NHS England

Appendix E: Engagement feedback report

NHS England

Appendix E: Engagement feedback report

1. Introduction

As part of the engagement on specialist cancer and cardiovascular services in north and east London and west Essex, a wide range of stakeholders were encouraged to participate and submit their feedback. Meetings were held for trust staff, drop-in sessions were held for members of the public and a number of workshops were held to discuss and evaluate the options from a clinical and non-clinical perspective. Feedback on the proposals was accepted by post, email or telephone from 28 October until 4 December 2013, although responses were accepted after this date.

In total, there were 130 responses from individuals and organisations including:

- Patient participation group representatives – William Harvey Research Institute, Europa Uomo and Epping Forest User Consultative Committee.
- Prostate cancer support groups – APPLE, PHASE and ProActive.
- Healthwatch – City of London.
- Political stakeholders – MPs, Councillors and London Assembly Members.
- Professional bodies – Association of Upper Gastrointestinal Surgeons of Great Britain and Ireland, Royal College of Surgeons, Tower Hamlets BMA, London Medical Committees for Barnet, Haringey and Tower Hamlets.
- NHS Trusts – University College London Hospitals NHS Foundation Trust's Governing Body, Epsom and St. Helier University Hospitals NHS Trust, The Royal Marsden NHS Foundation Trust and The Royal Free London NHS Foundation Trust.
- NHS England bodies including National Specialised Commissioning, National Clinical Directorate for Cancer and Medical Directorate.

This document outlines the comments received via written responses to the engagement and verbal feedback received at meetings and workshops. Analysis of feedback is grouped by:

- overall comments
- travel
- overall responses to cancer proposals
- response to cancer proposals by pathway
- overall responses to cardiovascular proposals
- engagement process

Feedback from health scrutiny committees and clinical commissioning groups (CCGs) is summarised in the *Engagement Overview Report*.

2. Overall comments

Overall, there was strong support and understanding of the need for the consolidation of specialist services within an integrated system, and the need to improve outcomes across the area.

A number of respondents commented on the need to improve the whole care pathway and some respondents wanted to see specific proposals for improving early diagnosis. Other respondents sought clarification about the care pathway including repatriation and follow-up care arrangements.

Some respondents sought clarification and assurances on communications between local and specialist units and the impact of the proposals on finances and the workforce. Many patients also used the engagement process as an opportunity to inform the review about the excellent levels of care they had received at various trusts.

Key theme	Summary of feedback	Response
Project need	• Understanding of and support for the need and rationale behind creating specialist centres of excellence. • Proposals clearly set out the clinical case for change.	• Support for the proposals is welcomed.
Impact on local services	• The majority of care should be kept as local as possible. • Moving services to central London, away from outer London boroughs which have high and growing need.	• If proposals are adopted, some specialist services will move to designated centres but, for the majority of their care, patients would continue to be treated locally. • For specialist cancer services, the proposed clinical recommendations would affect approximately (Feb 2012-Jan 2013): o 97 of 831 brain cancer surgical procedures o 241 of 394 head and neck cancer surgical procedures o 32 of 71 bladder cancer surgical procedures o 93 of 275 prostate cancer surgical procedures o 145 of 239 kidney cancer surgical procedures o 18 of 118 AML patients o 53 of 274 stem cell transplant patients o 53 of 131 OG surgical procedures • There is no change proposed to specialist cardiovascular services provided, only the relocation of some services from The Heart Hospital (thoracic surgery, some outpatient services and specialist support will be retained at UCLH) to a new facility at St Bartholomew's Hospital approximately 2.5 miles away. While the overall level of provision would not be changed, we would also expect to see service improvements as set out in the case for change.
Travel implications	• Travel impacts were raised by nearly all respondents, in particular those based in outer north east London.	• Detail on these specific concerns and mitigation measures currently being considered are listed in section 2.
Pathway integration	• Importance of specialist centres having effective pickup and handover systems for patients	• The aim of these proposals is to improve services across the whole care pathway from prevention and early diagnosis through to

	leaving and re-entering a non-specialist part of the pathway. • Demonstrate how specialist centres will work with primary care. For example, communication between GPs and consultants post-surgery and training opportunities for primary care.	treatment and long-term care. • Integrated specialist multi-disciplinary teams would use system-wide pathways and guidelines, which would be regularly updated, to ensure a seamless patient journey. • Further details are being explored as part of the planning for implementation work.
Choice and competition	• Perceived reduction in patient choice or equality of access. However, this was balanced with the view that patients are already travelling for surgery. • Impact on competition and status of discussions with Monitor.	• Clinicians believe that cancer and cardiovascular outcomes would be better with treatment delivered by the proposed provider(s) as they would be performing a large volume of operations using the latest technology, which is not currently offered to all. As all patients in the cancer and cardiovascular systems would be offered the full range of treatments, including the range of surgical techniques, choice would be improved. • Most treatments would still be delivered locally, and choice in these cases would not be affected. • NHS England is working with Frontier Economics to ensure that potential competition issues related to the proposals are considered.
Impact on workforce	• Impact on staff working lives if they have to move to another location and/or trust.	• If approved, the new centres would aim to become world leaders in cancer and cardiovascular care, and this can only be achieved with the help and support of staff. • If the recommendations are agreed, a full HR process would be undertaken to ensure that staff likely to be affected are fully supported and informed throughout any changes • Individual trusts will continue dialogue with staff as this process evolves. • Heart Hospital staff are by far the largest staff group affected (approximately 400 full time equivalents). The new centre is around 2.5 miles away or three stops on the London Underground.
Cost-effectiveness	• Clarification sought on the cost-effectiveness of the proposals and how changes to current service provision would be funded. • Demonstrate how specialist centres would help improve waiting times.	• While the primary driver for these changes is to improve the quality of care, a high-level financial analysis shows there should be an overall saving to the NHS. The financial implications will be outlined in a business case that is being developed by NHS England, which is expected to be finalised in spring 2014. This process will determine how the costs will be covered and what savings can be made. • The financial analysis will include consideration of reducing re-admission rates and reduced post-surgery complications, with both patient and health economy benefits. • The proposed new integrated cardiovascular centre would have greater capacity than the

		current services.

3. Travel and mitigation

The majority of respondents highlighted travel as an issue and the importance of considering the impacts on patients, carers and staff when examining the proposals and planning for implementation. This was balanced by responses that stated they believed patients would travel further for the best treatment and outcomes.

Key theme	Summary of feedback	Response
Travel and parking	• Patients going through varying stages of treatment may find it difficult to travel further distances, particularly the outer north east London boroughs. • Discomfort and feasibility of using public transport for patients, which has the added risk of infection and no toilet facilities (particularly important for prostate cancer patients). • Anxiety and difficulty for relatives and friends (often older people) visiting their loved ones in hospital, which is a key part of a patient's recovery. • Concern that longer journey times would impact patient's decisions as to whether or not to have treatment. • Limited provision of parking spaces • Increased travel costs including parking at individual hospitals.	For both cancer and cardiovascular care, the proposed specialist centres have existing travel and parking options for patients and relatives: • UCLH is increasing its number of disabled parking bays but car access for outpatients is discouraged through local government policy. The trust has also made commitments to improving the booking of NHS transport. • BHRUT provides free parking for all cancer patients undergoing treatments regardless of their home address. Improvements to local bus services are also being discussed. Patient transport is also available for eligible patients. • The Royal Free Hospital has made a commitment to provide reserved parking spaces for patients undergoing renal surgery. Patient transport is also available for eligible patients. The site has access to local buses and London Underground and Overground services. • No parking is available at St Bartholomew's Hospital but the site is also well served for public transport and a patient transport service is available for eligible patients. In addition: • Patients receiving specialist surgery at UCLH, and their partners, would also be offered the option of hotel accommodation overnight prior to surgery, when travel on the day of surgery is impractical. This will be at the four-star UCLH Charity Patient Hotel or another suitable hotel near UCLH. • Patients who travel to the Royal Free Hospital for surgery can choose if they would prefer to stay overnight prior to surgery in hotel accommodation, with a free double room provided for the patient and immediate relatives. As part of planning for implementation, commissioners will work with UCLPartners and the recommended providers to identify potential solutions to reduce the impact of the proposals on travel for patients and relatives including: • Assessing the suitability and quality of the

		existing hospital patient transport services. • Working closely with patient groups to identify innovative solutions to travel issues. • Ensuring that immunocompromised patients will continue to be eligible for the provision of NHS funded transport, and this will always be provided in personal use vehicles. • Look at how new technologies could support patients to stay in touch with their family during a hospital stay. For cardiovascular care, based on patient data by borough, over three-quarters of outpatients and two-thirds of inpatients would have less distance to travel to the new centre at St Bartholomew's if the proposals are implemented.
Communication	• Patients and their families need clear information on transport options	All trusts which are proposed to host specialist centres have initiatives in place to ensure clear communication of travel options to their patients: • UCLH is committed to ensuring that all potential options regarding travel are communicated to all patients and their families. • The Royal Free Hospital is committed to providing individualised transport information sheets for patients to optimise journey times. • Barts Health provides transport details on its website, welcome leaflets for all new patients to the cancer centre detailing transport options. In addition they work to provide personalised Transport for London plans for each patient needing to travel for their care. • BHRUT's specialist team informs patients of available travel support. The trust's cancer patients are supported by a Citizen Advice Bureau worker with two dedicated information centres that provide all necessary and relevant information for patients dependent on their condition.

Work is ongoing to assess the current quality and provision of hospital transport arrangements in order to identify what further mitigation measures may be needed.

4. Overall responses to cancer proposals

We received feedback on the proposed consolidation of specialist cancer services from clinicians, patients, members of the public and organisations, details of which are outlined in the table below.

Key themes	Summary of feedback	Response
Prevention and early diagnosis	• The importance of improving prevention and early diagnosis. This review cannot be seen in isolation from this. • Time, money and effort would be	While not detailed as part of the case for change, a large part of UCLPartners' work is focused on prevention, improving earlier diagnosis, reducing variation in services and improving patient experience. This work includes:

	better spent on enhancing prevention and early diagnosis as this helps more people and has a bigger impact on survivorship.	• understanding and addressing the root causes of why one in four cancer patients present at A&E; and the root causes of heart attacks and strokes (seeing them as a failure of prevention) • improving uptake in bowel screening by 14% in Camden • increasing the proportion of people whose atrial fibrillation is appropriately managed in primary care to reduce strokes • improvement in heart failure management in the community • interactive case-study GP and practice nurse education led by local multi-disciplinary teams • a new model of rapid access to specialist opinion and diagnostics for bowel cancer symptoms • workshops to reduce inter-trust delays in cancer and sharing clinical and performance data • a single process for assessing patients' holistic needs • interactive maps to help patients to navigate cancer care locally. Details of this work are evidenced on the *London Cancer* website. Consolidating specialist cancer surgery would allow for surgeons to spend more time working in local units. Hence, expertise would be available in pre- and post-operative care of patients treated with complex surgery in local units and at all stages of the pathway. The centres would operate consultant-delivered on-call rotas such that specialist treatment and advice are available throughout all units in the system at all times.
Outcome data	• Need for more robust outcome data to be made available as part of the clinical case for change, particularly for prostate cancer. • Specialist centres need to be held to account with the publication of outcome data.	• Audit of data is a priority and we would work with all providers to introduce a system for the collation and monitor data. • National cancer audits are in place, and providers work with local commissioning support units to ensure that they are submitting complete and timely data to these audits. The data is available online and in public portals designed by National Cancer Intelligence Network. • Outcome data on patients treated for prostate cancer with radical prostatectomy has been provided by UCLH and BHRUT to London Cancer and commissioners. The Royal Free has provided a detailed report (in December 2013) on kidney cancer outcomes treated to date at their centre and described how they are approaching improving their prospective data collection to include survival.

		• The London Clinical Senate, one of 12 clinical senates established by NHS England to provide oversight and advice on commissioning decisions for the healthcare populations they cover, will be undertaking an independent clinical assurance of all the proposals. In addition, the Senate will review the latest outcome data and the proposals for prostate and kidney cancer, in context of NICE guidance. The outcome of this review will inform commissioners' preferred recommendations. • For OG cancer, the mortality data is available and reported through the national audit Association of Upper Gastrointestinal Surgeons (AUGIS) and are already very low at all three current centres. Reducing this further is not the major or only reason for proposing further consolidation of OG surgery. • For specialist cardiovascular services, surgery mortality data and other outcome data was included in UCLPartners' clinical recommendations published alongside the case for change. Transformation leads have been appointed across all of the cardiovascular clinical workstreams. UCLPartners and Professor Richard Bohmer from Harvard Business School are working with the leads to outcome data and improvement metrics for the proposed new integrated cardiovascular centre at St Bartholomew's.
Impact on other services	• Potential impacts of the proposed changes on the core surgical services at the sites not delivering the complex surgery (in particular, impact on the major trauma centre at The Royal London). • Radiotherapy needs to be easily	• Clinicians (doctors and clinical nurse specialists) would work across both specialist and local cancer units in a networked model. The ambition is for clinicians to work as one team across the system. • The potential implications for the major trauma centre at The Royal London have been recognised and a workshop with clinicians was held on 16 January 2014, led by Medical Director at Barts Health Dr Steve Ryan and supported by National Lead for Trauma Care Dr Chris Moran. • These proposals aim to replicate the success of major trauma centres and stroke units by ensuring the small number of cancer patients who require once-in-a-lifetime treatment receive world-class care. • Major trauma centres and stroke units already collaborate between departments and providers. We believe similar joint-working arrangements with the proposed specialist cancer centres would enhance this system. • Radiotherapy services will continue to be

	accessible for patients. • Clarification of how the proposals will affect the new pathology venture at UCLH and how this will be organised in the future.	provided locally, with the exception of AML (level 2b) and haematopoietic stem cell transplantation at the Royal Free Hospital, where specialised services are proposed to move to UCLH. • The pathology joint venture between UCLH, Royal Free London and The Doctors Laboratory aims to bring together the best aspects of all partners to ensure both current and future top quality care for patients and best value for the health economy. It is crucial that the working relationship between cancer and pathology services focus on clinical and patient needs. The future needs of cancer patients in particular will need access to the highest quality pathology and diagnostic techniques. The joint venture will not only enable this, but make it more likely that the demands in this area are met now and into the future.
Site selection process	• More detail was requested as to the process used by clinicians to determine the optimum model and sites. • Questions were raised as to why UCLH is proposed to provide most specialist services.	• In April 2012 *London Cancer* was established as an integrated cancer system with an independent skills-based board that oversaw the work of clinically-led cancer pathway boards who reviewed the clinical evidence and developed the case for change and clinical recommendations for specialist cancer services. The pathway boards comprise patient representatives, primary care clinicians, and specialist clinicians (including a range of professions e.g. clinical nurse specialists, therapists, pathologists, oncologists and radiologists) representing every NHS trust currently providing cancer services in the locality. • Pathway boards developed pathway specifications based on national standards and international comparisons and evidence. The pathway specifications were sent to all trusts in the *London Cancer* integrated system with a request to submit an application to host either local or specialist services for the various pathways. Where more than one trust wished to provide the specialist surgical component of a service where the clinical recommendation was for only a single site, then the resulting submissions were assessed by an independent expert panel external to *London Cancer* to inform the *London Cancer* board prior to their forming any clinically-led recommendations later made to commissioners. • *London Cancer* published a report on their website in October 2013. This outlined and provided detail for the basis for their recommendations.

Thoracic surgery	• Clarity sought on the rationale for not including thoracic surgery in the review, particularly as it is a cancer pathway which causes a high volume of premature deaths.	• Lack of consensus led commissioners to decide that further work is required to determine the best solution to maximise benefits for all lung cancer patients. • Work will continue with providers to develop a high quality service, which addresses the urgent need to improve earlier diagnosis and active treatment rates to increase chance of survival for more patients. • A review will also be done to consider the implications for both cancer and cardiovascular pathways. • In the meantime, *London Cancer*'s lung cancer pathway board is developing a detailed specification for the whole pathway that will include best practice diagnostics to improve active treatment rates, accelerate molecular genotyping and time to treatment decision-making, as well as aspects to improve early diagnosis and holistic care along the pathway.

5. Response to cancer proposals by pathway

The case for change focused on specialist treatment for five cancer pathways:

- brain cancer surgery
- head and neck cancer surgery
- urological cancer surgery – prostate, bladder and renal
- acute myeloid leukaemia (AML) treatment and haematopoietic stem cell transplantation (HSCT)
- oesophago-gastric (OG) cancer surgery.

Where comments were made on proposals for specific pathways, an overview of the key and recurring themes are provided in the table below.

Pathway	Feedback	Response
Brain	• The proposals will provide the *London Cancer* population with access to the best possible care and treatment options. The joined-up pattern of care and equity of excellence will ensure all brain cancer patients are given the best possible chance.	• Support for the proposals is welcomed.
	• Concern that the move from Barts Health will be a loss of training potential for specialist trainees.	• Proposed specialist centres would work as part of an integrated cancer system across the locality. This will include collaborative working and training arrangements between sites and organisations.
	• Concerns that surgeons who currently perform micro-neurosurgery at Barts Health may	• All staff with specialist skills will be supported to ensure that their role in the system is identified clearly and in partnership with them.

	leave.	
Head and neck	• Proposed changes will raise standards of care and ensure that patients have access to the latest surgical and non-surgical treatments. The current surgical caseload for the existing three centres does not meet national specifications. Surgeons in these teams may not have significant exposure in all aspects of this work necessary to provide the high standards of care.	• Support for the proposals is welcomed
	• Centralisation of this pathway at UCLH will affect Barts Health's existing delivery of a first class service within the trust and at neighbouring hospitals.	• If approved, the new centres would aim to become the hub for a world-leading service and would provide the specialist elements of a whole pathway of care in partnership with local hospitals and primary and community care. *London Cancer* is committed to bringing the expertise as close to home as possible, where that is the best model of care for the patient and is feasible within current resources. Our patients need all of the experts that exist in our current system. • For surgeons working across sites, joint appointments between trusts would be in place to ensure that there is specialist input into the diagnostic, treatment and follow up care for patients at the current local hospital sites. These joint appointments would ensure that the majority of patients, who do not require a specialist surgical procedure, have equitable access to the expertise of the specialist team, who would be working in a new way to provide this.
	• Concerns that if head and neck cancer surgery is moved to UCLH, cyber-knife technology will not be used enough at St Bartholomew's to make it viable.	• Barts Health use cyber-knife technology for a variety of procedures and tumour types/sites, including: some intracranial diseases; lung cancer; liver metastases and primary liver tumours; pancreatic tumours and spinal tumours. The proposed move of head and neck cancer surgery from Barts Health to UCLH would not affect the use of this technology as patients would continue to have all non-surgical treatment and all types of radiotherapy at Barts Health.

Prostate	• Two-site model favoured by respondents (UCLH and BHRUT) with concerns raised about the cessation of this specialist service at BHRUT. • Comments were received stating that robotic prostatectomies should be included as part of a two site model • Evidence of BHRUT specialist surgeons undertaking large numbers of radical prostatectomies (totalling around 100 per annum). These high surgical volumes are associated with better patient outcomes in terms of mortality, continence and sexual function. • Concerns about travel impacts were prevalent for this pathway. Using public transport is problematic as not all trains have toilets.	• During the engagement period on urology in early 2013, stakeholders asked commissioners to assess a two-site model offering some specialist prostate surgery at a second centre at Queen's Hospital in Romford. This option was included as part of the options appraisal process, the results of which will form part of the initial business case. If selected as the preferred outcome, this option may require agreement at a national level, as it would differ from current national specifications. • It would be the decision of the Trust Development Authority and BHRUT as to investment for new technologies for specialist surgery. • An independent review of prostate outcome data provided by each of the current services at UCLH and BHRUT has been commissioned by NHS England and findings will be published as part of the initial business case, expected to be published in spring 2014. • Further detail on travel issues are provided in section 2.
Bladder	• Agreement that the current situation is unsustainable due to relatively small volume of this work and consolidation is needed for this type of specialist surgery in order for patients to have access to all potential options for bladder reconstruction. • Concerns that the loss of this specialist service at BHRUT would impact retention of local expertise and continuity of care.	• Support for the proposals is welcome. • Clinicians (doctors and clinical nurse specialists) would work across both specialist and local urological units in a networked model. The ambition is for clinicians to work as one team across the system. • Plans will be developed for trainee rotations across the cancer pathway between specialist centres and local hospitals.
Renal	• Centralisation of these services makes sense in the context of clinically-adjacent services (e.g. specialist nephrology including potential for dialysis and renal	• Support for the proposals is welcomed.

	transplants). • Concern about the loss of specialist services from BHRUT and Barts Health.	• Clinicians have recommended consolidating surgical renal cancer services into a single specialist centre at the Royal Free as it has many of the necessary supporting specialities including vascular surgery, liver and pancreatic surgery, renal medicine and 24-hour interventional radiology. Commissioners have undertaken a separate options appraisal process, the results of which will be available in the initial business case.
	• Request for full consultation if a one-site model is preferred by commissioners.	• The NHS has a duty under section 242 of the NHS Act 2006 to promote involvement and consultation in any service change. This involvement has to be proportionate to the extent of the proposed service changes. The NHS also has a duty under section 244 of the Act and the Local Authority (Overview and Scrutiny Committees Health Scrutiny Functions) Regulations 2002 to consult with local authorities on any proposal it considers is a substantial development or variation in the provision of the health service. Given the engagement done to date, the relatively small number of procedures affected and discussions held with scrutiny committees to date, it is the view of NHS England that formal consultation on the proposals is not necessary.
AML and HSCT	• Support for consolidation of these services to ensure that multi-disciplinary teams meet recommended standards and retain highly specialist skills, and ensure knowledge base of medical and nursing staff is appropriate for the complexity of patients. It will optimise access to clinical trials and build on best practice.	• Support for the proposals is welcomed.
Oesophago-gastric (OG)	• Support for consolidation and recognition that current centres do not meet national specifications and the number of surgeons in each team is insufficient to provide a specialist 24/7 emergency rota.	• Support for the proposals is welcomed.
	• Consensus that outcomes and patient experience is likely to be better in higher volume centres. Some respondents preferred a two-site model (UCLH and BHRUT) and others believed that the one-site model better met recent AUGIS recommendations.	• Proposals to consolidate specialist diagnostic and surgical services from three to two centres are to be considered in the short term. Further consolidation in the medium to long term would require further consideration and analysis, particularly regarding patient flows to outer north east London and Essex.
	• Need more evidence and data and	• *London Cancer* has published the expert panel's

	greater transparency and strengthening of the clinical case for a one-site model at UCLH.	report and produced a video to present the clinical perspective.
	• If a two-site model (UCLH and BHRUT) is adopted, it is important to ensure both centres are given equitable resources and opportunities. • Clarity needed on staffing arrangements for the two-site model and concerns that high performing staff will be 'cherry picked' to work in UCLH, inadvertently creating a two-tier system.	• If approved the new centres would aim to become the hub for a world-leading service and would provide the specialist elements of a whole pathway of care in partnership with local hospitals and primary and community care. In order to achieve this, we would require relevant expert staff working together across the entire system. For surgeons working across two sites, joint appointments between trusts would be in place to ensure that there is specialist input into the diagnostics, treatment and follow-up care for patients at the current local hospital sites. These joint appointments would ensure that the majority of patients, who do not require the specialist surgical procedure, have equitable access to the expertise of the specialist team, who would be required to work in a new way to provide this.
	• Concerns about the provision of services to the Essex population if a one-site model at UCLH is adopted.	• Patients would continue to be eligible for a choice of providers for surgical care, and travel and transport links would need full consideration and careful planning for implementation to ensure that this population is not disadvantaged. • Work is ongoing to examine and assess alternative provision for these services in Essex.
	• Concerns about the proposed move of OG specialised surgery from the Royal London Hospital due to good patient access and quality of current services.	*London Cancer's* approach to improvement has always been that the international evidence indicates that it is possible to improve performance for patients by working together in different ways (i.e. higher volume teams) rather than to suggest that any current service is not performing properly. The decision to recommend consolidation of three teams into a smaller number is not based on suggestion that the Royal London service is not good. It is based on the need to preserve all of the expertise in the system to work in a new high volume team for the complex surgical procedures, and to continue to provide their expertise locally for diagnosis, rehabilitation and follow-up of all patients and for non-surgical interventions for patients who are not deemed eligible for radical surgery.

6. Overall response to cardiovascular proposals

Overall, there was strong support for the cardiovascular proposals with only 10 of the 130 responses received relating to the proposed cardiovascular changes. Patients understand the constraints at the Heart Hospital and why this change will be of benefit.

Several individual comments were received with specific queries and concerns, more detail of which is listed in the table below.

Key issues	Detailed feedback	Response
Impact on Royal Free Hospital	• Increase of cath lab activity at the Royal Free Hospital for both primary and referral services following the proposed Heart Hospital closure. • Need to ensure sufficient resources and capacity at the Royal Free to accommodate the likely increase in Percutaneous Coronary Intervention (PCI) activity following the move of services at the London Chest Hospital to St Bartholomew's.	• The Heart Hospital does not have the capacity to expand to meet future demand. • Increases of activity and mitigation measures for these will be incorporated into planning for implementation work. • The majority of patients (two-thirds of inpatients) would live closer to the proposed new integrated cardiovascular centre so we would expect the majority of patients to transfer to St Bartholomew's and not Royal Free. The Heart Hospital undertook approximately 150 PCIs last year so the likelihood would be less than one additional PCI per week for the Royal Free. London Ambulance Service is currently undertaking modelling to confirm these assumptions.
Patient data	• Mechanisms needed to enable patient records and treatment plans to stay with the patient throughout the journey. • Safe transfer of data, such as imaging.	• Work is currently being carried out by clinicians to ensure that the transfer of data is fully considered and carried out effectively.
Impact of Barts Health financial turnaround	• Proposals are financially motivated to assist with the Barts Health financial turnaround. • Low morale at Barts Health due to financial turnaround and subsequent down-banding and job losses may negatively impact patient care.	• Primary driver is improving quality of care for cancer and cardiovascular patients. • Clinicians from trusts across north and east London have come together to develop a vision for cardiovascular care in the locality and have recommended developing the single integrated cardiovascular centre at St Bartholomew's. • Current data indicates excellent patient experience in respect of cardiovascular care at Barts Health, which is very similar to the Heart Hospital. The NHS as a whole faces a tough financial climate. These centres would boost the local health economy by providing more cost-effective services, as well as bringing in more money from research investment and national and international patient referrals.
Referrals	• No guarantee that current referral bases will send their patients to the proposed new centre. • Increased costs associated with the central London location may impact where commissioners send patients.	• The majority of patients would live closer to the new centre and the majority of local referrals are currently from City and Hackney, which is where the new centre is situated. • UCLP is supporting an integrated system approach with improvement across whole pathways being driven by the specialist centre. Local hospital stakeholders (e.g. cardiac leads at Barnet and Chase Farm) have indicated that the consolidation of specialist services would support better joint working and communication. • The new integrated cardiovascular centre at St Bartholomew's would be located around 2.5

		miles from the Heart Hospital. As such, any impact on cost to commissioners would be negligible. Current tariff costs are lower than at UCLH (due to market forces factor).
Heart attack centre location	• Impact on patients who have a heart attack in central London or other areas currently served by the Heart Hospital.	The Heart Hospital currently receives relatively few heart attack patients (423 in 2012/13) compared to other heart attack centres (London Chest received more than three times this amount during the same period). The majority of heart attack patients going to the Heart Hospital are from the Camden, Enfield and Islington. Fifty-one patients came from Westminster. In future, these patients are likely to be conveyed to the new centre just 2.5 miles away or to the other heart attack centres such as Royal Free, St Thomas' and Hammersmith with no compromise to patient care.
Maintaining Heart Hospital legacy	• Need to ensure good performance and patient experience is not lost following a move to St Bartholomew's. • Provision of adult congenital heart disease services at the new centre. • Future workforce planning needs to ensure staff at any new centre receive the necessary training (e.g. staff at the Heart Hospital have additional training and experience in congenital heart disease).	• Clinical outcomes and patient experience in cardiovascular at Barts Health are very similar to that achieved by the Heart Hospital. • Planning for implementation work already involves clinicians and patients from both trusts to ensure the new integrated cardiovascular centre brings together the best of both organisations. • Ten transformation leads have been appointed from both UCLH and Barts Health to co-develop the clinical and academic strategy for the new centre. • The Heart Hospital has little room to expand. This has already contributed to higher-than-average waiting times for surgery and higher readmission rates. The new centre would offer more capacity for adult congenital heart disease and other highly specialised areas in cardiology, for which demand is increasing. It would be the largest in the world for these types of patients and would benefit from research. Barts Health has already agreed to invest in additional adult congenital heart posts. • The proposed integrated cardiovascular centre would offer critical mass and more opportunity for training in specialist cases. A transformation lead has been appointed to ensure that there is a world class training and education programme to support the new centre.

Other comments included an interest in the provision of services for women with heart problems and the impact of the proposals on NHS services in north-west London. The planning for implementation process will address concerns and ensure that potential impacts on sites and trusts are mitigated.

7. Engagement process

NHS England undertook engagement on the case for change for specialist cancer and cardiovascular services in north and east London and west Essex between 28 October and 4 December 2013. The commissioner-led process was supported by clinicians and included events for staff, public drop-in sessions, stakeholder workshops and attendance at various meetings. For further information about the engagement process, please see the *Engagement overview report*.

Key issues	Detailed feedback	Response (if required)
Openness and transparency	• The engagement is not genuine and proposals are a fait accompli.	• This period of engagement was designed to gather feedback and information from patients, staff and members of the public on the case for change and clinical recommendations. Feedback will help shape the future scope of engagement and commissioners' preferred recommendations. A commissioner-led options appraisal process was also conducted during this period. • A further period of engagement will be undertaken on commissioners' preferred recommendations.
Scope of engagement	• Clarity sought on why cancer and cardiovascular disease were linked for the review.	• While there are no service co-dependencies, the two service areas were linked to enable commissioners to take a system-wide view of the financial implications. • The preliminary proposals also form part of the same case for change as there is a pressing need to improve the way that both services are delivered, which was identified by commissioners in the models of care published for cardiovascular and cancer in 2010. Stakeholders across the locality prioritised these areas as two-thirds of premature deaths in people under the age of 75 in London are a result of cancer and heart disease.
Format of public events	• A few attendees questioned the drop-in format and felt there should have been a formal presentation followed by Q&A. Others found the format a useful way of getting information and having discussions.	• The programme has sought to be socially inclusive by using various ways to present and explain the proposals. The events followed a similar format to those used on large-scale change programmes such as London 2012 Olympics, Crossrail and High Speed Two. • The drop-in session format was complemented by a number of meetings with patient groups, CCGs and councils and patient involvement in the option appraisal workshops. • The drop-in format of the events was designed to maximise attendance allowing members of the public to attend for as long or as little a time period as suited them. It was also considered of importance that all attendees had the opportunity to speak to a clinician or commissioner about the proposals, discuss aspects of the proposals that were most

		relevant to them personally, and have their questions answered, which is not always possible in a public meeting-style event.
Publicity of engagement events	• Comments were received from a few respondents that the public engagement events had not been advertised or widely promoted.	• Letters were issued to 540 stakeholders with an electronic copy of the case for change and a link to further information about relevant engagement events. • Information on the engagement and listings of public engagement events were published on NHS England, UCLPartners and *London Cancer* websites. • Colour advertisements listing all public events were placed in 14 local newspapers. • A ‘reminder’ article was posted on NHS England’s website to encourage responses to the engagement. • UCLPartners tweeted details to +700 followers each time new information was added to the website, the day before events and on the day of the events. • NHS provider trusts were also encouraged to publicise the dates on their websites, and tweeted details of events.