnosis and follow up treatment would still be undertaken locally and health officers stated that only a very few patients would need to travel for their operations.

Working groups drawing up the proposals included patients and GPs and had recommended specialist centres in order that surgeons could perform as many as 50 complex urological operations per year. Each centre would have approximately six surgeons attached to it.

There were not enough patients in the region to make two centres viable and research had shown that functional outcomes in terms of reduced incontinence or erectile dysfunction were better in a single centre. Better facilities such as access to Da Vinci robots would also be available in a single centre.

It was emphasised that the vast majority of patients would still receive their care locally and that fewer than 1 in 5 would need to receive care at a specialist centre. It was estimated that around 225 patients in the sector would need complex surgery for bladder/prostate cancer and around 270 would need such surgery for kidney cancer. In terms of the ONEL boroughs and West Essex, numbers for complex bladder/prostate surgery ranged from 19 per year in Barking & Dagenham to 49 per year in West Essex. For kidney cancer, the equivalent figures varied from 14 in Barking & Dagenham to 29 in West Essex.

The patient pathway would see patients returned to local care as soon as possible after having their operation in a specialist centre. Emergencies would also be treated locally. In some cases, recipients of complex surgery would only need to stay in the specialist centre for one night. The only visits needed to the specialist centres in most cases would be for one pre-op appointment and for the operation itself. The proposed locations for the specialist centres were UCLH for bladder/prostate surgery and the Royal Free Hospital for kidney surgery. Further information on the proposals and the recommendations reached was available on-line.

Engagement on the surgery proposals was taking place from January to April and meetings would also be taking place with patient groups and local CCGs. Additional clinical information and a video on the proposals were available on the website.

Officers felt that the benefits of the clinical outcomes of the proposals outweighed any travel difficulties. It was accepted however that travel concerns were the main issue in Outer North East London and West Essex. Options being considered to address travel concerns included providing more car parking, offering a taxi service or a hotel stay at UCLH. Work was also ongoing with the Mayor's Office and TfL to offer reduced fares to patients and relatives. Another option could be to loan out I-pads to allow patients to communicate with relatives via Skype.

Other feedback from the consultation process had included concerns about Patient Choice although officers confirmed that patients could still, if they wished, attend facilities outside of the London area. Concerns about having a second centre and communication between different centres had also been raised but officers confirmed that the recommendation was to have a single specialist centre. It was also confirmed that any removal of urological surgery from BHRUT would not have an impact on other specialist work carried out by the Trust.

Next steps in the process would include continuing analysis of feedback received and workshops with Health Trusts on implementation. Engagement would also continue and officers were due to meet with the Inner North East London JOSC at the end of April. A final report with recommendations would be presented to NHS England at the end of this process.

The Committee was addressed by the Chairman of Pro-Active a local patient group. The group was disturbed at the effect of the proposals, particularly the impact of travel and access problems on patients who were likely to be mainly middle-aged or elderly. The group felt that there was no good reason for having a single centre and that the location chosen was not the most accessible. 76% of existing operations of this type were currently carried out at Chase Farm, King George or Whipps Cross Hospitals.

The group therefore felt that the proposals did in fact constitute a substantial service change and that full consultation should have been carried out.

Other concerns included the lack of an options appraisal, that the engagement process was too hurried and that no engagement meetings had been held in Essex or Hertfordshire.

Officer responded that the population of the affected areas was insufficient to make more than one specialist centre viable and there also may not be sufficient numbers of surgeons if two centres were to be in operation. In emergency cases, consultants would travel to a patient's local hospital and the patient would not need to re-attend the specialist centre. All stakeholders had been written to in order to confirm timings for meetings etc and officers were also due to meet with the Pro-Active group. Meetings had also been attended in areas including Stratford, Hackney, Hertfordshire, West Essex and Ilford.

Although the engagement period had not been formally extended, responses were still being accepted and meetings held during this period. Any arrangements re transport etc to hospitals would apply to carers as well as patients and details of this would be confirmed in due course. It was agreed that the London Cancer website would be amended to indicate that responses were still being accepted.

Some changes had already taken place as a result of e.g. the Barts Health merger. Some patients had also already chosen to go to UCLH in order to benefit from the robotic surgery being offered there. It was important to diagnose prostate cancer early and bladder cancer was also becoming more common with more women now affected. Officers were therefore considering having patients go straight to diagnostic centres rather than GPs. It was expected that the new model would be implemented within a year. Pilot studies had also been undertaken on carrying out blood tests for prostate cancer in the community.

Members remained concerned at the travel implications for residents of Outer North East London and West Essex. Officers responded that discussions were still ongoing but agreed to keep the Committee informed of the outcome. It was noted that some patients from West Essex would in fact be treated at Addenbrookes or Colchester Hospitals rather than at UCLH. Travel concerns were taken seriously and health officers would be meeting with the Mayor of London in order to discuss these issues. A representative from West Essex was a member of the programme pathway board but felt that the clinical benefits of the proposals outweighed any transport issues.

The largest risk factor for bladder cancer was smoking and risks remained elevated for as much as 30 years after smoking had stopped. Bladder cancer was becoming more common in women and in people aged 50-60. A bladder removal was a very large operation. Prostate cancer was more common in black men, particularly in Africa and the USA although there was a lack of data on these areas. It was thought that this may relate to lower levels of vitamin D and studies were ongoing in this area. Foods such as

cooked tomatoes, green tea and pomegranate juice helped to reduce the risk of bladder cancer.

Officers had discussed the proposals with experts in Manchester, Oxford, Glasgow, Chelmsford and Basildon and remained happy to meet with interested groups. All decision making papers were also available on the consultation website. As regards future work, there was a total of 17 pathway reports from London Cancer, the first of which would come forward from September 2013 onwards.

Three further pilots on bladder diagnosis in the community had been funded by Camden CCG. It was emphasised however that this did not bypass GPs who would become involved as soon as a diagnosis had been made. Much of the follow up care would also be carried out via a patient's GP. Members welcomed these pilots and wished to see the community diagnosis service extended as widely as possible.

The Committee thanked the officers for their attendance and input to the meeting and for the quality of their presentation. The Committee asked that it be noted that they retained concerns over the travel issues and **AGREED** to take an update on the matter in six months. The Committee otherwise **NOTED** the presentation.

36 CO-OPTION OF REPRESENTATIVES OF LOCAL HEALTHWATCH

The Committee **AGREED** unanimously to co-opt one representative from each of the Local Healthwatch organisations for Barking & Dagenham, Havering, Redbridge and Waltham Forest.

37 COMMITTEE'S WORK PROGRAMME 2013/14

In addition to an update on the urological cancer proposals in six months, the Committee also agreed to take an update on the maternity situation as soon as possible. The Committee also requested a presentation on the NHS 111 telephone service. It was felt that scrutiny of the performance of CCGs could best be carried out at a local level.

38 URGENT BUSINESS

Dates and venues of future meetings were **AGREED** by the Committee as follows (all 3.30 pm start):

Tuesday 2 July (Barking & Dagenham)

Tuesday 1 October (Havering)

Tuesday 7 January (2014) (Redbridge)

Tuesday 1 April (Waltham Forest)

Chairman