MINUTES OF A MEETING OF THE
JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE
Council Chamber, Redbridge Town Hall
20 November 2013 (3.30 - 5.20 pm)

Present:

COUNCILLORS

London Borough of Barking & Dagenham	Sanchia Alasia
London Borough of Havering	Wendy Brice-Thompson, Nic Dodin and Pam Light
London Borough of Redbridge	Stuart Bellwood, Hugh Cleaver, Filly Maravala and Joyce Ryan (Chairman)
London Borough of Waltham Forest	Richard Sweden
Essex County Council	Chris Pond

Healthwatch Representatives:
Barking & Dagenham – Frances Carroll (substituting for Richard Vann)
Havering – Ian Buckmaster
Redbridge – Mike New
Waltham Forest – Jaime Walsh

Scrutiny officers present:
Barking & Dagenham – Glen Oldfield, Mark Tyson
Havering – Anthony Clements (clerk to the committee)
Redbridge – Jilly Szymanski, Jon Owen
Waltham Forest - Corrina Young

NHS officers present:
David Fish, NHS England
Ian Grant, Haematologist, BHRUT
Neil Kennet-Brown, NHS England
John King, Barts Oncology Pathway Director
Charles Knight, Barts Health
Mansoor Mughal, UCLH
Hilary Ross, UCL Partners

Approximately five members of the public were in attendance.

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

20 CHAIRMAN'S ANNOUNCEMENTS

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

21 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 Richard Vann, Healthwatch Barking & Dagenham (Frances Carroll substituting).

22 DISCLOSURE OF PECUNIARY INTERESTS

There were no disclosures of interest.

23 MINUTES OF PREVIOUS MEETING

Members made the following comments:

On page 3M, the date of the first Care Quality Commission listening event had not been known to the Joint Committee at the time of the meeting and health officers were in fact unable to give these details during the meeting itself.

On page 5M, officers had been asked to confirm whether Barts Health had spoken to TfL re helping patient and relatives from outlying districts to get to Whipps Cross, rather than solely those from the Redbridge area.

The Chairman also asked if it could be fed back to the Care Quality Commission that, as mentioned at the meeting, a guide for what Councillors should look out for when visiting hospitals etc would be very useful.

Subject to the comments above, the minutes of the meeting held on 8 October 2013 were **AGREED** as a correct record and signed by the Chairman.

24 REVISED COMMITTEE MEMBERSHIP

The Committee noted that Malcolm Wilders had recently resigned from the Committee due to ill health. The Committee **AGREED** that it should record its thanks to Mr Wilders for his contribution whilst a member of the Committee.

25 CHANGES TO CANCER AND CARDIOVASCULAR SERVICES

Presentation from NHS Officers

NHS officers explained that cancer and cardiovascular disease were the two biggest reasons for early mortality. It was felt that current services were not coordinated enough and that specialist centres such as the Hyper Acute Stroke Unit at Queen's Hospital led to better outcomes for patients. Centres such as these would also give a better patient experience.

There were proposals affecting several different types of cancer including bladder, prostate, kidney, leukaemia, brain, head & neck and stomach. It was emphasised that the strongest drivers for change were improving patient outcomes and improving the patient experience.

Many cancer services in the region were not meeting national guidelines and it was wished to have specialist care available on a 24:7 basis. This would include better technology such as the use of robotic surgery for prostate cancer, specialist nursing and access to clinical trials.

All pre and post operation services would continue to be delivered on a local basis. BHRUT would see a rise in some operations such as those for brain cancer and upper oesophago-gastric (OG) cancers, although the latter was planned to eventually move to one site at UCLH. There would be fewer bladder, prostate and renal cancer operations at BHRUT under the proposals. Overall, BHRUT would see a 3% reduction in episodes of care under the proposals.

Feedback to date had shown overall support for the proposals to consolidate specialist services but people had also indicated that services should be kept local where possible. In Outer North East London, there had been support to move from 3 to 2 OG centres but concerns had been raised over the plan to move to a single centre eventually and this proposal was still being considered. There had also been feedback that a second centre for prostate cancer should be located at BHRUT in order to reduce travel difficulties. It was accepted by NHS officers that travel issues were very important although patients had stated they would be willing to travel further for better outcomes.

UCLH would provide a number of travel support initiatives for patients including procuring more disabled parking bays, giving better information on travel options and, in some cases, supplying hotel accommodation for patients and their families. Similar support would be available from the Royal Free Hospital for kidney cancer patients.

It was not anticipated that there would be much impact of the cardiovascular proposals on Outer North East London as patients from this area already travelled to the London Chest Hospital which would transfer to the Barts site at Farringdon from 2014. As with the cancer services, officers explained that there would be a concentration of very specialist services with no change to

local services which would continue to be provided at BHRUT and Basildon Hospitals.

The heart unit at Barts would be the largest in the UK and it was expected this could save 1,000 extra lives per year if even the average outcomes for England could be reached. 24:7 specialist care could however only be provided by having a larger unit such as that on the Barts site. There had been strong support overall for the Cardiovascular proposals. The Chairman asked if it would be possible to visit the Farringdon Barts site once it was receiving patients.

Address by PHASE

The Committee were addressed by representatives of PHASE – a prostate cancer support group covering the BHRUT area. The representatives explained that prostate cancer was the most common form of male cancer and that late diagnosis was a major issue due to the lack of a cancer screening system.

The main provider of prostate operations was BHRUT and NHS England wished to transfer these operations from BHRUT to UCLH. PHASE felt that the current service provided by BHRUT was centrally located within the ONEL area. The service was also cheaper with a cost per operation 12% lower than at UCLH and, in PHASE's view, the change was not supported by local clinicians.

PHASE had not seen any specific evidence that a transfer to UCLH would give better outcomes for patients and therefore wished to keep services at BHRUT. PHASE also considered that there should be a full public consultation on the proposals.

Questions and Discussion

NHS officers clarified that the figure of 1,000 lives saved was based on the current death rates for the local area and the annual average figures for England.

A travel analysis of the proposals was being carried out and it was anticipated that approximately 20-30 patients per borough would be affected. Most cancer services at Queen's Hospital would be unchanged although a small number of patents would be affected.

Officers emphasised that there had been no final decisions as yet. The proposals were recommendations to NHS England. The number of patients affected by the urological changes i.e. those men having radical prostatectomies, was a very small proportion of the overall number of patients. It was also thought that the numbers of patients requiring surgery of this type may reduce in the coming years. It was also planned to offer enhanced diagnostic services for prostate cancer at all hospitals including King George.

Services such as Hifu Unltasound were a very significant treatment for prostate cancer and it was probable that a new centre for this treatment would be established at Queen's Hospital. The work proposed to transfer to UCLH was therefore a very small proportion of the total number of prostate treatments.

A PHASE representative stated that the group had spoken to clinicians at BHRUT who did not support the changes but the Chairman felt that the Committee needed to see evidence of this.

The NHS officers agreed that they did not currently know how many prostate cancer cases are diagnosed too late to have surgery. Early detection would mean more cases could be treated by surgery and hence fewer deaths. Tumours were more aggressive in late diagnosed cases. 63% of BHRUT prostate patients had less aggressive tumours which indicated that early diagnosis had been taking place.

Officers would supply for the Committee details of the travel impact assessment that had taken place. Alternative centres to UCLH for patients outside Greater London would be Addenbrokes Hospital in Cambridge and Basildon Hospital although formal discussions on where surgery for Essex NHS patients would be located had not taken place as yet.

Officers were not aware of any charges for the UCLH patient hotel although they would confirm if this was the case. Centralisation was the preferred option due to the small numbers of operations taking place currently in each hospital. It was emphasised however that 97% of current cancer care would remain local. Thus brain cancer surgery was planned to cease at the Royal London Hospital and this would lead to a corresponding increase in activity at Queen's. Reducing oesophago-gastric surgery from three to two sites would also bring numbers of operations per site up to national guidelines. As regards prostate surgery, it was hoped that commissioners could provide more accurate figures for the number of radical prostatectomies carried out.

Given new NICE guidance that prostate conditions should be treated more with active surveillance rather than operations, officers felt this could mean the number of prostate patients from this region having to travel into London would reduce to as low as 3-4 per month. Members felt that data on complication rates etc was also required.

Members were concerned at the lack of data with which to make a decision on the proposals. The NHS officers confirmed that they were committed to getting this information and would also supply to the Committee borough data that had been given to Health and Wellbeing Boards and Clinical Commissioning Groups. Prostate outcomes in the BHRUT area compared to the rest of London were currently being investigated.

Clinicians had been involved in the development of the cancer services case for change and officers reiterated that the priority was to improve

patient outcomes and experience. Clinicians felt that there was clear evidence that the more operations a clinician carried out, the higher their skills level would become. Officers also accepted that prevention and early diagnosis needed to improve. There were projects running on patient pathways and work was in progress with primary care physicians on e.g. avoiding heart attacks in patients. It was felt that specialist centres would drive improvements across the whole system. Members asked for further information to be provided on this work.

No diagnostic services would be lost from Whipps Cross and it was planned to make procedures such as gastroscopies more available to people. Work was also under way to investigate why some patients are only diagnosed with cancer when they present at A&E. A report on this work would be publicly available from early December.

Whipps Cross would lose some renal activity to the Royal Free Hospital. Officers would confirm the numbers involved but it was thought this would be in the region of 10-20 operations per year. There would also be a movement from Whipps Cross to UCLH for robotic pelvic cancer surgery but it was noted that most patients were already choosing to have surgery of this type at UCLH rather than Whipps Cross. Dialysis would continue to be delivered locally as would other existing kidney services. The proposed changes only related to kidney cancer surgery.

A representative of Healthwatch Redbridge was unhappy with the current engagement arrangements and NHS officers confirmed they were happy to discuss this. NHS England had also confirmed that they were committed to a period of formal engagement once the clinical preferred option had been established.

It was planned that a summary of the feedback received would be presented to the Chairmen of the JOSCs for ONEL, INEL and North Central London at a meeting to be held in the week commencing 9 December. This meeting would also seek to establish which, if any, of the proposals the JOSCs felt required formal consultation.

The Committee discussed the proposals and felt overall that, whilst there were some significant changes, that a formal consultation process was unlikely to be necessary. Members did feel that there should have been more public engagement and that much of the data and information requested would need to be provided by NHS officers before a final decision on whether consultation would be necessary could be taken.

It was **AGREED** that an item be taken at the next meeting giving an update on the position with the cancer and cardiovascular services proposals.

Chairman

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