

# Public Document Pack

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## Notice of Meeting

### Inner North East London Joint Health Overview & Scrutiny Committee (INEL JHOSC)

**7.00 pm on Wednesday 20 November 2013**

**Venue:** London Borough of Hackney, Room 3, Assembly Hall,  
Hackney Town Hall, Mare Street, London E8 1EA

**Map here:** <http://www.hackney.gov.uk/Assets/Documents/hackney-council-buildings-map.pdf>

**Issue date:** 12<sup>th</sup> November 2013

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## Public Agenda

- 1. Welcome and Introductions**
- 2. Membership of the Committee - attached**
- 3. Apologies for absence and announcement of substitutes**
- 4. Declarations of Interest**

*Any Member of the Committee, or any other Member present in the meeting room, having any personal or prejudicial interest in any item before the meeting is reminded to make the appropriate oral declaration at the start of proceedings. At meetings where the public are allowed to be in attendance and with permission speak, any Member with a prejudicial interest may also make representations, answer questions or give evidence but must then withdraw from the meeting room before the matter is discussed and before any vote is taken.*

- 5. Minutes of the previous meeting**
- 6. Actions and matters arising from the previous meeting**
- 7. Barts Health NHS Trust - Report on financial turnaround**
- 8. Improving specialist cancer and cardiovascular services in north and east London and west Essex - Consultation on case for change**
- 9. Any other business**

*[Each written report on the public part of the Agenda as detailed above:]*

- (i) *was made available for public inspection from the date of the Agenda;*
- (ii) *incorporates a list of the background papers which (i) disclose any facts or matters on which that report, or any important part of it, is based; and (ii) have been relied upon to a material extent in preparing it. (Relevant documents which contain confidential or exempt information are not listed.); and*
- (iii) *may, with the consent of the Chair and subject to specified reasons, be supported at the meeting by way of oral statement or further written report in the event of special circumstances arising after the despatch of the Agenda.]*

***Exclusion of the Press and Public***

*There are no matters scheduled to be discussed at this meeting that would appear to disclose confidential or exempt information under the provisions Schedule 12A of the Local Government (Access to Information) Act 1985.*

Should any such matters arise during the course of discussion of the above items or should the Chair agree to discuss any other such matters on the grounds of urgency, the Committee will wish to resolve to exclude the press and public by virtue of the private nature of the business to be transacted.

**INNER NORTH EAST LONDON JOINT HEALTH OVERVIEW & SCRUTINY  
COMMITTEE 2013/2014**

**PARTICIPATING AUTHORITIES**

<b>Authority</b>	<b>Appointed Member</b>
City of London Corporation	Common Councilman Wendy Mead
London Borough of Hackney	Cllr Luke Akehurst
	Cllr Ann Munn
	Cllr Benzion Papier
London Borough of Newham	Cllr Terence Paul
	Cllr Ted Sparrowhawk
	Cllr Winston Vaughan
London Borough of Tower Hamlets	Cllr Dr Emma Jones
	Cllr Rachael Saunders
	Cllr Lesley Pavitt

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<b>Inner North East London Joint Health Overview and Scrutiny Committee</b>  20 November 2013  <b>Minutes of the previous meeting</b>	Item No  <b>5</b>
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### **Outline**

Attached are the draft minutes for the previous meeting of INEL JHOSC held on 29 May 2013.

### **Action**

The Committee is requested to agree the minutes and note any matters arising.

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**MINUTES OF A MEETING OF THE INNER NORTH EAST LONDON JOINT  
OVERVIEW AND SCRUTINY COMMITTEE FOR HEALTH**

**WEDNESDAY, 29TH MAY 2013 AT 7.00 PM  
OLD TOWN HALL, STRATFORD**

<b>Members Present:</b>	Councillor Winston Vaughan (Chair), Councillor Luke Akehurst (Vice Chair), Common Councilman Wendy Mead, Councillor Ann Munn, Councillor Lesley Pavitt and Councillor Ted Sparrowhawk
<b>Member Apologies:</b>	Councillor Terence Paul, Councillor Dr Emma Jones, Cllr Rachel Saunders
<b>Officers in Attendance:</b>	Tahir Alam (Strategy Policy and Performance Officer, LB Tower Hamlets), Hafsha Ali (Head of Scrutiny, LB Newham), Sarah Barr (Senior Strategy, Policy and Performance Officer, LB Tower Hamlets), Luke Byron-Davies (Scrutiny Manager, LB Newham and Jarlath O'Connell (Overview and Scrutiny Officer, LB Hackney)
<b>Also in Attendance:</b>	Judith Bottriell (Head of Governance Standards and Risk Management, Barts Health NHS Trust), Councillor Leanora Cameron (LB Newham), Dr Clare Dollery (Deputy Medical Director, Barts Health NHS Trust), Mark Graver (Head of Stakeholder Relations and Engagement (Barts Health NHS Trust), Councillor Wendy Mitchell (LB Hackney), Peter Morris (Chief Executive, Barts Health NHS Trust), Councillor Nicholas Russell (LB Waltham Forest) and Michael Vidal (Hackney resident)

**1 Welcome and Introductions**

- 1.1 The Chair welcomed everyone to the meeting and stated it had been convened to jointly consider the draft Quality Accounts for Barts Health NHS Trust. This was the first year this matter had been considered by the JHOSC as it had been agreed amongst Members that because activities of the newly merged Trust crossed the four borough boundaries as well as neighbouring Waltham Forest, that it would be appropriate to consider the Quality Accounts jointly.

**2 Membership of the Committee**

- 2.1 The Committee noted the updated Membership list for Inner North East London Joint Health Overview and Scrutiny Committee. It was noted that Common Councilman Mead had replaced Common Councilman Littlechild from the City of London.

### **3 Apologies for Absence**

- 3.1 Apologies for absence were received from Cllrs Saunders and Jones from Tower Hamlets and Cllr Paul from Newham.
- 3.2 An apology for absence was also received from Cllr Hayhurst, a member of Health in Hackney Scrutiny Commission.
- 3.3 The Chair stated that he had received an apology also from Cllr Khewyn Limbajee, the Chair of Waltham Forest Council's Health Scrutiny Committee who had been invited to attend as an observer.

### **4 Minutes of the previous meeting**

- 5.1 The Committee gave consideration to the minutes of the meeting held on 30 April 2013.

<b>RESOLVED:</b>	<p><b>The minutes of the meeting of the Committee held on 30 April 2013 were agreed as a correct record subject to the following amendment:</b></p> <p><b>- top of page 4 - the 'Q' and 'A' indicating 'question' and 'answer' were in the wrong order for the first two questions.</b></p>
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### **5 Declarations of Interest**

- 4.1 There were none.

### **6 Actions and matters arising from the meeting on 30 April 2013**

- 6.1 The Chair reported that following the previous meeting of INEL JHOSC on 30 April on London Cancer's case for change on the provision of urological cancer services, he had written to NHS North and East London Commissioning Support Unit summarising the key points from the meeting and suggesting that the NHS officers come back to the Committee in six months on the actions they would be taking in particular to mitigate the transport issues. It was suggested that as Outer North East London's JHOSC (ONEL JHOSC) had similar issues that a briefing to both committees meeting jointly in Oct-Nov would be best. Officers would liaise with their counterparts in ONEL JHOSC to set this up with the London Cancer representatives and INEL Members would be informed.

<b>ACTION:</b>	<b>INEL support officer to liaise with ONEL officer on a date on which to invite London Cancer and NHS NEL CSU back to provide an update on the implementation of the urological cancer service changes.</b>
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**7 Barts Health Trust Quality Accounts 2012/13**

- 7.1 The Chair welcomed the following senior officers from Barts Health NHS Trust to the meeting:

Mr Peter Morris, Chief Executive

Dr Clare Dollery, Deputy Medical Director

Judith Bottriell, Head of Governance Standards and Risk Management

Mark Graver, Head of Stakeholder Relations and Engagement

and Members gave consideration to the Barts Health NHS Trust Draft *Quality Accounts for the period 1 April 2012 to 31 March 2013*.

- 7.2 In introducing the Quality Accounts Mr Morris stated that the newly merged Trust was entering its second year and in the first six months it had successfully collapsed the governance arrangement for the three legacy Trusts and created a single governance structure across the new organisation. Six new Clinical Advisory Groups had been created across the organisation with advanced leadership in place. They had taken down the site based arrangements and replaced them with the new structure. Quick progress had been made in the first year with 38 new clinical directors and 5 clinical service lines set up across the organisation and he suggested that the new organisation had now turned a corner and they could be satisfied with the level of progress made in just one year.
- 7.3 There were two areas of under-performance - on A&E and on Urgent Care and they had channelled activity towards addressing these. In terms of finances, the Trust would end the year with a small surplus (subject to audit) and this was an achievement considering that the consolidation of three trusts into one had represented the biggest NHS merger in the country.
- 7.4 In terms of priorities for the coming year they needed to attend to the long term financial stability of the Trust. Progress in the second year would be extremely challenging with c. 4% of non recurrent funding to be made up and the need to wean the organisation off this element of funding and put it on a more secure footing. This would create a steep uphill curve for the organisation in its aims to achieve financial balance. In the first quarter there had been a 50% increase in the savings target for example so a period of catching up would be necessary. Post the Francis Report there was a lot of work to be done around the issues of values and behaviours and the kind of culture the Trust needed to engender. The Trust was also having to handle important changes on the London scene with significant changes on the provision of services for cardiovascular disease, cancer and intensive care coming downstream. The Trust was submitting bids on provision of lung and gastric cancer surgery in a reconfigured system and they were applying for Out of Hours surgery provision in Newham. He concluded that the Board was functioning well and the organisation now had to create the right relationships and not act as an independent entity doing its own thing.

**Questions and answers**

- 7.5 **The Chair opened the questioning by asking the officers if they could outline what in their view are the three best and the three worst performing areas in the Trust.**
- 7.6 Ms Bottriell replied that in terms of the standard national surveys the Trust had been performing consistently well. They had performed well on the amount of shared sleeping areas and bathroom and shower facilities. They also performed well on communications with GPs and on the sharing of referral letters. In terms of areas which needed improvement - food service and nutrition required more attention with less patients satisfied with the quality of food and not getting sufficient help with feeding and the CQC had picked up on this in their inspection of Mile End Hospital. To respond to this they had put in place an Older Peoples Improvement Programme and nutrition was a key part of that. There had been some disappointing results also on clinical teams and around nursing but a lot was being done to improve these systems.
- 7.7 Mr Morris added that the Trust needed to rapidly improve on its handling of complaints and on the connections between Complaints and the local management teams. They also had to improve the administration of the appointment bookings system and on the issue of making people feel that Barts was a caring organisation. They had had excellent performance reports and the areas where there was room for improvement outlined by the CQC were taken very seriously. He stated he was encouraged this year that the levels of activity from the CQC. The Trust received regular external assurance and it needed to be pointed out the CQC had had no major concerns.
- 7.8 **Cllr Pavitt described the experience of a friend in the Royal London who had received no assistance with feeding and food had been left on trays five days running. The senior managements attention to these issues did not seem to be filtering down to the Health Care Assistance and she was concerned that the report did not make clear how the performance issues which were being raised were disseminated down to the wards.**
- 7.9 Ms Bottriell replied that this was an important point. The issue with the Quality Accounts Report however was that a high level overview was required but she agreed that Health Care Assistants and Matrons were vital in implementing these actions. On this specific point: trays had to be checked more frequently and these issues should also be brought up at Clinical Fridays, where all senior managers in the hospitals go "back to the floor". Nutrition was audited as part of a rolling programme so they understood which wards were not doing well.
- 7.10 **With reference to p.45 of the accounts and the NHS National In-patient Survey Results , Cllr Munn asked whose expectation was this?**
- 7.11 Ms Bottriell replied that it was the Commission for Quality Improvement Scheme CQIN and this was a national Department of Health improvement area. Statistically it was a crude measure but they had to report on it she added.
- 7.12 **Cllr Munn commented that the problem with this diagram was that it was difficult to work out where Barts stood and where it needed to get to.**

- 7.13 Mr Bottriell agreed that there needed to be a baseline added to this chart and targets had to be set individually. It was demonstrating a 5% improvement but she agreed that this chart needed to be made easier to understand.
- 7.14 Cllr Akehurst stated in relation to the Patient Experience CQUIN results on page 45 that if these figures were reversed they would be quite frightening i.e. more than half those surveyed did not find someone on the hospital staff to talk to about their worries and fears. Also, nearly 60% stated that a member of staff had not told them about the side effects of their medication and what to watch out for when they went home. He asked what was being done to address these. These indicators were very important he added because they shaped the patients perception of the hospital in a profound way.
- 7.15 Ms Bottriell replied that they ensured that every patient was treated with empathy. She cautioned that this particular survey had had a small sample size of less than 300 people. These indicators were measured more widely and a one-off survey once a year should not be relied on on its own. Dr Dollery added that they had also initiated a Discharge Booklet for patients.
- 7.16 Cllr Mitchell asked whether there were other sources of data that the Committee should be aware of if this survey had a small sample size and was therefore not sufficiently reliable.
- 7.17 Mr Morris explained that these small surveys were run to test the temperature as it were in certain specific areas but that more broadly there are a wide variety of different methods used to collect patients views. Ms Bottriell added that they would start to standardise the data here and improve the matrices used. They had focused in this part of the report on a high level survey but also added some local data as well. Mr Morris added that what was important was the degree of leadership provided, the prevailing climate and the ensuring that the organisations values were about listening and acting on concerns raised. They were doing some work on leadership and specifically on the leadership at ward level and a key focus was getting feedback and ensuring issues were acted on.
- 7.18 Cllr Sparrowhawk raised a concern about people he knew who had received appointments at three different Barts Trust hospitals on the same day and asked what was being done to sort this out. Transport remained a key problem for the elderly and the vulnerable he added.
- 7.19 Cllr Pavitt took issue with the rules about carers attending appointments and stated that in cases where elderly people had memory loss or dementia it was critical that they had their carer with them at all times.
- 7.20 Mr Morris replied that Barts did not excel on out-patients experience and in particular on bookings, appointments and the issuing of appointment letters. This problem was compounded by having three different information systems across the three legacy Trusts and it would be corrected carefully over the next few years. On the issue of transport there was a more positive story to tell and improvements were being made.

- 7.21 With reference to the chart on the number of serious incidents, Cllr Russell (Health Scrutiny Member from Waltham Forest Council) asked what was being done to address the high number of incidents in Whipps Cross Hospital. In addition he asked what work was being done on the treatment of learning disabled and learning disabled children and their carers. Finally, he stated that prior to the merger Whipps Cross had had a Disabled Patients Forum but this had been disbanded and he asked if this could be re-instated.
- 7.22 Dr Dollery replied that a lot of effort was being put into addressing the important issue of serious incidents with a clear focus being put on prevention. If systems were in place early enough there would be a significant reduction in these. In relation to patient representatives there would be a patient representative on all the Clinical Academic Groups (CAGs) but not all had been recruited yet. In relation to the group at Whipps Cross she stated that it was of course important to learn from the patient involvement arrangements at Whipps Cross and they would look to re-instate the Disability Consultative Group. Mr Morris thanked Cllr Russell for these detailed questions and undertook to take these issues back.
- 7.23 Cllr Sparrowhawk asked how the hospital would go about choosing the patient representative on the Disabled Patients Group. He commented that many patient representatives were self selecting and did not provide enough challenge.
- 7.24 Dr Dollery replied that all the new CAGs were in the process of recruiting people
- 7.25 With reference to the serious incidents chart on page 29, Cllr Pavitt stated that it was difficult to read the comparisons in the chart as it needed more information on scale and the rate of incidents per day.
- 7.26 Ms Bottriell replied that if you looked at the complexity of the patient pathway it was difficult to present this information simply. For example a trauma department will have a higher risk of incidents so it is difficult to compare and there are also other factors at play. The numbers of serious incidents tell you very little e.g serious incidents in maternity wards are represented as SI's yet these are a natural consequence. It was important to understand that there were a number of factors at play.
- 7.27 Cllr Munn stated that a lot of context was missing from these charts and that a more accurate description of the situation being described would have been preferable.
- 7.28 Mr Morris replied that Barts Health Trust did need to look more closely at how to represent the differences of scale in the charts presented.
- 7.29 Cllr Munn asked what has the impact of the merger been on staff from hospital ward level upwards.
- 7.30 Dr Dollery replied that there were stresses involved but there was an extensive programme of briefings going on and senior staff were going out into the wards.

Progress was being made on the quality of staff appraisals and they had also introduced for example a 'Barts Heroes' award for staff.

- 7.31 **Cllr Munn asked if the staff could easily raise issues on an ad hoc basis and how can you measure the effectiveness of this.**
- 7.32 Mr Morris commented that the best way for senior management find out about issues by simply asking people questions. It is important then to move on issues locally. The Trust was routinely surveying 2000 people within the organisation each month. He stated that every Friday he was out on the wards and the non-exec Board members were also frequently seen on walkabouts. One of the issues he picked up for example was the perception at Whipps Cross that decisions seemed to be taken elsewhere. A lot of listening goes on and it was also interesting he added that the issues which most occupy staff were not the merger per se but issues of perhaps a more prosaic nature such as it taking longer to organise a recruitment panel or to replace a tv set in a ward. Ms Bottriell added that each site had a Professional Nurse Lead so that staff would always have access to her and there was still local ownership of issues. Mr Morris added that staff capacity had improved greatly for example one year previously Whipps Cross had 3 consultants and 1 locum in post and now they had 8 and this was in part because of the benefit of the Barts Health brand.
- 7.33 **Cllr Sparrowhawk followed on from Mr Morris' comments on Friday walkabouts that it was mentioned in the news that the weekend was the worst time to have an operation, considering the reduced staffing available in hospitals at weekends**
- 7.34 Mr Morris commented that the Trust should be operating 24/7 but they did have systems in place to ensure that proper care was provided during off-peak times
- 7.35 **Cllr Sparrowhawk asked how the Barts structure encouraged a culture of feedback to ensure that any poor practice was identified at an early stage.**
- 7.36 Mr Morris replied that staff were continually reminded of their professional obligations to report any shortcomings. He added that the Trust had a robust process of risk assessment in place and they were paying particular attention to ensure that staff could always report issues. The key message to staff was "when in doubt escalate".
- 7.37 **Cllr Pavitt again expressed concern that these messages didn't get through to ward staff. She detailed a case of an individual who for medical reasons needed three pillows instead of one and yet it had been difficult to even get this escalated.**
- 7.38 Ms Bottriell commented that in the light of the Francis Inquiry it was important that that situation was not replicated where everybody knew about the problems but nobody took ownership.
- 7.39 **Common Councilman Mead stated that the Committee had just been through a scrutiny of the changes to urological cancer services and had asked a number of searching questions. She asked why Barts Health had missed out on its two bids to take on these consolidated services.**

- 7.40 Mr Morris clarified that they hadn't put in for bladder and prostate cancer surgery but had contested for renal and had missed out on a good bid made by the Royal Free Hospital. There were a number of bidding opportunities in the pipeline and they intended to bid for oesophagus, stomach and lung cancer surgery. They would be competing with UCH on these tumour groups and they were working to put the best possible service forward. Outside of cancer, they were also bidding for future opportunities relating to thoracic and chest surgery.
- 7.41 **Cllr Akehurst asked (a) how had the merger facilitated the principle of "localise where possible, centralise where necessary" (b) what was the Trust doing to mitigate against the lessons learned from other large hospital mergers and (c) the Quality Accounts were historical but how would this evidence base be used to make sure that the needs of the population were being met.**
- 7.42 In relation to (a) Mr Morris replied that this principle was firmly embedded in the approach of the CAGs in formulating their strategies. There was an element of both at play. Some provision had moved out of teaching hospitals and some had moved in. They needed to be evidencing both the quality improvements and economic gains to be had from centralising. He added that one area being explored to override geographical considerations was the use of Skype clinics when they were appropriate. Newham for example had 85% broadband coverage and this area had potential.
- 7.43 In relation to (b) he stated that some large mergers had been a success: Sheffield, Newcastle, Central Manchester but in other mergers many trusts had got very lost in the first two years. They learned the lessons from the South London Trust who had taken an extraordinary amount of time to even get their new Board in place. The key elements were Leadership, Culture and Engagement and the Trust had got a clear strategy in place and alignment of activity both inside and outside the trust. They learned much from the Sheffield, Greater Manchester and in London the Imperial mergers. Dr Dollery added that they had secured specialist advice from experts and Imperial had sent over their patient safety people to oversee their changeover plans. Ms Bottriell added that on centralisation they had worked hard on a due diligence approach and they had known that processes had to be embedded quickly. They had quickly engaged with the CQC and they had got a centralised team in place quickly so they were ready to go on Day One. Mr Morris added that they had learned from other mergers how quickly other system degraded after day one if the organisation was not in strong position to begin with. The difficulties around integrating information did have an impact on the frontline and they would pay rather more attention to back office integration.
- 7.44 **In relation to CQC inspections the Chair asked why they only mentioned certain outcomes and how many outcomes would the CQC look at. The report listed 4 for Newham and 6 or 7 for Mile End.**
- 7.45 Mr Morris replied that they were not chosen by the Trust they were chosen by the CQC. The CQC does unannounced inspections and generally look at 4 or 5 outcomes, they just turn up and arrive on a ward so the first person they might see could be a Healthcare Support Worker. There had been a complete change in how the CQC carried out inspections and how the Trust reacted to

them and it was impossible to prepare staff. The CQC met doctors, nurses and patients and what they fed back was what they found on that day. It was important to note however that they had never had any grave concerns arising from any of their visits to the Trust's sites.

- 7.46 The Chair stated that Barts was 9<sup>th</sup> in the country on the Standard Mortality Indicator but it was also now the largest trust and suggested therefore that being 9<sup>th</sup> wasn't good enough.
- 7.47 Dr Dollery replied that it was her aspiration of course to get to no. 1. In relation to Cllr Akehurst's question (c) Ms Bottriell added that the Trust has clearly indicated where there were shortcomings and they knew the areas where they needed to improve. Using better integrated data systems and better performance data systems would help and an example of this was the new 'Integrated Performance Dashboard' which tracked all areas of poor performance in a consistent fashion. The Quality Assurance Sub Committee of the Board has identified 6 quality priorities and would track the progress of all these closely in the year ahead.
- 7.48 Cllr Russell asked if senior staff on the 'back to the floor' walkabout days also visited outpatients departments.
- 7.49 Mr Morris replied that they did.
- 7.50 Cllr Russell asked what was being done to improve transfer of care and in particular what was being done to assist patients who may have psychological crises.
- 7.51 Mr Morris replied that the issue of how to manage care closer to home was a very big topic for the Trust now. They also had a good relationship with the local Mental Health trusts in each area and had agreed to prioritise this issue at a board level conversation between the Trusts and they would be pleased to come back with more specifics on this following that meeting. Mr Graver added that in the three emergency departments they ran they reviewed patient cases and attendances and in particular at the issue of patients arriving at A&E who might have mental health support needs. Work was ongoing with the ELFT and NELFT (the relevant mental health trusts) on this. Mr Morris added that there was a System Group set up on integrated care and it would be good to have a collective account of this.
- 7.52 Mr Vidal, a Hackney resident, asked in relation to CQC outcome 13 and 14 in the board papers and the specific reference to the point that the Trust was 15% under its staff complement.
- 7.53 Mr Morris replied that they were far too reliant on bank and agency nurses and doctors in certain areas and they certainly aimed to employ more permanent staff and he wished to give this a higher priority. Dr Dollery added that the challenge if you had agency staff was that they often didn't have computer log-ins quickly enough and so they were not able to immediately function at the highest level required consistent with modern medical practice.
- 7.54 The Chair summed up by stating that he had found many good things in the Report and it was good to see positive signs of improvement. The report had

**Wednesday, 29th May, 2013**

been written in business language and so at times it had been difficult to decipher and this should be attended to. There were some areas where they would provide some additional feedback he added.

- 7.55 Mr Graver stated that because of the Department of Health deadlines they were subject to on this they would need the response letter from the Chair by 5 June for submission with the Quality Accounts. It was noted that the minutes of this meeting would also be submitted in due course.
- 7.56 The Chair replied that this could be done but where there were outstanding issues which Members wanted to go into in more detail, then this would best be achieved in the individual Health Scrutiny Committees.
- 7.57 The Chair thanked Mr Morris and the officers for taking the time to attend and answer the Members' questions.

<b>RESOLVED</b>	<b>That the draft Quality Accounts and the discussion be noted.</b>
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<b>ACTION:</b>	<b>Chair to submit to Barts Health NHS Trust by 5 June a formal response from the Committee on the Quality Accounts.</b>
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## **8 Any other business**

- 8.1 There was none.

**Duration of the meeting:** 7.00 - 9.00 pm

**Signed**

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**Chair of Committee**

**Contact:**

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<b>Inner North East London Joint Health Overview and Scrutiny Committee</b>  20 November 2013  <b>Barts Health NHS Trust – report on financial turnaround</b>	Item No  <b>7</b>
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### **Outline**

At the previous meeting of INEL JHOSC on 29 May the Committee considered the draft Quality Accounts for Barts Health NHS Trust.

Since then the Trust has put itself in financial turnaround and the Chief Executive of the Trust has been invited by the Committee to present a briefing on the current situation.

Attached please find

- a) Briefing note from Barts Health NHS Trust
- b) Presentation from Peter Morris, Chief Executive
- c) Briefing on Barts Health Workforce consultation

Attending the meeting to answer Members' questions will be:

- Peter Morris, Chief Executive
- Mark Cubbon, Director of Delivery

### **Action**

The Committee is requested to give consideration to the briefings.

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## **Our cost improvement programme**

### **Briefing for Inner North East London Joint Health Overview and Scrutiny Committee**

**20 November 2013**

#### **Background**

In the current economic climate, each NHS trust is expected to deliver national productivity and efficiency gains. The national tariff, which determines the amount trusts are paid for individual treatments and procedures, has been reduced centrally by 4% in 2013/14. As the largest NHS trust in the country, this requirement equates to £50m per year for Barts Health. In addition, we have a further local target of £28m on top of this as we received transitional funding following our merger, and we have also experienced some reductions in education funding.

Last year, we achieved financial balance, but benefitted from £50m funding support. That short-term arrangement falls away over a two year period. Therefore, this year and next year our savings programme has been set at a higher level to ensure that the Trust operates without relying on this additional support.

Additionally, in 2012/13, income from our local commissioners was fixed. It was not based on the amount of attendances, admissions and treatments we provided – the 'Payment by Results' system - which normally applies to trusts in the NHS in England. For 2013/14, we have moved to Payment by Results, and this requires significant changes in our processes, so that we are paid in full for the work we do and we avoid financial penalties that are inherent in this type of contract.

Overall, we need to improve standards of care, efficiency and our financial position by:

- Maximising income and minimising financial penalties under our Payment by Results contract
- Achieving financial balance and reducing our current underlying financial deficit
- Standardising our staffing structures in clinical services to provide clear lines of command and supervision and a strong focus on quality and safety, and to do so equally across all our sites and services
- Maximising the benefits and opportunities our merger brings us, including:
  - Better, more joined up patient pathways which mean patients can be seen quicker and we waste less time and resources
  - Identifying and removing duplication and inefficient ways of working
  - Getting better value for money from suppliers through reviewing and revising existing contracts and identifying opportunities for new ways of procuring goods and services
- Consistently meeting NHS performance targets, including the key national targets covering emergency care access, the 18-week referral-to-treatment standard for routine care and rapid access to cancer care, all of which are making a real difference to the quality and timeliness of the care that patients receive across the NHS in England

We have already made a clear commitment to stay true to the values that our Board and the Trust have committed to, and to our mission to change lives in east London through delivering excellent healthcare, reducing inequalities and improving health in our local

communities. These commitments are not changed or reduced by the need for us to improve efficiency, quite the reverse.

### **Our turnaround programme**

In July, Barts Health NHS Trust decided to move into a period of financial turnaround to accelerate the development and delivery of safe cost savings and productivity improvements. It is a whole organisation effort to improve the robustness and pace in the development and delivery of safe cost improvements, whilst never losing focus on quality.

Turnaround is not the whole story. It is the first part of a three-year plan to get us to a sustainable long term financial position. This year, we are concentrating on stabilising the organisation's finances, by ensuring that we take out un-necessary costs, maximise income under our new Payment by Results contract and make these changes at a pace which will allow us to meet and exceed our savings targets for the year. In 2014/15, the focus will be on reducing and eliminating our underlying financial deficit, so that in 2015/16 we can post a financial surplus.

Turnaround has not been imposed upon Barts Health. We have chosen to take this approach to enable the extra focused attention that is required to ensure we meet our organisational goals. Executed well, turnaround will enable Barts Health to be a stronger, more effective organisation, with a better capability to effect change at pace.

### **How efficiency schemes can improve patient care and standards**

Being efficient is not all about money - it is also about making sure our systems and processes are fit for purpose. All too often, we hear frustrations from patients, carers and our staff around problems with simple things like booking appointments and receiving confirmation letters.

As a new organisation which was formed less than two years ago, we are still going through a process of streamlining and standardising the way we do things across all our services and hospitals. At the moment, there are areas where we still have three or more different ways of doing the same things, based on the arrangements which were in place in the three legacy organisations that came together to form Barts Health.

We have a range of key workstreams, all of which are closely tied to improving service quality as well as efficiency.

<b>Area</b>	<b>Focus</b>
Operating theatres	Improving theatre utilisation time, so that more procedures can be carried out each day
Length of stay	Reducing length of stay in line with recognised clinical best practice, where it is safe to do so
Pharmacy	Using the most appropriate drugs for each patient and realising cost benefits from stronger buying powers
Diagnostics	Ensuring each patient is booked for the appropriate tests for their needs, and that un-necessary tests are not routinely booked
Corporate back office	Reviewing and renegotiating contracts and reviewing working practices to improve delivery and efficiency
Estates and Facilities	Reviewing soft service provision and ensuring contracts are running correctly, eg cleaning at Whipps Cross
Demand and capacity reviews	Making sure we have the appropriate resources in place for each service and clinical speciality
Eliminating fines	Ensuring we perform within our contract and that our

	coding and monitoring processes are fit for purpose. Meeting all CQUINs
Income	Identifying and planning to generate additional opportunities for income not currently being realised
Workforce	Making sure our structures are fit for purpose, including rotas and leadership arrangements
Variable pay	Reducing and eliminating agency staffing, and reviewing our own staff bank arrangements

Within these workstreams are a range of around 1,280 individual cost improvement programmes (CIPs). Robust processes are in place to:

- Assess all schemes for impact on patient safety and service quality
- Assess all schemes for risk of non-delivery
- Assure the development and assessment of schemes through a project management office
- Ensure there is ongoing monitoring of all CIPs via an agreed quality impact assessment

When considering where improvements can be made, our clinical and corporate teams ask four standard questions:

- Is the service working to national best practice?
- Can the team/service be more efficient?
- What can we do to improve the patient experience?
- Are we spending our budgets wisely?

### Where we have already saved money and improved care

Changing how we buy replacement hip and knee joints
<b>Issue</b> - Barts Health is a major provider of joint replacement surgery, carrying out nearly 1,000 such procedures a year. We were paying over £2million a year for replacement joints whilst existing contracts that had been in place before our merger continued.
<b>What we did</b> - Our procurement team analysed the existing contracts and proposed best value options for the orthopaedic department to consider. Following a competitive tender process, suppliers were keen to negotiate a good deal in order to work with us.
<b>How we did it and ensured safety and quality</b> - Changing a surgical implant can be difficult, as each product requires a specific set of skills and many surgeons are trained and comfortable with a specific brand of implant. Therefore, the decision to change supplier needed to be clinically led. We set up a group to evaluate the options, and our orthopaedic teams reviewed clinical best practice guidance and research to make sure that the decision to change supplier was clinically based and would maintain high standards of quality.
<b>What we achieved</b> - a saving of over £800,000 that can be re-invested into patient care.

Effective use of medicines brought from home – Newham University Hospital
<b>Issue</b> - Patients are always encouraged to bring their own medicines into hospital so that we have an accurate drug history for them. Traditionally, these drugs have then been disposed of or sent back home with a family member rather than staying with the patient for them to use during their stay. With a greater national emphasis on how patient medicines brought from home are managed in hospitals, it was essential that we reviewed our practices to provide the best care, improve patient safety and reduce wastage.
<b>What we did</b> – Our pharmacy team worked with other trusts who had introduced medicines management technicians to understand best practice. We then ran a pilot on one ward to

better understand how to introduce the role, whether it would make a difference for patients and what processes needed to be in place to make it work effectively. Following a successful pilot, the pharmacy team prepared a business case for rolling out the medicines management technicians throughout the hospital.

**How we did it and ensured safety and quality** - The team of pharmacy medicines management technicians check the medicines that patients bring with them to the hospital to ensure that they are labelled correctly and still appropriate for the patient to use. This helps to promote patient safety by ensuring they continue with their current medications and are not given multiple or conflicting medicines. Previously, patients may have had a set of medicines at home, but were then discharged from hospital with another set which increased the risk of overdose, duplication in therapy and continuation of a medication stopped in hospital. It also reduces wastage as we no longer need to provide a new or additional supply of the same medication.

**What we achieved** – Improved patient safety and care, whilst also saving £124,000 over the last year. Members of our own existing pharmacy team were trained as accredited medicines management technicians, therefore gaining further career development opportunities.

### Improving the pathway for colorectal patients

**Issue** - We are a major provider of colorectal surgery and care. Our colorectal outpatients' clinics were not functioning effectively and were often overbooked, meaning that patients were either seen much later than their allotted time or had their appointment put back. The poor management of clinics was impacting on our ability to treat patients within the 18 week standard, led to a higher level of complaints and required us to book additional clinics which had a financial impact.

**What we did** – The Colorectal Service at Barts Health is one of the services participating in the productive outpatients' programme, a transformational initiative supported by colleagues at University College London Hospitals NHS Foundation Trust. We established a core project team of clinicians and managers supported by the programme coach. This team reviewed colorectal clinics and ways to improve patient and staff experience from the point of referral right through to the clinic day through more streamlined administration and booking processes and improving the efficiency of clinics. The project team was provided with training and received support from programme coaches to enable them to drive change and improvements. The team then gathered and analysed data about the clinics, mapped the current pathway, interviewed patients, analysed the reasons why patients failed to attend appointments and audited clinic waiting times and the time patients spent with doctors. Their findings were presented to a wider group of staff who were able to identify a number of areas where the pathway and processes could be improved. The project team then developed a new model of working.

**How we did it and ensured safety and quality** - The new pathway provides patients with an initial appointment where all tests and treatment are discussed and put into motion allowing treatment and any follow up to be undertaken much quicker. All referrals are now vetted by a consultant before booked, speeding up the process and allowing any non-specialist cases to be directed to the most appropriate service for that patient's needs.

We are also introducing best practice ways of working from other trusts, including piloting a one stop clinic at Whipps Cross Hospital that will allow us to manage referrals within just two weeks. We are continuing to look at best practice and how we can redesign our pathways to provide the most effective services, reducing unnecessary work for staff and improving the patient experience.

**What we achieved** – We are reducing waiting times from up to six months to no more than

six weeks, improving the patient experience and making better use of staff time.

## Other improvement examples

### Theatres

- Reduced average late starts by between 40% and 80%
- Improved utilisation on all sites by up to 20%
- Appointed delivery managers for each of our three main theatre suites (Newham, Royal London and Whipps Cross)
- Working to standardise scheduling processes across the Trust and increase cross-site working, for example by offering empty theatre slots on one site to teams from another

### Clinical coding – ensuring we are paid in full for all the work we do

- Improved coding processes and procedures, particularly in outpatients, bringing in around £5m a year of additional income
- Appointing an additional 12 coding staff
- Siting coding staff within CAG teams to improve coding in real time

### SwapShop scheme

- Set up an online system to allow staff to advertise any unwanted office equipment and furniture
- Managers can then order from this pool rather than buying in new equipment

### Energy efficiency

- Introduced Operation TLC (turn off, lights off and close doors) campaign to encourage staff to take these three simple steps to reduce energy usage and to improve patient and staff environments
- Research from the Clinical Research Centre shows that one in three patients experience better privacy and one in four patients experience less disturbed sleep in wards that have been taking the Operation TLC actions
- Since January 2013, we are saving £100,000 a year in energy bills and avoiding 800 tonnes of carbon dioxide, as well as creating a better healing environment for our patients
- The scheme picked up the Energy Efficiencies award at this year's HSJ (Health Service Journal) Efficiency Awards

### More information

The appended slide pack includes more detail on our cost improvement processes, in particular how schemes are assessed and monitored for impact on patient safety and service quality.

For more information on our cost improvement programmes or any aspect of Barts Health's operations, please contact a member of our communications team:

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# Barts Health 2013-14 cost improvement programme

Update for Inner North East London  
Joint Health Overview and Scrutiny Committee

20 November 2013



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  8. Process for assessing CIP impact
  9. Next steps



# **1. Objective of our turnaround programme**

To sustain or improve the quality of patient care, increase the speed of delivery, whilst improving efficiencies and reducing costs so that we are able to live within our annual budgets and meet our operating commitments.

## **Our mission and values**

To be clear - we are not altering our mission. This is to change lives in east London through delivering excellent healthcare, reducing health inequalities and improving health in our local populations. To be just as clear - we will stay true to the values that the board and the organisation have committed to.

**There is no room for deviation from our mission or our values**



## 2. Barts Health Care Campaign

#becausewecare

- We need to radically improve the quality and safety of our services in order to improve community confidence and trust in Barts Health
  - The care campaign is our opportunity to relentlessly focus on our patients' best interests, to keep patients safe and to create a climate of care where:
    - saying "that's wrong" is right (openness, transparency and candour)
    - we relentlessly pursue excellence in care (fundamental standards and beyond)
    - working together is the norm
    - learning is at the centre of all we do
    - compassionate, caring and committed nurses, midwives and AHPs is the norm
    - we develop our leaders and support them to be focused on the right things
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## 2. Barts Health Care Campaign

#becausewecare

### Our objectives

Best Leadership

Environment/cleanliness

Complaints matter

Accreditation

Upholding our values

Safety first – deteriorating patients

Eliminating falls and pressure ulcers

Welcoming and listening to patient and staff feedback

Everyone matters – team meetings, appraisal and supervision

Caring with compassion

Assurance – check outcomes and drive improvements

Risks are well managed

Economical – cost effectiveness and productivity



# 3. CIP Assurance: Patient Safety & Quality

A

## Quality Assurance & Independent Panels

What is the process for approving schemes? How is the Independent Panel process working?

B

## Letters of representation & Clinical sign-off

What are they, and what was the process for clinical sign-off?

C

## CSUs and CCG' – assurance

What assurance is required?

D

## Risks, Quality & KPI's for CIPs: Linking to our performance & on-going assurance

How will KPIs related to CIPs be monitored?

Process required to approve schemes prior to Chief Nurse and Medical Director sign-off. There have been over 30 Independent Panels to date, reviewing CIP schemes for approval. As at the time of the last Board, £47M of schemes had been approved. It is anticipated that by the Trust Board on 28<sup>th</sup> August 2013, that additional schemes will be approved, resulting in an overall CIP value (FYE) of £77.5M.

Each CAG has provided a letter of representation, as part of the clinical sign-off process for CIPs, to provide assurance to the Board that the necessary systems and processes are in place within the CAG, to ensure that no CIP has a negative impact on patient safety. Schemes are ultimately approved by the Chief Nurse and Medical Director and the Trust Board.

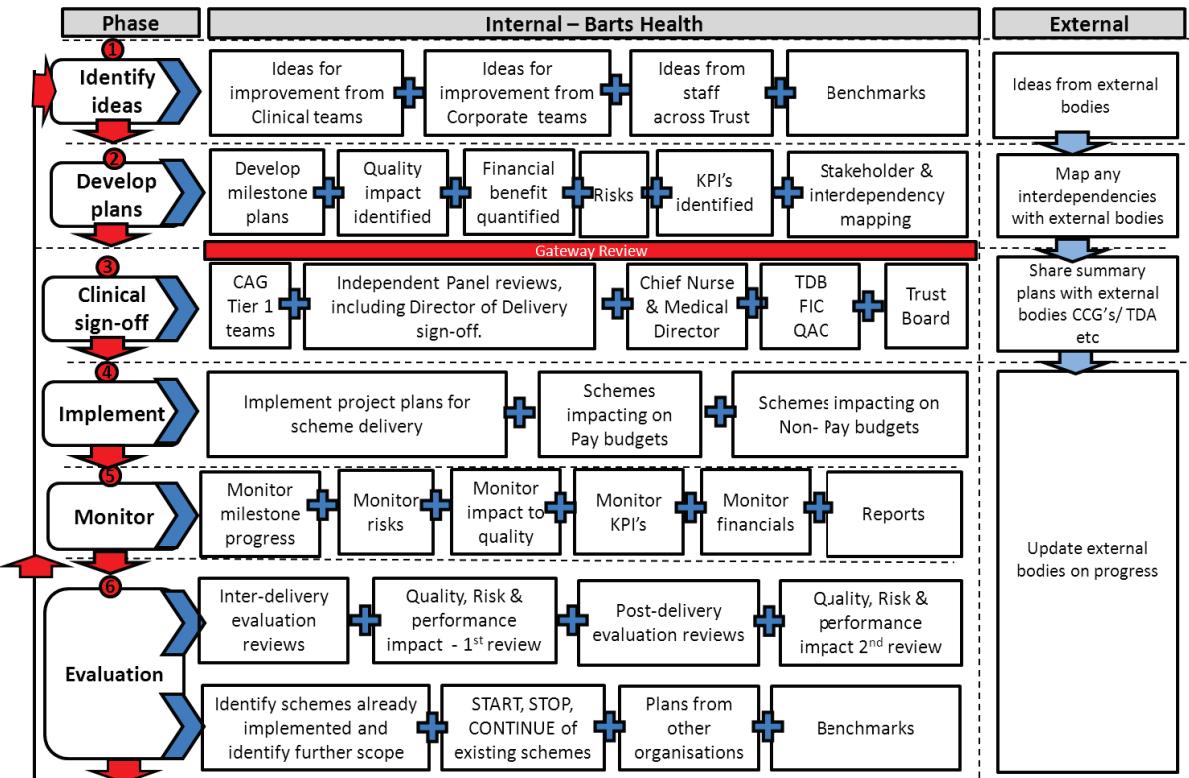
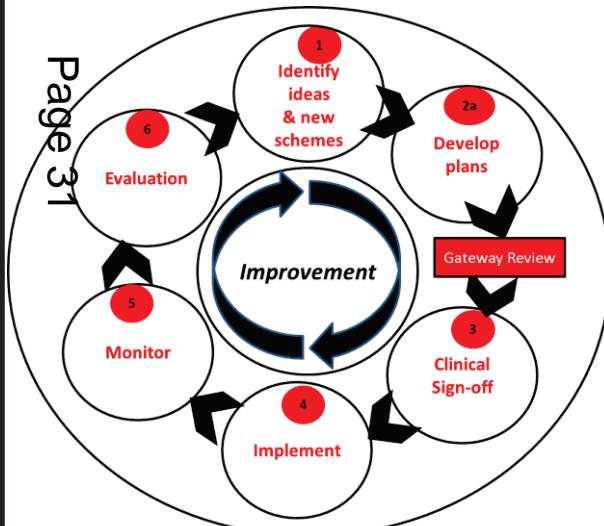
The NHS England provider assurance framework sets out requirements for ensuring safe delivery of CIPs. We have been allocated a current Green-Amber rating, and we are continuing to work with the CCGs and the CSU to receive assurance of our CIP process. They will be seeking evidence of our process in practice on an on-going basis, and will be reviewed via the commissioner led Clinical Quality Review Meetings. (CQRMs).

The Trust will be reviewing performance and incident indicators, to assess any potential link to the CIP programme, and identifying any linkages or root causes of performance issues or incidents etc which are directly linked to CIP implementation. Each CAG will monitor this through their boards, but this will also feature as part of their performance review meetings, with regular updates and oversight provided to the Quality Assurance Committee.

# 4. The Barts Health CIP programme cycle

## Barts Health CIP Programme cycle

The below diagram and process flow shown to the right, demonstrate the systems and processes adopted for CIPs, from identification, through to clinical sign-off, implementation and review.



## 5. Themes of our CIP programme

Variable Pay

Theatres

Workforce

Length of stay

Demand and capacity reviews

Estates and Facilities

Pharmacy

Income

Procurement

Corporate back office

Diagnostics

Eliminating fines

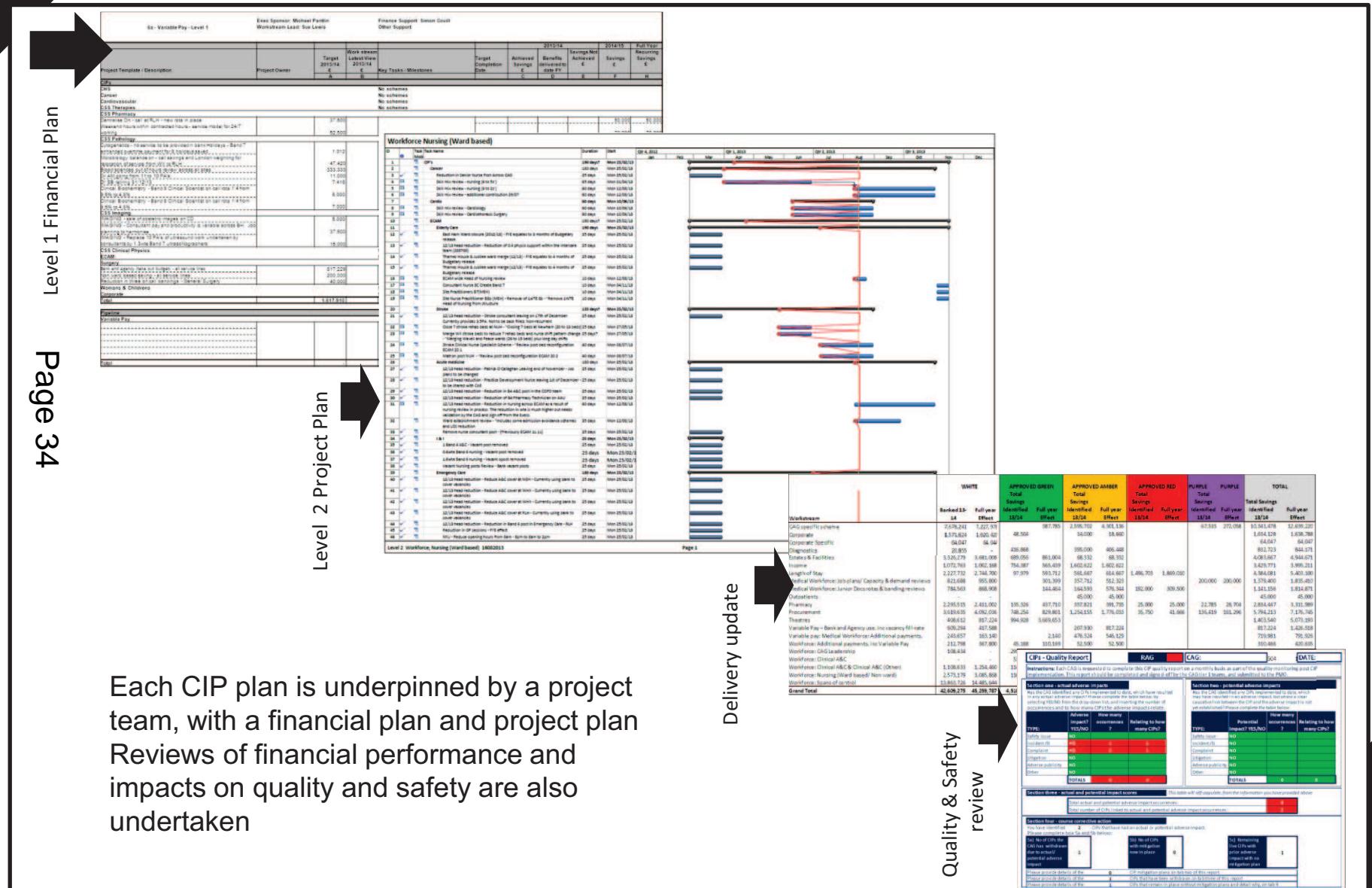


## 6. Our progress so far

- £60.9m part year effect CIPs now identified
- In addition:
- Non-recurrent schemes with a value of £2.7M in-year also identified
- Cost avoidance schemes with a value of £0.4m in-year also identified
- Total identified workstreams, cost avoidance and non-recurrent schemes is £64.1M

Workstream	TOTAL	
	Total savings identified 13-14	Total Full Year Effect Savings
CAG specific scheme	12,819,697	16,679,196
Corporate	1,571,624	1,620,420
Corporate Specific	418,709	1,531,832
Diagnostics	738,723	751,987
Estates & Facilities	4,083,667	5,016,004
Income	3,429,771	3,995,211
Length of Stay	3,974,081	5,463,100
Medical Workforce: Job plans/ Capacity & demand reviews	1,324,516	1,839,482
Medical Workforce: Junior Docs rotas & banding reviews	1,024,003	1,125,569
Outpatients	624,143	1,025,114
Pharmacy	2,784,619	3,243,580
Procurement	4,661,942	6,270,345
Theatres	947,085	3,115,949
Variable Pay – Bank and Agency use, inc vacancy fill-rate	817,224	1,234,812
Variable pay: Medical Workforce: Additional payments,	243,657	163,140
Workforce: Additional payments, inc Variable Pay	212,798	367,800
Workforce: CAG Leadership	803,043	2,016,981
Workforce: Clinical A&C & Clinical A&C (Other)	1,297,527	1,490,073
Workforce: Nursing (Ward based/ Non ward)	4,473,967	6,598,124
Workforce: Spans of control	14,662,567	15,573,588
Grand Total	60,913,364	79,122,305

# 7. CIP Assurance: Project management



# 8. Assessing impact of CIPs on quality and safety

Barts Health has developed a user-friendly process for undertaking a quality impact assessment across a number of domains to access CIP impact.



## Quality and safety impact assessment prior to clinical sign-off and CIP implementation

Quality impact assessment assesses CIP impact on six main domains:

- Patient Safety
- Clinical outcomes
- Patient Pathways
- Patient Experience
- Accessibility
- Staff

Any negative impacts identified must be mitigated, with detailed actions.

A CIP with negative impact on patient safety will not be approved

CIP Ref number/ Scheme:	[ENTER TITLE OF SCHEME]					
	Negative	Neutral	Positive			
Patient Safety	X					
Clinical Outcomes			X			
Patient pathways			X			
Patient Experience			X			
Accessibility	X					
Staff	X					
	major change	moderate change	minor change	no change	minor change	moderate change
						major change



# 8. Risk assessing our CIPs

Barts Health has in place a business-as-usual process for undertaking risk assessments. This has been adopted for undertaking CIP risk assessments.

1. Include the name/ ref number for your CIP as used on the tracker Tab

2. From the drop-down list, categorise the risk assessment you are completing - either service provision risk post CIP implementation; or risk to delivery of the CIP

3. Describe the risk and undertake the current risk scoring. Risk scores are available from the drop-down. For further info, refer to the Instructions tab

	1 - Rare	2 - Unlikely	3 - Possible	4 - Likely	5 - Almost certain
5 - Catastrophic	5	10	15	20	25
4 - Major	4	8	12	16	20
3 - Moderate	3	6	9	12	15
2 - Minor	2	4	6	8	10
1 - Negligible	1	2	3	4	5

Low Risk	1-6
Medium Risk	8-12
High Risk	15-25

4. For all risks, ensure that mitigating actions are included, with an anticipated risk rate once mitigation is completed. A deadline for completing mitigation and a risk owner should be added.

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CIP Scheme Reference number:	Risk assessment type: TYPE 1 TYPE 2 <i>Select from dropdown</i>	PRE MITIGATION (CURRENT RISK LEVEL)			POST MITIGATION (PLANNED RISK LEVEL)			Owner	Date risk last updated	15+ risk added to datix YES/NO/n/a	
		Likelihood	Consequence	Risk Rate	Mitigating action	Likelihood	Consequence	Risk Rate			
		3	3	9		2	2	4			
				0				0			
				0				0			



# 8. Ongoing monitoring of CIPs: Impact on quality and safety

## Reactive

1

All CAGs are required to consider all incidents and complaints in light of implemented CIPs

CAGs will consider linkages between CIPs and incidents and complaints via their business as usual governance processes. In addition, CAGs will be requested to complete a monthly CIP quality dashboard report, which will detail the number of CIPs linked to incidents and complaints, and the course corrective actions taken.

CIPs - Quality Report		RAG	CAG:	DATE:	
Instructions: Each CAG is requested to complete this CIP quality report on a monthly basis as part of the quality monitoring post CIP implementation. This report should be completed and signed-off by the CAG tier 1 teams, and submitted to the PMO.					
<b>Section one - actual adverse impacts</b>					
Has the CAG identified any CIPs implemented to date, which have resulted in any actual adverse impact? Please complete the table below, by selecting YES/NO from the dropdown list, and inserting the number of occurrences and to how many CIPs the adverse impacts relate.					
Type:	Adverse Impact? YES/NO	How many occurrences?	Relating to how many CIPs?		
Safety issue					
Incident/SI					
Complaint					
Litigation					
Adverse publicity					
Other					
<b>TOTALS</b>	<b>0</b>	<b>0</b>			
<b>Section two - potential adverse impacts</b>					
Has the CAG identified any CIPs implemented to date, which may have resulted in an adverse impact, but where a clear causal link between the CIP and the potential impact is not yet established? Please complete the table below:					
Type:	Potential Impact? YES/NO	How many occurrences?	Relating to how many CIPs?		
Safety issue					
Incident/SI					
Complaint					
Litigation					
Adverse publicity					
Other					
<b>TOTALS</b>	<b>0</b>	<b>0</b>			
<b>Section three - actual and potential impact scores</b> <small>This table will self-populate, from the information you have provided above</small>					
Total actual and potential adverse impact occurrences:			<b>0</b>		
Total number of CIPs linked to actual and potential adverse impact occurrences:			<b>0</b>		
<b>Section four - course corrective action</b>					
You have identified 0 CIPs that have had an actual or potential adverse impact. Please complete box 5a and 5b below:					
5a) No of CIPs the CAG has withdrawn due to actual/potential adverse impact:	0	5b) No of CIPs with mitigation now in place:	0	5c) Remaining live CIPs with potential adverse impact with no mitigation plan:	0
Please provide details of the CIP mitigation plans on tab two of this report.		Please provide details of the CIPs that have been withdrawn on tab three of this report.		Please provide details of the CIPs that remain in place without mitigation plans and detail why, on tab 2.	

## Proactive

2

All CAGs are required to continue to quality impact assess all CIPs via Quality Impact Assessments

All CIPs continue to be required to be underpinned by a completed Quality Impact Assessment. Any CIP identifying a potential negative impact MUST be supported by a mitigating plan to reduce the impact.

CIP Ref number / Scheme:	Scheme X		
	Negative	Neutral	Positive
Patient Safety	X		
Clinical Outcomes		X	
Patient pathways		X	
Patient Experience		X	
Accessibility		X	
Staff		X	
	<small>Negative</small>	<small>Neutral</small>	<small>Positive</small>
	<small>major change</small>	<small>moderate change</small>	<small>minor change</small>
	<small>moderate change</small>	<small>minor change</small>	<small>no change</small>
	<small>major change</small>	<small>moderate change</small>	<small>minor change</small>



## 9. Next steps for the programme

- Continue to monitor any impacts on quality and safety as a result of CIP implementation
- Continue to identify, approve and implement new schemes, in order to fulfil our CIP requirement
- Continue with our programme management arrangements to ensure CIP identification and delivery
- Continue to engage with our stakeholders and communicate details of our programme



## **Management, Nursing and Administrative & Clerical Workforce Efficiency Consultation**

### **Responding to outcomes from the consultation – summary for stakeholders**

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#### **Appendices**

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## **Background**

Immediately after our merger in 2012, we undertook a review of our corporate functions, including finance, human resources and information services, to align our structures with the new organisation. A similar process has now been conducted for management, nursing and administrative posts within our clinical services. It is essential that we maintain a skilled, adaptable and efficient workforce that is able to deliver excellent clinical and non-clinical services and fulfil our commitment to research and education. Therefore, months, we have carried out a comprehensive review of staffing levels and clinical practices across the organisation to help us ensure that our structures and processes are fit for purpose.

## **Executive summary of the consultation process and the outcome**

We launched a formal collective consultation process on proposed changes to our workforce on 27 August 2013. Our recognised trade unions and staff representatives were involved in a review of lessons learnt from our 2012 consultation and including information which staff told us they wanted to see in future consultations. Appendix 4 includes information on the function of a collective consultation.

All Barts Health staff were invited to comment and provide feedback on the proposals. An original deadline for comments of 30 September was subsequently extended until 4 October to provide additional time for staff to submit feedback. Staff were able to comment via a dedicated email address, at open meetings, at meetings with line managers and via trade union representatives. We also accepted comments from stakeholders, including local Healthwatches. The Trust's full response to the consultation was issued to our staff representatives on 25 October, and was published on our staff intranet on the same day.

The Trust is grateful for the time and effort taken by many staff to provide comments on the consultation. This input has enabled a robust view to be taken of the proposals, and many changes have been made as a result. These are summarised in appendix 1.

Overall, there will be 161 fewer nursing posts in our structures, a figure which has reduced by 24 as a result of the feedback we received. The proposed reduction of 161 posts is less than 3% of the total number of nursing posts across the Trust. It is extremely important to emphasise that these are **posts**, not people, and that we will attempt to deploy as many of those individuals whose post is lost into other nursing roles across the Trust.

There are currently 5,675 full time equivalent substantive nursing staff working for the Trust. We want to achieve a level of 95% permanent staffing by the end of March, and **will be recruiting an additional 600 nursing staff over the next few months.**

Details of precise staffing numbers, including the changes made as a result of the consultation, are included in appendix 2.

We are committed to avoiding redundancies, but we acknowledged the potential that 100 or more staff may be at risk of redundancy as a result of the proposed changes. Therefore, the consultation was launched under the requirement to consult at least 45 days before any dismissals take place. The consultation period is expected to last for 96 days, more than twice the legal and policy minimum, as no dismissals are anticipated before 1 December 2013. A dismissal occurs when an employee leaves, not when notice is served.

## **The benefits to patient care of the proposals**

The nursing models proposed were drawn up in order to provide a number of key benefits, including:

- Moving to an average 1:7 ratio of registered nurse to patient across non-specialist adult areas, higher than the 1:8 ratio identified by the [Safe Staffing Alliance](#) study and other recommendations on ward safety which found that patient safety is compromised at a ratio of registered nurse to patient of 1:8
- Remaining slightly above the 65:35 ratio of registered to unregistered staff recommended by the RCN's 2012 guidance on safe nurse staffing levels in the UK
- Taking into consideration the acuity and speciality of our paediatrics areas to comply with the RCN's 2013 guidance for children and young people's nursing
- Providing more supervisory time for band 7 nurses in their wards and clinical areas
- Providing a flatter hierarchy between the chief nurse and band 7 ward managers to enhance clarification of roles and accountability
- Recognising the logistics of each individual ward in the staffing lay-out proposed
- Ensuring a consistent approach to nursing establishments below band 7 in all our hospitals, rather than the three different staffing structures that were present in our legacy organisations
- Addressing unacceptably low staffing levels in some wards
- Investing in key areas such as older people's services and surgery
- Using benchmarking work from PwC and McKinsey to deliver more effective staffing models based on evidence from other similar organisations
- Redefining the band 6 nursing role to include both a ward sister/charge nurse position and a separate position to specifically focus on quality
- Establishing site based senior leaders, allowing for increased visible clinical leadership

## **What we proposed in the consultation**

In summary, our proposals were to:

- Review the leadership structure across five of our six Clinical Academic Groups (CAGs) - Women's and Children's Health, Emergency and Acute Medicine (ECAM), Surgery, Cardiovascular and Cancer. The review included the roles of heads of nursing/midwifery, matrons, general managers, service managers and service delivery managers.  
Proposals included increasing the span of control of management posts within the CAGs and delivering a headcount reduction and cost improvement across each CAG
- Review the governance teams within the Women's and Children's Health, Cardiovascular and Cancer CAGs
- Implement our ward based nursing review, following work from McKinsey and PwC on benchmarking, including reducing the number of band 6 and band 3 posts and growing the number of band 5 and band 2 posts
- Review the band 6 and band 3 posts in theatres
- Propose combining the role of Deputy Group Director with the role of Director of Midwifery in the Women's and Children's Health CAG, thus removing one post
- Review the arrangements for clinical site management across the Trust
- Review the administrative and clerical grades in the Women's and Children's Health, Cancer and Cardiovascular CAGs, Community Health Services, Health Records, the Emergency Department/Trauma team and the Immunisation and Infectious Diseases department
- Review the discharge team at Whips Cross
- Review non-ward based nursing roles
- Review all vacancies within the Trust to determine whether it is essential for each role to be filled

## **Benefits to staff of the proposals**

There are a number of benefits from the proposals, including:

- Increasing the number of band 6 staff in theatres at The Royal London Hospital
- Introducing a band 5 'floor co-ordinator' nursing post in the clinical site management teams at all our hospitals

Other benefits outside of the consultation include:

- Improvement programmes in outpatients and theatres
- Our older people's services improvement programme, which has seen a £0.75 million investment to enable ward teams to be released to go through a programme of appraisal and up-skilling to improve our overall approach to caring for older people
- Further investment in staffing levels in the Emergency Department at Newham Hospital
- A review of the Chief Operating Office roles within the Trust, the outcome of which will support some of the concerns raised about the impact of the consultation on senior nursing roles at our three acute hospitals (The Royal London, Newham and Whipps Cross) There is now a dedicated Hospital Director at each of these sites, who will be supported by a senior site nurse and named medical leads with site responsibility
- The senior site nurse is a new post which will help to ensure that there is consistent senior professional leadership, supporting the delivery of the highest possible standards of patient care and driving improved patient experience on each site

## **Engagement with the consultation**

A formal response was received from our staff representatives and is summarised in appendix 1. 517 emails were submitted to the dedicated consultation inbox, and letters and emails also came in from staff to the CAG leadership teams, the chief operating officer, chief executive and chairman. Meetings were held across the Trust on a regular basis. We also received some comments from key stakeholders including local Healthwatchs and a group of volunteers.

Many staff put a great deal of time and effort into providing a response to the consultation. We acknowledge the wealth of experience amongst our workforce and have taken the time to carefully review all responses.

## **Responding to the results of the consultation**

The Trust received responses from individual staff as well as a collective response from staff representatives. Individual staff concerns have also been considered, but where they concerned personal issues, they are being dealt with on a one to one basis and they have not been summarised in the full response.

A request for more time to give feedback was received from our staff representatives. We extended the time for comments to 4 October from 30 September, whilst also extending the outcome delivery date by three weeks from 4 October to 25 October. A full response to comments from staff representatives has been provided, and it is summarised in Appendix 3.

The Trust's full response to the consultation was published on 25 October.

Changes will be implemented subject to amendments, and staff affected are now being contacted with full details of the time frame for interview and selection processes.

### **Effect on staff whose role is to be downbanded**

Across the Trust, 198 Band 6 nursing posts will be downbanded to Band 5 and 265 Band 3 nursing posts will be downbanded to Band 2, a total of 463 posts. However, we anticipate that the number of individuals involved will be substantially lower than 463, because some staff will re-deploy to nursing vacancies elsewhere in the Trust on their original band.

When our merger took effect on 1 April 2012, we inherited three legacy staffing structures. The review has given us the opportunity to ensure a consistent approach to staffing across the Trust. Currently, healthcare support workers in some of our hospitals are Band 2, while those in other hospitals in the Trust are Band 3. Using Agenda for Change criteria, the duties of most healthcare support workers at our hospitals, based on the job description, were evaluated as a Band 2 role. There are exceptions in specialist areas such as cancer care and cardiovascular services, where we will continue to employ Band 3 healthcare support workers.

### **What we are doing to support staff**

Every effort will be made to re-deploy staff whose position is lost to one of our many vacancies for qualified and unqualified nurses. This will mean that roles previously filled by agency staff will now be filled permanently by staff members whose position has become redundant in the review. It is still too early at this stage of the process to determine the likelihood of redundancies, but our aim is to keep these to an absolute minimum by re-deploying staff.

Anyone whose pay has been reduced as a result of a change of Agenda for Change grade will have pay protection for up to 18 months, allowing them time to seek another role at their original banding and avoid a financial detriment. The decision to reduce pay protection from a maximum of three years to 18 months was agreed in partnership with staff representatives. We are also putting in place a dedicated team to work proactively with affected individuals and their line managers to enable them to return to their original banding in a different role as soon as possible.

A support pack has been produced for staff affected. It includes advice and guidance for staff seeking to refresh their interview, selection and self-marketing skills, such as model CVs, tips on networking, how to write a covering letter and example interview questions.

### **Next steps and timeframe**

The following table details the next steps in the process and when they will take place. The only exceptions are staff in our Tower Hamlets community health services teams and leadership roles within the Women and Children's Clinical Academic Group. These staff were involved in a separate earlier consultation, where resultant changes have already taken effect.

Action/Comments	Deadline
Post consultation meetings with staff representatives	To continue on a weekly basis
25 October	Outcome communicated to staff representatives and Trust staff
28 October to 8 November	Invitations to interview and online assessment
4 November to 22 November	Interview process
24 November	Deadline for band 6 staff to take on-line assessment
25 November to 29 November	Selection decisions made
2 to 6 December	Selection decisions communicated to staff
2 to 6 December	One to one meetings with staff who have not secured a job and are at risk
9 December onwards	Implementation of structures

## **Overall conclusion**

We have taken on board the comments of staff representatives and our staff members and changes to the proposals have been made to reflect service and clinical needs and commissioning issues. Overall, we believe that the proposals will enable us to improve standards of care through:

- Strengthened and clearer clinical leadership arrangements, particularly for ward based staff
- Common structures, operating procedures and practices across all our hospitals and within each service, and standard processes for monitoring them

Our drive to achieve a 95% permanent staffing rate by the end of March 2014 will contribute further to these improvements.

## **Appendices**

Appendix 1 provides a summary of amendments to the original proposals.

Appendix 2 provides a summary of overall staffing numbers.

Appendix 3 provides a summary of the feedback from staff representatives and the Trust's response

Appendix 4 provides information on the function of a collective consultation

## Appendix 1

Amendments to the original proposals made as a result of feedback during the consultation.

CAG/Service Area	Scheme	Amendment
General	All	Timescale extended to 4 October for staff comments and 25 October for outcome delivery.
General	Nurse Leadership	As a result of separate structural changes, three new FTE posts (likely to be band 8c) added to structure for site based senior nurse and AHP leadership
Cancer	Nurse Specialists in Haemato-oncology	Reduce by one FTE rather than two
Cancer	Nurse Specialists in Palliative Care	Not now removing one band 7 and 0.6 band 6 complementary therapy roles from the structure
Cancer	Nurse Specialists in Uro-oncology	Maintain one band 8a post until 2014
Cancer	Ward based Nursing – ratio on ward 4A	Maintain 1:5 ratio instead of proposed 1:7
Cardiology	Nurse Specialists in Rehabilitation	Not now removing one band 8a leadership post from structure
Cardiology	Nurse Specialists in Arrhythmia	Not now removing 0.8 band 7 post from structure
Cardiology	Nurse Specialists in Chest Pain	Not now removing one band 7 from structure
Cardiology	Ward based nursing – ratio on 13 E	Maintain 1:6 ratio instead of 1:7 (therefore not removing 2.6 FTE)
Cardiology	Ward based nursing – band 6 posts on LCH CCU	Implement 6 band 6 posts instead of 5.2 as proposed replace with a band 3 post to fund
Cardiology	Ward based nursing – band 6 posts on 13E and 13C	Implement three band 6s on each ward instead of two as proposed
Community Health Services	Child Health	Put on hold plans to move caretaker posts out of CHS (line management change only)
Community Health Services	GP Out of Hours	Implement one additional band 5 and one less band 4
Clinical Site Management	Band 3 and 4 Assistant Practitioner posts at Whipps Cross	Retain three band 3/4 posts until April 14 to enable transfer of work to other roles
Clinical Site Management	Administrative Support	Maintain one FTE for administrative support instead of reducing to 0.5
ECAM	Ward based nursing – band 6 on Nightingale & Faraday wards at Whipps Cross	Additional band 6 per shift agreed (11 instead of 9 FTE)

Emergency Care and Acute Medicine (ECAM)	Ward based nursing – Healthcare Support Workers on older people's wards - 10E and 14E (Royal London), Syringa (Whipps Cross) Tayberry and Thistle (Newham)	Additional band 2 on night shift
ECAM	Ward based nursing – Healthcare Support Workers on Conifer	Additional band 2 on night shift
ECAM	Ward based nursing – Healthcare Support Workers	Analysis of night-time dependency to be undertaken before complement of Healthcare Support Workers on nights is decided
ECAM	AAU at Royal London	Alternative model accepted – band 2 increased from 25.1 to 29 FTE; band 5 decreased from 58.4 to 52.4 FTE; band 6 increased from 13.2 to 16.3 FTE
ECAM	AAU at Whipps Cross	Three additional band 6 FTEs to receive GP referrals
ECAM	Nurse Specialists in Sexual Health	Not now removing two 8c nurse consultant roles in HIV and sexual health
ECAM	Nurse Specialists in Tuberculosis	Implement 17.6 FTE instead of 15.8 proposed. Includes separate funding from Tower Hamlets for one band 6 post
ECAM	Nurse Leadership	Additional two 8c Associate CAG Director of Nursing (called 'Head of Service' in proposals) – four in total
ECAM	Nurse Specialists in Neurosciences	Not to proceed as proposed. Alternatives to be considered
ECAM	Immunology and Infectious Diseases (I&I) Administration	One additional band 5, to be funded by one less band 2 and reduction in band 3
Surgery	Nurse Leadership	Additional two 8b Senior Nurse posts – five FTE in total
Surgery	Nurse Leadership	One 8a dental matron not to be removed from structure
Surgery	Nurse Leadership	One 8a ophthalmology matron not to be removed from structure
Surgery	Nurse Specialists in Retinoblastoma	Not now removing 0.4 FTE band 7 from structure
Surgery	Nurse Specialists in Pain Management	Not now removing one band 5 role (acupuncture) from structure
Surgery	Non ward based nursing - Theatres	The original proposal for the number of band 6's has increased by 35.5 wte.

		Distribution of band 6 roles will be split across the three core sites based on the number of theatres.
Women and Children's Health	Nurse Leadership	Senior Nurse to cover service line instead of being site based (no change to proposed FTE)
Women and Children's Health	Governance Team	Not now removing 0.72 FTE band 8a from the structure
Women and Children's Health	Ward based nursing – Healthcare Support Workers	Retain band 3 role on children's wards (but not neonates)
Women and Children's Health	Nurse Specialists in Gastroenterology	Not now removing 0.5 FTE from structure
Women and Children's Health	Nurse Specialists in Respiratory	Not now removing one FTE from structure
Women and Children's Health	Administrative Support	Additional band 6 office manager and additional band 5 PA

## Appendix 2

The change to whole time equivalents in each band and staff group is shown in the table below. The new current establishment and revised totals reflect the range of schemes now being implemented rather than those proposed.

### SUMMARY OUTCOME OF WORKFORCE REVIEW TRUSTWIDE

Banding	Current Budgeted Establishment WTE	Proposed establishment Pre Consultation WTE	Proposed establishment Post Consultation WTE	Movement in establishment Post and Pre Consultation WTE	Proposed (Increase/decrease) in Establishment WTE
<b>Ward Based Nursing</b>					
Band 2	248.43	496.41	524.12	27.71	275.69
Band 3	319.86	56.51	54.81	-1.70	-265.05
Band 4	38.27	25.00	25.00	0.00	-13.27
Band 5	1,220.87	1,388.89	1,367.15	-21.74	146.28
Band 6	628.08	416.34	429.24	12.90	-198.84
Band 7	140.61	117.36	117.36	0.00	-23.25
Band 8A	0.00	0.00	0.00	0.00	0.00
Band 8B	0.00	0.00	0.00	0.00	0.00
Band 8C	0.00	0.00	0.00	0.00	0.00
Band 8D	0.00	0.00	0.00	0.00	0.00
<b>Total Ward Based Nursing</b>	<b>2,596.12</b>	<b>2,500.51</b>	<b>2,517.68</b>	<b>17.17</b>	<b>-78.44</b>
<b>Non Ward Based Nursing</b>					
Band 2	5.00	2.00	2.00	0.00	-3.00
Band 3	24.00	19.00	19.00	0.00	-5.00
Band 4	15.84	5.00	5.00	0.00	-10.84
Band 5	233.61	265.07	260.07	-5.00	26.46
Band 6	184.33	121.21	127.01	5.80	-57.32
Band 7	196.09	169.56	173.36	3.80	-22.73
Band 8A	26.02	17.60	19.60	2.00	-6.42
Band 8B	5.60	3.90	3.90	0.00	-1.70
Band 8C	9.00	7.00	7.00	0.00	-2.00
<b>Total Non Ward Based Nursing</b>	<b>699.49</b>	<b>610.34</b>	<b>616.94</b>	<b>6.60</b>	<b>-82.55</b>
<b>Total Nursing</b>	<b>3,295.61</b>	<b>3,110.85</b>	<b>3,134.62</b>	<b>23.77</b>	<b>-160.99</b>

<b>Management Teams</b>					
Band 2	0.00	0.00	0.00	0.00	0.00
Band 3	0.00	0.00	0.00	0.00	0.00
Band 4	0.60	0.00	0.00	0.00	-0.60
Band 5	1.00	6.82	6.82	0.00	5.82
Band 6	0.00	0.00	0.00	0.00	0.00
Band 7	2.00	0.00	0.00	0.00	-2.00
Band 8A	68.12	29.34	29.34	0.00	-38.78
Band 8B	6.00	17.50	19.50	2.00	13.50
Band 8C	16.00	10.00	10.00	0.00	-6.00
Band 8D	2.50	0.00	0.00	0.00	-2.50
<b>Management</b>	<b>96.22</b>	<b>63.66</b>	<b>65.66</b>	<b>2.00</b>	<b>-30.56</b>
<b>Admin &amp; Clerical</b>					
Band 2	244.12	275.02	273.42	-1.60	29.30
Band 3	129.69	110.10	115.30	5.20	-14.39
Band 4	88.43	53.78	52.07	-1.71	-36.36
Band 5	23.20	13.00	15.00	2.00	-8.20
Band 6	9.40	9.00	10.00	1.00	0.60
Band 7	3.00	3.00	3.00	0.00	0.00
Band 8A	0.00	0.00	0.00	0.00	0.00
Band 8B	0.00	0.00	0.00	0.00	0.00
Band 8C	0.00	0.00	0.00	0.00	0.00
Band 8D	0.00	0.00	0.00	0.00	0.00
<b>Admin &amp; Clerical</b>	<b>497.84</b>	<b>463.90</b>	<b>468.79</b>	<b>4.89</b>	<b>-29.05</b>
<b>Grand Total</b>	<b>3,889.67</b>	<b>3,638.41</b>	<b>3,669.07</b>	<b>30.66</b>	<b>-220.60</b>

<b>ALL POSTS</b>					
Band 2	497.55	773.43	799.54	26.11	301.99
Band 3	473.55	185.61	189.11	3.50	-284.44
Band 4	143.14	83.78	82.07	-1.71	-61.07
Band 5	1,478.68	1,673.78	1,649.04	-24.74	170.36
Band 6	821.81	546.55	566.25	19.70	-255.56
Band 7	341.70	289.92	293.72	3.80	-47.98
Band 8A	94.14	46.94	48.94	2.00	-45.20
Band 8B	11.60	21.40	23.40	2.00	11.80
Band 8C	25.00	17.00	17.00	0.00	-8.00
Band 8D	2.50	0.00	0.00	0.00	-2.50
<b>Grand Total</b>	<b>3,889.67</b>	<b>3,638.41</b>	<b>3,669.07</b>	<b>30.66</b>	<b>-220.60</b>

### **Appendix 3**

Summary of feedback received from staff representatives and the Trust's response.

<b>Comment</b>	<b>Response</b>
Insufficient time to meaningfully consult with members.	Extended time was agreed and provided.
Universal staffing establishment does not take into account needs of speciality, acuity and location.	Consultation document clearly explained how workforce plans had been produced. Bottom-up assessment of staffing ratios on each ward took all these factors into consideration. All alternative proposals submitted during the consultation were considered and some amends have been made (see Appendix 2).
The PwC benchmarking exercise is too blunt, and available workforce data is often unreliable and hard to interpret.	This exercise and the McKinsey report provided a starting point to help us compare the shape of our workforce with peer trusts. Our own senior nurses considered workforce requirements by ward and shift, including location and physical layout of each ward.
Lower banded staff and reduced staff numbers will increase risks to patient care. Francis Enquiry into Mid Staffordshire underlines this.	There is no dispute that Mid Staffordshire had low staffing levels, but they were well below those proposed for Barts Health, often at 1:9 or 1:10. We have followed the RCN's 2012 guidance on safe staffing levels and are satisfied that our proposals are reasonable. We will continue to monitor all areas through our "safety net" – a weekly report which reviews key safety and quality indicators, including falls, pressure ulcers and complaints.
Amalgamating and reducing band 8 roles will lead to loss of leadership, experience and skills.	Our proposals increase the visibility of site based clinical leaders. We have retained the 8a senior nurse post in key areas such as the Emergency Departments. The new senior site nurse post will help ensure consistent professional leadership.
The proposal to downband all band 3 staff to band 2 is demoralising. This staff group are in the lower pay bands and have the worst career development options available.	The rationale is to ensure consistency of banding across the organisation and to ensure that roles and banding are clearly linked. We are committed to developing career pathways for healthcare support workers, and our education academy team is working with <a href="#">Skills for Health</a> to develop a framework for assessing and assuring minimum competency levels. In addition, our Older People's Improvement Programme includes the development of healthcare support workers.
Poor morale is now endemic, and will increase clinical risk and damage the health economy.	We acknowledge the impact that change management exercises have on staff and staff morale. We have offered various mechanisms of support to staff and we are pulling together an employee support package for affected staff. We will continue to work on staff engagement across the organisation.

There is a high potential for increased sickness levels due to work related stress, and people will be less likely to consider working for Barts Health	Sickness absence and turnover are monitored on a monthly basis and we use the information to help us understand trends within the organisation. Sickness absence has not increased to date, but we will continue to monitor workforce information closely.
The negotiations over reduction in pay protection was badly timed and affected staff perception of management.	The negative perceptions of staff may have been minimised if the rationale for change had been communicated earlier - both Trust leadership and staff representatives can learn from this. The Trust has committed to providing a redeployment team until January 2015 to focus on assisting pay protected staff to find a role at their former pay band.
Risk assessments, impact assessment and equality impact assessments need to be reviewed by both staff and patient groups.	Risk and Quality assessments for the proposals were undertaken by each CAG and reviewed by independent panels. There has been an open invitation in place for staff representatives to attend the independent panels. An Equality Impact Analysis (EQIA) has been completed twice (on the draft consultation paper and on the final version) and is an appendix of the consultation paper. A third EQIA was completed on the specific issue of the protected characteristics of the band 3 Healthcare Support Workers. A further EQIA will be completed after the proposals have been implemented.
The evidence for change is flawed, and staff views must be considered	Significant time has been spent briefing and educating staff representatives on the Trust's financial position and plans.
Staff representatives and trade unions have been excluded from development of staffing levels.	Staff representatives have been aware of the work that led to the proposals since discussions began in 2012. Proposals were discussed at several Staff Partnership meetings, and no concerns or requests for more proactive involvement were raised by staff representatives at these meetings.
Some job descriptions were not available during the consultation process.	Although job descriptions are not a specific requirement of collective consultation, we have aimed to provide as much information as possible, and many job descriptions were published on the intranet as appendices to the consultation paper.
The agreed process for job evaluation has not been applied for the roles identified in the consultation.	The job evaluation process was correctly followed. During a consultation, job descriptions may be commented on and may need to change, and should therefore be evaluated after comments have been received.
Full time officers and staff representatives have not had sufficient time to collectively consider the proposals in relation to selection and pooling.	Discussions on pooling and selection arrangements began before the consultation launched, and agreed principles from the merger were already available and required adaptation for this exercise. Proposals have been discussed on a regular basis at the

	weekly dedicated consultation sub-committee and full responses to staff representatives' comments were included in this process.
Suggestions were raised around the online assessment process for band 6 roles, including allowing staff to opt out of the process and voluntarily move to a band 5 role on pay protection, and a guarantee that staff can stay on their existing ward or department.	Staff cannot opt out of the process and volunteer for pay protection. Although we cannot guarantee that staff will stay in the same ward or department, all preferences will be considered. Guidance on the on line assessment tool was circulated to affected staff immediately after the consultation response was published, and skills workshops were promoted prior to this date,
Individual staff need more information on pension and retirement options.	Pension workshops have been arranged with the Trust's pensions manager.
We need to agree a policy position on redundancy.	This was acknowledged and information is to be provided.
Workforce planning around the proposed nursing ratios needs to take into account planned and unplanned absence.	There is a 'cover' budget for annual leave, sickness and study leave in addition to the establishment.
The review of leadership roles needs to take into account the effect of previous recent restructures and the increased workload that will be placed on postholders in these roles.	Following the consultation, some changes have been made to the original proposals. The new structures will bring front line service delivery closer to CAG senior leadership teams. Benchmarking ourselves against peer trusts shows that we have a proportionately higher number of staff in key nursing pay bands, in the administrative and clerical group and in the higher pay bands. Band 7 ward sister/charge nurse roles are not under review. Management teams will work with these individuals to ensure they are supported through the change.
Why was there a need to review current clinical site management structures?	We need to ensure robust and appropriately consistent staffing arrangements at the three acute sites, each of which currently has a different clinical site management configuration and different ways of working/operating procedures. In particular, The Royal London and Whipps Cross need the same configuration due to the size and complexity of services on these sites.
The proposals could mean that there are fewer senior nurses and managers to investigate and respond to serious incidents and complaints.	Only the Governance teams in Cancer & Cardiac and Women & Children's Health were reviewed. An amendment has been made to the Women & Children's Health proposals.

## **Appendix 4**

### **The function of a collective consultation**

In law, a collective consultation is required if there are proposals to dismiss 20 or more staff by reason of redundancy. If 100 or more staff might be dismissed, consultation must happen 45 days before the first dismissal. A dismissal occurs when an employee leaves, not when notice is served. Any member of staff who is put at risk of redundancy is then invited to an individual consultation meeting where they can discuss their own particular situation.

In these circumstances, employers have a duty to consult with the appropriate representatives of the employees who may be affected by the proposed dismissals or by measures taken in connection with those dismissals. For the purposes of this consultation, the appropriate representatives were the local trade union representatives that make up our Staff Partnership Forum.

The general purpose of collective consultation is to discuss ways of avoiding dismissals, reducing the number of dismissals or mitigating the consequences of dismissal. The employer has a duty to disclose:

- the reason for the proposals
- the number that it is proposed to dismiss
- the number of staff affected in each pay band
- the number of staff currently employed
- the proposed selection process
- the method of calculating redundancies

This information was provided to local trade union and staff representatives as part of the consultation process.

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<p><b>Inner North East London Joint Health Overview and Scrutiny Committee</b></p> <p>20 November 2013</p> <p><b>Improving specialist cancer and cardiovascular services in north and east London and west Essex – The case for change</b></p>	<p>Item No</p> <p><b>8</b></p>
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## Outline

The Committee has received a request from NHSE England to give preliminary consideration to a case for change on improving specialist cancer and cardiovascular services.

This case for change area encompasses the 13 authorities which make up INEL, ONEl and NCL JHOSCs<sup>1</sup> in addition to Westminster, west Essex and Hertfordshire.

A representative from Westminster has been invited to this meeting.

A representatives from Essex Council already participates in ONEl and a representative of Hertfordshire County Council has been invited to the NCL meeting.

Please find attached

- a) Briefing from NHS England
- b) Presentation from NHSE – North Central and East London
- c) The formal letter of request to the Chair
- d) Cancer and Cardio full Case for Change document

## Action

The Committee is requested to give consideration to the proposals.

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<sup>1</sup> INEL comprises Newham, Tower Hamlets, City, Hackney; ONEl comprises Redbridge, Barking & Dagenham, Havering and Waltham Forest; NCL comprises Camden, Islington, Haringey, Barnet and Enfield.

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<b>NHS INNER NORTH EAST LONDON</b>	<b>BOROUGHS:</b> Hackney, Newham, Tower Hamlets and City of London Corporation <b>WARDS:</b> ALL
<b>PRESENTATION TITLE:</b> Specialist cancer and cardiac service reconfiguration	
<b>PRESENTATION OF:</b>	
<p><b>Neil Kennett-Brown</b>, Programme Director, Change Programmes, North and East London Commissioning Support Unit</p> <p>Clinical representatives from <i>London Cancer North and East</i> and UCLPartners.</p>	
<b>FOR SUBMISSION TO:</b> Inner North East London Joint Health Overview & Scrutiny Committee	<b>MEETING DATE:</b> 20 November 2013
<b>EXECUTIVE SUMMARY OF PRESENTATION:</b>	
<p><b>Background to the proposals</b></p> <p>A 2010 pan-London review found that cancer and cardiovascular services in the capital did not always give patients the best chance of survival and the best experience of care. Public engagement on the pan-London case for change and model of care was undertaken in 2010 (<a href="#">cardiovascular care</a> and <a href="#">cancer care</a>).</p> <p>Building on the pan-London review, clinicians (working through the academic health science network UCLPartners for cardiovascular care and <i>London Cancer North and East</i> the integrated cancer system for north and east London and west Essex for cancer care) have looked at how best to improve services locally.</p> <p>As commissioners, NHS England has published a case for change and begun engaging with the public, patients and staff to gather views on the clinical recommendations, and to inform the development of a business case, and period of any further engagement. The engagement will run from 28 October to 4 December 2013.</p>	
<p><b>Cancer pathways</b></p> <p><i>London Cancer</i> has established a number of cancer pathway groups involving clinicians, GPs and patient representatives. By building on the Model of Care, and with an ambition to provide the quality of care that patients deserve, <i>London Cancer North and East</i>'s pathway groups have developed clinical recommendations for providing the cancer services across north and east London and west Essex. While most cancer care would remain unchanged and would be provided locally, clinicians are recommending specialist services for the following five pathways in fewer specialist centres:</p> <ul style="list-style-type: none"> <li>• Brain cancer surgery</li> <li>• Head and neck cancer surgery</li> <li>• Urological (bladder, prostate and kidney) cancer surgery</li> <li>• Stem cell transplants and treatment of acute myeloid leukaemia</li> </ul>	

- Oesophago-gastric (upper GI) cancer surgery.

If *London Cancer North and East's* recommendations are fully implemented as proposed, the estimated overall change at Barts Health is -1% of all cancer spells as shown on the diagram below.

## Cancer activity at Barts Health

**Estimated change in cancer activities = - 1% of cancer spells**

✓ - No change      ↑ - Increase in activity      ↓ - Decrease in activity      ↓✗ - All activities moving to another site  
No change to other rare tumour services currently provided at Barts Health e.g. Testicular, penile, ocular cancer and teenage and young adult cancer services.

Tumour	Referral & Diagnosis	Complex Diagnosis	Surgery & Interventional Treatment	Systemic Anti-cancer Therapy	Radiotherapy	Follow-up & Monitoring
Brain	✓	↓✗	↓✗	✓	✓	✓
Breast	✓	✓	✓	✓	✓	✓
Colorectal	✓	✓	✓	✓	✓	✓
Gynaecology	✓	✓	✓	✓	✓	✓
Haematology Other (I & IIa)	✓	✓		✓	✓	✓
AML (IIb)	✓	✓		↑	✓	✓
HPSCT	✓	✓		↑	✓	✓
Head & Neck	✓	✓	↓✗	✓	✓	✓
Lung	✓	✓	✓	✓	✓	✓
Skin	✓	✓	✓	✓	✓	✓
UGI (HPB)	✓	✓	✓	✓	✓	✓
UGI (OG)	✓	↓	↓✗	✓	✓	✓
Urology Bladder & Prostate	✓	✓	↓	✓	✓	✓
Renal	✓	✓	↓✗	✓	✓	✓

An overview of the location of all specialist centres can be found on page 11 of the case for change.

### Cardiovascular services

Separately, clinicians are proposing to improve patient outcomes through integrating specialist cardiovascular services. The proposal is for specialist cardiovascular currently offered by both University College London Hospital (UCLH) NHS Foundation Trust and Barts Health NHS Trust, to come together in a single centre for excellence at St Bartholomew's Hospital in late 2014.

The services provided at the London Chest Hospital, operated by Barts Health NHS Trust, are already planned to move to St Bartholomew's in 2014 and this new clinical proposal would see the cardiac services from UCLH's Heart Hospital also relocated to create one centre of excellence.

### ***Options appraisal***

NHS England (on behalf of commissioners) is considering these proposals and engaging patients, clinicians and key local stakeholders on the options for delivering these specialised centres of excellence. Part of the engagement is to identify a short-list of options that can be formally appraised. This appraisal will develop preferred options which can be formally engaged upon before any decisions are taken.

Options appraisal meetings have been held with representatives from commissioning, public health and patient groups. Clinical and non-clinical appraisal meetings will continue until December 2013.

### ***Scrutiny and decision-making***

NHS England as the lead commissioner will be the decision-making body on any proposals for specialised cancer and cardiovascular services. CCGs as commissioners for any non-specialised elements of the pathways will be important stakeholders in the process and their formal feedback will be used to inform the decision-making process.

NHS England has written to the INEL Joint Health Overview and Scrutiny Committee (as well as JHOSCs from Outer North East and North Central London) to consider in respect of which recommendations, if any, constitute a substantial variation of services, and the extent of involvement under section 242 of the Health Act 2006. If a formal consultation is not required, NHS England would still undertake a further period of formal engagement around the commissioner recommendations for each pathway.

If a formal consultation is required then in the new Local Authority (Public Health, Health and Wellbeing Board and Health Scrutiny) Regulations 2013, where an NHS body/health service provider service change impacts on more than one local authority's area and it has to consult more than one local authority, those local authorities must appoint a single joint overview and scrutiny committee for the purposes of the consultation for the area affected. In this case, the area affected would be the London Boroughs in north and east London plus Westminster, west Essex and Hertfordshire.

NHS England would agree the scale and duration of any formal engagement or consultation with the affected boroughs.

### ***Engagement***

The case for change, supporting documents and event details were made available on the [NHS England website](#) on 28 October 2013. A [media release](#) was also issued by NHS England and received coverage in the Evening Standard. A news story was also posted on [London Cancer North and East's website](#) and [UCLPartners website](#), which pointed to the NHS England webpage.

Letters announcing the launch of the case for change and advising of ways to get involved were sent to circa 630 stakeholders, along with a copy of the case for change:

- local and national Healthwatch
- local and national cancer and cardiovascular patient support groups

- Chairs of Health and Wellbeing Boards, Directors of Adult Social Services and Directors of Public Health
- MPs, London Assembly Members and LMCs
- Chairs of ONEl, INEL, NCL JHOSCs and the OSCs of Westminster, Hertfordshire and Essex
- CCGs and London adult specialist care providers.

Five public drop-in events are planned for the engagement. The events were advertised in 15 local newspapers (Harlow Star, Epping Forest Independent, Epping Forest Guardian, Romford Recorder, Ilford Recorder, Newham Recorder, Waltham Forest Guardian, Barnet Hendon Press, Enfield Independent, Enfield Advertiser, Barnet & Potters Bar Times, Camden New Journal, Islington Tribune, Islington & Hackney Gazette) during the week commencing 4 November. All event dates were advertised in each publication to give members of the public the option of attending any (or all) of the events.

- Tuesday 12 November, 1.30-3.30pm, Harlow Leisurezone Conference Room, Second Avenue, Harlow, CM20 3DT
- Wednesday 13 November, 5.30-7.30pm, Romford Central Library, St. Edwards Way, Town Centre Romford, RM1 3AR
- Monday 18 November, 6-8pm, Main Hall, The Old Town Hall, 29 Broadway, Stratford, E15 4BQ
- Tuesday 19 November, 3-5pm, Green Towers Community Centre, 7 Plevna Road, Edmonton, N9 0BU
- Monday 25 November, 6-8pm, Camden Centre, Bidborough Street, London, WC1H 9AU

Five staff events are planned for the engagement and have been promoted via Trusts internal communications channels. The events have been located at sites across north and east London with staff encouraged to attend any (or all) events.

Outputs, such as attendance numbers and key themes, for the events being held prior to the 20 November will be presented at the JHOSC meeting.

### ***Timings***

Late 2013	Engagement and business case development
Early 2014	Formal engagement or consultation
Mid 2014	Decision by NHS England and CCGs
Late 2014-2018	Implementation, if approved

### **Conclusion**

The Committee is asked to note the overview of the clinical recommendations and engagement, and is invited to provide formal comment on the clinical recommendations for specialist cancer and cardiovascular services. The Committee is also asked to note the request for the Chair to participate in a meeting with NHS England and Chairs of the INEL and NCL JHOSC to consider

the full outcomes of engagement and to consider which, if any, pathways require formal consultation and what time period that formal consultation would run.

Attachments include: Case for Change.

**CONTACT OFFICER:**

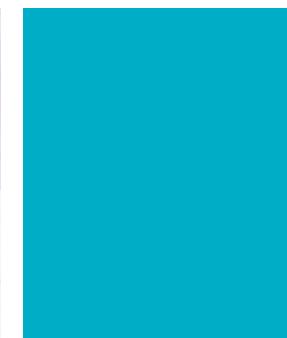
Nadine House  
Communications, Transformational Change  
North and East London Commissioning Support Unit

Neil Kennett-Brown  
Programme Director, Change Programmes

**DATE: 8 November 2013**

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## Cancer and cardiovascular services



**THE NHS  
CONSTITUTION**  
the NHS belongs to us all

# Why we need change

- Local services are not organised in a way that gives patients the best care
- Specialists, technology and research spread across too many hospitals
- Evidence suggests that focused specialist centres lead to better outcomes



# What it would mean for patients

- Improved experience and outcomes
- Prompt access to the right treatment and state-of-the-art equipment
- Specialist care available 24/7 and shorter waiting times
- Better access to the latest treatments and technology through more access to clinical trials



# Cancer



# Scope of the engagement

- Clinicians reviewed specialist services for five rare or complex types of cancer:
  - Brain cancer surgery
  - Head and neck cancer surgery
  - Bladder, prostate and kidney surgery
  - Treatment for acute myeloid leukaemia and stem cell transplants
  - Oesophago-gastric (OG) cancer surgery

Clinicians believe that these changes would affect less than 10% of all cancer services

# Cancer activity at Barts Health

Estimated change in cancer activities = - 1% of cancer spells

✓ - No change

↑ - Increase in activity

↓ - Decrease in activity

↓ X - All activities moving to another site

No change to other rare tumour services currently provided at Barts Health e.g. Testicular, penile, ocular cancer and teenage and young adult cancer services.

Tumour	Referral & Diagnosis	Complex Diagnosis	Surgery & Interventional Treatment	Systemic Anti-cancer Therapy	Radiotherapy	Follow-up & Monitoring
Brain	✓	↓ X	↓ X	✓	✓	✓
Breast	✓	✓	✓	✓	✓	✓
Colorectal	✓	✓	✓	✓	✓	✓
Gynaecology	✓	✓	✓	✓	✓	✓
Haematology Other (I & IIa)	✓	✓		✓	✓	✓
AML (lib)	✓	✓		↑	✓	✓
HPSCT	✓	✓		↑	✓	✓
Head & Neck	✓	✓	↓ X	✓	✓	✓
Lung	✓	✓	✓	✓	✓	✓
Skin	✓	✓	✓	✓	✓	✓
UGI (HPB)	✓	✓	✓	✓	✓	✓
UGI (OG)	✓	↓	↓ X	✓	✓	✓
Urology Bladder & Prostate	✓	✓	↓	✓	✓	✓
Renal	✓	✓	↓ X	✓	✓	✓

# Vision for cancer care

- Create an integrated system of care providing:
  - Local care where possible, specialist care where necessary
  - High performing multi-disciplinary teams of surgeons, specialist nurses, anesthetists and therapists
  - High capacity specialist teams that strengthen local services
  - Training and research opportunities for staff
  - Open and transparent data collection

**Specialist centres would work with local hospitals and GPs to improve the patient journey from diagnosis to follow-up care**

# Brain cancer surgery

- Currently three neuro-oncology centres serve a population of over 3.9 million
- Current services do not always meet national standards of:
  - Two million population size
  - At least 50% of the time spent in neuro-oncological surgery

## Clinical recommendations

- Consolidate neuro-oncology surgery at two centres
- Improvements to the pathway:
  - Immediate referral to neuro-oncology surgery centre
  - CNS support for holistic care
  - Rapid diagnosis and referral to oncology after surgery
  - Follow-up care and rehabilitation

# Head and neck cancer surgery

- Surgery is currently carried out at three centres serving a population of 3.2 million
- Current services do not always meet national standards of:
  - At least one million population
  - Patients should be managed by a specialist MDT that manages at least 100 new cases a year

## Clinical recommendations

- Consolidate head and neck cancer surgery at one centre
- Improvements to the pathway:
  - Sustaining dedicated facilities, 24/7 specialist medical, nursing and therapy support teams
  - Faster diagnosis and screening
  - Patients offered all suitable treatment options and reconstruction
  - Access to cutting-edge radiotherapy
  - Local follow-up and enhanced recovery packages during and after treatment

# Bladder and prostate cancer surgery

- Around 100 bladder cancer patients and 220 prostate cancer patients require complex surgery a year in north and east London
- Four centres currently serve over 3.2 million
- Each centre does between 54-89 complex operations
- Services do not always meet national standards:
  - Treatment should be managed by MDTs
  - Centres should serve at least one million people

## Clinical recommendations

- Centralising complex bladder and prostate procedures (undertaken robotically) at University College Hospital
- Stakeholders have also asked commissioners to consider the option of offering some specialist prostate surgery at a second centre at Queen's Hospital in Romford

# Renal cancer surgery

- Most renal cancer patients need complex surgery
- Nine centres currently serve our 3.2 million population
- Numbers of procedures done at each centre ranges from 10 – 72
- Not all hospitals have access to latest technologies (e.g. robotics, focal therapies)
- Renal cancer surgery should have renal medicine and dialysis facilities

## Clinical recommendations

- Consolidate services into one specialist centre at the Royal Free
- Royal Free has necessary supporting specialities including:
  - Vascular surgery
  - Liver and pancreatic surgery
  - Renal medicine
  - 24-hour interventional radiology
- Royal Free also has the ability to expand facilities in line with its strategy for renal diseases

# AML treatment and stem cell transplants

- Currently north and east London has:
  - Six level 2b AML centres treating 2-39 new patients intensively
  - Three transplants centres
- Services do not always meet recommended standards of:
  - 100 transplants a year
  - 10 new AML cases a year

## Clinical recommendations

- Level 2b AML treatment should be consolidated into three centres
- Stem cell transplant services should be consolidated into two centres

# OG cancer surgery

- 25% of OG patients require specialist treatment
- The local area currently has three specialist OG centres
- Services do not always meet recommended standards of:
  - Serving a population of one million
  - Performing at least 60 operations a year

## Clinical recommendations

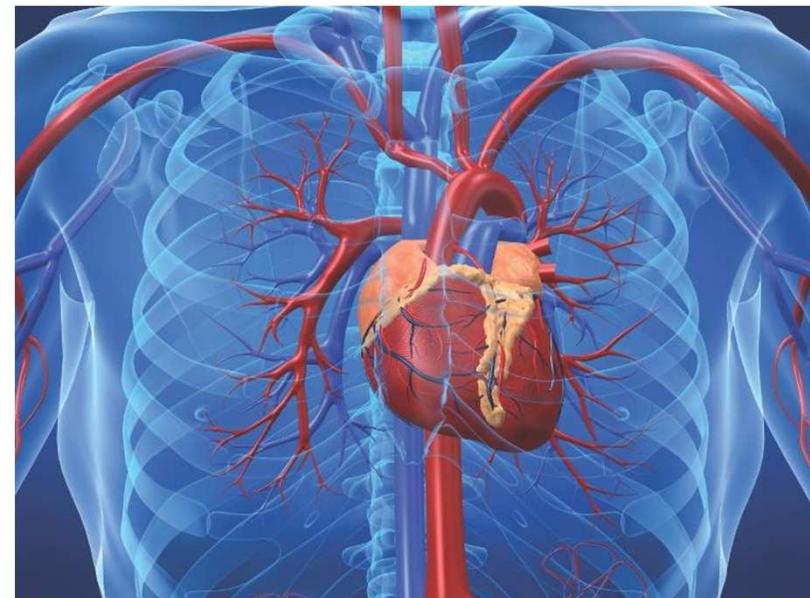
- Staged consolidation of specialist diagnostics and surgical services
- Initially two centres:
  - Queen's Hospital in Romford
  - University College Hospital
- Medium to long term, further consolidation into a single centre at UCLH

# Cardiovascular Introduction



# Cardiovascular

- This review focuses on specialist adult cardiovascular services:
  - Adult congenital heart disease
  - Cardiac anaesthetics and critical care
  - Cardiac imaging
  - Cardiac rhythm management
  - Cardiac surgery
  - General interventional cardiology
  - Management of complex/severe heart failure
  - Inherited cardiovascular disease



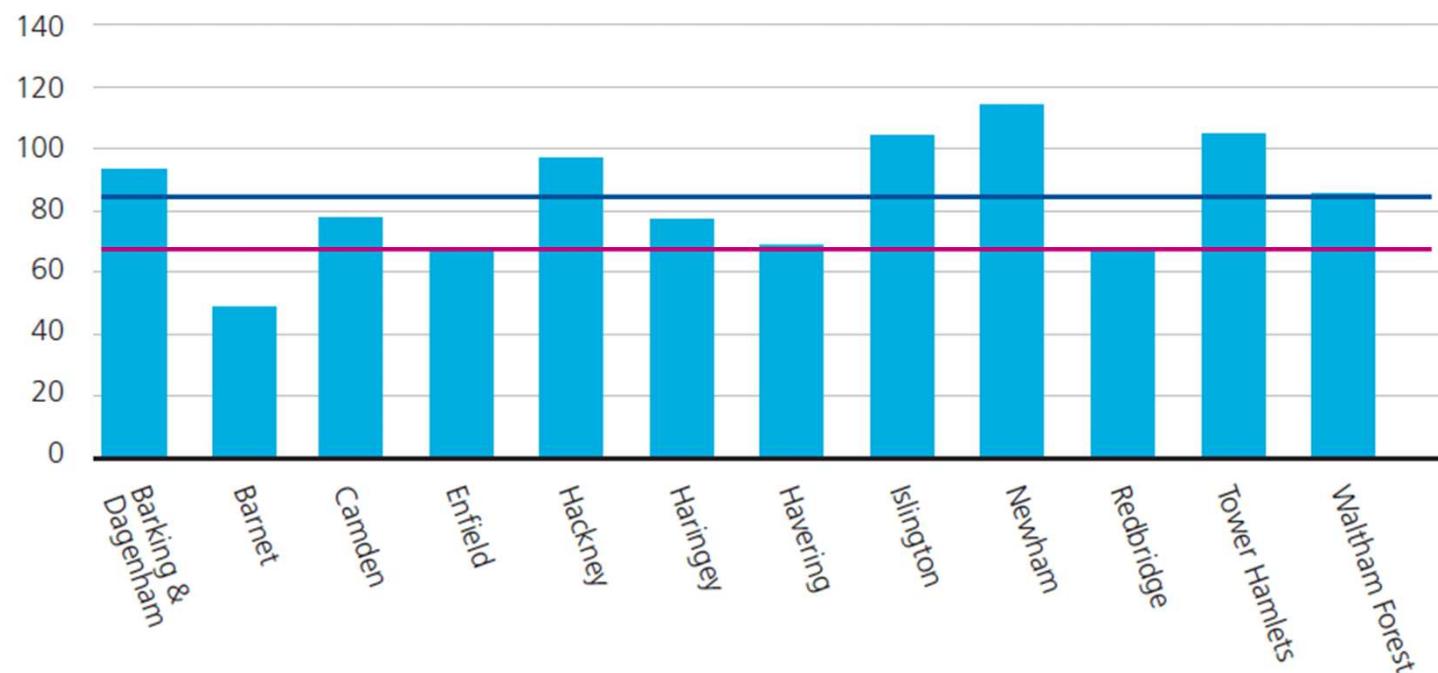
# Local need

Over 1,000 lives could be saved if we equalled the England average.  
Over 2,000 when equalling the European rate

Diverse, ageing and growing population with many facing significant deprivation

Premature death from all circulatory disease (2008-10)

— North and east London average  
— England average



# Why we need to change

- Some of our patients are waiting unacceptably long for treatment
- Too many patients are having their surgery cancelled
- Hospitals cannot deliver 24/7 care by specialist teams without sufficient patient numbers
- Not all our services are delivering the national standards for care and patient outcomes could be improved

These challenges  
threaten good  
patient experience

# Clinicians' recommendations

- Create a world-class integrated cardiovascular centre at the new St Bartholomew's Hospital site
- Develop a comprehensive, joined-up network of care spanning from prevention and earlier diagnosis through to treatment of disease
- The majority of care would continue to be provided close to people's homes



# Engagement

**cancerandcardiovascular@nelcsu.nhs.uk**

**www.england.nhs.uk/london/engmt-consult/**



# Feedback to date

- Update to be provided at the meeting

# Staff events

- 31 Oct, 17.30 - 19.30, Conference Room, West Wing, St Bartholomew's Hospital, West Smithfield, London, EC1A 7BE
- 4 Nov, 15.00 - 17.00, Seminar Room 2, James Fawcett Education Centre, First Floor, King George Hospital, Barley Lane, Ilford, IG3 8YB
- 5 Nov, 12.00 - 14.00, Education Centre, 1st Floor West, 250 Euston Road, NW1 2PG
- 15 Nov, 14.00 – 16.00, Peter Samuel Hall, 1<sup>st</sup> floor, Royal Free Hospital, Pond Street, NW3 2QG
- 25 Nov – Queen's Hospital TBC

# Public events

- 12 Nov, 1.30-3.30pm, Harlow Leisurezone Conference Room, Second Avenue, Harlow, CM20 3DT
- 13 Nov, 5.30-7.30pm, Romford Central Library, St. Edwards Way, Town Centre Romford, RM1 3AR
- 18 Nov, 6-8pm, Main Hall, The Old Town Hall, 29 Broadway, Stratford, E15 4BQ
- 19 Nov, 3-5pm, Green Towers Community Centre, 7 Plevna Road, Edmonton, N9 0BU
- 25 Nov, 6-8pm, Camden Centre, Bidborough Street, London, WC1H 9AU

25 October 2013

Dear Cllr Vaughan

**Specialist cancer and cardiovascular services in north and east London and west Essex:  
the case for change**

Following our meeting in September I am writing on behalf of NHS England to update you on the review of specialised cancer and cardiovascular services in north and east London and west Essex.

NHS England, together with CCG partners, will now be engaging with local people on clinicians' recommendations for improving these services.

Most care for these diseases would continue to be provided locally, for highly specialist services clinicians want to bring together expertise to provide better care and save more lives. Their vision is to create world-class specialist centres that work with other hospitals in the area to provide a comprehensive system of care.

As commissioners, we will be publishing a case for change and starting to engage with a range of stakeholders including the public, patients and staff to gather views on the clinical recommendations, and to inform the development of a business case, and period of any further engagement. The engagement will run from 28 October to 4 December 2013.

In the meantime, we wanted to share an embargoed copy of the case for change and let you know details of upcoming events. I would be very grateful if you could circulate this email and the attached document to members of the committee.

NHS England will also be considering with the existing Joint Health Overview and Scrutiny Committees (Inner North East, Outer North East and North Central London) in respect of which recommendations, if any, constitute a substantial variation of services, and the extent of involvement under section 242 of the Health Act 2006. If a formal consultation is not required, NHS England would undertake a further period of formal engagement around the preferred options.

If a formal consultation is required then in the new Local Authority (Public Health, Health and Wellbeing Board and Health Scrutiny) Regulations 2013, where an NHS body/health service provider service change impacts on more than one local authority's area and it has to consult more than one local authority, those local authorities must appoint a single joint overview and scrutiny committee for the purposes of the consultation for the area affected. In this case, the area affected would be the London Boroughs in north and east London plus Westminster, west Essex and Hertfordshire.

The scale and duration of any formal engagement or consultation would be agreed with the affected boroughs.

We look forward to presenting the proposals at the next Inner North East London JHOSC meeting on 20 November. In the meantime, we would welcome the opportunity to meet with you or attend any individual HOSC meeting.

We are also holding local engagement events to give people an opportunity to find out more about the proposals.

- Tuesday 12 November, 1.30-3.30pm, Harlow Leisurezone Conference Room, Second Avenue, Harlow, CM20 3DT
- Wednesday 13 November, 5.30-7.30pm, Romford Central Library, St. Edwards Way, Town Centre Romford, RM1 3AR
- Monday 18 November, 6-8pm, Main Hall, The Old Town Hall, 29 Broadway, Stratford, E15 4BQ
- Tuesday 19 November, 3-5pm, Green Towers Community Centre, 7 Plevna Road, Edmonton, N9 0BU
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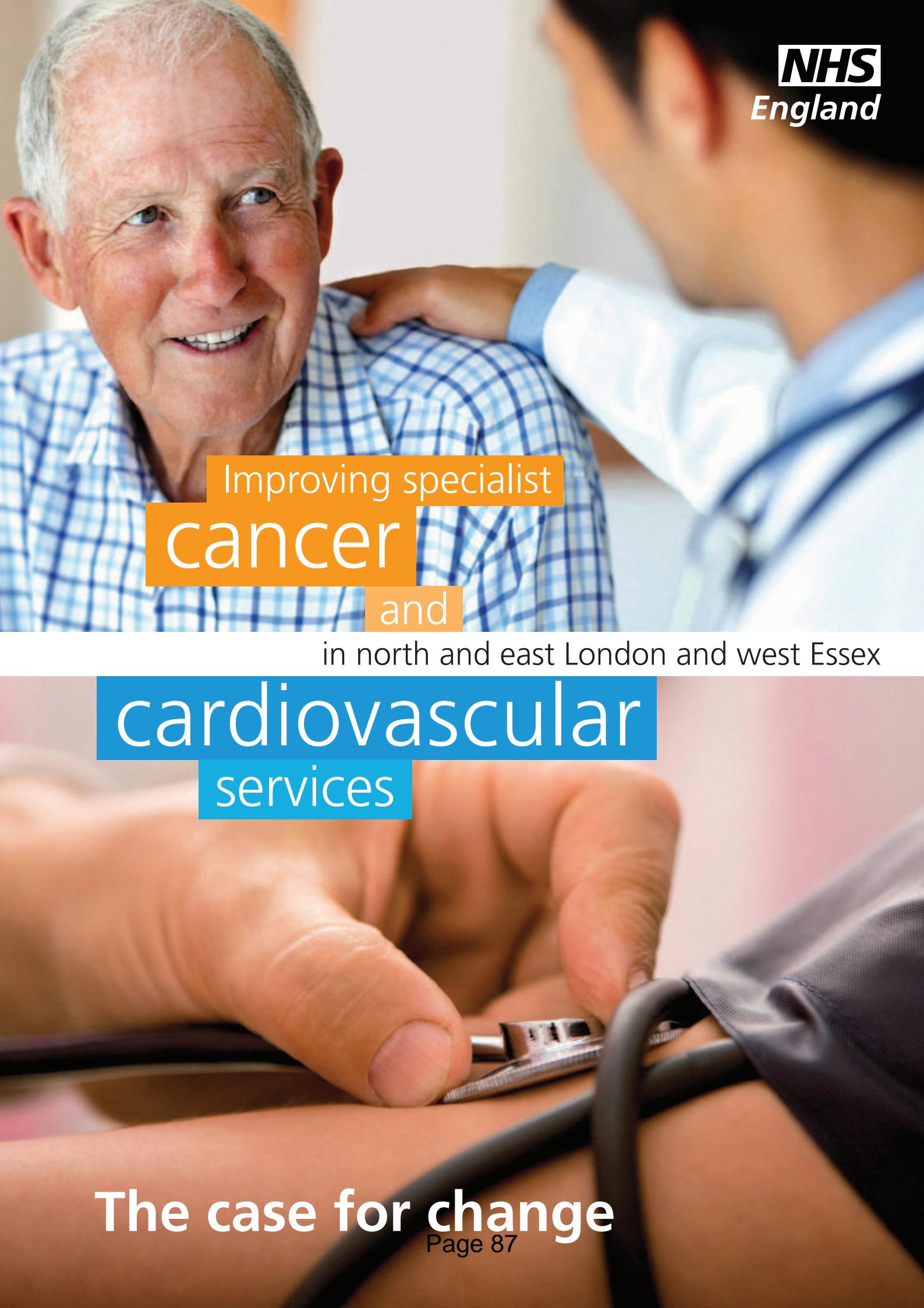
Comments can be made until 4 December in one of the following ways:

Visiting: [www.england.nhs.uk/london/engmt-consult](http://www.england.nhs.uk/london/engmt-consult)  
Emailing: [cancerandcardiovascular@nelcsu.nhs.uk](mailto:cancerandcardiovascular@nelcsu.nhs.uk)  
Telephoning: 020 3688 1086  
Writing to: Cancer and cardiovascular programmes  
c/o North and East London Commissioning Support Unit  
Clifton House, 75-77 Worship Street, London EC2A 2DU

If you have any further queries, please do not hesitate to contact myself by emailing neil.kennett-brown@nelcsu.nhs.uk or by calling 020 3688 1222.

Yours sincerely

**Neil Kennett-Brown**  
Programme Director, Transformational Change



Improving specialist  
**cancer**  
and

in north and east London and west Essex

**cardiovascular**  
services

**The case for change**  
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# Foreword

Cancer and cardiovascular disease cause two-thirds of early deaths in London.

If we were to improve local survival rates for heart disease and all cancers in line with at least the rate for England, we could save over 1,200 lives a year.

So we can and must do better.

To support this straightforward aim, we have examined how we provide these services in north and east London. And we have developed a vision for how we could improve them.

Patients want to have health services that are locally accessible. But when they are critically ill they want the best specialists, with the best equipment, to give them the best chance of recovery. We share this view and recommend the development of two world-class specialist centres in north and east London, one for cardiovascular services at St Bartholomew's Hospital and one for cancer services at University College Hospital.

By bringing expertise, state-of-the-art technologies, research and education together in centres of excellence we can improve the whole pathway of care. This means patients who need specialist cancer and cardiovascular care would have better outcomes, a better experience of care and better local services.

The NHS faces a tough financial climate. These centres of excellence would boost the local health economy by providing more cost-effective services, as well as bringing in money from more research investment and national and international patient referrals.

However, for cancer treatments, The Royal London Hospital, St Bartholomew's

Hospital, Queen's Hospital and the Royal Free Hospital would also retain and develop expertise and services for specific tumour types, providing the very best specialist care and facilities. Working as specialist centres they would provide a comprehensive system of care, much of it close to people's homes.

This document sets out why services need to change to improve services for today's patients and future generations. It also gives expert advice from local clinicians on how best to do this. The proposals build on developments across the country and around the world over the past few years. They are designed to seize the once-in-a-lifetime opportunity arising from the new facility at St Bartholomew's Hospital and University College Hospital's cancer centre development.

We are keen to hear your views on this case for change. Details of how you can respond are on page 71. We need to receive your comments by 4 December 2013.

**Dr Andy Mitchell**

Medical Director (London Region)  
NHS England

**Simon Weldon**

Director of Commissioning (London Region)  
NHS England

## Introduction

North and east London has some of the best cancer and cardiovascular experts in the country but our specialist services are not organised in a way that gives patients the best chance of survival and the best experience of care.

Specialists, technology and research are spread across too many hospitals to provide the best round-the-clock care to all patients.

In 2010 a clinical review recommended changes to cancer and cardiovascular services in London. After discussion with patients and the public, the review concluded that fewer specialist high-volume units would improve clinical outcomes, accelerate the uptake of new technologies, achieve greater quality and optimise efficiency.

Building on the London review and using clinical evidence, local doctors, GPs, nurses, health professionals, public health professionals and patients have looked at how we could improve cancer and cardiovascular services in north and east London.

Clinicians want to bring together expertise to give better care and save more lives. To do that, we need to change the way we deliver specialist cancer and cardiovascular services:

■ For cardiovascular care, clinicians have told us we should combine services currently provided at The Heart Hospital, The London Chest Hospital and St Bartholomew's Hospital to create a single integrated cardiovascular centre. With The London Chest Hospital closing next year and The Heart Hospital not having capacity for the whole region, clinicians have recommended we locate the centre in the new building at St Bartholomew's Hospital (which is 2.5 miles from The Heart Hospital). The Royal Free Hospital and the integrated cardiovascular centre at St Bartholomew's Hospital would act as heart attack centres for the area.

■ For five complex or rare cancers, clinicians have told us we should provide specialist treatment in four centres of excellence across the area with a hub at University College Hospital. We would continue to provide services locally for other types of cancer and general cancer services, such as diagnostics and chemotherapy.

This case for change is part of a UK-wide strategy to bring fairness and excellence to specialist services<sup>1</sup>, and to strengthen the NHS's status as a pioneer of medical innovation<sup>2</sup>. In developing their ideas, clinicians have been guided by the

### What are specialised services?

Specialist services are those provided in only a few hospitals, to only a few patients. These services should be located in specialist centres that can recruit staff with the right expertise and enable them to develop their skills. So you only tend to go to these places if you have a condition that needs really specialist care, perhaps because it is particularly rare or complex.

## Who is leading this review of cancer and cardiovascular services?

NHS England, the main commissioner for specialised services, is leading the review of specialist cancer and cardiovascular services, together with a number of local clinical commissioning groups (CCGs). CCGs are groups of GP practices that commission most healthcare services for their local population (excluding specialised services). These include planned hospital care, rehabilitative care, urgent and emergency care, mental health and learning disability services and most community health services, including a few associated with these proposals.

Clinicians from across north and east London and west Essex have developed this vision for cancer and cardiovascular services. Patient representatives have also been involved in developing the vision.

All hospital trusts that provide cancer and cardiovascular services have come together through UCLPartners – an academic health science partnership. Academic health science networks are a key part of NHS England's plan to bring innovation and research into routine practice in the NHS. UCLPartners supports the healthcare system that serves over six million people in parts of London, Hertfordshire, Bedfordshire and Essex. Its member organisations are working together to tackle the most pressing healthcare challenges faced by the local population. As well as improving specialist cancer and cardiovascular services, UCLPartners is also looking at ways to prevent and detect diseases earlier and to develop care pathways where services are better integrated.

This document summarises the expert clinical advice that teams working across UCLPartners have given to commissioners. Further information is available in UCLPartners' recommendations to commissioners in *A case for change in specialist cancer services* and *A proposal for clinical change in specialist cardiovascular services across north and east London*.

Department of Health's national outcomes strategies and NHS England's national service specifications.

Not all people with cancer and cardiovascular disease need specialist treatment, but these changes will improve the whole pathway of care for everyone.

Specialist centres of excellence are part of an overall plan to establish better coordinated, more efficient care. They would work closely with local hospitals and GPs to ensure patient care is provided seamlessly.

These specialist centres would be more cost-effective and could generate income for the NHS through research funding and international referrals of patients. The focus on research and education would also give more patients access to the latest technology and clinical trials, which improve health outcomes.

NHS England and CCGs would now like your views on the clinical recommendations for improving specialised cancer and cardiovascular services. This will help those who commission health care ('commissioners') to develop preferred recommendations for change.

<sup>1</sup> Department of Health, *The NHS Outcomes Framework 2013/14*, November 2012. Available at: [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/213055/121109-NHS-Outcomes-Framework-2013-14.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213055/121109-NHS-Outcomes-Framework-2013-14.pdf)

<sup>2</sup> Department of Health, *Innovation Health and Wealth: Accelerating Adoption and Diffusion in the NHS*, December 2011. Available at: <https://www.gov.uk/government/news/accelerating-adoption-of-innovation-in-the-nhs>

### **Who uses these services?**

Most of the hospitals that are part of this review are located in north and east London. But many patients from elsewhere use their services, particularly those from west Essex.

We will be discussing this document's recommendations with people from these areas.

Wherever you live, we encourage you to send us your feedback as outlined on page 71.

### **Travel and patient choice**

Clinicians know that concentrating specialised cancer and cardiovascular services in fewer hospitals would increase travel times for some patients, many of whom are very ill and coping with severe symptoms and the side effects of treatment.

Clinicians only want patients to travel further when it is absolutely necessary for them to receive better, more specialist care. Most patients would continue to be diagnosed and, where possible, receive their outpatient treatment and follow-up care at their local hospital.

Clinicians think the proposals in this document would greatly improve their ability to provide the highest quality care and better outcomes for patients.

The impact of longer travel times for patients and carers will be carefully considered as the proposals develop. We will be asking patient groups to tell us what they think and how we could lessen any problems. Options include better car parking and taxi services for those in need.



**The Macmillan Cancer Centre at University College Hospital, which opened in April 2012.**

The potential options considered in this document are subject to further analysis and the ongoing assessment and investigation of patient benefits, which involves additional analysis in compliance with our statutory obligations and the guidance surrounding them (not included or addressed in this document as not directly relevant to the clinical case for change).

If you have any comments or questions on these issues, email [cancerandcardiovascular@nelcsu.nhs.uk](mailto:cancerandcardiovascular@nelcsu.nhs.uk)



# Improving specialist cancer services

in north and east London and west Essex

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# Cancer

Cancer is one of the biggest causes of death and disability in the UK. Every year, around 13,600 Londoners die from the disease. The number of new cases is predicted to rise from 27,000 a year to 28,500 in 2022.

In north and east London, it is estimated around 12,900 people are diagnosed with cancer and 5,700 die from the disease each year.

Over the last decade, good progress has been made in prevention and treatment, so more people are surviving cancer, but there is still a lot of room for improvement. Cancer patients in London have worse survival rates and lower satisfaction about the care they receive compared to the rest of England. Within London there are also inequalities in specialist cancer care and outcomes between areas.

Local clinicians – working under the leadership of *London Cancer* (part of UCLPartners) – have been reviewing local cancer services and looking at how outcomes could be improved.

This section focuses on the recommendations that *London Cancer* clinicians have made about specialist services for:

We propose changing specialist services, such as surgery, for five types of cancers.

We do not propose to change general cancer services and all services for other types of cancers such as bowel and breast cancer. However, clinicians are looking at how these services can continue to be improved.

This means your local hospital or GP will continue to provide most services.

- brain cancer
- urological (bladder, prostate and kidney) cancer
- head and neck cancer
- acute myeloid leukaemia (AML) and haematopoietic stem cell transplantation (HSCT – transplanting stem cells derived from the bone marrow or blood)
- oesophago-gastric cancer (OG – cancer of the stomach or oesophagus).

To achieve world-class standards of care and ensure that local specialist cancer services can continue long term, clinicians agree we have to change the way we provide these services.

Most care will continue to be provided locally. But clinicians believe that centralising services for these tumour types into specific specialist centres will save more lives and help to achieve the wider improvements that are needed along the whole pathway of care, as we have seen with stroke care in London.

These include:

- tests such as X-rays, ultrasounds, genetic screening, mammograms and scans
- chemotherapy
- follow-up checks
- support services such as physiotherapy, occupational therapy and counselling
- palliative care.



An artist's impression of the new proton beam therapy centre at University College Hospital (design not yet finalised).

Whilst not part of this case for change, *London Cancer* has been reviewing other types of cancer to see how services could be improved. For these cancer services, clinicians are not currently recommending fewer sites but their current thinking about them is shown below:

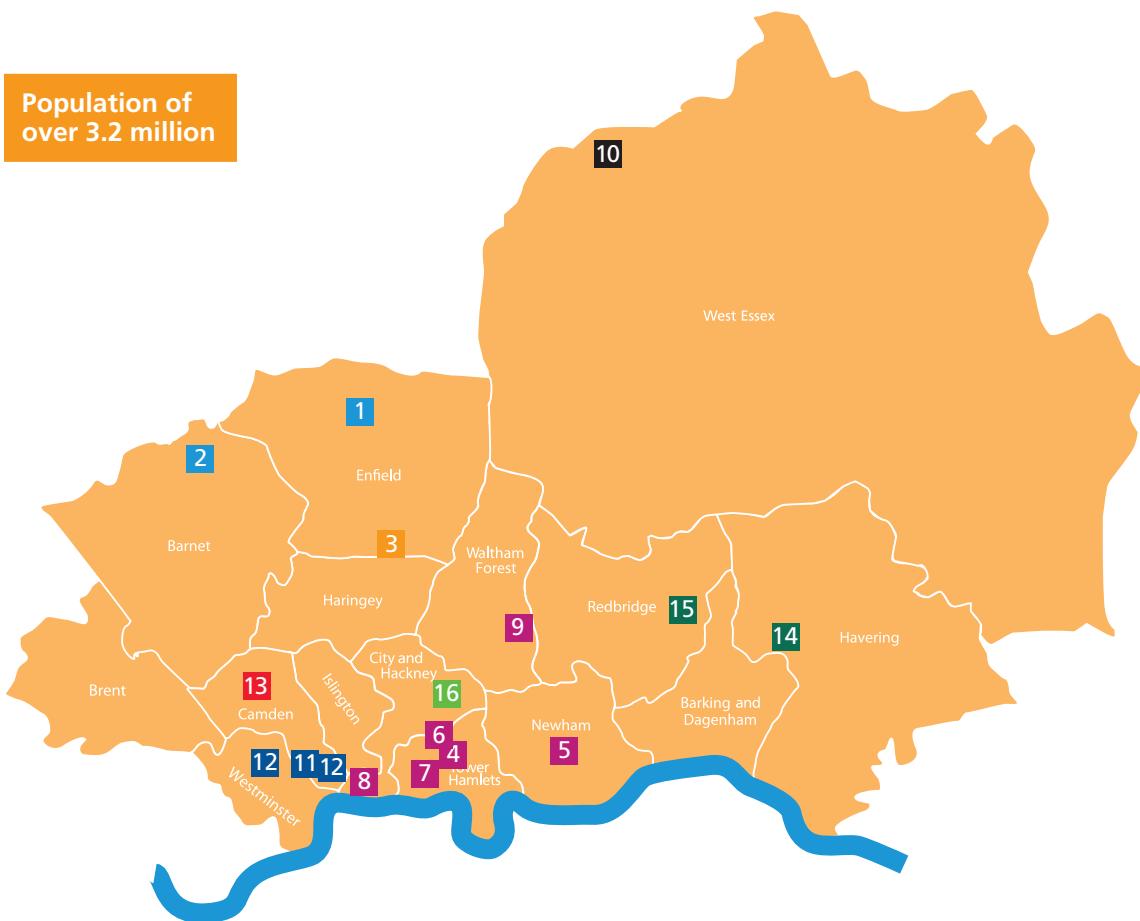
#### **■ Common cancers such as breast, lung and colorectal cancer**

Clinicians are looking at how the care pathway could be improved to meet service standards and best practice. This will include better joint working and some further specialisation of teams. In future they may recommend to commissioners that hospital services be reorganised. Commissioners are looking at a range of options to help improve service quality and outcomes in these more common cancers. For lung cancer this could include a single specialist multi-disciplinary team with a lead provider.

#### **■ Gynaecological and liver and pancreatic cancers**

These specialist services have already centralised and are meeting service standards for the number of patients and the population they serve. Barts Health and University College London Hospital Trust provide gynaecological cancer services to north and east London, west Essex and many areas of Hertfordshire. For liver and pancreatic cancers, the Royal Free Hospital and The Royal London Hospital provide services for north and east London, as well as Essex. In both cases, the two hospitals providing these services are working as a joint centre through *London Cancer* to share best practice, audit information and ways of doing things.

## Hospitals in north and east London and west Essex providing specialised cancer services



### Barnet and Chase Farm Hospitals NHS Trust

- 1 Chase Farm Hospital
- 2 Barnet Hospital

### North Middlesex University Hospital NHS Trust

- 3 North Middlesex University Hospital

### Barts Health NHS Trust (Barts Health)

- 4 Mile End Hospital
- 5 Newham University Hospital
- 6 The London Chest Hospital
- 7 The Royal London Hospital
- 8 St Bartholomew's Hospital
- 9 Whips Cross University Hospital

### Princess Alexandra Hospital NHS Trust

- 10 Princess Alexandra Hospital

### University College London Hospitals NHS Foundation Trust (UCLH)

- 11 University College Hospital
- 12 The National Hospital for Neurology and Neurosurgery (NHNN)

### Royal Free London NHS Foundation Trust

- 13 Royal Free Hospital

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

- 14 Queen's Hospital
- 15 King George Hospital

### Homerton University Hospital NHS Foundation Trust

- 16 Homerton University Hospital

## Where specialised cancer services are provided now

Current	Barnet	CFH	RF	WHIT	UCH	NHNN	NMUH	PAH	HUH	BH	RLH	WX	NUH	KGH	QH
Brain						S					S				S
Head and neck		S			S					S					
Prostate and bladder	S	L	L	S			L	L			L	S		S	L
Kidney	S	S	L	S			L	S	S		S	S	S	S	
HSCT		S		S						L	S				
AML	S		S		S		S			S					S
OG	L	L		L	S		L	L			S	L	L		S

## Where local clinicians are recommending specialised cancer services be provided

Future	Barnet	CFH	RF	WHIT	UCH	NHNN	NMUH	PAH	HUH	BH	RLH	WX	NUH	KGH	QH
Brain						S					L				S
Head and neck		L			S					L					
Prostate and bladder	L	L	L	S			L	L			L	L		L	L
Kidney	L	S	L	L			L	L	L		L	L	L	L	
HSCT		L		S				L	S						
AML	L		L	S			L			S					S
OG	L	L		L	S		L	L			L	L	L		S

S - Specialist provider

L - Local service

	Hospital	Trust
Barnet	Barnet Hospital	Barnet and Chase Farm Hospitals NHS Trust
CFH	Chase Farm Hospital	
RF	Royal Free Hospital	Royal Free London NHS Foundation Trust
WHIT	The Whittington Hospital	Whittington Health
UCH	University College Hospital	University College London Hospitals NHS Foundation Trust
NHNN	National Hospital for Neurology and Neurosurgery	
NMUH	North Middlesex University Hospital	North Middlesex University Hospital NHS Trust
PAH	Princess Alexandra Hospital	Princess Alexandra Hospital NHS Trust
HUH	Homerton University Hospital	Homerton University Hospital NHS Foundation Trust
BH	St Bartholomew's Hospital	Barts Health
RLH	The Royal London Hospital	
WX	Whipps Cross University Hospital	
NUH	Newham University Hospital	
KGH	King George Hospital	Barking, Havering and Redbridge University Hospitals NHS Trust
QH	Queen's Hospital	



# Why we need to improve

Clinical outcomes for patients with rare or complex cancers and patients' experience of cancer services in north and east London are not as good as in other areas of the country. One local borough – Barking and Dagenham – has the country's lowest proportion of total cancer patients who survive more than a year after their diagnosis.

While there has been significant improvement, services often fall short of the high standards that local patients expect. In the past year, cancer patients in England have rated nine out of the 10 worst trusts as being in London – four of those were in north and east London.

Every cancer type is different, but local clinicians have given the following reasons for changing the way we provide our specialist cancer services:

## ■ Local cancer patients have relatively poor clinical outcomes

Over recent years, improvements in one-year survival in the region have lagged behind those reported in England as a whole (Office for National Statistics 2011). The London-wide review estimated there are 400 avoidable deaths from cancer in north and east London and west Essex every year.

For some types of cancer, where services are spread across a number of local hospitals, clinicians do not see enough patients to build and maintain their skills. For example, National Institute of Health and Care Excellence (NICE) *Improving Outcomes Guidance for Cancer* recommends hospitals serve a population of between one and two million, which would mean they perform at least 60 operations for oesophago-gastric cancer each year. None of the hospitals in our local area meet this minimum number.

## ■ There are inequalities in patient outcomes

Cancer rates and survival vary significantly within London and between ethnic and socio-economic groups. For example, the UK five-year survival rate for Afro-Caribbean men with prostate cancer is 30% worse than for white men.

## ■ Services are fragmented

Local cancer services have developed at numerous hospitals over the years in an unplanned way. They do not make the most efficient use of the limited and highly skilled workforce so patients are not fully benefiting from advances in medical care. Specialist teams are spread across too many hospitals, making it difficult to provide all patients with the best quality care. For example, not all patients with acute myeloid leukaemia have enough input from clinical nurse specialists with specific expertise in their condition. Locally, there are also high staff turnover and vacancy rates.

## ■ Patients do not always have a good experience

The 2012/13 national cancer patient experience survey found that patients diagnosed with rarer cancers tend to have a worse experience (i.e. lower levels of satisfaction) than patients with more common cancers. Locally, an average of 85% respondents rated the care provided by hospitals in north and east London as very good or excellent, compared with 91% for the Royal Marsden Hospital which is a specialist cancer care centre.



**■ Not enough specialisation to make the most of the latest advances in treatment**

Advances in medicine and surgery mean clinical staff and equipment need to become more specialised. For example, not all head and neck cancer patients have access to advanced radiotherapy techniques, such as intensity-modulated radiation therapy. This technique delivers more precise radiation doses and can reduce the side effects of treatment. From 2017, University College Hospital will be one of two sites in England that offer proton beam therapy, which can reduce the side effects of radiation therapy for some types of brain and head and neck cancers.

**■ Not enough patients are involved in clinical trials**

Taking part in clinical trials improves outcomes for cancer patients<sup>3</sup>. A lot of research takes place locally, but less than a quarter of cancer patients take part in clinical trials during their treatment. This means many are missing the opportunity of new drugs and treatments.

*"Clinical trials are important to us as patients because we believe that they are key to improvements in cancer treatments and outcomes. People are keen to participate in clinical trials for a variety of reasons. Some people hope a trial will lead to improved outcomes for themselves, while for others it's about improving treatments for future cancer patients. It's also a way to turn the negativity of a cancer diagnosis, and the difficulties of cancer treatment, into a positive contribution to the ongoing work to bring cancer into the realms of a chronic (or curable) illness."*

Elizabeth Benns, member of Independent Cancer Patients' Voice and a non-executive director on the board of London Cancer

<sup>3</sup> NHS Commissioning Support for London, *A model of care for cancer services: Clinical paper*, August 2010, p.110-112. Available at: <http://www.londonhp.nhs.uk/wp-content/uploads/2011/03/Cancer-model-of-care.pdf>

# Improvements underway to cancer services

Specialist treatment is only a small part of a long and difficult journey for cancer patients. Work is needed across all services to reduce the number of people who die from the disease. NHS England, CCGs, *London Cancer* and local authorities across north and east London and west Essex are working hard to improve all cancer services.

For instance, *London Cancer* aims to reduce avoidable deaths from cancer in the local population by 200 each year from 2015/16 by increasing screening for people at risk and supporting GPs to detect signs and symptoms of cancer earlier.

## ■ Earlier detection and intervention

Cancer is no longer a fatal disease. Advances in medicine mean many forms of cancer have high survival rates, provided they are diagnosed early. However, 16-35% of all new cancers in north and east London and west Essex are diagnosed only when a patient arrives at hospital in an emergency<sup>4</sup>. This means the cancers are often detected late, resulting in poor survival rates one year after diagnosis.

In Camden, commissioners, clinicians and academic experts are working together to design a programme to improve early detection in people most at risk of cancer. This work includes analysis to understand 'at risk' groups and the use of community champions to encourage people with symptoms to visit their doctor.

## ■ Supporting patients who are living with and beyond cancer

Patients with cancer who receive holistic, coordinated and personalised care have a better experience. Over the next two years, *London Cancer* aims to work with expert groups to introduce the recovery packages recommended by the National Cancer Survivorship Initiative. These will start at the point of diagnosis by offering everyone living with cancer a holistic needs assessment, treatment summaries detailing their care and key staff, as well as health and wellbeing sessions to learn about local support services and healthy lifestyles.

Patients will also receive cancer care reviews with their GP after they have been diagnosed.

## ■ Developing pathway specifications

Health professionals and patients have developed care pathway specifications that tackle all aspects of the care a patient receives. These focus on the whole patient pathway – from prevention to diagnosis and treatment. They are planned around patient need and they are motivated by the wish to reach 'global excellence' for each cancer area. The local specifications are in line with the national specifications for specialised services (where these apply).

## Our vision for cancer care

Patients with cancer are cared for by a range of clinicians and organisations during their treatment. It is essential that services are coordinated and that all their clinicians have access to training, support and peer review.

*London Cancer* plays a lead role in ensuring that improvements in cancer care are provided across all care settings and organisations. At the heart of *London Cancer's* vision for cancer care is the development of an integrated system of care.

Most care will continue to be provided locally. But *London Cancer* clinicians agree that patients with rare or complex cancers would have better outcomes if specialist care were centralised.

Specialist centres would provide clinical and research excellence along the whole of the cancer pathway. These centres would work with local hospitals and GPs to share best practice, resulting in a more joined-up experience for patients and their relatives. Building specialist teams would mean, for example, that we could offer up to 190 more oesophago-gastric cancer patients a year potentially life-saving surgery.



Fewer, specialist centres would provide the following:

- Expert care closer to where patients live – through joint consultant appointments, outreach clinics, joint multi-disciplinary teams and local ‘one-stop’ diagnostic clinics for patients who urgently need a range of tests.
- Multi-disciplinary care teams including specialist nurses, anaesthetists and therapists with enough qualified staff to give suitable cover.
- Better access to research and clinical trials, which are essential for finding new treatments and therapies.
- An improved working environment for all staff, better access to improved training and more opportunities to get involved in research.
- The opportunity to collect better data on outcomes and quality of care to continually raise standards for patients.

Clinicians believe that concentrating specialist cancer services at fewer higher-volume sites would save more lives and provide more productive, efficient and sustainable services.

Their view is backed by the following national guidance and London-wide strategies:

- The Department of Health’s *Improving Outcomes: A strategy for cancer*, which sets out the Government’s plans to raise England’s cancer survival rates and improve survivors’ experience of care and quality of life.
- The London-wide model for cancer services<sup>5,6</sup>, which sets out the capital’s needs for cancer services. The strategy was developed by lead cancer clinicians after a review of cancer services.
- NICE *Improving Outcomes Guidance*, which recommends which professionals should be involved in treating and caring for cancer patients and the types of hospital or cancer centre that are best suited to give that care.

NHS England’s national service specifications set out the requirements for a world-class service.

All hospitals providing specialist cancer care are being assessed against these national service standards. Action plans will tackle any shortfalls. In some cases, hospitals will not be able to meet the national standards and commissioners will need to make other plans to ensure high-quality services.

5 NHS Commissioning Support for London, *Cancer services: Case for change*, March 2010. Available at: <http://www.londonhp.nhs.uk/wp-content/uploads/2011/03/Cancer-case-for-change.pdf>

6 NHS Commissioning Support for London, *A model of care for cancer services: Clinical paper*, August 2010. Available at: <http://www.londonhp.nhs.uk/wp-content/uploads/2011/03/Cancer-model-of-care.pdf>

## The evidence for specialist care

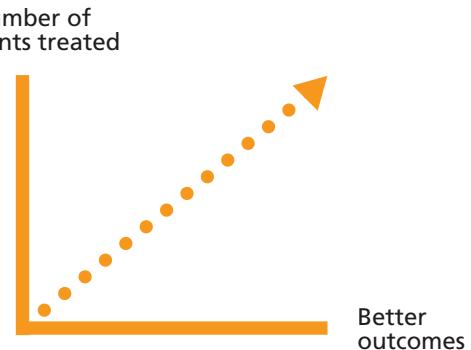
There is strong evidence that cancer patients have better outcomes in centres that see larger numbers of patients with the same condition (known as high-volume centres)<sup>7</sup>. Patients who are treated in these centres are more likely to survive after surgery and live longer, fuller lives. Numerous studies over the past 10 years have found this is very important for specialist cancer services.

- A review of 135 published studies covering a range of surgical procedures or clinical conditions looked at how many patients hospitals saw and the number of patients each surgeon saw<sup>8</sup>. Most of these studies found a direct relationship between higher numbers of patients and improved outcomes. This was strongest in complex or high-risk procedures, including cancer treatment.
- A US literature review of urological cancer surgery found that the larger number of patients, the better the outcomes<sup>9</sup>.
- Another review found that patient outcomes improved as hospitals treated more people<sup>10</sup>. Mortality (i.e. death) rates in hospitals performing fewer than five pancreatic operations a year were between 13.8% and 16.5%, compared with mortality rates of between zero and 3.5% in hospitals performing more than 24 pancreatic operations a year.

■ A 2005 review of cancer procedures in the UK found that high-volume hospitals had much better outcomes for complex cancer surgery.

■ A recent review of all patients treated in England for cancer of the stomach or oesophagus between 2004 and 2008 found that patients operated on in high-volume hospitals had the best short- and long-term outcomes. The review supported further centralisation of surgical services<sup>11</sup>.

Specialist services need to be provided by suitably qualified teams with enough practice to maintain their skills and expertise. Creating centres of excellence brings together scarce clinical expertise, supports training and ensures staff levels are sufficient. These improvements raise clinical quality and ensure all patients receive the best possible care.



<sup>7</sup> K Bilimoria, DJ Bentrem, JM Feinglass, et al, 'Directing Surgical Quality Improvement Initiatives: Comparison of Perioperative Mortality and Long-Term Survival for Cancer Surgery', *Journal of Clinical Oncology*, 2008, 26:4626-4633.

<sup>8</sup> EA Halm, C Lee, MR Chassin, 'Is volume related to outcome in health care? A systematic review and methodologic critique of the literature', *Annals of Internal Medicine*, 2002, 137:511-52.

<sup>9</sup> M Nuttall, et al, 'A systematic review and critique of the literature relating hospital or surgeon volume to health outcomes for 3 urological cancer procedures', *The Journal of Urology*, 2004.

<sup>10</sup> T van Heek, et al, 'Hospital Volume and Mortality After Pancreatic Resection', *Annals of Surgery*, 2005, 242(6): 781-790.

<sup>11</sup> Coupland, Victoria H et al. 'Hospital volume, proportion resected and mortality from oesophageal and gastric cancer: a population-based study in England, 2004–2008', *Gut*, 2013; 62: 961-966.



Treating more patients also improves research, particularly for rarer cancers. There is evidence that cancer patients who take part in clinical trials have better outcomes. Indeed, all patients treated in centres that undertake clinical research do better whether or not they are part of a trial<sup>12,13</sup>.

You can find out more about the evidence for creating specialist, high-volume centres in *A case for change in specialist cancer services*.

12 J West, J Wright, D Tuffnell, D Jankowicz, R West, 'Do clinical trials improve quality of care? A comparison of clinical processes and outcomes in patients in a clinical trial and similar patients outside a trial where both groups are managed according to a strict protocol', *Qual Saf Health Care*, 2005;14:175-178.

13 Peppercorn JM, Weeks JC, Cook EF, Joffe S., 'Comparison of outcomes in cancer patients treated within and outside clinical trials: conceptual framework and structured review', *Lancet*. 2004 Jan 24;363(9405):263-70.

# Brain cancer

There are many types of brain tumour. Unlike other types of cancer, it is not always easy to class them as 'benign' (non-cancerous) or 'malignant' (cancerous). Benign brain tumours are sometimes treated with radiotherapy and chemotherapy because they can also cause serious symptoms and be life-threatening.

Patients with brain cancer usually attend A&E with severe symptoms such as seizures. Patients referred to hospital by GPs rarely have tumours. Most patients require surgery (neurosurgery) with high levels of support and follow-up care.

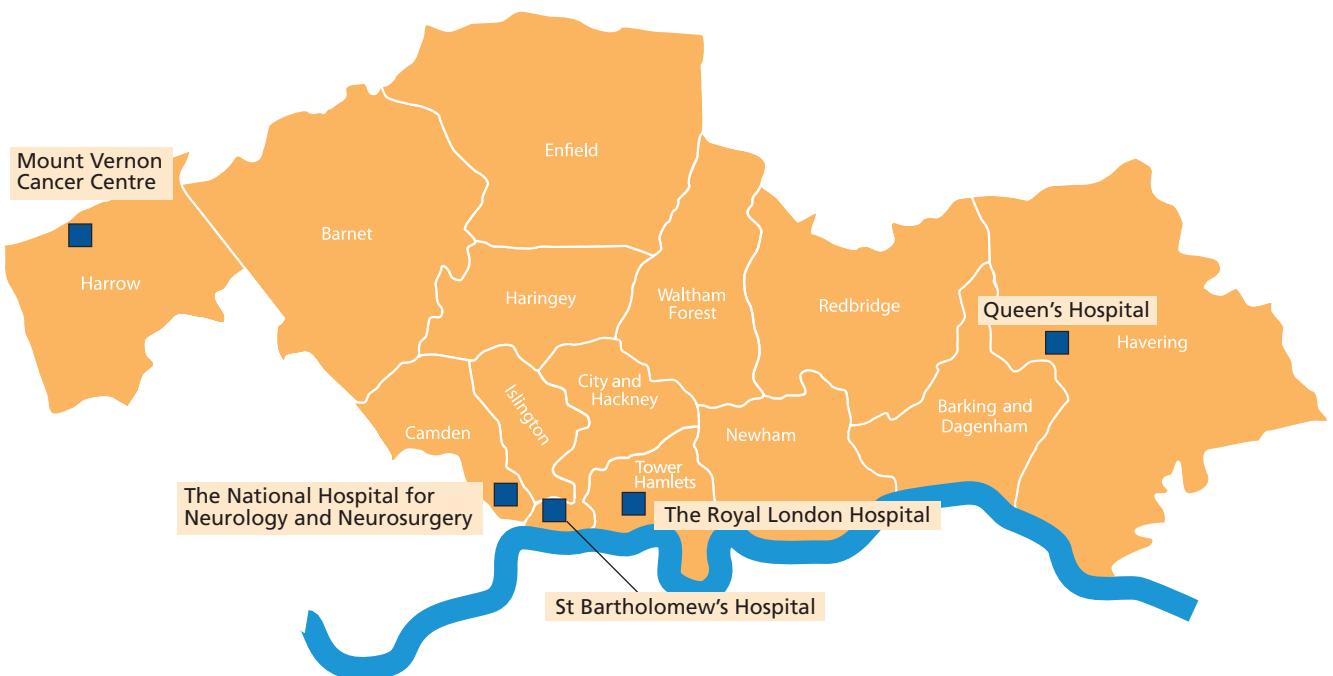
There are currently three neuro-oncology surgery centres (for malignant and non-malignant tumours), each with its own multi-disciplinary team:

- The National Hospital for Neurology and Neurosurgery (NHNN)
- Queen's Hospital in Romford
- The Royal London Hospital.

Queen's Hospital provides the regional neurosurgical and neuro-oncology service for the whole of Essex.

Both the NHNN and Queen's Hospital in Romford have on site or nearby access to oncology (radiotherapy and chemotherapy). The Royal London Hospital's patients have oncology at St Bartholomew's Hospital. Oncology for brain cancer patients also takes place at Mount Vernon Cancer Centre, part of East and North Hertfordshire NHS Trust.

## Hospitals providing specialist brain cancer services in north and east London



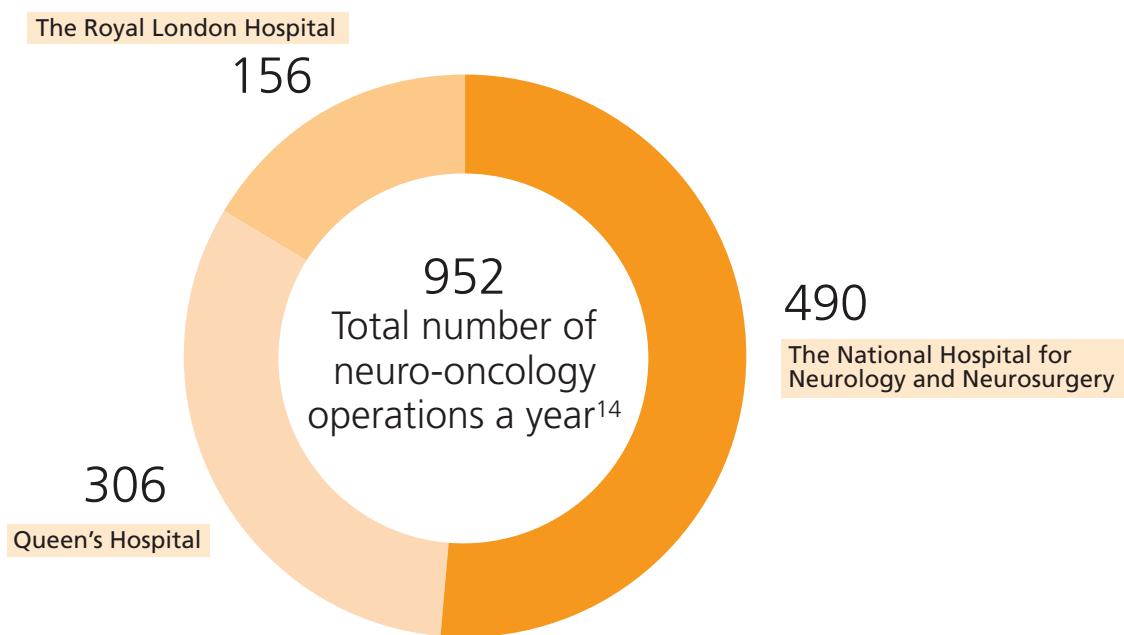


*"We aim to provide world-leading brain integrated cancer care that meets the holistic needs of our patients – including access to rapid and accurate diagnosis, all the most effective treatment options, cutting-edge clinical trials and innovation in rehabilitation."*

*"We will judge our success, not just on clinical outcomes, but on the quality of the patient experience, and whether our patients feel fully supported throughout their care, whether it is in hospital or at home."*

Mr Andrew Elsmore, Pathway Co-Director for Brain and Spine Cancer, Consultant Neurosurgeon and Dr Jeremy Rees, Pathway Co-Director for Brain and Spine Cancer, Consultant Neurologist

### Brain cancer procedures in north and east London (2010/11)



<sup>14</sup> Activity at the NHNN increased by 29% between 2011 and 2012. Data from 2011/12 is not available for Queen's Hospital in Romford or The Royal London Hospital. This increase in activity at NHNN follows the trend of recent years due, in part, to the move of the neuro-oncology surgery service from the Royal Free Hospital in Hampstead to NHNN during this time.

## Overview of service standards

NICE guidance<sup>15</sup> and national<sup>16</sup> service standards recommend that:

- specialist multi-disciplinary teams are based in neuroscience and cancer centres serving a population of two million
- neurosurgeons who manage brain tumours spend at least 50% of their time in neuro-oncological surgery and be regularly involved in dedicated speciality clinics for these patients
- neuroscience specialist teams are centred on neurosurgery with a 'cancer network' multi-disciplinary team to deal with the oncological aspects of follow-up treatment
- radiologists who investigate brain tumour patients spend at least 50% of their time in neuroradiology
- patients have access to specialist neuro-rehabilitation services coordinated in every region by an allied health professional such as a physiotherapist or occupational therapist.

The London-wide review recommended that the number of hospitals in the capital providing specialist services for brain cancer patients be reduced to four, each serving a population of two million.

## Why services need to change

Services are not meeting recommended levels of care

Currently, three centres serve a population of over 3.9 million (north and east London and Essex). This means they are well below the minimum population of two million set by the national standards.

### Time dedicated to neuro-oncology surgery and radiology

To varying degrees, all three local centres have neurosurgeons and radiologists managing and investigating brain cancer for less than 50% of their time. This is below the level set by the national standards.

### Not all patients are getting the best possible care

- Currently, there is no full 'cancer network' multi-disciplinary team at either NHNN or The Royal London to manage the non-surgical and supportive care of brain tumour patients. In particular, The Royal London Hospital only has an oncologist one day a week and only limited specialist nursing support, whereas the NHNN has a dedicated brain cancer ward with specialist staff – one of the few nationally.
- A clinical audit has shown neuropathology services at The Royal London Hospital do not perform as well as those at the other two centres.
- Radiotherapy for some types of brain cancers should take place as soon as possible and always within six weeks. An audit has shown wide variation in waiting times at local centres, with some patients at The Royal London Hospital waiting over six weeks.
- Maximising the chance of an improved quality of life and minimising the side effects of treatment depend on good access to neuro-rehabilitation services. This is a key principle of the NICE *Improving Outcomes Guidance* but providing these services remains a national problem. Locally, we need more coordinated and consistent access to neuro-rehabilitation services.

<sup>15</sup> NICE, *Guidance on Cancer Services – Improving Outcomes for People with Brain and Other CNS Tumours – The Manual*, 2006. Available at: [http://www.nice.org.uk/nicemedia/pdf/CSG\\_brain\\_manual.pdf](http://www.nice.org.uk/nicemedia/pdf/CSG_brain_manual.pdf)

<sup>16</sup> NHS England, *Service specification for brain/central nervous system tumours*, 2013. Available at: <http://www.england.nhs.uk/wp-content/uploads/2013/06/b13-cancr-brain-cent-nervous.pdf>



## Clinical recommendations

Local clinicians recommend that the three current neuro-oncology surgery services should be consolidated to two centres. This would mean keeping the service at Queen's Hospital in Romford (for Essex and outer north-east London) with services at The Royal London Hospital and NHNN coming together, providing for a population in excess of two million. Clinicians have recommended that the NHNN should become the single centre for inner north-east London and north-central London. The Royal London Hospital is currently the smallest centre and lacks access to the full range of specialist clinical and support service staff available on the other two sites. The NHNN has a national and internationally established reputation for excellence and a range of specialist facilities for brain cancer patients.

In addition to consolidating care onto two sites, clinicians have recommended ways of improving the patient pathway:

- Immediate referral – local hospitals should refer patients with a suspected brain tumour immediately to a neuro-oncology surgery centre. These referrals should include clinical information, the original CT scan, and the named point of contact at the referring unit.
- Clinical nurse specialist support – all patients should have information and support from a clinical nurse specialist at diagnosis and before surgery. These nurses would do holistic needs assessments at key points in the pathway, including start and end of treatment, and proactively support patients.
- Rapid diagnosis and referral to oncology after surgery – all patients should experience a seamless pathway. Neuropathologists, neuroradiologists, neurosurgeons, radiotherapy physicists and neuro-oncologists should work

together as a team to reduce delays in the patient pathway.

- Suitable follow-up – neuro-oncology surgery centres should work in partnership with oncology centres, local cancer units, GPs and hospices to implement new methods of long-term follow-up.
- Improved access to neuro-rehabilitation – all patients should have access to a suitable level of neuro-rehabilitation. Neuro-oncology teams should work with commissioners, charities, community care and other neuroscience colleagues to improve access to neuro-rehabilitation.



## How services would work: an example

Margaret, 64, from north London, had a seizure while she was at home with her husband Charlie. An ambulance took them both to their local A&E department.

In A&E, the team organised a CT scan of her brain. The scan showed a suspected brain tumour and Margaret was immediately referred to the neuro-oncology surgery centre at NHNN in central London.

Margaret and Charlie were taken to the NHNN. They arrived at the same time as the scan from the local hospital, which was transferred electronically for review by the specialist neuro-oncology surgery team. Margaret had an MRI scan without delay. Having seen the results, the consultant surgeon and nurse specialist told Margaret she had a suspected brain tumour. They said she would need urgent surgery to relieve the pressure on her brain, allow the team to give her an accurate diagnosis and see what further treatment would be needed. Margaret had surgery the next day.

The tumour was removed and samples were sent to pathology where a specialist team quickly established the type of tumour. The neuro-oncology multi-disciplinary team (including a surgeon, pathologist, oncologist, clinical nurse specialist, palliative care consultant, radiologist and radiotherapist) met to discuss the results and discuss Margaret's ongoing treatment.

After the team had met, the consultant surgeon and a clinical nurse specialist explained the diagnosis and recommended treatment plan to Margaret and Charlie. They set out the options, risks and side effects. She was given a choice about where to have radiotherapy – at UCLH, a radiotherapy centre elsewhere in London or in a neighbouring area. This was arranged for her without delay.

Margaret then returned to her local hospital for follow-up care before going home. When she was ready for her further treatment she attended her chosen radiotherapy department as an outpatient.



## Head and neck cancer

Most patients with head and neck cancers are middle-aged or older. Survival rates depend mainly on the site of the cancer and how far it has spread when first detected.

Most head and neck cancers are found on the lip, mouth, back of the throat, voice-box and upper gullet. Other rarer forms of head and neck cancer include the salivary glands, nose, and sinuses.

Those that start in the connective tissues of the head and neck are even rarer.

Surgery is the most common treatment although more head and neck cancers are being treated with chemotherapy and radiotherapy.

Specialist surgery for head and neck cancer is currently carried out at three local centres:

- Chase Farm Hospital
- St Bartholomew's Hospital
- University College Hospital.

*"There is a real will amongst us all to shape the future of head and neck cancer care for the benefit of our patients. My role is to lead the process of integration and improvement and to ensure head and neck cancer care compares to the very best international standards, which our patients and local population deserve."*

Mr Simon Whitley, Pathway Director for Head and Neck Cancer, Consultant Oral and Maxillofacial Surgeon

### Hospitals providing specialist head and neck cancer services in north and east London

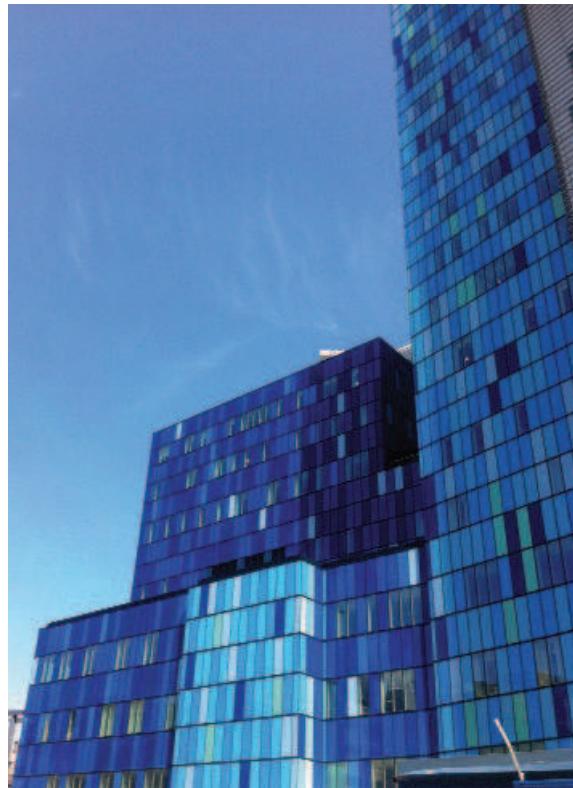


In 2012/13, St Bartholomew's Hospital saw around 163 head and neck patients. There were around 149 patients at University College Hospital and 56 at Chase Farm Hospital in the same period.

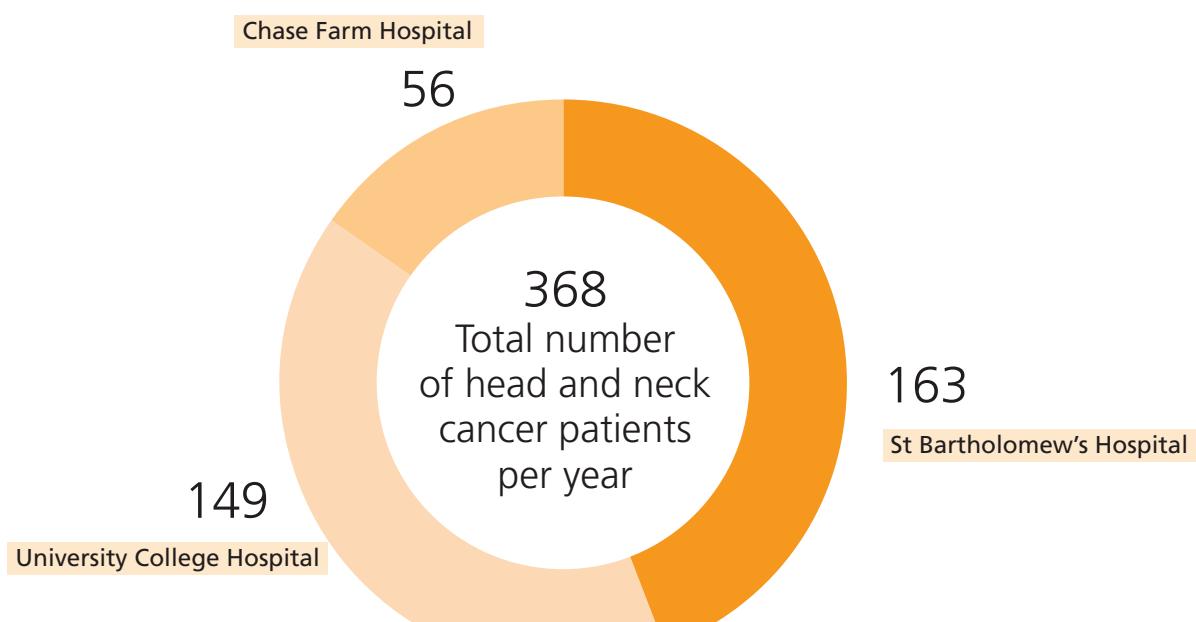
### Non-surgical treatment

We may use radiotherapy to treat cancers that are small and have not spread, or where surgery could seriously affect important functions such as speech. We often use it along with surgery to reduce the risk of the cancer recurring.

Chemotherapy is usually given in combination with radiotherapy. Very occasionally, it is given to shrink tumours before surgery or for palliative treatment.



### Head and neck cancer patients in north and east London (2012/13)





## Overview of service standards

National service standards and NICE guidance<sup>17</sup> recommend specialist multi-disciplinary teams for head and neck cancer serving populations of at least one million. Also all surgery should be provided by a specialist multi-disciplinary team in a designated centre, and surgeons and their teams should manage at least 100 new cases of head and neck cancer a year.

The 2010 London-wide review<sup>18</sup> said services for head and neck cancers should be brought together. It recommended that London should have five surgery providers, with two centres for base-of-skull and pituitary cancers.

## Why services need to change

**Not all services meet recommended levels of care**  
Some head and neck cancer services in north and east London do not meet the recommended levels of care. For example, the number of patients treated at Chase Farm Hospital is well below the recommended level.

**Unequal access to the right people and facilities**  
Currently not all patients have access to the wide range of specialities they need, such as plastic surgery, specialist nurses, dentists and dieticians, all in one place. As a result, patients often have to make many trips to hospital.

Hospitals providing head and neck cancer services in north and east London are only doing relatively low volumes of surgery, which does not allow surgeons to develop expertise such as robotic surgery and surgical voice-box reconstruction. Currently, not all hospitals provide cutting-edge technology such as advanced radiotherapy techniques, which can reduce side effects. Only University College Hospital will provide proton beam therapy, which may be used for this type of cancer to reduce side effects.

### Lack of joined-up care results in delays and a poorer quality of care

- Diagnosis of head and neck cancer often takes too long as patients may be referred to several different services, need numerous tests and have to wait for test results. The 2012 National Cancer Patient Experience Survey found that only 60% of head and neck cancer patients felt they were seen as soon as necessary; only 56% felt their tests were properly explained to them; and over 20% felt their symptoms got worse while waiting for a diagnosis.
- Currently there are no enhanced recovery programmes. These programmes cut the time in hospital after surgery by up to half. And because they reduce complications, patients can return home sooner to recover.

17 NICE, *Guidance on Cancer Services – Improving Outcomes in Head and Neck Cancers – The Manual*, 2004. Available at: <http://www.nice.org.uk/nicemedialive/10897/28851/28851.pdf>

18 NHS Commissioning Support for London, *A model of care for cancer services: Clinical paper*, August 2010, p.86-88. Available at: <http://www.londonhp.nhs.uk/wp-content/uploads/2011/03/Cancer-model-of-care.pdf>

- Local surgical centres enrol few people in clinical trials, and each centre collects data differently.
- Not all patients have access to a key worker at diagnosis, and follow-up and holistic needs assessment are not widely carried out. Not all patients have access to speech and language therapists and dieticians. Poor communication between care providers means only 36% of head and neck cancer patients say the people taking care of them worked well together.



## Clinical recommendations

Local clinicians recommend that the current three head and neck cancer surgical services for the local population of 3.2 million should be centralised onto one specialist surgical site.

Low patient volumes and planned changes as part of the Barnet, Enfield and Haringey Clinical Strategy mean that Chase Farm Hospital would no longer be able to sustain specialist head and neck oncology surgery.

Clinicians recognise that whilst the two remaining centres meet national minimum volumes and service standards they recommend centralising services at University College Hospital. Clinicians believe this would create the best possible head and neck cancer services and enable all patients to access the wide range of specialists they need in one place. These include facial reconstruction surgeons; ear, nose and throat surgeons; plastic surgeons; clinical oncologists; speech and language therapists; dieticians; restorative dentists; and clinical psychologists.

As University College Hospital is also developing advanced treatments such as proton beam therapy and specialist radiology treatments, centralising services at University College Hospital would ensure that all patients could readily get these new treatments.

Clinicians have also recommended ways of improving the patient pathway:

### **■ Faster diagnosis and screening –**

Most patients who are referred with a suspected head and neck cancer turn out not to have cancer. The maximum time patients with suspected head or neck cancer should wait before being seen by a consultant would fall from two weeks to one. In addition the waits for diagnostic scans such as MRI and CT would also fall to a week. Wherever possible initial assessment and diagnostics tests would take place at a local hospital close to home.

### **■ Discussing treatment options –**

Patients should be offered all suitable treatment options and reconstruction. The decision-making process should involve rehabilitation and supportive care professionals. All patients would be discussed in coordinated multi-disciplinary meetings.

### **■ Radiotherapy services –**

All patients would have access to cutting-edge techniques, such as intensity-modulated radiotherapy, where suitable. This reduces the harmful side effects of radiotherapy. Care would be coordinated to allow patients to be treated at the most convenient of the four current radiotherapy centres.

### **■ Local follow-up –**

After treatment at the specialist surgical centre or radiotherapy centre, patients should get their ongoing care closer to home. Regular patient follow-up clinics should be held locally to tackle patients' holistic needs. Each team should include a surgeon, oncologist, clinical nurse specialist, rehabilitation specialists (speech and language therapists, dieticians, occupational therapists, and physiotherapists), and palliative care specialists.

### **■ Implement an enhanced recovery programme –**

Enhanced recovery reduces the time patients need to spend in hospital and they recover faster. A larger-volume centre staffed with specialist surgeons, nurses, anaesthetists and therapists would be able to develop and provide an enhanced recovery programme for head and neck cancer patients.

# Urological cancers

Around 2,300 people are diagnosed with prostate, bladder or kidney cancer in north and east London each year. Of these, around 300 bladder and prostate patients and 300 kidney cancer patients need complex surgery. This gives them the best chance of controlling their cancer and reducing the risk of long-term side effects.

## Bladder cancer

Around 400 people are diagnosed with bladder cancer each year locally. Eighty per cent of them have early bladder cancer, which can often be treated by relatively simple surgery in most hospitals. Far fewer bladder cancers, less than 100 a year locally, are more advanced and have spread. These often need to be treated with complex major surgery, radiotherapy and chemotherapy.

## Prostate cancer

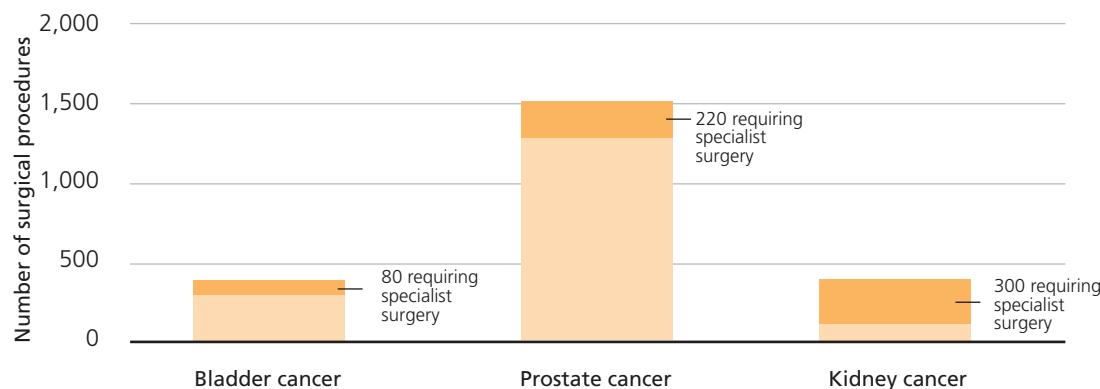
Prostate cancer is the most common cancer in men – around 1,500 local men are diagnosed each year but few need complex surgery. In 2010/11, only 220 complex operations for prostate cancer took place locally.

Small areas of cancer in the prostate are very common and may stay inactive for many years. There are many types of treatment and each has different benefits and side effects. Treatment options include monitoring the cancer, radiotherapy or brachytherapy (implanting small radioactive seeds in the prostate), hormone therapy, high-intensity focused ultrasound (a heating treatment), cryotherapy (a freezing treatment) or surgery, including surgery that is increasingly being done robotically. Newly diagnosed patients need clear information and unbiased support to help them decide what treatment is best for them. This is very important for these patients because of the range of treatment options – each with different risks of side effects such as incontinence or impotence.

## Kidney cancer

Kidney cancer is rare – only around 400 new cases locally each year. It is twice as common in men as in women. There are few treatment choices for kidney cancer and is most often surgical. Some operations are simple, others are very complex. All rely increasingly on emerging technologies such as keyhole surgery and robotically assisted surgery.

## Proportion of urological cancer patients needing specialist treatment in north and east London





## Current services

There are four bladder and prostate cancer surgical centres in north and east London, each serving a population of between 600,000 and one million. They are:

- Chase Farm Hospital
- King George Hospital
- University College Hospital
- Whipps Cross University Hospital.

In 2010/11, each bladder and prostate centre carried out between 54 and 89 specialist operations – a total of 296 (220 for prostate cancer and 76 for bladder cancer).

Currently, bladder and prostate surgery does not take place at Chase Farm Hospital; these patients have their surgery at University College Hospital. Most bladder and prostate surgery previously done at Whipps Cross University Hospital takes place at University College Hospital as more patients are taking up the option of robotic surgery.

*"I believe that the new system would allow us to achieve substantial improvements in our patients' care and experiences at a rapid pace. It would enable us to offer all our patients access to innovation and the best treatment options, regardless of location and circumstances. As a result, our service will flourish far into the future."*

Mr John Hines, Pathway Director for Urological Cancer, Consultant Urological Surgeon

## Hospitals providing specialist bladder and prostate cancer services in north and east London



## Hospitals providing specialist kidney cancer services in north and east London



Across the same area, kidney cancer surgery is provided at:

- Chase Farm Hospital
- King George Hospital
- The Royal London Hospital
- University College Hospital
- Whipps Cross University Hospital
- Royal Free Hospital
- Newham University Hospital
- Princess Alexandra Hospital
- Homerton University Hospital.

In 2010/11, they each carried out between 10 and 72 kidney cancer operations – a total of 292 operations.



## Overview of service standards

NICE guidance for urological cancer services recommends that patients with cancers that are less common or need complex treatment should be managed by specialist multi-disciplinary teams in large hospitals or cancer centres-, serving at least one million people.

The London-wide review recommended five specialist surgical centres in the capital serving a population of at least two million. Each centre should carry out at least 100 operations a year for bladder and prostate cancer. For kidney cancer, the review concluded that these cases should only be managed by specialist urology multi-disciplinary teams.

## Why services need to change

### Services are not meeting recommended levels of care

Some concentration of services has already happened. However, four centres currently provide bladder and prostate cancer services for a population of over 3.2 million, which does not meet national or London-wide standards. Also, all the current centres fall short of the recommended yearly number of bladder and prostate operations.

### Unequal access to the right people and equipment

Specialist services for urological cancer patients are currently widely dispersed, particularly for kidney cancer, with some centres only doing 10 operations a year. This means some clinicians do not see enough patients to develop or maintain their expertise in these procedures. In addition, not all hospitals have access to the latest technologies, such as robotic surgery.

Clinicians estimate that up to 50 bladder and prostate patients each year do not receive beneficial surgery because not all treatment options are discussed with them. The challenge is to ensure that everyone who needs specialist surgery is offered it. It is also important to prevent unnecessary operations where less invasive treatments might be suitable.

### Access to other specialities

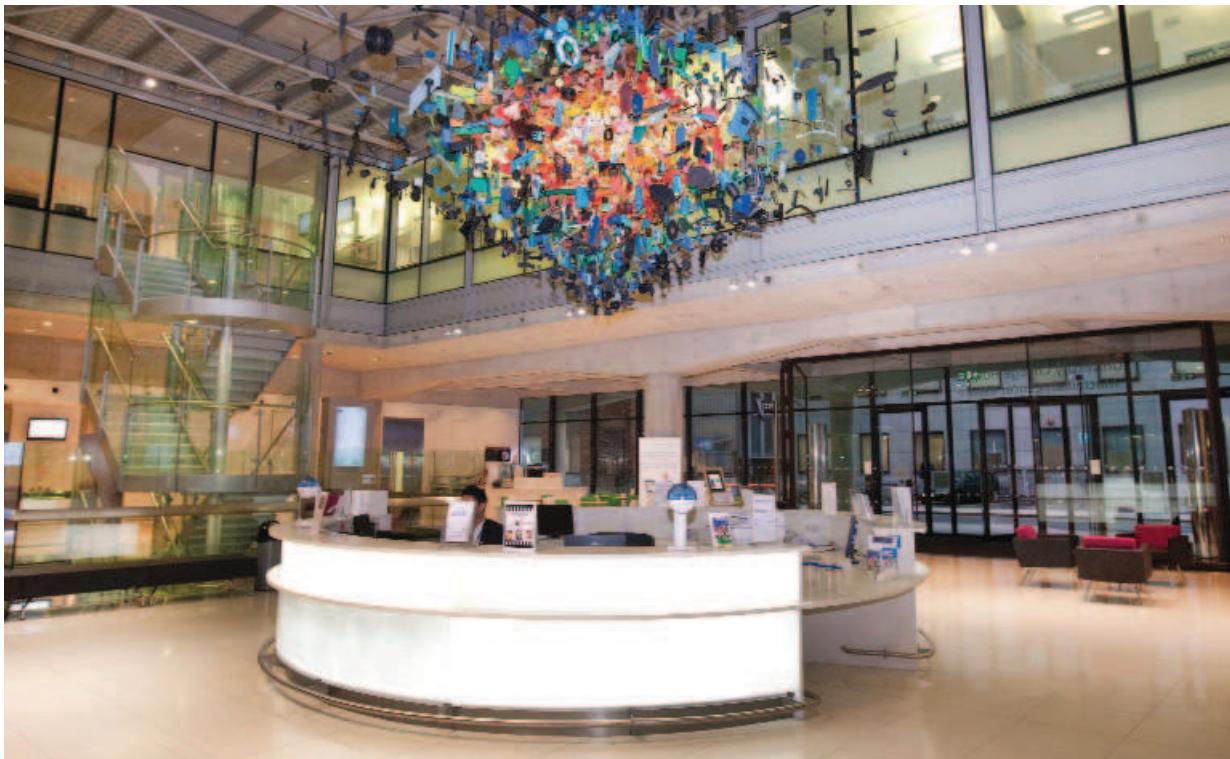
As kidneys are close to other organs, surgery should be carried out in a hospital with liver and pancreas surgeons. Kidney cancer can spread through blood vessels to the heart so it may be necessary for cardiac surgeons to assist. Kidney cancer surgery should also take place in a hospital that has renal medicine and dialysis facilities.

## Clinical recommendations

The London-wide model for cancer care recommended five specialist surgical centres in the capital, serving a population of at least two million. For north and east London, that would mean reducing the current four to one, or a maximum of two, hospitals providing specialist bladder and prostate cancer care (two

hospitals would still be below the minimum recommended population size).

Local clinicians think a more ambitious approach is needed to provide the world-class services local people deserve. They recommend centralising all complex bladder and prostate procedures at one specialist centre.



**The interior of University College Hospital's Macmillan Cancer Centre.**

This specialist centre would be at University College Hospital and it would:

- ensure that patients receive care from health professionals with specialist expertise, reducing the risk of incontinence and other post-operative complications
- employ a suitable number of health professionals with specialist expertise to look after patients during and after their surgery, and specialist teams would work at both the specialist centre and local hospitals
- maximise investment in skills, technology and research and the use of the most advanced techniques and facilities, such as robotics
- increase the number of new urological cancer patients taking part in clinical research if they wished to do so.

During a commissioner-led discussion on potential changes to bladder and prostate services in early 2013, some stakeholders

proposed a different option. They said we should look at the possibility of providing some specialist prostate surgery at Queen's Hospital in Romford.

Under this option, whilst all complex bladder surgery and most complex prostate surgery (undertaken robotically) would be centralised at University College Hospital, some specialist prostate cancer surgery could be offered at a second centre at Queen's Hospital in Romford. This would mean the current service at King George Hospital moving to Queen's Hospital.

For kidney cancer, clinicians recommend consolidating surgical services into a single specialist centre at the Royal Free Hospital as it has many of the necessary specialities to support surgery, including vascular surgery, liver and pancreatic surgery, renal medicine and 24-hour interventional radiology.

Services for penile and testicular cancer would remain the same as now.



### How services would work: an example

Michael from Leyton was diagnosed with prostate cancer after tests at his local hospital, Whipps Cross University Hospital. His consultant urological surgeon explained the diagnosis in detail and discussed the treatment options, which included robotic surgery for a prostatectomy. Michael was told about the side effects and benefits of each option and was supported in his decision to have robotic surgery.

On the day of the operation, Michael travelled by train to the specialist urological unit at University College Hospital where a team performed the surgery using the latest technology and medical advances.

Two days later, after recovering from surgery, Michael was able to go home. Michael had one follow-up appointment at University College Hospital, where the team assessed the results of the surgery and he was given the all-clear.

Michael now has his follow-up appointments at his local hospital to assess how he is getting on.



# Acute myeloid leukaemia and haematopoietic stem cell transplantation

**Acute leukaemias** are rare aggressive cancers of white blood cells that progress rapidly and need immediate treatment. There are two main types:

- Acute myeloid leukaemia (AML) involves myeloid cells, which perform such tasks as fighting bacterial infections, defending the body against parasites and preventing the spread of tissue damage.
- Acute lymphocytic leukaemia (ALL) involves lymphocytes, which mostly fight viral infections and generate an immune response. Treatment for this type of leukaemia is already centralised and so it does not form part of this review.

Younger patients – usually under 70 years of age – with AML need up to four courses of intensive chemotherapy to cure them or significantly extend their life expectancy. Chemotherapy for AML is very demanding. Each course of chemotherapy, given on an inpatient basis, leaves the patient without white blood cells for three to four weeks at a time. During this period patients are vulnerable to infection and other complications. About 15-20% of patients require intensive care.

High-quality facilities, close supervision and monitoring on a 24-hour basis are essential. Great care has to be taken to minimise the risk of infection and treat it rapidly and effectively if it occurs. This is best provided by a team of specialist nurses and doctors available around the clock.

Clinical nurses, psychologists and palliative care specialists have a central role. They ensure patients and their carers receive support, coordinated care and the information they need during the illness.

Some patients, particularly older patients, cannot withstand intensive therapies and would be treated ‘non-intensively’, usually on a day-case or outpatient basis. For these patients, the aim is to control the disease and manage complications. Services for patients being treated non-intensively do not form part of this review.

**Haematopoietic stem cell transplantation (HSCT)** means transplanting stem cells derived from the bone marrow or blood. The transplant increases the chance of a cure or remission for various haematological cancers and blood disorders. HSCT needs clinical expertise and suitable support facilities. These include specialist medical and nursing staff as well as support from other clinical specialists including those in respiratory medicine, cardiology, microbiology, virology, and infectious diseases. Because many complications can occur, support is often needed from other surgeons.

It is essential for on-site facilities and intensive care teams who know how to manage such patients to be available. Facilities for renal replacement therapy and bronchoscopy should also be readily available on site.

Transplantation is an intensive treatment. It can take several weeks for the bone marrow to recover and make enough new blood cells. During this time patients need to be in hospital or hospital hotels and be closely monitored for potential complications.

Local clinicians agree that any review should cover both transplant services and AML as the facilities and staff who give HSCT services are often the same as those who give intensive therapy for AML.

*"Our vision is to provide people in our area with an excellent integrated haematological cancer service that can compete with the best centres in the world. A service that helps people to be diagnosed as quickly as possible, have full access through a seamless service to all available treatment options and innovative research."*

Dr Kirit Ardeshta, Pathway Director for Haematology, Consultant Haemato-Oncologist



## Levels of care

The British Committee for Standards in Haematology defines four levels of care:

- Level 1 – Outpatient units provide treatment orally or intravenously, which does not normally cause significant loss of white blood cells.
- Level 2a – These centres provide treatment that results in short periods (less than seven days) of bone marrow and white blood cell loss, requiring short hospital stays.
- Level 2b – These centres provide complex chemotherapy needed to treat patients with relapsed lymphomas, as well as providing intensive treatment for AML.
- Level 3 – These centres provide intensive treatment for acute lymphoblastic leukaemia and transplant services.

This review focuses on our level 3 treatment centres and which level 2b units should continue to treat patients who have AML and those who need intensive chemotherapy.

## Current services

Six centres in north and east London provide level 2b treatment for patients with AML, each with their own multi-disciplinary team:

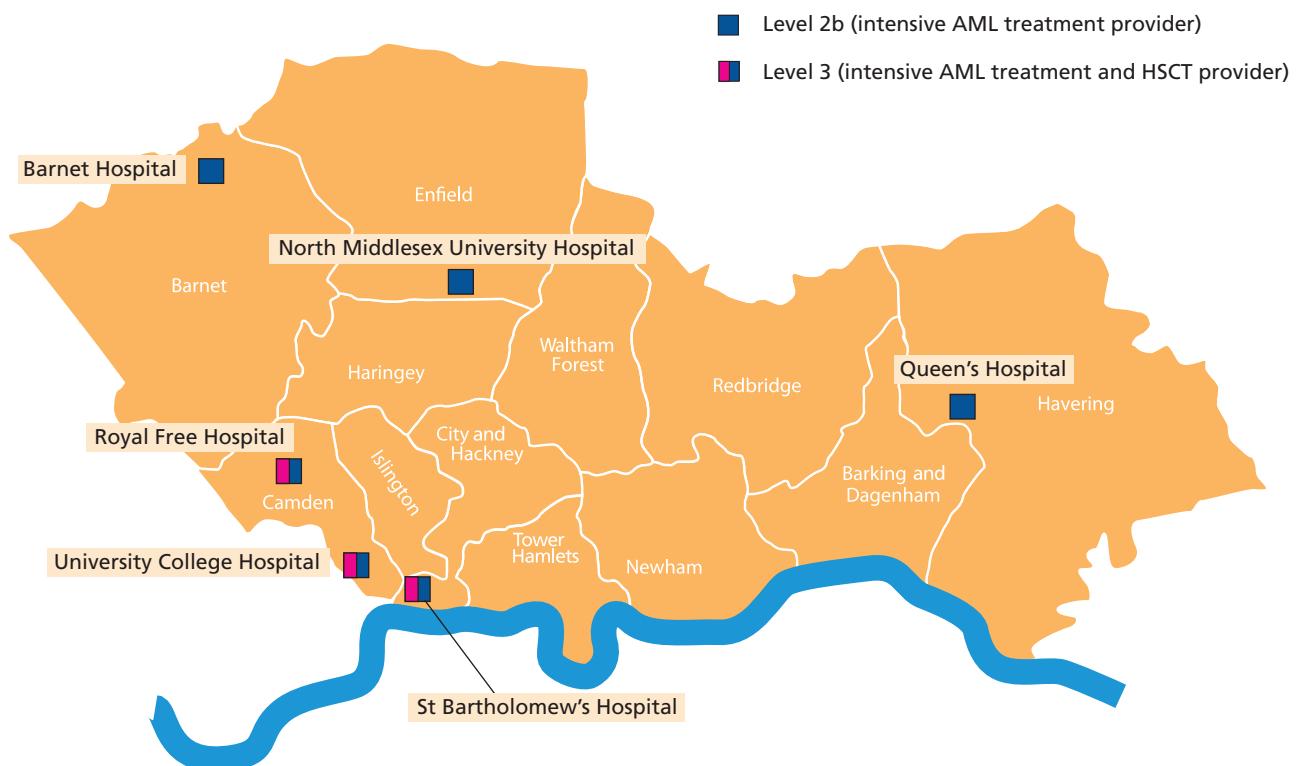
- Queen's Hospital in Romford
- North Middlesex University Hospital
- Barnet Hospital
- St Bartholomew's Hospital
- Royal Free Hospital
- University College Hospital.

In 2012/13, the centres treated 179 new patients, 104 of whom had intensive treatment. Each centre treated between 2 and 39 new patients intensively.

**Number of new NHS patients diagnosed with AML and the number of patients treated intensively**

	April 2011 – March 2012		April 2012 – March 2013	
	Number of new patients diagnosed with AML	Number of patients treated intensively	Number of new patients diagnosed with AML	Number of patients treated intensively
Queen's Hospital	34	16	36	9
North Middlesex University Hospital	9	5	3	2
Barnet Hospital	12	9	14	5
St Bartholomew's Hospital	51	30	58	39
Royal Free Hospital	26	15	23	15
University College Hospital	41	36	45	34
Total	173	111	179	104

**Hospitals providing AML and HSCT services in north and east London**





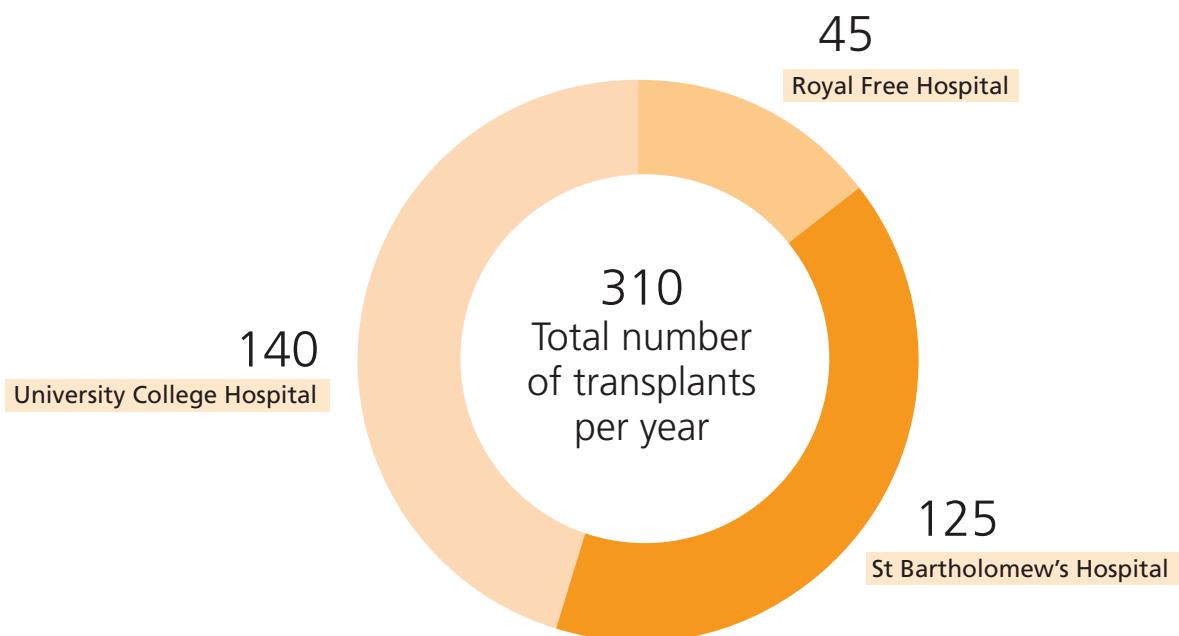
Transplant services are provided at three centres:

- Royal Free Hospital
- St Bartholomew's Hospital
- University College Hospital.

These centres perform a total of around 310 transplants a year. St Bartholomew's Hospital and University College Hospital each perform over 100 of these. The Royal Free Hospital performed only 45 transplants in 2011/12.



#### Transplants in north and east London (2011/12)



## Overview of service standards

NICE<sup>19</sup> guidance states that multi-disciplinary teams should treat intensively at least five new AML patients a year. It recommends that treatment be provided at a single facility on any one hospital site, in designated wards with continuous access to specialist nurses and haematologists. Local clinicians have recommended that providers should treat with intensive chemotherapy at least 10 new cases of AML a year. They believe that this number enables clinicians to become sufficiently familiar with the complex therapy needed to cure AML.

For HSCT, NICE and London-wide guidance recommends that centres take on at least 100 new cases a year<sup>20</sup>. The London-wide review<sup>21</sup> recommended that, given the specialist expertise and range of facilities required for stem cell transplants, the number of HSCT service providers in London should be reduced from eight to five.

## Why services need to change

### Services do not always meet recommended levels of care

Not all our HSCT services are carrying out the minimum 100 transplants each year recommended by the London-wide review. The Royal Free Hospital currently treats less than half that number of patients.

Local clinicians have recommended that units treat intensively at least 10 new AML patients a year. Last year Barnet Hospital and North Middlesex University Hospital treated five or fewer patients.

### Not all patients have access to specialist support

Each centre should have haematologists familiar with managing cancer on-site during working hours and available out-of-hours. This means patients with AML can be treated by clinicians with suitable expertise.

### Centres need a long-term future

Intensive treatment for AML and HSCT takes a lot of time and expertise and is therefore costly. Larger services will be more cost-efficient and better able to provide the care patients need.

## Clinical recommendations

Local clinicians recommend that the number of hospitals providing level 3 care including HSCT be reduced from three centres to two. As the Royal Free Hospital takes less than half the recommended number of cases, it would make sense for this service to transfer to University College Hospital. Level 3 HSCT and AML services would continue at St Bartholomew's Hospital and University College Hospital.

Since the NICE guidance was published, treating AML has become more complex. Local clinicians recommend that services should treat

at least 10 new AML cases intensively each year. To achieve this they recommend reducing the current six centres in north and east London to three. Two of these would be located with the recommended level 3 HSCT centres at St Bartholomew's Hospital and University College Hospital. London Cancer has recommended that the third centre be located at Queen's Hospital in Romford. After the Royal Free Hospital, Queen's Hospital in Romford is the only hospital to have enough new AML cases to meet the local recommended minimum of 10 cases a year.

<sup>19</sup> NICE, *Guidance on Cancer Services – Improving Outcomes in Haematological Cancers – The Manual*, 2003. Available at: [http://www.nice.org.uk/nicemedia/pdf/NICE\\_HAEMATOLOGICAL\\_CSG.pdf](http://www.nice.org.uk/nicemedia/pdf/NICE_HAEMATOLOGICAL_CSG.pdf)

<sup>20</sup> NHS Commissioning Support for London, *A model of care for cancer services: Clinical paper*, August 2010, p.93.

<sup>21</sup> NHS Commissioning Support for London, *A model of care for cancer services: Clinical paper*, pp.88-89.



# Oesophago-gastric cancer

Oesophago-gastric (OG) cancer is cancer of the stomach or oesophagus. It is the fifth most common cancer and the fourth most common cause of cancer death in the UK, affecting around 13,500 people each year<sup>22</sup>. Each year 830 new patients are likely to be diagnosed locally. The rate of OG cancer is increasing and the five-year survival rate is poor.

Diagnosing and managing patients with OG cancers involves a number of professional groups including GPs, specialist OG surgeons, clinical nurse specialists, dieticians, radiologists and physiotherapists.

Surgery offers the best chance of long-term survival for patients with early-stage OG cancer if it is operable. Usually, these patients also need chemotherapy.

About 75% of OG cancer patients have inoperable disease and need palliative and non-surgical treatment such as chemotherapy,

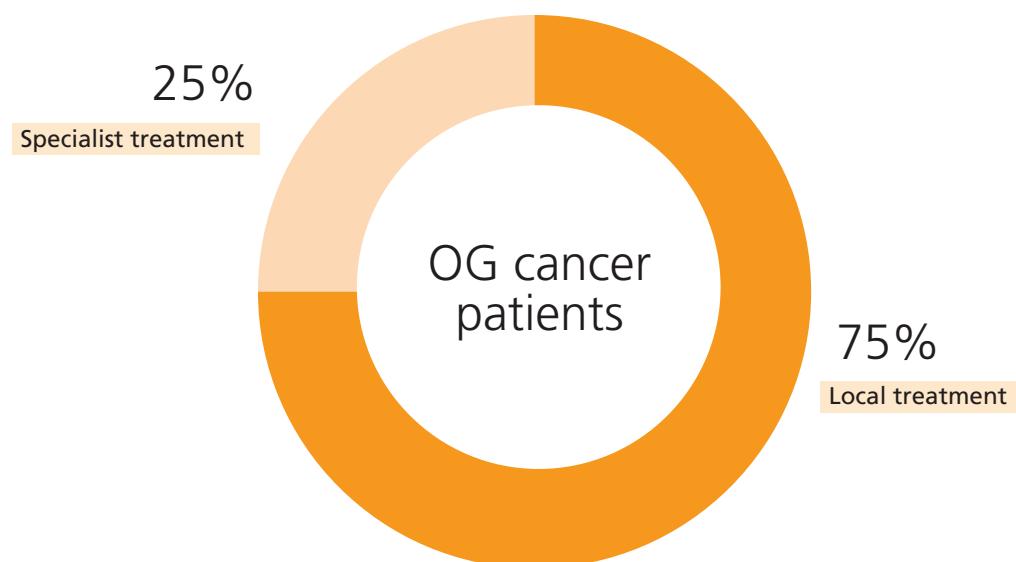
radiotherapy or endoscopic therapy to relieve symptoms. Specialist multi-disciplinary teams have to make the treatment recommendation for these patients, but the actual treatments may be provided in local units.

Specialist areas of OG cancer services include:

- endoscopic therapies
- all surgery, whether life-saving or palliative
- chemotherapy, radiotherapy and brachytherapy provided by a specialist team at a place decided by the network guidelines.

OG cancer patients who undergo surgery need 24/7 specialist care for around 30 days to give them the best chance of survival.

## Proportion of OG cancer patients needing specialist treatment



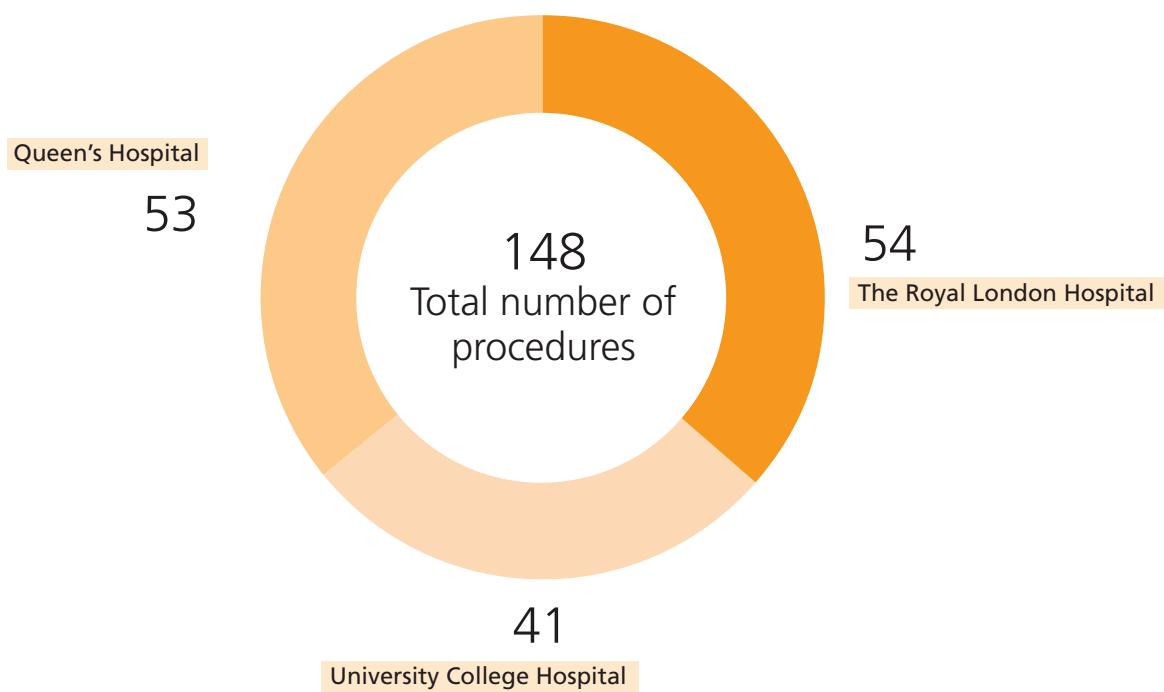
Currently, there are three specialist OG centres in north and east London:

- University College Hospital
- The Royal London Hospital
- Queen's Hospital in Romford.

The specialist centres work in partnership with their local hospitals to diagnose and treat patients through multi-disciplinary team meetings involving specialist clinicians in OG surgery, oncology, pathology and radiology as well as nursing and dietetics.

These centres perform a total of around 150 procedures a year, each doing between 41 and 54 operations. Each centre has its own multi-disciplinary team.

#### **OG cancer procedures in north and east London (2012)**



*"As clinicians, we aim to provide upper gastro-intestinal cancer patients with the most equitable, effective and responsive service in the UK, comparable with the very best in the world. We want patients to feel fully-supported in their care and treatment; and for every patient to have access to the best available treatment options, no matter where they live or first access our care, and wherever appropriate, they should benefit from participation in clinical trials."*

Professor Muntzer Mughal, Pathway Co-Director for Upper GI Cancer, Honorary Clinical Professor in Surgery, Consultant Surgeon and Mr David Khoo, Pathway Co-Director for Upper GI Cancer, Consultant Surgeon



## Overview of service standards

National service standards state that patients with OG cancers should be managed by specialist multi-disciplinary teams in centres serving at least one million people and performing at least 60 operations a year.

The Association of Upper Gastrointestinal Surgeons recommends that an individual specialist surgeon should carry out at least 15 to 20 operations a year at centres that have four to six surgeons and serve a population of 1.5-2 million.

NICE guidance recommends that OG cancer centres serve a population of one million.

The 2010 London-wide strategy recommended that OG surgical centres serve a population of at least two million people.

## Why services need to change

Services are not meeting recommended levels of care. Currently, three units serve a population of over 3.2 million, each doing an average of 50 operations a year. This means none of the current services meets national or London-wide standards.

Larger-volume OG cancer surgical centres have lower death rates in England and internationally. OG patients are more likely to survive for five years after their operation if it is done in a centre that performs over 60 such operations a year. Recent studies show that mortality rates are even lower in centres that perform over 80 operations a year<sup>23</sup>.

### Limited ability to provide 24/7 surgical cover

The current surgical work volumes cannot support an increase in the numbers of surgeons if three centres remain. This limits the ability of each centre to provide 24/7 consultant cover, which has been shown to reduce the length of stay in hospital and increase survival chances. Concentrating surgeons in fewer centres would also maximise training opportunities and improve services for patients in the future.

### The current system is not sustainable

Clinicians recognise that the current system is unlikely to be sustainable beyond the next few years. Improvements in earlier diagnosis and non-surgical treatments will eventually mean fewer patients need surgery. So the number of surgeons should fall in the future, and this will result in unworkable on-call arrangements unless the number of centres also falls.

### Leading improvements along the pathway

OG cancer patients are more likely to have a planned treatment if they are diagnosed by a GP or hospital doctor. Existing centres lack the capacity to improve local screening and early detection.

<sup>23</sup> Victoria H Coupland, Jesper Lagergren, Margreet Lüchtenborg, et al 'Hospital volume, proportion resected and mortality from oesophageal and gastric cancer: A population-based study in England', 2004–2008.

## Clinical recommendations

Local clinicians agree that the number of local specialist OG cancer centres and multi-disciplinary teams should reduce in order to provide the best outcomes for patients and meet national standards<sup>24</sup>. Surgical teams working in OG centres should carry out at least 60 oesophageal and gastric operations each year.

To achieve these standards, local clinicians recommend a staged consolidation of services in north and east London over three to five years. Initially, clinicians recommend the current three centres be reduced to two:

- One centre in outer north-east London at Queen's Hospital, Romford.
- One centre in inner north London at University College Hospital.

The specialist centres would be able to provide the most up-to-date radiotherapy and chemotherapy for OG cancer. In addition, this would enable sharing and standardisation of best practice for OG cancer across all specialist fields of work.

In the medium to long term, clinicians recommend the work be consolidated further into a single specialist centre at University College Hospital.

## How services would work: an example

Abeeda, 43, visits her GP after having difficulty swallowing during the previous month. Her GP sends her to the local hospital to have a CT scan and biopsy, which show stomach cancer. She is immediately referred to the specialist centre. Her local hospital sends the specialist centre her clinical information and test results.

A team of surgeons, radiotherapists, chemotherapy and support services consider Abeeda's case and recommend surgery to remove the tumour. Abeeda agrees and her operation is performed by an expert surgeon. Throughout her treatment she is cared for by a clinical nurse specialist, who talks regularly with the nurses at Abeeda's local hospital.

After the tumour is removed Abeeda stays in the specialist centre where she is monitored 24/7 by the specialist team. After two weeks she returns home and has follow-up checks at her local hospital. The local hospital and specialist centre continue to review Abeeda's progress in their weekly team meetings.

<sup>24</sup> NICE, Review consultation document: Review of the section on organisation of specialist teams for curative surgery for oesophago-gastric cancer within the Cancer Services Guidance on Upper Gastro-intestinal Cancers, March 2013.



## Conclusion

Local clinicians have highlighted areas where we are not making the most efficient use of staff and resources to care for patients or to introduce innovations and make improvements. They provide strong reasons for change. These reasons are supported by work done nationally and across London, which also puts forward strong arguments for making changes in these specialist cancer services.

We need to ensure that surgeons and care teams have the best opportunity to improve their expertise. We also need to consider cost-effectiveness and hospitals' long-term ability provide services.

Local clinicians believe their recommendations for reorganising specialist cancer services take advantage of this unique opportunity to provide better outcomes, better coordination of care and a better experience for our patients.

# Improving specialist cardiovascular services

in north and east London and west Essex

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## Cardiovascular

Cardiovascular disease affects millions of people in the UK and is one of the biggest causes of early death and disability. It is estimated that 5,436 people in north and east London die early because of heart disease and stroke.

Prevention and treatment have improved over the last decade but more needs to be done to bring the UK in line with the best international outcomes, and to speed up the adoption of new technologies.

Local clinicians have identified the need to make further improvements along the cardiovascular pathway – from prevention and detection to treatment and follow-up care.

Improving specialist cardiovascular services is one part of clinicians' vision for the whole pathway of care. They agree that, to achieve world-class standards, we must change the way we provide specialist adult cardiovascular services including:

- adult congenital heart disease
- cardiac anaesthetics and critical care
- cardiac imaging
- cardiac rhythm management
- cardiac surgery
- general interventional cardiology
- management of complex/severe heart failure
- inherited cardiovascular disease.

**Cardiovascular disease includes all the diseases of the heart and circulation such as:**

- cardiomyopathy (deterioration of the heart muscle)
- arrhythmias (irregular heart beat such as atrial fibrillation)
- congenital heart disease
- coronary heart disease (angina and heart attack)
- heart failure
- stroke (stroke services are not in the remit of this review).

Cardiovascular disease risk increases with:

- smoking
- high blood pressure
- high blood cholesterol
- being physically inactive
- being overweight or obese
- diabetes
- family history of heart disease
- ethnic background
- gender – men are more likely to develop cardiovascular disease at an earlier age than women
- age – the older you are, the more likely you are to develop cardiovascular disease.



Specialist cardiovascular services, and a range of supporting services, in north and east London are mainly provided by Barts Health NHS Trust (Barts Health), University College London Hospitals NHS Foundation Trust (UCLH) and the Royal Free London NHS Foundation Trust. Some invasive cardiology takes place at Whipps Cross University Hospital (Barts Health) and King George Hospital (Barking, Havering and Redbridge University Hospitals Trust), which is not changing as part of this review.

UCLH's specialist cardiovascular services are mainly provided from The Heart Hospital in Westminster. Some general cardiology services are also provided from University College Hospital to support patients with other conditions.

Barts Health provides specialist cardiovascular services at The London Chest Hospital in Bethnal Green and St Bartholomew's Hospital. Barts Health is due to move the specialist cardiac services currently provided at The London Chest Hospital and St Bartholomew's Hospital to a new state-of-the-art facility in the St Bartholomew's Hospital complex, when the building is complete at the end of 2014. Cardiology support for patients will continue at The Royal London

Hospital – mainly to treat acute admissions at the major trauma centre there.

St Bartholomew's Hospital and The Heart Hospital are both electrophysiology hubs for north and east London and provide 24/7 emergency services.

There are eight heart attack centres in London, three in north and east London – The London Chest Hospital, the Royal Free Hospital and The Heart Hospital.

The heart attack centre at The London Chest Hospital currently receives around 1,500 patients a year – the highest number of the three centres in north and east London. These patients mainly come from east and north-east boroughs of London. Most patients taken to the Royal Free Hospital and The Heart Hospital come from north London. The Royal Free Hospital receives more of these patients.

As well as heart attack services the Royal Free Hospital provides complex invasive cardiology and vascular surgery.

Specialist cardiac care for children is provided at Great Ormond Street Hospital NHS Foundation Trust.



## Hospitals providing specialist cardiovascular services in north and east London



- 1 The London Chest Hospital (Barts Health)
- 2 St Bartholomew's Hospital (Barts Health)
- 3 The Heart Hospital (UCLH)
- 4 Royal Free Hospital (Royal Free London NHS Foundation Trust)

Some invasive cardiology takes place at Whipps Cross University Hospital (Barts Health) and King George Hospital (Barking, Havering and Redbridge University Hospitals Trust), which is not changing as part of this review.



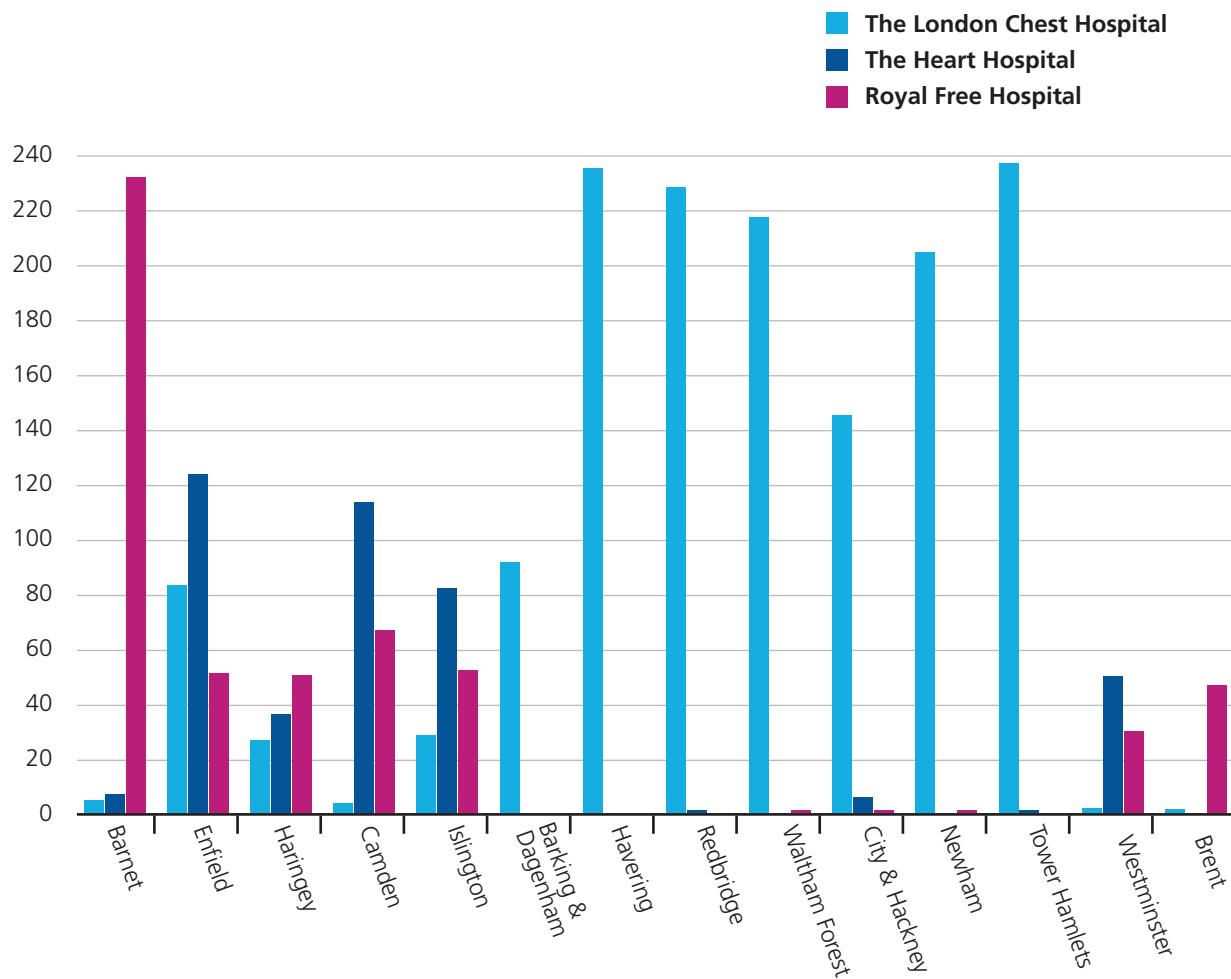
## Heart attack centres in London



- 1 The London Chest Hospital
- 2 Hammersmith Hospital
- 3 Harefield Hospital
- 4 The Heart Hospital
- 5 King's College Hospital
- 6 Royal Free Hospital
- 7 St George's Hospital
- 8 St Thomas' Hospital



## Number of patients taken to heart attack centres by borough (2012/13)



This document describes why we need to change and how we can improve these services locally. Clinicians recommend that to do this we should bring together the specialists, facilities and research currently at The Heart Hospital (part of University College London Hospitals NHS Trust) with services currently provided at The London Chest Hospital into a single, world-class integrated cardiovascular centre at St Bartholomew's Hospital.

Emergency care for heart attacks would be provided at two hospitals in north central and east London – the integrated cardiovascular centre proposed at St Bartholomew's Hospital and the current heart attack centre at the Royal Free Hospital.

Further information is available in UCLPartners' recommendations to commissioners *A proposal for clinical change in specialist cardiovascular services across north and east London*.



## Context – national and London-wide reviews

The 2010 review of cardiovascular services<sup>25</sup> in London found significant variation in outcomes for patients. Patients were waiting too long for surgery and hospital treatment, and there were inequalities in access to treatment and patient experience.

The review highlighted the importance of:

- multi-disciplinary team working
- concentrating the roll-out of new technologies in fewer centres to ensure there would be suitable infrastructure and staff experience to set standards for future use
- consolidating and integrating research activity and improving cooperation with universities
- reducing waiting times for urgent surgery, for example coronary artery bypass graft and length of stay
- greater specialisation, specifically in certain areas of cardiac surgery
- dedicated 24/7 rotas, enabling patients to have rapid access to specialist expertise.

The London-wide review recommended that hospitals providing specialist cardiovascular care come together in fewer units seeing a higher volume of patients.

In 2013 the government published a national *Cardiovascular Disease Outcomes Strategy*<sup>26</sup>. It identified actions needed to raise patient outcomes to international standards.



These include:

- improving prevention and risk management
- better early management and secondary prevention in the community
- improving acute care, including providing world-class specialist 24/7 services for heart attack, unstable angina and acute arrhythmias.

The Heart Hospital and The London Chest Hospital have both self-assessed their services against NHS England's national service specifications and comply with them<sup>27</sup>. Merging the two centres will improve their compliance against the national specifications and create an opportunity for more clinicians to share expertise along the pathway.

25 NHS Commissioning Support for London, *Cardiovascular project: The case for change*, August 2010 <http://www.londonhp.nhs.uk/wp-content/uploads/2011/03/Cardiovascular-case-for-change.pdf>.

26 Department of Health, *Cardiovascular Disease Outcomes Strategy: Improving outcomes for people with or at risk of cardiovascular disease*, 5 March 2013. Available at: [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/214895/9387-2900853-CVD-Outcomes\\_web1.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/214895/9387-2900853-CVD-Outcomes_web1.pdf).

27 NHS England, *Complex Invasive Cardiology service specification*. Available at: <http://www.england.nhs.uk/resources/spec-comm-resources/npc-crg/group-a/a09/>; NHS England, *Cardiac Surgery service specification*, Available at: <http://www.england.nhs.uk/resources/spec-comm-resources/npc-crg/group-a/a10/>



## Improvements underway to cardiovascular services

Improving the cardiovascular health of people in north and east London is a key priority for local NHS organisations and local authorities<sup>28</sup>.

There are high levels of need in local communities and evidence shows that up to 30% of cardiovascular disease patients on GP registers are on unsuitable medication<sup>29</sup>. Clinicians say more co-ordinated care is needed between community services, GPs, hospitals and providers of specialist services.

Local providers of cardiovascular care are working together as an 'integrated cardiovascular system' through UCLPartners<sup>31</sup>. Working across organisational boundaries and with CCGs and local authority partners, the integrated system aims to improve services along the whole cardiovascular pathway. These include:

- preventing cardiovascular disease by identifying patients with hereditary risk factors and modifiable life-style risks and ensuring they have access to adequate screening and support
- earlier detection of cardiovascular disease, offering health checks to all eligible people
- improving treatment of people with cardiovascular disease. For example, better management of atrial fibrillation will help prevent major cardiovascular events such as heart attack or stroke.



Preventing and diagnosing cardiovascular disease earlier will save lives. It will also ensure that more people living with cardiovascular disease get the support and treatment they need.

These are changes we are already making to improve cardiovascular services and provide a smooth pathway for patients.

*"UCLP is working for Camden CCG on a range of joint community initiatives aimed at preventing heart attacks and stroke. These include identifying high-risk patients, improving blood pressure monitoring through new technologies, improving management of patients with atrial fibrillation. These actions should complement the wider work on cardiovascular services and improve outcomes for Camden residents."*

Dr Caroline Sayer, Chair, Camden Clinical Commissioning Group

28 All local authorities in north and east London recognise cardiovascular disease in their joint health strategic needs assessments.

29 Department of Health, CVD Mortality Audit. Available at: <http://www.institute.nhs.uk/images/documents/wcc/HPHL/HINST%20resources/Mortality%20Audit.pdf>



## Examples of local initiatives for improving cardiovascular health

### Community coronary heart disease service

The coronary heart disease community service in Barking, Dagenham, Havering and Redbridge supports local people with heart problems and suspected heart problems. The multi-disciplinary team helps people to understand and manage their illness and its treatment. The service aims to help people make beneficial lifestyle changes and supports them as they return to as full and normal a life as possible. The team also provides monitoring and support in the community for patients who have heart disease and diagnosis of uncomplicated heart conditions such as suspected heart failure.

### Cardiac rhythm management group

Nurse-led primary care arrhythmia services hosted by Barts Health NHS Trust have succeeded in identifying patients, providing therapy and reducing referrals to secondary and specialist care. With services based at local hospitals and some GP practices, patients have access to care closer to home.

### Chronic heart failure

Chronic heart failure affects over half a million people in England. There is widespread under-diagnosis of heart failure and it accounts for five per cent of all emergency admissions to hospital. GPs in Enfield and Camden are working with specialist heart failure nurses to manage patients in the community.





## Why we need to change

In north and east London, we have some of the best cardiovascular experts in the country. However, services are not organised in a way that enables us to give patients the best outcomes. Clinicians have identified five main reasons why we need to change:

1. The risk of cardiovascular disease is already high and is increasing with our growing and ageing population. People with heart disease in north and east London are more likely to die prematurely than other people in London or England<sup>30</sup>.
2. Current services cannot meet recommended standards for care. We have high levels of unmet need and unequal access to treatment. Clinicians think they could save more lives if expert teams saw more patients.
3. Specialists are needed 24/7 to provide expert emergency care and enable them to do more work as sub-specialists, such as in aortic valve disease. Our medium-sized units cannot sustain this.
4. Too many people are waiting too long for routine surgery. Patients at both The London Chest Hospital and The Heart Hospital are waiting longer for surgery than the national average of 63 days. Some patients at The Heart Hospital wait up to 93 days<sup>31</sup>. Capacity at The Heart Hospital is limited, with no room for expansion.
5. There is an opportunity to integrate research and innovation into daily practice. This would improve care for local people and attract extra funding.

### The risk of cardiovascular disease is already high and is increasing, with evidence of significant unmet need

North and east London has a diverse, ageing and growing population, with many people facing significant deprivation. These factors increase the risk of cardiovascular disease and the resulting demand for services in the future.

Locally, many of our communities have deep health needs and there is clear variation in outcomes from cardiovascular disease.

On average, people with heart disease in north and east London die earlier than people with heart disease in the whole of London and in England<sup>32</sup>. Eight of the 12 London boroughs in this area have premature death rates far higher than in England as a whole<sup>33</sup>. The rate of early death in north and east London is also much higher than in other European countries<sup>34</sup>; if our rate of early death was in line with the European average, about 2,200 lives would be saved each year.

We could save 1,117 lives a year locally if we could bring our rate of early deaths from cardiovascular disease into line with the England average.

We could save about 2,200 lives if our rate of early deaths was the same as Europe's.

30 South East Public Health Observatory, CVD profiles 2011-12. Available at: [www.sepho.org.uk](http://www.sepho.org.uk).

31 Dr Foster Intelligence. Available at: [www.drfosterhealth.co.uk](http://www.drfosterhealth.co.uk)

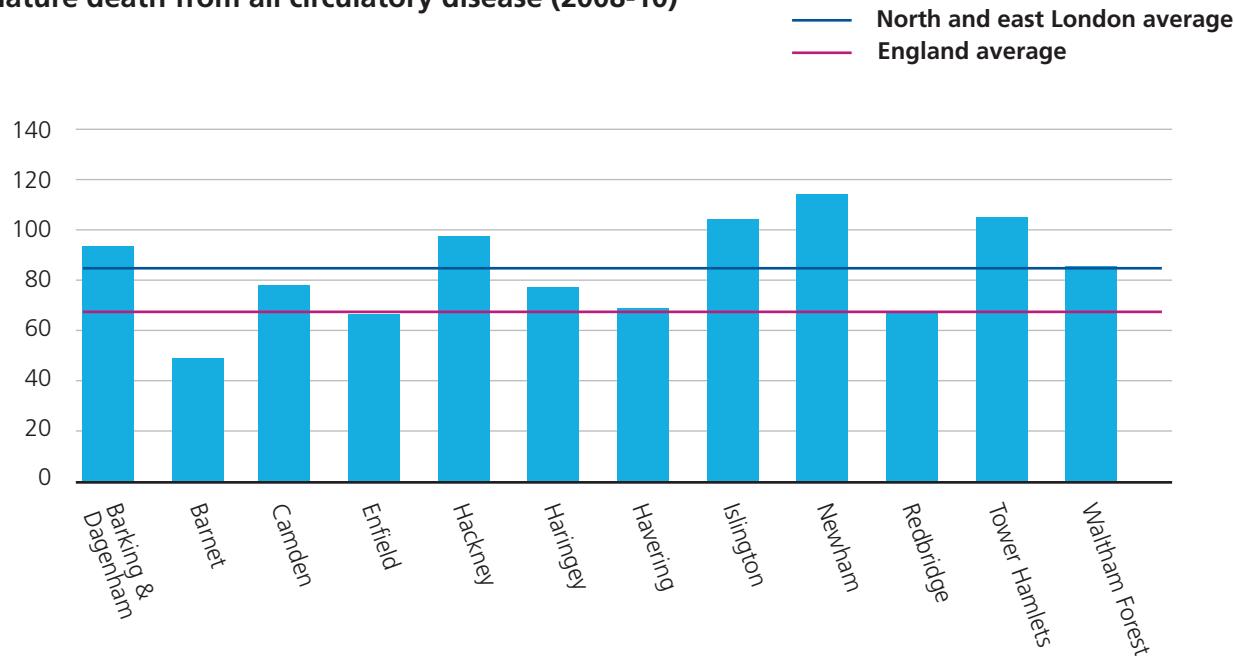
32 The rate of early deaths from heart disease and stroke in north and east is 84.8/100,000, significantly higher than the rate for London (71.5/100,000) and England (67.3,100,000). South East Public Health Observatory, Health Profiles, 2012. Available at: [www.sepho.org.uk](http://www.sepho.org.uk)

33 The gap between the estimated and observed prevalence in heart disease in north and east London (43.7%) is wider than for London as a whole (47%), and considerably wider than for England (58.2%). South East Public Health Observatory, Health Profiles, 2012. Available at: [www.sepho.org.uk](http://www.sepho.org.uk)

34 The European rate of early deaths is 50.4/100,000. 'UK health performance: findings of the Global Burden of Disease Study 2010', *The Lancet*, March 2013, Volume 381, Issue 9871, Pages 997–1020.



## Premature death from all circulatory disease (2008-10)



There is also a huge variation between and within local areas. Barnet has some of the lowest rates of premature death from cardiovascular disease – it is ranked ninth out of 150 local authorities in England. Newham and Tower Hamlets have some of the highest – ranking 141st and 144th.

Cardiovascular services need to be better coordinated across north and east London to ensure all patients have the best chance of survival.

Locally, we have a high rate of unidentified cardiovascular disease, which contributes to early death. It is estimated that over half of people with cardiovascular disease locally are undiagnosed<sup>35</sup>. These people do not have access to the support they need to be healthy.

For instance, only 15% of people at risk of a genetic disorder of high cholesterol in the blood (known as familial hypercholesterolemia or FH) are detected, which suggests that over 5,400 unidentified people are living at risk of FH in our region. Around 70% of men and 50% of women with FH will have a coronary heart disease event (such as a stroke)

before they are 65. By identifying and treating our FH population we could prevent 3,254 coronary heart disease events in under 65 year olds.

Latest data<sup>36</sup> shows that only 18.9% of people aged between 40 and 74 in north and east London are offered a health check and of those offered it, fewer than half (47%) take up the offer<sup>37</sup>. The proportion of people we identify for treatment for cardiovascular disease, or for the management of cardiovascular disease risk factors, is likely to grow as local authorities lead a drive to offer health checks to all the eligible population.

Emergency admissions from coronary heart disease and heart failure are much higher in our region than in England<sup>38</sup>. This suggests poor prevention and management of cardiovascular risk factors and a high unmet need among our population. Reducing admissions for coronary heart disease to the England rate would prevent around 700 emergency admissions a year, saving nearly £3.2 million<sup>39</sup>. Reducing admissions for heart failure to the England rate would prevent around 1,120 emergency admissions a year, saving nearly £2.6 million<sup>40</sup>.

35 South East Public Health Observatory, CVD profiles 2011-12. Available at: [www.sepho.org.uk](http://www.sepho.org.uk)

36 South East Public Health Observatory, CVD profiles 2011-12. Available at: [www.sepho.org.uk](http://www.sepho.org.uk)

37 2012-13 Healthchecks, Integrated performance monitoring. Available at: <http://www.england.nhs.uk/statistics/statistical-work-areas/integrated-performance-measures-monitoring/nhs-health-checks-data/>

38 The rate of emergency admissions in north and east London is 224/100,000 population. The rate for England is 198.3/100,000. South East Public Health Observatory, CVD profiles 2011-12. Available at: [www.sepho.org.uk](http://www.sepho.org.uk)

39 NICE, *Prevention of cardiovascular disease: Costing Report: Implementing NICE Guidance*, June 2010, NICE Public Health Guidance 25, p.21.

40 NICE, *Chronic Heart Failure: Costing Report: Implementing NICE Guidance*, 2010, NICE Clinical Guideline 108, p.19.



## Current services do not always meet recommended standards for care

Prompt access to sustainable emergency 24/7 services for unstable angina, complex surgery and other urgent care will save lives.

Medical advances also mean clinical teams are now specialising in a field of cardiac surgery such as revascularisation, aortic valve disease, complex valve disease and other cardiac surgical procedures<sup>41</sup>. Such sub-specialisation in small or average-sized units will not be possible.

## Primary percutaneous coronary intervention

Service standards recommend hospitals do 300 primary percutaneous coronary intervention (PCI – also known as coronary angioplasty) procedures, and at least 100 procedures, a year<sup>42</sup>. Last year The Heart Hospital only took 156 primary PCI cases.

For PCI in general, there is evidence suggesting improved outcomes for patients who are treated in higher-volume centres, particularly those that do 400 procedures a year.

Centres in the UK with the highest volumes (such as Leeds General Infirmary, which did around 1,200) tend to have good outcomes. In a national audit of primary PCI there was no significant difference in the results of any of the centres but there is a national trend towards higher-volume centres having lower death rates.

The combined unit would have similar levels of activity to the UK's top-performing units.

## Mitral valve repair

Neither the London Chest nor the Heart Hospital currently provide the 85% ratio of mitral valve repair to mitral valve replacement recommended for patients with degenerative mitral valve disease specified by the London-wide review. Minimal-

access mitral valve repair is less invasive and enables patients to recover faster – three weeks instead of three months – and return home sooner<sup>43</sup>. It requires specialist surgical, imaging and anaesthetic skills. Achieving the desired ratio would improve outcomes for around 100 patients a year. The surgical techniques are changing rapidly which is another reason why teams benefit from treating more cases.

The Heart Hospital and The London Chest Hospital both provide good outcomes and patient experience but neither is large enough to meet all current and future expectations for high-quality service. Here are some of the reasons:

- Surgical teams see too few patients to achieve full subspecialisation in mitral valve. Neither hospital has a dedicated surgeon to perform mitral valve repairs.
- Neither hospital has the full range of cardiovascular services in one place. For example, vascular surgery is an important linked service for major aortic surgery and is not available at The Heart Hospital. The new facility at St Bartholomew's Hospital will have a significant on-site presence for vascular surgery and interventional vascular radiologists.
- Meeting the challenge of seven-day working will be difficult, particularly for support services and intensive treatment unit staff. Given national workforce shortages in areas such as cardiac physiology, it is unlikely that either hospital will be able to have the staff they need under the current services set-up.

41 NHS England, Cardiac surgery service specifications. Available at: <http://www.england.nhs.uk/wp-content/uploads/2013/06/a10-cardi-surgery-adult.pdf>

42 NHS England, 2013/14 NHS England Specialised Commissioning Service Specification for Complex Invasive Cardiology, 2013. Available at: <http://www.england.nhs.uk/wp-content/uploads/2013/06/a09-cardi-prim-percutaneous.pdf>

43 Cleveland Clinic. Available at: <http://my.clevelandclinic.org/heart/disorders/valve/mitral-valve-repair.aspx>



Mitral valve repair – rather than replacement – improves life expectancy and quality of life for selected patients. They do not need long-term anticoagulation drugs, which can cause bleeds. And they do not need risky repeat operations, such as those needed to re-replace valves once they have reached their lifespan.

### Specialists are needed 24/7 to deliver expert emergency care

Medical advances in techniques and technology, such as primary PCI, mean we can now save more people who have acute heart attacks. As a result, we do more cardiac surgery and interventional cardiology on an urgent or emergency basis rather

than as planned care. For instance, 10 years ago most heart attack patients who needed a PCI were given it on a planned basis. Two-thirds of PCIs are now given on an emergency basis<sup>44</sup>.

This type of urgent or emergency care needs to be provided in large specialist centres that can give a 24/7 service.



An extra 364 heart-failure patients a year would survive if managed by a cardiology team.

44 UCLPartners, Percutaneous Coronary Intervention Procedures, p. 9 fig.3. Available at: [http://www.uclpartners.com/lotus/wp-content/uploads/2013/02/ICVS\\_Percutaneous.Coronary.Intervention-\\_FEB2013.pdf](http://www.uclpartners.com/lotus/wp-content/uploads/2013/02/ICVS_Percutaneous.Coronary.Intervention-_FEB2013.pdf)



The new facility being built at St Bartholomew's Hospital in Farringdon.

Providing more care on a 24/7 urgent or emergency basis has also increased the on-call commitments of clinical teams. These 24/7 heart attack centres need rotas of highly trained staff in adequate numbers – it is hard to maintain this level of staffing (in particular, physiologists) at three centres in north and east London. With two heart attack centres nearby and the London Ambulance Service (LAS) already taking fewer patients there compared with the Royal Free Hospital and The London Chest Hospital, it is likely that The Heart Hospital would not see enough patients to sustain this rota of experts.

The number of heart attack patients at The Heart Hospital is likely to reduce further when The London Chest Hospital moves to St Bartholomew's Hospital in Farringdon. Many patients in Islington, Enfield and Haringey live closer to the St Bartholomew's Hospital than to The Heart Hospital and in an emergency would be taken directly to St Bartholomew's Hospital by the LAS.

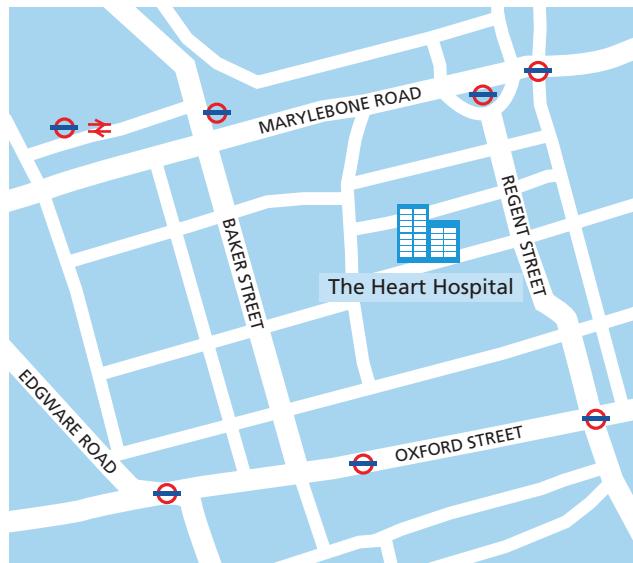
Centralising care would ensure that people needing urgent expert help could get it 24 hours a day, seven days a week.



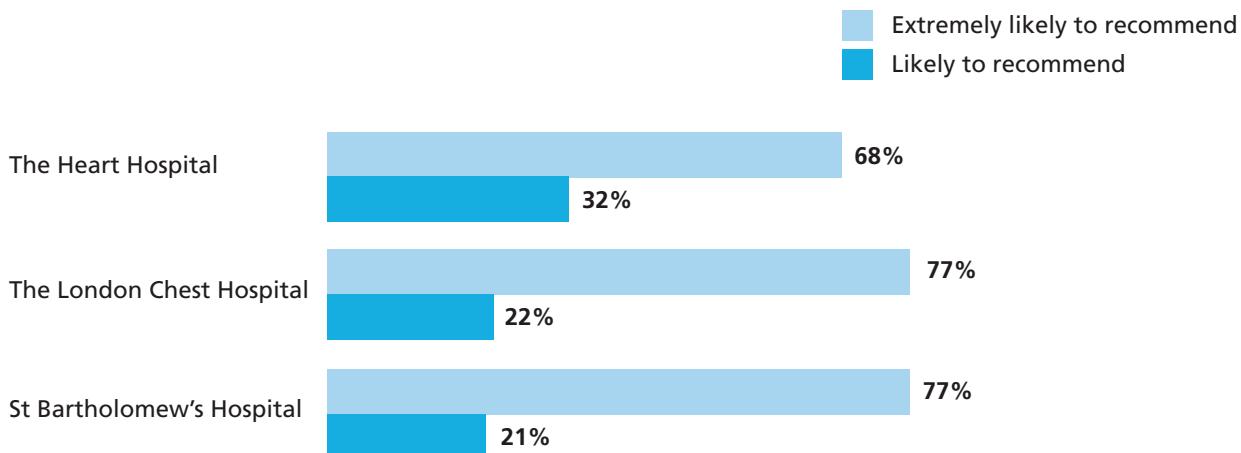
## Limited capacity at The Heart Hospital

All hospitals providing specialised cardiovascular services in north and east London provide high-quality care and good patient experience. However, The Heart Hospital faces a number of difficulties.

Located in central London, it cannot expand yet demand is increasing. When the hospital opened in 2001 we expected it would need to be reorganised or moved to a new location in the future; this is now overdue.



### Information about whether patients would recommend a hospital to friends and family (NHS Choices, 2013)



Patients who need heart bypass surgery wait 30 days longer at The Heart Hospital than the national average of 63 days.



#### Main difficulties:

- The hospital has little room to expand. This has already contributed to higher-than-average waiting times for surgery and higher readmission rates<sup>45</sup>. For instance, coronary angiography patients wait 10 days longer at The Heart Hospital than The London Chest Hospital and readmission rates are above the national average<sup>46</sup>. Bed occupancy at The Heart Hospital currently approaches 95% and activity is increasing year on year and will continue to grow.  
Demand is also increasing particularly for conditions such as adult congenital heart disease, inherited cardiac conditions and other highly specialised areas in cardiology.
- Surgical procedures are increasingly being cancelled. Critical care capacity limits surgical and catheter lab interventions. Around 250 planned operations were cancelled at The Heart Hospital last year.
- While most patients are happy with their overall care, limited capacity is reducing their satisfaction. In a recent survey patients at The Heart Hospital reported less choice of admission dates and were more likely to have their appointment changed than the national average<sup>47</sup>. Patients at The Heart Hospital were also more likely to share a sleeping area with patients of the opposite sex than at other sites<sup>48</sup>.

45 Dr Foster Intelligence. Available at: [www.drfosterhealth.co.uk](http://www.drfosterhealth.co.uk)

46 Dr Foster Intelligence. Available at: [www.drfosterhealth.co.uk](http://www.drfosterhealth.co.uk)

47 Picker Institute Europe, *Inpatient Survey 2012*, Site Report: The Heart Hospital, 2013.

48 Picker Institute Europe, *Inpatient Survey 2012*, Site Report: The Heart Hospital, 2013.



*"Integrating primary, secondary and specialist care and providing care closer to home will deliver a better patient experience, optimal management to reduce heart attack and stroke, and equitably improve the health of our population."*

Professor John Robson, Tower Hamlets GP and primary care lead for the UCLPartners integrated cardiovascular system

### Opportunity to integrate research and innovation into daily practice

Both UCLH and Barts Health host major biomedical cardiovascular research resources. Clinicians think they can help achieve better cardiovascular outcomes if, rather than working separately on two nearby sites, they combine their specialist academic and clinical services on a single campus. This would

provide a better environment for sharing best practice, engaging trainees and encouraging high-quality research opportunities. It will also help improve outcomes because more patients will be able to take part in clinical trials.





# Our vision for cardiovascular care

Our vision is to provide world-class experience and outcomes for patients, underpinned by world-leading academic research and education.

To achieve this vision clinicians have identified seven key aims:

- 1 Establish a seamless pathway and better co-ordination of care for cardiovascular patients across all NHS organisations.
- 2 Provide world-class standards of care and improve patient outcomes and experience.
- 3 Improve access to cardiovascular care and reduce waiting times.
- 4 Ensure our population benefits from the latest technological advances, research and access to clinical trials.
- 5 Ensure services are sustainable for the future.
- 6 Maximise efficiencies and attract national and international investment in research.
- 7 Ensure continuous training and education in cardiovascular disease is of a high standard across north and east London.

Clinicians have identified a strong and pressing need to change the way we deliver specialist cardiovascular services in north and east London. They recommend developing a single integrated cardiovascular centre at St Bartholomew's Hospital with the Royal Free Hospital remaining as a second heart attack centre.

Existing cardiology services would continue to be provided at UCLH to support routine and other specialist care (for example, cancer care).



An artist's impression of a general ward at the new facility at St Bartholomew's Hospital.

## How services would work: an example

Robert, 47, has a heart attack at home in Haringey. His wife calls an ambulance and he is taken to the specialist heart centre at St Bartholomew's Hospital by ambulance. The ambulance arrives at the emergency entrance and the crew take him to the specialist heart centre. Robert reaches the assessment unit via a dedicated lift for emergency patients, which the crew know will be available for their immediate use. As Robert arrives at the cath lab floor he suffers a cardiac arrest. This is managed in a dedicated private receiving room next to the cath labs. His circulation returns and he is taken into the cath lab for a primary angioplasty. His family is reassured that he is receiving the best possible care.



## How we could improve services

Clinicians believe that bringing specialist cardiovascular services from The Heart Hospital and The London Chest Hospital into a single, integrated high-volume cardiovascular service would improve outcomes for local people.

Evidence shows that outcomes are better for patients treated by clinicians who are experienced and have high volumes of cases. This includes complex and emergency procedures such as mitral valve surgery<sup>49</sup>, primary angioplasty<sup>50</sup>, ablation<sup>51</sup> and implantable cardioverter defibrillator implantation<sup>52</sup>.

If we bring together specialist services in north and east London, they would work at a scale to provide world-class results. Also we would reduce duplication, so we could rationalise investment, particularly in a field that is increasingly technology-driven. Better use of resources would help to improve productivity, which the NHS needs so it can invest in new technologies and cope with more work.

In addition, a single centre offering the latest technologies and treatments would attract more national and international patient referrals. This would create an income stream that does not rely

only on local NHS resources. It would also enable us to maximise investment through increased research and cooperation with industry, supported by the academic health science partnership.

A single high-volume integrated cardiovascular centre at St Bartholomew's Hospital would do the following:

- Achieve sub-specialisation in surgery and supporting services such as anaesthetics. This would enable us to develop a high-volume centre for mitral valve repair and a regional aorto-vascular centre with a specialist 24/7 rota.
- Enable us to invest in new technologies. For example, the hybrid theatre planned for the new development at St Bartholomew's Hospital for aorto-vascular surgery will place state-of-the-art 3D-imaging within a theatre, enabling surgeons and interventional radiologists to work together. This facility will be unique among the cardiac units in London and most of England, helping it to grow and improve. Similarly, larger sub-specialist teams would make it cost-effective to invest in technology such as robotic equipment.

*"Clinical staff are ambitious to bring together their expertise so that cardiovascular care continues to improve, is delivered to more patients, and is focused on care in the best environment and prevention."*

Dr Edward Rowland, Clinical Director, UCLH

49 Birkmeyer, J.D., Findlayson, E.V.A. & Birkmeyer, C.M., 'Volume Standards for High-Risk Surgical Procedures; Potential Benefits of the Leapfrog Initiative', *Surgery*, 2001, 130: 415-422.

50 Van de Werf, F. et al. 'Management of acute myocardial infarction in patients presenting with persistent ST-segment elevation', *European Heart Journal*, 2008.

51 Aliot, E.M., W.G. Stevenson, J.M., Almendral-Garrote et al EHRA/HRS Expert consensus on catheter ablation of ventricular arrhythmias', *Eurpace*, 2009, 11: 771-817.

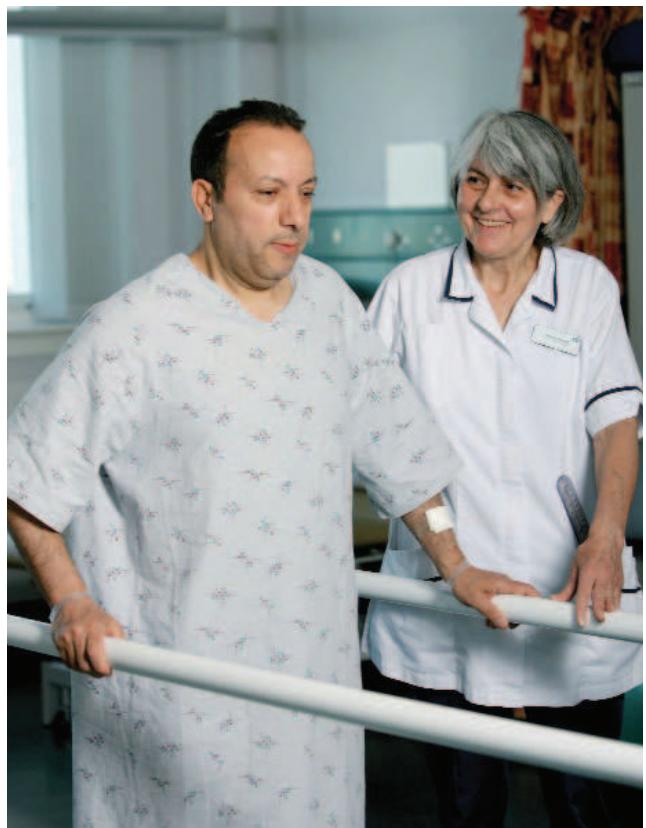
52 Al-Khatib, S.M., L. Lucas, J.G. Jollis, D.J. Malenka, and D.E Wennberg, 'The relation between patients' outcomes and the volume of cardioverter-defibrillator implantation procedures performed by physicians treating medicare beneficiaries', *Journal of American Cardiology*, 2005, 46: 1536-1540.

*"Creating partnerships with the life sciences industry is at the heart of the UK health and wealth agenda. Industry wants to align with the biggest and the best. Integrating cardiovascular services would create the biggest cardiovascular clinical and research centre in Europe, on a par with the best in the world – an unbeatable proposition for London."*

Professor Bryan Williams, Professor of Medicine and Director of the Biomedical Research Centre, UCLH

- Help us meet and surpass the recommended number of complex and emergency procedures in cardiology, which is a recognised marker for clinical safety and quality.
- Create a regional service for transcatheter aortic valve implantation (where the aortic valve is replaced without full open-heart surgery) for high-risk patients and those who are unsuited to conventional surgery.
- Enable us to offer on-site 24/7 services such as vascular surgery.
- Streamline care pathways and create clearer referral routes for emergency units, ambulance services, GPs and community services.
- Create greater capacity and flexibility to respond to demand, reducing waiting times and cancellations.
- Drive innovation forward – a high-volume centre is more likely to be selected to test innovative technology and create models of use across cardiovascular units.
- Maximise efficiencies and enable us to invest in the latest technologies and medical advances.
- Increase expertise among the whole workforce, improving outcomes and giving patients a better experience of care. Many services at the new centre would be the largest in the UK, bringing the benefits of high-volume work to our population.
- Improve training and recruitment – creating one of the UK's largest surgical units would enhance education and training opportunities for all staff. The service would be able to recruit from a world-class pool of expertise.
- Strengthen research, science and clinical trials. By creating access to data from such a large, diverse population and broad range of activity, we would attract funding for clinical trials. This would benefit local patients.

The specialist centre would provide overall system leadership, working with local acute hospitals and primary and community health services to improve care, ensuring that we provide the benefits of world-class research and development along the whole pathway.





*"A centre of global excellence in the management of cardiovascular diseases will attract the very best national and international trainees in recognition of the advantages our training programmes will bring to them and their future patients."*

Professor Jean McEwan, Consultant Cardiologist and Higher Education Institute representative for North-Central and East London Local Education and Training Board

*"Creating an integrated cardiovascular centre would be a great opportunity for nurses and allied health professionals. Treating higher volumes of rare clinical cases would support the establishment of roles such as nurse practitioners who would improve the efficiency of patient pathways and patient experience."*

Jonathan Hanbury, Divisional Senior Nurse, The Heart Hospital, UCLH



## What this would mean for patients

Clinicians believe we can save more lives, ensure all patients have a good experience and improve the quality of life for people with cardiovascular disease.

Cardiovascular care would be provided as part of an integrated system with an expert specialist centre at its hub. Patients and carers would be treated by a specialist service working closely with local hospitals, GPs and community services to support prevention, early identification of disease, diagnosis, treatment and rehabilitation. Patients would continue to access a range of cardiovascular services locally, including outpatient services.

The integrated system would ensure that patients get ongoing support, with a clear management or care plan understood by everyone involved in their care. Patients and carers would get information to help them make choices about their treatment and work with clinicians to speed up their recovery.

Clinicians believe their vision for specialist cardiovascular services would produce benefits including these for local people:

- **Improved patient experience and outcomes**, which would be measured to ensure that services continue to provide high-quality care.
- A single integrated centre, which would provide **prompt access to treatment** in all departments. This would help reduce long waits and cancellations.

- A high-quality environment with **greater access to new diagnostics and state-of-the-art equipment** in all departments. Local people would experience the same high standards of care no matter where they live.
- **Expert multi-disciplinary teams** with the knowledge and understanding that comes from treating lots of similar conditions. Emergency services would be provided 24/7 by highly skilled individuals and more services could be provided seven days a week and for more hours of the day as a result of larger pools of expert staff.
- Patients would be able to take part in a **wider range of clinical trials**. They would know they were being treated by teams working at the forefront of innovation. Patients would be able to contribute to and benefit from the development of new technologies. Patients with rare diseases would be treated by teams who see some of the highest numbers of patients in the world with their condition, making clinical and research breakthroughs more possible.

Consolidating services would create the largest cardiac surgery centre in England based on number of patients seen.



# What other options did we consider?

We have considered the three main sites currently providing specialist cardiovascular care in north and east London – The London Chest Hospital, The Heart Hospital and St Bartholomew's Hospital.

While the Royal Free Hospital provides some cardiovascular services, it does not offer specialist cardiac surgery. Establishing a surgical service at the Royal Free Hospital would need significant investment so we did not consider this option. If these recommendations are agreed, there would be no change to the cardiovascular services offered at the Royal Free, which would continue to be a heart attack centre and provide planned cardiology care.

We are keen to find out what everyone thinks about the options proposed.

## 1. The Heart Hospital

A single integrated high-volume cardiovascular centre could not be located at The Heart Hospital as it has no room to expand.

## 2. The London Chest Hospital

The London Chest Hospital services are already moving to St Bartholomew's Hospital in late 2014 as part of the new hospital development.

## 3. St Bartholomew's Hospital

Local clinicians believe that bringing together two average-sized specialist cardiac centres – The Heart Hospital and The London Chest Hospital – and the services located at the old St Bartholomew's Hospital onto a new, state-of-the-art campus would have great benefits.

A new world-class cardiovascular centre would attract national and international patient referrals, bringing income from outside the NHS. St Bartholomew's Hospital would also become a centre for therapeutic innovation, in partnership with Queen Mary University, University of London and University College London. Strong academic links to improve training and research would attract staff and give patients access to new technologies.

The new hospital being built at St Bartholomew's Hospital gives us a unique opportunity to set up an integrated purpose-built cardiovascular centre with enough capacity to support clinicians' vision of care. We currently have an opportunity to utilise the new hospital building for additional cardiovascular activity, which ideally would have complementary services.

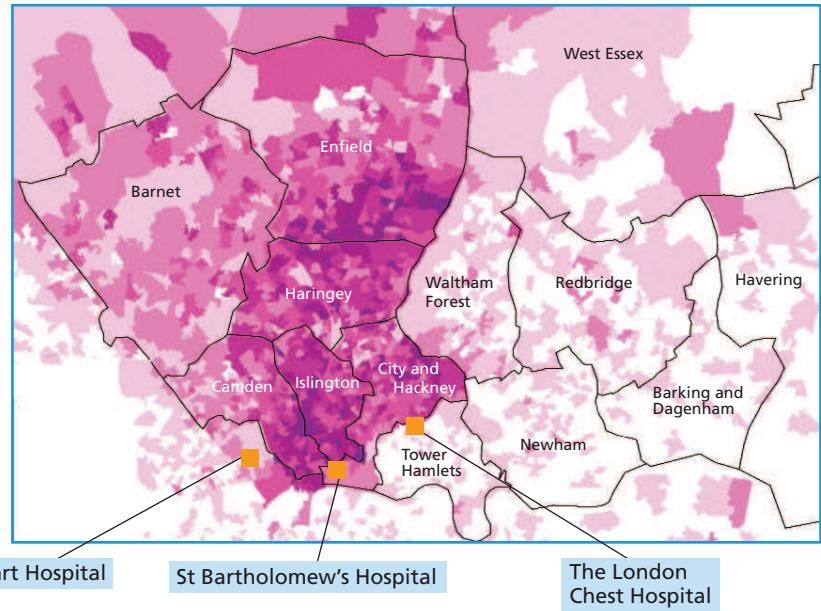
The Heart Hospital and St Bartholomew's Hospital are only 2.5 miles apart, which would minimise any increase in journey time for patients currently attending The Heart Hospital. While patient choice needs to be considered, patients would be getting a better service providing world-class standards of care. Five other trusts provide cardiac surgery in London.

## 4. New building at The Royal London Hospital or University College Hospital

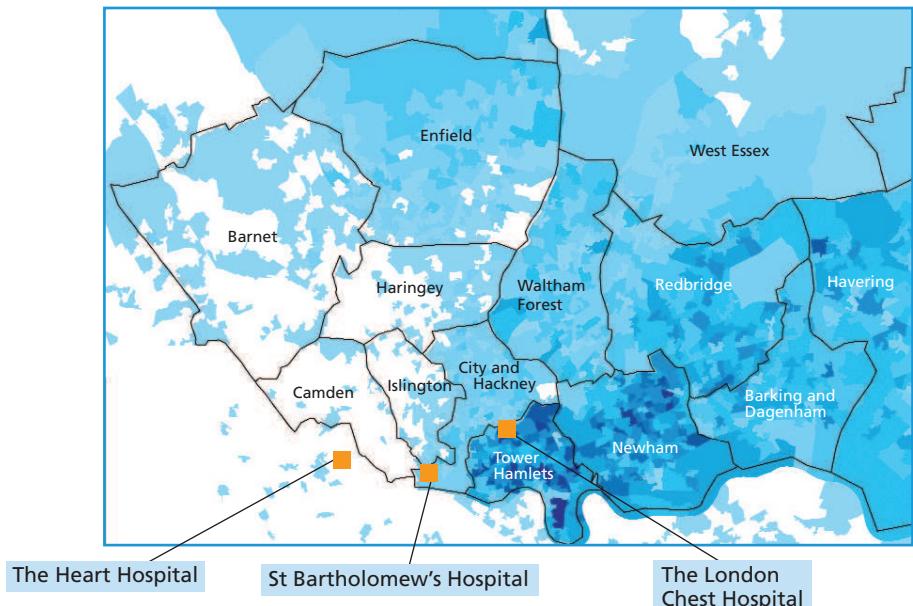
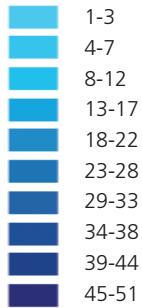
We could not afford new buildings at these hospitals. The NHS already has facilities that could accommodate, or be adapted to accommodate, this activity at a much lower cost.



## Patient flows for The Heart Hospital



## Patient flows for The London Chest Hospital



These maps show that most people who are currently referred to The Heart Hospital live in north-central London and most people who are referred to The London Chest Hospital live in north-east London. So travelling to an integrated cardiovascular centre at St Bartholomew's Hospital would be a reasonable alternative for patients who are currently treated at The Heart Hospital.

### 5. Options outside north and east London

If these proposals proceed, a few patients currently accessing care at The Heart Hospital would probably be treated by hospitals in west and south London (The Royal Brompton Hospital and Guy's and St Thomas' Hospitals).

However, for most people (about 80-90%) who currently access care at The Heart Hospital, St

Bartholomew's Hospital would be the nearest alternative. Because of this we have worked on the basis that cardiovascular services should be concentrated in north and east London. We have not tested in detail any options that would mean a lot more patients travelling to be treated in west or south London.



## Conclusion

Clinicians and a wide range of stakeholders in north and east London have created a vision for integrated specialist cardiovascular services to rival the best in the world.

We need to seize this opportunity to improve patient outcomes by integrating specialist cardiovascular services into new state-of-the-art facilities at St Bartholomew's Hospital.

In the current economic climate two medium-sized specialist cardiovascular hospitals, 2.5 miles apart, are unlikely to be sustainable. Both need highly trained staff with specialist skills and increasingly depend on expensive technologies and innovations to provide improved outcomes for patients.

This vision is to provide the highest-quality and most innovative care for patients, and to be leaders in international cardiovascular medicine. Bringing together the best in cardiovascular medicine and research in a purpose-built facility would help us achieve this vision.

Parts of this vision relate to improving care along the cardiovascular pathway with more co-ordination between GP, hospital and community care. There is major unmet need for cardiovascular services in our growing population. Current services cannot meet recommended standards and are unsustainable in the future. Other parts of the vision focus on more specialist interventions and treatments, and the opportunities for bringing services together in a single integrated centre. Both these approaches are necessary if we are to identify unmet needs, ensure early diagnosis and provide access to the highest-quality services for acute events such as heart attacks.



## Get involved

We are now seeking the views of local people – including staff, clinicians, patients, the public and other stakeholders – on this vision for change.

We are keen to hear your views and will use feedback to help us develop our preferred recommendations.

During November 2013, there will be workshops and meetings with clinicians who will explain why they want to change specialist cancer and cardiovascular services.

If you would like to attend an event, or if you would like to invite a speaker to attend a meeting of your local group, please contact us.

We also welcome comments on the case for change by email, letter or phone by 4 December 2013. However, if you do have comments after this date, do please send them to us.

To get involved or to request a summary of this document in another language, alternative format or large-print:

Email: **cancerandcardiovascular@nelcsu.nhs.uk**

Telephone: **020 3688 1086**

Write to: Cancer and cardiovascular programmes  
c/o North and East London Commissioning  
Support Unit Clifton House, 75-77 Worship Street,  
London EC2A 2DU

Visit: [www.england.nhs.uk/london/engmt-consult](http://www.england.nhs.uk/london/engmt-consult)

To request a summary of this document in another language, alternative format or large-print email: [cancerandcardiovascular@nelcsu.nhs.uk](mailto:cancerandcardiovascular@nelcsu.nhs.uk)