London Clinical Senate

Advice on proposals to consolidate, mainly specialised, cancer and cardiac services in north central and north east London

June 2014

Response to Request for Advice on Proposals to Consolidate Mainly Specialised Cancer and Cardiac Services in North Central and North East London

Prepared for:	**NHS England (London)**
Approved by:	**London Clinical Senate Council**
Date:	**9 June 2014**

AIMS OF THE REPORT: To provide to NHS England (London):

Advice on whether NHS England (London) adopted a sufficiently robust clinical process to arrive at the recommended options for the future configuration of these specialised services, considering the clinical involvement and evidence used. As part of this, advice on the depth of clinical involvement and support has also been requested.

Advice on a specific aspect of the proposals to inform a recommendation on the future model and location (s) of radical prostatectomies is the subject of a separate report.

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1 Summary

This report presents the London Clinical Senate's advice to NHS England (London) on proposals to consolidate, mainly specialised, cancer and cardiac services in north central and north east London. It describes the approach that we took, the issues we considered and gives our conclusions and recommendations.

The Clinical Senate was asked to give advice on two issues. The first was whether the overall process that NHS England deployed to develop recommendations on the future configuration of services was robust, considering clinical involvement and evidence used. The second was more specific and related to the relevance of outcome data and recently published national guidance in determining the future model for radical prostatectomies.

We established two Reference Groups to assist the Clinical Senate in exploring the issues and formulating advice. We are grateful to everyone involved for the time they committed and the level of enquiry, expertise and objectivity that they brought. Talking to stakeholders who had participated in NHS England's process was an important part of our approach. Over the course of two days we met a significant number of clinicians and patients and we are also grateful to them for the flexibility they showed in making the time to see us and for the openness with which they shared their views.

This report gives our conclusions and advice on the overall process. A separate report gives our conclusions and advice in relation to commissioning a service for the surgical treatment of radical prostatectomies.

In considering NHS England's overall process we agreed a set of criteria to help us form a view about its robustness. Taking all of our findings into account we concluded that the criteria have largely been met and therefore we believe that the process was, overall, a robust one.

Through our discussions with stakeholders we did identify some areas where the process could have been stronger and where learning can be drawn for the next stage. Significant efforts were clearly made to review and build on previous work to improve quality and outcomes for these services and to engage clinicians, patients and the public. Despite this, we felt that a longer period of engagement may have been helpful. The approach has been more effective at engaging clinicians in secondary care than in primary care and more cancer patients have been willing to get involved than cardiac patients. Very few members of the general public engaged in the process. We believe this partly reflects the level of interest and perceived relevance of the changes to different stakeholders.

Our advice therefore includes further development of the engagement approach in the next stage of this process. We have also identified several important issues that relate to the practical implementation and consequences of NHS England's proposals for these services and have made recommendations about these which will also need to be addressed as the process moves forward.

We believe there is a strong evidence base behind the proposals and we found significant support for the majority of recommendations amongst the clinicians and patients whom we met. The future model for radical prostatectomies is the one area where some clinicians and patients continue to voice concerns. Please refer to our second report for the advice that we have given to NHS England to inform commissioning decisions about this service.

Professor Christopher Harrison
Clinical Senate Vice-Chair

2 Advice Request

NHS England (London) asked the London Clinical Senate to provide independent clinical advice in relation to proposals to consolidate, mainly specialised, cancer and cardiac services in north central and north east London. NHS England is the significant majority commissioner of these services.

The Clinical Senate's advice will contribute to NHS England (London)'s assurance of the process through which commissioning recommendations have been developed. To avoid conflicts of interest, this process is being led by the Reconfiguration Team within NHS England (London)'s Transformation Directorate as NHS England's regional direct commissioning function led the process.

NHS London initially submitted a request for advice in November 2013. It was revised on 11 December 2013 to be clearer about the advice requested and refined again on 14 January 2014 to further clarify scope. A copy of the request is included as Appendix 6.2.

2.1 Scope of Advice Requested

The advice which the London Clinical senate has been asked to provide is in two parts:

(a) To give advice on whether NHS England adopted a sufficiently robust clinical process to arrive at the recommended options, considering the clinical involvement and evidence used; as part of this, advice on the depth of clinical involvement and support was also requested and

(b) To give advice on specific aspects of the proposals relating to the future model and location(s) of radical prostatectomies to inform the option recommended by the commissioner. The advice has three elements:

- A comparative analysis of current outcomes data,
- Which outcome measures should be used to compare radical prostatectomy effectiveness, and
- Implications of recently published NICE prostate guidance.

To be clear, with respect to (a) the advice sought relates to the *process* through which commissioner recommendations have been developed and not to the recommendations themselves.

This report relates to the advice requested in (a) which we refer to as the "overall review". A separate report provides the advice requested in (b), which we refer to as the "prostate review".

3 Background

Models of Care to improve cancer and cardiovascular services in London were published in August 2010. Each was developed through a commissioner supported pan-London programme involving expert reference groups, patients and other stakeholders with experience in each clinical area. The Models of Care were developed in response to previously published cases for change which set out how cancer and cardiovascular services in London could be improved. The ambition of both was to achieve quality of care and outcomes that matched the best in the world.

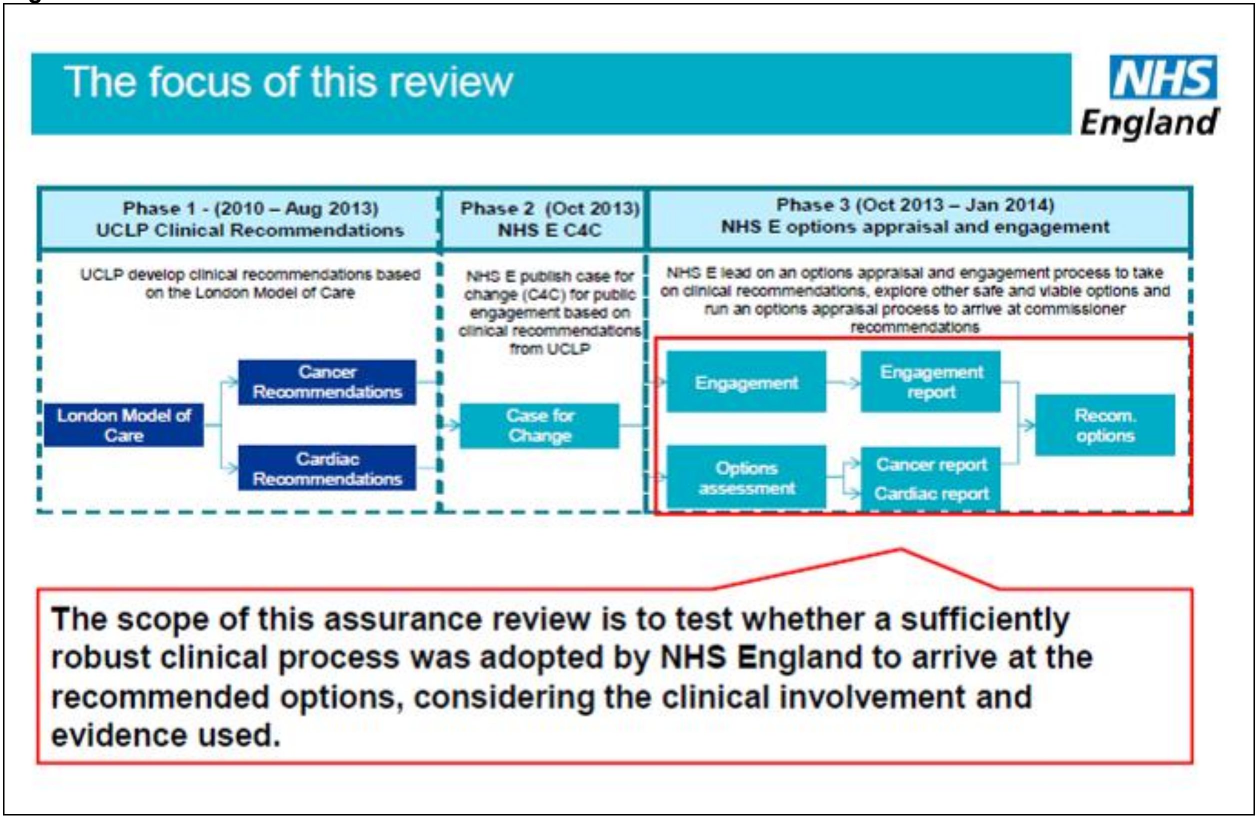
Informed by the Models of Care, University College London Partners (UCL Partners) developed recommendations for specialised cancer and cardiovascular services across its constituent organisations in north central and north east London. These were shared with NHS England, as the commissioner of the services, in August 2013. Proposals for service change should be commissioner led and NHS England (London) prepared a 'Case for Change' informed on the UCL Partner's clinical recommendations.

Following publication of the 'Case for Change' in October 2013 NHS England ran an engagement process to seek views on the recommendations and to identify and appraise options for delivering them. In addition to options put forward by UCLP this included other options identified as safe and viable to ensure all potential opportunities for achieving desired improvements were explored.

This process concluded in January 2014 with NHS England (London)'s recommendations on how these services should be commissioned in the future.

The overall process described above is shown in Figure 1. The advice that the Clinical Senate was asked to provide relates to Phase 3.

Figure 1: The focus of the Clinical Senate's advice



The focus of this review

NHS England

Phase 1 - (2010 – Aug 2013)
UCLP Clinical Recommendations

UCLP develop clinical recommendations based on the London Model of Care

London Model of Care

Cancer Recommendations

Cardiac Recommendations

Phase 2 (Oct 2013)
NHS E C4C

NHS E publish case for change (C4C) for public engagement based on clinical recommendations from UCLP

Case for Change

Phase 3 (Oct 2013 – Jan 2014)
NHS E options appraisal and engagement

NHS E lead on an options appraisal and engagement process to take on clinical recommendations, explore other safe and viable options and run an options appraisal process to arrive at commissioner recommendations

Engagement

Engagement report

Options assessment

Cancer report

Cardiac report

Recom. options

The scope of this assurance review is to test whether a sufficiently robust clinical process was adopted by NHS England to arrive at the recommended options, considering the clinical involvement and evidence used.

4 Formulation of Advice

4.1 Terms of Reference

The process to formulate advice was led by Professor Christopher Harrison, Clinical Senate Council Vice-Chair. Draft terms of reference for the Council's work were developed following a briefing by the Programme Director for NHS England's process and discussed by the Clinical Senate Council on 21 January 2014. A number of considerations were identified at that meeting, including agreement that the approach to formulate advice for the overall review should consider patient involvement as well as clinical involvement. The Council felt this to be core to any process involving service change proposals. The Council also agreed that the Reference Group for the overall review should include a minimum of two Senate lay members. Final terms of reference, which include the overall review and the prostate review, are included as Appendix 6.3.

Terms of reference were shared with NHS England's Programme Director and taken to the overarching Programme Board. This ensured that the advice which the Clinical Senate had been asked to provide, and the approach to formulating it, were transparent to all stakeholders. No specific comments or feedback were received.

4.2 Review Process

At the start of the review NHS England submitted a wide range of documentary evidence together with a “navigator paper” which provided background information and stated the purpose of each document and its relevance to NHS England’s process. The submission was well structured and easy to follow.

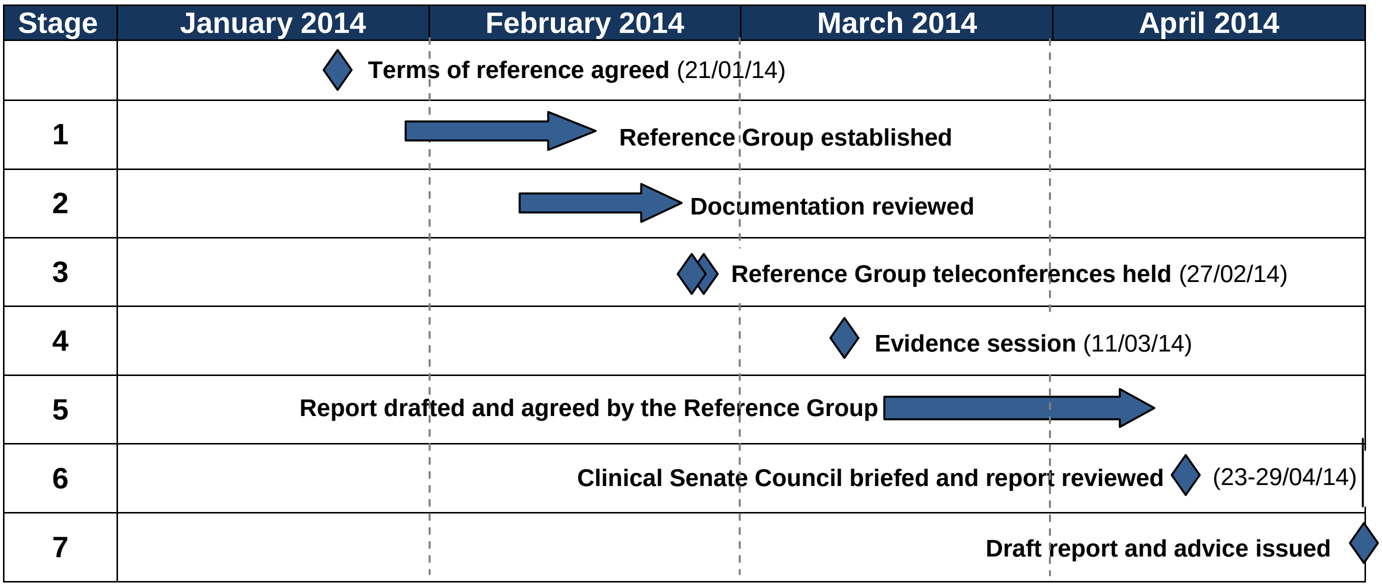
The broad approach to formulating the advice for the overall review involved the following key stages:

Stage	Activity
1	Reference Group established
2	Key documentation was shared and reviewed by Reference Group members
3	Reference Group members shared views and findings, agreed issues to explore and finalised the approach to each workstream
4	A panel drawn from the Reference Group held an evidence session with key stakeholders involved in NHS England’s process to discuss key issues and then formulated conclusions
5	A report was drafted setting out overall findings and recommendations and agreed by the Reference Group
6	The findings and advice was presented to the Clinical Senate Council and Council members have reviewed the final report. Recommendations have been endorsed.
7	The final report and advice was provided to NHS England (London)

Establishing a credible Reference Groups was a critical task in the approach. Care was taken to ensure an appropriate mix of perspectives and independence from stakeholders involved in the processes subject to review; both Reference Groups included relevant clinical experts from outside of London. Notwithstanding this, potential conflicts and associations were declared during the process. These are recorded in Appendix 6.6).

4.3 Timescale

The Clinical Senate formulated advice between January and April 2014. NHS England initially requested advice by the middle of February 2014 to inform a planned decision point in early March. The Clinical Senate considered the timescale too short to establish a sufficiently credible process. The agreed terms of reference aimed to provide provisional advice by the middle of March and to provide final advice in early April 2014. In practice the process of drafting and agreeing the report took longer than anticipated. Key milestones are noted below:



Stage	January 2014	February 2014	March 2014	April 2014
	Terms of reference agreed (21/01/14)			
1		**Reference Group established**		
2		**Documentation reviewed**		
3		**Reference Group teleconferences held** (27/02/14)		
4			**Evidence session** (11/03/14)	
5			**Report drafted and agreed by the Reference Group**	
6				**Clinical Senate Council briefed and report reviewed** (23-29/04/14)
7				**Draft report and advice issued**

4.4 Limitations

Wherever possible the Reference Groups have attempted to triangulate findings from the information gathered through the evidence sessions and the documentation provided.

The Clinical Senate confirmed date for the evidence session (11 March 2014) on 13 February 2014 with an indication of the likely stakeholders that the Reference Groups would like to see, however a specific list of stakeholders and timings could not be confirmed until after the Reference Group discussed findings from the documentation review on 27 February 2014. This impacted on availability of some stakeholders for the overall review evidence session e.g. no General Practitioners (GPs) were available to meet the Reference Group in person however a GP and CCG representative were able to participate by telephone on the day.

In the time available it was only possible to talk to a proportion of stakeholders involved in the overall review process.

This is one of the early reviews undertaken by the London Clinical Senate and there was no defined process to follow. The approaches adopted were discussed with the Senate Council and shaped by the Reference Groups and are considered fit for purpose. The Clinical Senate will identify any learning and use this to inform further work that it carries out.

5 Review Findings

5.1 The overall review leading to commissioner recommendations for specialised cancer and cardiac services

The Reference Group

- Professor Chris Harrison, London Clinical Senate Council Vice Chair, Medical Director and Director of Public Health, Imperial College Healthcare NHS Trust (**Chair**)
- Dr. Ros Given-Wilson, Medical Director, St. George's Hospital NHS Trust
- Elizabeth McManus, Executive Director of Nursing and Quality, Chelsea and Westminster Hospital NHS Foundation Trust
- Sally Kirkpatrick, London Clinical Senate Lay Member
- Wai Pang SHAM, London Clinical Senate Lay Member
- Dr. Rachael Liebmann, Consultant Histopathologist, RCPath Registrar and Consulting Lead and Member South East Coast Clinical Senate Council
- Mr. Anthony Blower, Medical Director, The Christie NHS Foundation Trust
- Dr. David Smith, Consultant Cardiologist, Royal Devon and Exeter NHS Foundation Trust
- Dr Junaid Bajwa, GP, Greenwich and London Clinical Senate Council member

Specific issues on approach

Documents identified by NHS England as critical to its process were reviewed by each member of the Reference Group. In addition the Cancer and Cardiovascular Models of Care were reviewed by the independent clinical experts.

NHS England asked for advice on the robustness of the clinical process used to reach commissioner recommendations. There is no absolute definition of "robust" in this context. In 2010 the Government introduced four tests that proposed service changes should be able to demonstrate. Planning and delivering service changes for patients guidance, published in December 2013, states that the four tests provide a helpful mechanism for assuring the robustness of plans throughout the process (of developing them) and includes a set of key questions that commissioners and other bodies may find helpful to consider in preparing proposals for assessment against the four tests. The Clinical Senate drew from this guidance in considering the robustness of the process adopted by NHS England (London), specifically the Reference Group:

A. Considered the seventeen key questions in the guidance and agreed a sub-set which were felt to be the most relevant to explore
B. Considered the key components of the "clear clinical evidence base" test
C. Considered issues that the Senate Council has identified as being important to improving quality and outcomes[1]

There was some overlap between these three categories and with further refinement the Reference Group agreed ten criteria for enquiry as a framework to test its robustness. This forms the structure for the presentation of findings in the following section.

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[1] These are: integration (ensuring a seamless patient journey), patient centred, supporting self-care, standards, outcomes and value

5.1.1 Evidence and Discussion

The evidence session held on 11 March 2014 involved presentations and question and answers structured around the ten agreed criteria (see the previous page).The Reference Group formed a judgement on the robustness of the process undertaken by NHS England (London) based on the extent to which each criterion was considered to be met. The table below shows key points captured from the discussion at the evidence session. These have been mapped against each of the criteria for ease of understanding.

#	Robustness Test Criteria	Discussion and Supporting Evidence
1	Did the process demonstrate that the proposals will deliver real **benefits to patients?**	The panel explored the improvement in outcomes and standards that the proposals are intended to deliver and how these had been considered in reaching the recommendations. Clinical stakeholders said that meeting NICE guidance and national standards were the key drivers behind the proposals and described where current services were not achieving these, in particular highlighting where specialist surgical activity did not meet recommended volumes. There was significant agreement that consolidating services into fewer, larger centres will allow surgeons and other clinicians to maintain skills and further develop techniques by having opportunities to operate on a larger volume of patients; to trial innovation and research and increase resilience e.g. through provision of cross cover. Ultimately, this should result in benefits to patients. The options appraisal process assessed benefits in three areas: clinical quality and outcomes, patient experience and research, education and training. Pathway specifications have also been developed for all tumour sites as vehicles to improve services and these set out the outcomes and standards that services had to deliver. Patients as well as clinicians were involved in this work. Factors that impact on outcomes beyond overall volumes e.g. mortality data and workforce issues (including activity at an individual surgeon level) were also reported to have been considered. Clinicians and commissioners with a good understanding of current performance against standards and guidance were involved in the options appraisal. When asked if the recommendations from this process would ensure that the best outcomes currently being achieved could be replicated in the proposed configuration, one stakeholder replied that they would be and another indicated that this had not been a specific consideration, rather the focus had been on improving outcomes overall. The point was also made that as no service was meeting the recommended surgical volumes for the tumour types being considered, and there is a relationship between volume and outcomes, a focus on current outcomes seemed less important. The lack of robust data on clinical outcomes for current services was noted by the panel and this includes functional outcomes for patients. It was considered that using patient throughput volume as a surrogate for quality outcomes was not always appropriate. The clinical case needs to demonstrate continuous improvement in clinical outcomes with increasing volume and should not simply state that larger centres will deliver better outcomes than smaller ones, for example where the proposal is for a single centre; the relative benefits of different service configurations e.g. single site versus two site, need to be shown as clearly as possible to inform stakeholder's views. Current outcomes for cardiovascular services were reported to be good and to compare well with other centres. The main drivers for change revolve around quality of care due to capacity constraints causing increases in waiting times, cancelled operations and poor patient experience. This is particularly evident at the Heart Hospital at UCLH. Proposals for change also seek to benefit patients by enabling sub-specialisation (where recommended standards

#	Robustness Test Criteria	Discussion and Supporting Evidence
		are not currently being achieved), increasing the robustness of services and efficiency of facilities through 24/7 working and co-locating clinicians and academics. Whilst outcomes are good, clinicians emphasised their ambition to make further improvements and expressed the view that the proposed changes would enable this. Patients whom the panel met discussed the implications of the proposals on travel and access, for both patients and relatives, especially those requiring assistance. Some patients felt that this had not been given sufficient attention and could have a detrimental impact. The panel did hear, however, that the programme team had used the Transport for London (TfL) database to estimate the impact on patients needing to travel to alternative sites for surgery and that mitigation had been considered such as increased use of patient hotels and additional parking spaces at trusts. Organisational travel policies had also been investigated to ensure that patient transport was a viable option and innovative technologies such as issuing able patients with iPads to Skype relatives had also been investigated. Despite this patients had not yet seen any firm proposals. Patients from disease-specific groups such as the Cardiomyopathy Association, did voice a concern that the proposals could see already very ill patients having to make multiple visits to a more distant site e.g. for some investigations such as MRI scans as well as for surgery. To mitigate this, they were keen that potential resolutions such as overnight accommodation arrangements, as well as assisted travel, would be investigated thoroughly. A GP from West Essex CCG commented that patients spoken to (including a prostate Lobby Group and the Epping Forrest Forum) identified quality as the key issue however whilst the concept of patients having to travel for elements of their care was not new to patients (or GPs), how far they would have to travel and access for relatives was the other issue raised.
2	Were the proposals underpinned by a **clear evidence base?**	The programme team and clinicians seen by the panel described the cancer and cardiovascular Models of Care as the “blueprint” for the proposals. Both referenced underpinning evidence. The ‘Case for Change’ published by NHS England in October 2013 also draws on evidence from the Models of Care, NICE guidance and other evidence particularly relating to the relationship between volume and outcome. The rationale for large centres of sufficiently high activity were well understood and voiced by many of the clinical experts that the panel met. The fact that poor outcomes in London, when compared to the UK and the rest of Europe, were a major driver behind the proposed changes for specialist cancer services was widely accepted and a view supported by the programme team and panel members. Similarly, there was felt to be evidence to support the view that outcomes in specialist cardiovascular services could be improved through sub-specialisation and that this would be enabled by the increased volume of a larger centre. Discussion indicated that evidence drawn from national guidance relating to the recommended volume of primary angioplasties appeared to have been misunderstood in the clinical case and this raised concerns amongst the panel.

#	Robustness Test Criteria	Discussion and Supporting Evidence
		It was also acknowledged that the evidence behind some anticipated benefits was less clear e.g. benefits arising from co-locating clinicians and academics. Though the assertion seemed a reasonable one this had not been done elsewhere at the scale proposed. This has the opportunity to contribute to the evidence base. Patients whom the panel met said they supported the Models of Care and the ‘Cases for Change’, and understood the relationship between volume and outcomes however some felt that they had not been shown the evidence demonstrating the benefits of one “extremely large centre”; this particularly related to prostate cancer. The programme team explained how evidence had been used in the process to identify a shortlist of safe and viable options and to inform the criteria for appraising the options. When considering the evidence base for the evaluation, lay members on the panel felt that the scoring methodology could have been described more clearly and the rationale behind the decisions on the final outcome could have been better explained. A similar point was made by some patient representatives who met the panel and who emphasised the need for transparency of voting and scoring systems in options appraisal processes. The Programme Director confirmed that the in the next stage of the process the reports from the options appraisals will be made public so that the methodology, including associated evidence, and outcomes from the process are transparent.
3	Did the process demonstrate that the options considered would be **deliverable and sustainable**?	Much of the discussion concerning the deliverability and sustainability of the proposals focused on infrastructure, clinical capacity and surgical activity, which had been looked at in some depth during the options evaluation process. The UCLP team described how the Heart Hospital at UCLH was physically constrained and could not expand further to accommodate anticipated increase in demand. To an extent existing facilities at Barts have the same problem. A consolidation of services would, therefore, provide capacity for more beds including additional ICU beds required to unblock theatre issues. Mothballed space at the Barts site is earmarked for this. A lead consultant from the Heart Hospital confirmed the current capacity issues at that site and strongly supported the view that critical volume is vital for high quality sub-specialties and that none of the current centres was meeting recommended numbers of cases. The panel was advised that an important issue when assessing the deliverability of the proposals would be the requirements placed on High Dependency Units (HDUs) for cardiac patients and noted this would be investigated in greater depth during the next stage of the process. It was also stated that the greater critical mass of activity at a single centre should allow more efficient use of facilities around the clock and this would also increase capacity. The programme team confirmed the plans for providing the physical capacity to manage the increase in cardiovascular patients at Barts and described the proposed sequencing of service changes prior to achieving a consolidated service in 2016. This will require capital investment and be subject to business case approval. Changes in the volume of cardiovascular activity were described in broad terms and one clinician advised they had not yet seen the final numbers though said this will be confirmed in the business case. The panel was also advised that for proposed changes in cancer services the volume of activity for most tumour sites was around 50 cases per year therefore easier to accommodate.

#	Robustness Test Criteria	Discussion and Supporting Evidence
		The panel explored the extent to which the clinical capacity required to deliver the proposed models had been considered. The programme team confirmed that this had been part of the evaluation process for cancer services; this assessment involved a change to the location of surgery but no change to non-surgical management, which will be carried out locally to the patient. A future model was described in which surgeons would spend 50% of their time at a specialist centre and 50% of their time in a local trust. An example was given to evidence that this arrangement was working currently therefore is likely to be achievable. This should ensure that expertise is maintained and there is no dilution of skill in the "base" trust, whilst skills will also be enhanced by working in the specialist centre. It was also noted however that surgery at a site further away (from current locations) would require an inpatient stay further away from the patient's home, reinforcing the importance of satisfactorily addressing patients' concerns about travel. The London Cancer led process through which trusts expressed interest in providing services to meet specifications agreed by Cancer Pathway Boards involved considering the impact of losing specialist services as well as accommodating increased activity, except in the case of the urology pathway where the process occurred at an earlier stage and focused on accommodating activity only. Although this process took place before NHS England's process it was clear that the work remained relevant in understanding the deliverability and sustainability of recommendations. For example, when asked how expertise would be maintained at trusts which did not provide specialist cancer services in future the London Cancer Medical Director advised that specialist MDTs (SMDTs) would be maintained locally though the model may vary for different pathways e.g. three SMDT's are proposed for the urology pathway each covering a population of 1 million and ensuring geographical spread. Discussions with the national peer review group to inform this are ongoing. A key first step would be integration across sites and local access to MDTs was also seen as important. More minor, though nevertheless important, aspects of implementation affecting deliverability were mentioned by some and these touched upon items such as patient leaflets and the use of iPads for patient/family communication. Assurance was gained from the programme team that these are the sort of issues discussed at Pathway Integration Workshops and that patients and the public would be involved to shape the future implementation. Some patients whom the panel met felt that plans of how the changes would be delivered were not yet as well developed as they would have liked. The programme team confirmed that the London Ambulance Service (LAS) had been consulted with regard to the proposed changes and impact on ambulance flow.
4	Were **clinicians sufficiently engaged**?	The programme team confirmed that official clinical engagement channels were exploited as much as possible to engage with clinicians and that where possible, cancer and cardiac lead clinicians were involved throughout clinical engagement events. In general, the programme team's engagement was driven by a combination of offer and invitation. This was supported by the Bart's clinicians, who reassured the panel that they had been greatly involved and had discussed many of the pathways, including head and neck, upper GI, lung, brain and renal/bladder cancer pathways.

#	Robustness Test Criteria	Discussion and Supporting Evidence
		The Medical Director, London Cancer explained the approach that London Cancer had taken through the clinical leadership of Pathway Boards (which have multi-professional membership including GPs and patients) to develop service specifications for delivering services. Several other clinicians emphasised the extent of clinical involvement in the Pathway Boards and that there had been broad clinical consensus on service specifications initially developed (the London Cancer Medical Director informed the panel that all but one clinician on the urology pathway board had supported the proposal for a single specialist surgical site for bladder/prostate and a single specialist surgical site for renal cancer complex surgery). In developing specifications clinicians were asked how aspects of the pathway could be improved and covered areas such as workforce and infrastructure. The panel was reminded by some stakeholders that the cancer and cardiovascular Models of Care, and the initial proposals which UCLP presented to NHS England in August 2013 were also clinically led. The view from specialised commissioners was that compliance with best practice recommendations had largely driven the proposals and that this had generated good clinical enthusiasm and engagement. The Programme Team advised that all CCGs had received the ‘Case for Change’ (CfC) documentation and a number of GP meetings had been used to talk through the proposals, e.g. Tower Hamlets GP Forum. It was also noted that as the majority of specialist services are commissioned by NHS England, CCGs are not at the forefront of these proposals. This view was supported by Camden CCG which was of the opinion that the changes had been driven by clinical specialists rather than by local need (supported by GP involvement). It was further noted that some engagement with CCGs had been hampered due to the lack of cancer leads in post at that time; where cancer leads were in post, evidence of engagement was stronger. CCG representatives did voice a concern that the involvement of GPs in some local centres had not been optimal. Whilst some GPs had clearly been very involved in this work, including membership of Pathway Boards, the panel’s observation was that broad engagement with GPs in the recent engagement process has not been as strong. The panel explored how the views of clinicians who were not supportive of changes were listened and taken into account. The Programme Team gave several examples: a meeting was held between some Camden GPs, London Cancer Medical Director and Pathway Directors and the Programme Director to listen and respond to GPs concerns about partnership working in the community; a two site option for radical prostatectomies was included in NHS England’s ‘Case for Change’ following concerns expressed by clinicians in BHRUT that only a one site option had been considered at an earlier stage; the Programme Team proposed a two site option for OG cancer (UCLH and BHRUT), as opposed to the preferred one site option, pending clarity about future arrangements in Chelmsford (which fell outside the scope of the review) otherwise the proposals risked making decisions that could affect provision of services in that area.

#	Robustness Test Criteria	Discussion and Supporting Evidence
5	Were **patients sufficiently engaged**?	The Programme Team confirmed that more than 500 stakeholders had been engaged to date, utilising a variety of methods, including meetings and drop-in sessions promoted through emails and local newspapers. The programme team informed the panel that all engagement invitations had been passed to CCGs to disperse to wider groups and that drop in sessions had been held at different times of day and in geographically convenient locations. Patients were also involved in the options' appraisal workshops. It was acknowledged that although Health and Wellbeing Boards (HWB) were engaged, the conflict between the HWB focus on illness prevention and the programme's focus on specialist services did reduce the interest shown by HWBs. The Programme Director reported that Healthwatches and numerous supporting charities and voluntary sector organisations were written to as well as patient groups in north central and north east London. The programme team also engaged with the relevant Overview and Scrutiny Committees. Following on from an earlier engagement programme relating to proposals for urological cancer a lot of engagement activity was around the Outer North East London population as well as BHRUT (this was true for clinical engagement too). The Programme Director advised that the team responded to engagement requests (e.g. the Programme Director has attended monthly meetings of the former NE London Cancer Network Patient Experience Group) however the approach was generally one of proportionality; from a population of 3.2M in north central and east London with 5,500 cardiovascular spells per year, only 10 written responses were received from patients. This compared with an expected shift of 500 cancer surgical cases which generated 140 responses from cancer patients. The CCG view was that patient involvement in cardiac service discussions could have been greater locally in the boroughs, but felt the response was probably largely as a result of the changes not being controversial enough to create more interest. The patients who gave evidence were of the opinion that they had been well engaged, through a number of different means, including attendance at meetings, provision of (a lot of) documentation, discussion with the programme team and sometimes with clinical staff. However, they also said that some invitations often arrived with what they felt to be very late notice, making involvement impossible on these occasions and felt the engagement period (5-6 weeks) was not long enough. A degree of frustration was also reported in that the overall process seemed to be an emerging one and the process for decision making arrangements was not clear; they felt a clearer explanation of the whole process at the outset would have made it better. Patients also highlighted an issue about use of language e.g. there did not appear to be a common understanding of terms such as complex, very complex and specialist amongst different stakeholders. It was also reported that patient groups with long associations with the trusts affected (e.g. Cardiomyopathy Association and GUCH), had been well engaged and found it easy to attend meetings and become involved, e.g. access to clinicians and the programme lead through the Patient Information Group at the Heart Hospital. The panel heard that proposals to move services from the Heart Hospital had been talked about for so long that they were accepted as a planned development and were not considered controversial (feedback from the engagement process would seem to support this). One patient told the panel that a group of patients had been given the opportunity to tour the proposed facilities at Barts and said that they had been impressed.

#	Robustness Test Criteria	Discussion and Supporting Evidence
		Some patients said that their late involvement meant that they felt they were being informed of a change that had already been decided rather than feeling their opinion could be instrumental in shaping proposals. Patients did have opportunities to raise concerns, however got the impression that they were not being acted on and consequently felt they had to raise them repeatedly, which was frustrating. Travel was a key concern as many proposals involved a shift of service from outer to central London and whilst there has been a lot of discussion, there had been no resolution. This particularly related to proposals for prostate cancer. One patient who thought not enough consideration had been given to patients' support and well-being as well as the logistics of accessing services felt that people were listening but did not know what to do about it. Patients confirmed that they had been told what the next stage of the process was and that this would address concerns. Patients would like to see concrete plans not just further discussion. The Programme Director explained the considerations relating to formal public consultation and confirmed that there has been significant discussion about the changes with the three Joint Health Overview and Scrutiny Committees whose populations would be most affected. The panel was advised that the JHOSCs have written to confirm their view that the proposed changes do not constitute a substantial variation of service and therefore, in their view, do not require formal consultation. The Programme Director however assured the panel that NHS England is committed to ongoing engagement and discussion with patients and the pubic affected. The Programme will continue to work with the OSCs, as well as involving patients, in the next phase of planning implementation to ensure that issues raised through engagement process so far are addressed e.g. relating to travel and access and patients' experience of new pathways.
6	Did the process demonstrate that cancer and cardiac services are seen as part of the **broader pathway?**	The Medical Director, London Cancer, referred to the London Model of Care for Cancer as the blue print for the development and improvement of services and whilst the focus of the specific recommendations being discussed is on specialist services, the Model of Care considers the whole pathway. The panel was also advised that the greater part of London Cancer's work programme related to the non-specialist elements of the pathway; Several examples were given to demonstrate this e.g. strengthening the relationship between primary and secondary care and improving GPs' access to diagnostics and investigations, plans for future work on 'living with and beyond cancer' with CCGs and co-production of recovery packages of care with community services and local authorities. The involvement of GPs on Pathway Boards also lent itself to the broader pathway being considered. Similarly, the proposals for cardiovascular services were described in the context of a cardiovascular system and work with CCGs and primary care in relation to heart failure and atrial fibrillation was described (see section 10 below).
7	Did the process consider **potential risks and unintended consequences** of the proposals?	The panel explored unintended consequences and how well the process had taken these into account in assessing the risks and viability of options. The UCLP team confirmed that work stream leads had been appointed to look at reshaping the delivery so that something 'truly different and beneficial' would be delivered and that to support this, Richard Bohmer from the

#	Robustness Test Criteria	Discussion and Supporting Evidence
		Harvard Business School had been employed to enable development and implementation of detailed work plans. In addition to this, specific Patient Reported Outcome Measures (PROMs) were being developed. London Cancer's work to develop pathway specifications involved discussions on risks. Barts' clinical leads felt that a significant amount of work has been carried out in relation to implementing the cardiovascular recommendations with clinicians from Barts and UCLH meeting regularly over several months; however they felt that consideration of the impact of the proposed changes for cancer services was not as advanced. Specific issues relating to risks and unintended consequences that emerged from the discussion were: • Some clinical and patient opposition continues in relation to the proposals for radical prostatectomies • Other remaining reservations from clinicians were, in the main, felt to relate to changes to personal employment and not to the clinical model • The Bart's team highlighted the potential impact of proposals on the infrastructure for the Major Trauma Centre at the Royal London Hospital (noted to be the busiest in the UK and reportedly with the best outcomes for critically injured people). Determining ongoing working arrangements that secure multi-disciplinary time dependent trauma care was raised as the most significant issue (and neurosurgery the biggest issue within this). Work to address this is clearly underway; the panel heard that a successful engagement day was held recently (led by the Medical Director at Barts Health and involving the National Lead for Trauma Care) - and others are planned. • Following on from the point above, it was suggested that perhaps all pathways and not just the specialist pathways, should have been considered together to mitigate against interacting risks • The Bart's team commented that although they decided not to submit a bid for head and neck surgery, which some clinicians were unhappy with (though it was emphasised that they continue to support the principles behind the proposed changes) they did consider taking on more non-surgical services from other centres and they had considered this as part of the unintended consequences of the proposal. • Arrangements for delivery of acute, local cardiology and cardiac support for other specialties (including cancer) was an issue being addressed though not yet resolved. One CCG representative who spoke to the panel comment that CCGs would have liked to have seen greater risk assessment of how the proposed changes may affect other related areas such as early diagnosis, access to diagnostics, accident and emergency services and the 18 week referral to treatment waiting times. Contrary to a suggestion that the changes to the NHS commissioning system introduced in April in 2013 may have affected the process in a negative way, the CCGs view was that any changes to the original plans happened as a result of picking up an already well developed piece of work and carrying out additional checks to ensure that the evidence base in place was secure enough. The UCLP Managing Director also welcomed NHS England's process as an opportunity to add further scrutiny and objectivity in considering proposals which would ensure greater rigour overall.

#	Robustness Test Criteria	Discussion and Supporting Evidence
		The panel noted that the issues raised above should be included in the programme risk register; plans to mitigate these need to be robust and should be shared with stakeholders.
8	Did the process consider the options objectively using **criteria aligned to the stated benefits and evidence**?	Discussion at the evidence session focused on cancer services. This again reflected a general thread through this session that whilst the recommendations for cardiovascular services represented the greatest change in terms of scale and potential number of patients affected it seemed less controversial compared to the recommendations for cancer services, which would have a greater impact on access and travel for some patients and on the ways of working and work location for some clinicians. The programme team described the non-financial appraisal methodology and steps taken to ensure the process was objective, transparent and robust. It was commissioner-led and involved clinicians, and patients. To ensure objectivity the process started with a long list of all theoretical options that could deliver the proposals in the 'Case for Change' and this work involved providers from outside north central and north east London. Short-listed options for all pathways were assessed against four criteria (patient experience, clinical outcomes, deliverability and research) and then subject to a number of sensitivity tests. Weightings to be applied to each of the criteria had been agreed by a panel of patient representatives, GP Clinical Leads, Cancer Commissioning Team Specialised Commissioners; this put most emphasis on clinical outcomes, then patient experience, deliverability and proportionately less weighting on research, education and training. It was acknowledged that although some outcomes available through the commissioning process were considered, higher volumes would have been needed to assess more meaningful functional outcomes to patients in addition to those considered The specialised commissioning view was that there remained questions around the strength of the radical prostatectomy outcomes data, especially with regard to quality, type of data and comparability between sites. Options were scored over the course of several workshops and the evaluation was carried out by independent cancer specialists (Cancer Commissioning Team). This appraisal was combined with engagement feedback to developed preferred options. The Programme Team used two examples (one for cardiovascular services and one for cancer services) to show the way in which final scores were derived including how sensitivity analysis was applied and how the outcome of engagement informed recommendations. The Programme Team advised the panel that the final business cases for these recommendations will include the options appraisal reports so they will be publicly available and transparent in terms of how decisions were reached. One of the panel lay members observed that it was not clear from the information presented and the documentation previously shared how a final decision was arrived at where the difference between consolidated weighted scores appeared relatively small. The panel noted this was an important observation in relation to further engagement. The Programme Team also followed this up by meeting with the panel lay member and explaining this aspect of the options appraisal process in more detail, which provided assurance.

#	Robustness Test Criteria	Discussion and Supporting Evidence
9	Did the process consider the opportunities to support **better integration of services**?	Several stakeholders were clear that achieving better integration was seen as important and an implicit if not explicit goal. Clinicians made several references to integrating care across pathways, for example integration of specialised MDTs, more integrated working between secondary and primary care and the fact that where specialised services are concentrated onto fewer sites surgeons and clinical nurse specialists will have an integration role as they move between local services and the specialist centre. The UCLP team commented that the proposed changes were more than just about volumes of surgery at one site, and that it was about ensuring benefits to the whole system, including primary care, were realised. However, some different views were expressed about the extent to which the current engagement process focused on integration and this may have been a factor which hampered engagement of GPs and some clinicians in district general hospitals. For example, one stakeholder expressed the view that the focus was on a small part of the pathway, i.e. specialist surgery, compounded by the fact that these changes affected a very small number of patients with specific conditions. Others referred to the underpinning work led by London Cancer which had a very clear focus on integration and felt this was reflected through the process. . The changes to cardiovascular services were described by one stakeholder as being about creating a cardiovascular system, which included supporting primary care, which indicates the intention to have a more integrated approach. The panel questioned whether sufficient thought had been given to seamless sharing of clinical patient information across sites and organisations. Patients were similarly concerned about aftercare at sites other than where the surgery was carried out. They felt that access to services for patients and family members and related issues of ‘wellbeing’ had not been given equal consideration. Integrated and coordinated care is clearly very important to patients and there is insufficient assurance from the process to date about how this will be achieved.
10	Did the process consider **the impact of the proposals on the wider health and care system**?	The engagement programme has attempted to reach across the wider health and care system, including Local Authorities, Health and Well-being Boards, and voluntary sector organisations, though the panel heard that feedback had been limited. The UCLP team confirmed that with regard to the wider health and care system, Richard Bohmner, a transformational lead from Harvard Business School, had been employed for his opinion and expertise in creating new systems. Additionally, heart failure and atrial Fibrillation (AF) in the community were being considered and work on rehabilitation and prevention was being undertaken in liaison with many CCGs to demonstrate this commitment. In support of these criteria, the Programme Team reported that not only were options derived from expressions of interest, other options identified as viable and safe were considered too and appraisal included impact on the wider health and care system and involved opinion from outside of London.

5.1.2 Conclusions

Following a review of the core documentation and having had the opportunity to explore a range of issues with stakeholders involved in NHS England's process the panel concluded:

#	Robustness Test Criteria	Conclusions
1	Did the process demonstrate that the proposals will deliver real **benefits to patients?**	There was good evidence that the proposals, if implemented effectively, should improve quality and outcomes for patients and meet (and in some cases exceed) national standards for cancer services. The case for consolidating services is generally well made, understood and supported by patients and clinicians as are the clinical benefits that would arise. Benefits tend to be described rather than quantified and the availability of outcome data needs to be further developed. For both cancer and cardiovascular services whilst the improvement goals are clear, benefits were generally described rather than quantified and milestones were not identified. The aims and benefits described by stakeholders relating to cardiovascular services are underplayed in the Case for Change. Lack of data made it difficult for patients to understand benefits in terms of clinical outcomes. In some cases, recommendations mean that patients and their relatives would have to travel further and stay overnight in a location further from their home and this would present issues that need to be thoroughly investigated and resolved to mitigate an impact on wider benefits being achieved. The concerns about travel implications related to proposals for cancer services. For cardiovascular services the distance between the current and proposed new centre is relatively short and the majority of in and out patients will live closer to it. From many discussions, stakeholders were expecting and wanted the changes to become a reality and produce benefits to patients more quickly than current expectations. Through the engagement programme a number of stakeholders acknowledged that a focus on prevention and early diagnosis will have a much greater impact in improving outcomes and examples of work taking place were described.
2	Were the proposals underpinned by a **clear evidence base?**	It was clear from discussions that a substantial amount of work has taken place over several years leading to the development of proposals. This was generally felt to be thorough and evidence based. In particular there is a strong evidence base to show that larger, consolidated centres assist with improving clinical ability, research and innovation and provision of better clinical support. The evidence base was felt to be stronger for the specialised cancer services proposals. There was an incongruity between information in the 'Case For Change' for specialised cardiovascular services and the verbal evidence provided, in that the documentation did not fully describe the large amount of work that had been undertaken nor make the case as strongly as it could have e.g. by presenting more evidence about current quality and compliance against guidance and standards. National guidance about volumes of primary angioplasties had been misinterpreted by several stakeholders and there seemed to be a lack of ownership for the data quoted. It could be that a London specific agreement has been reached that differs from national guidance, though this was not explained.

#	Robustness Test Criteria	Conclusions
		There were instances where the evidence base appeared not to have been communicated as well as it could be, for example, some clinical outcomes data had not been shared with all patient groups and some patients felt they had not seen evidence to demonstrate the benefits of one "extremely large centre" for radical prostatectomies. The draft engagement report shows that some CCGs have also questioned evidence in this area. Where there were different views on interpretation of the evidence e.g. relating to prostate cancer further action had been taken to try and resolve this. It was felt that the 'Case for Change' document could have been improved if it had more of a patient focus and greater attention to detail with regard to images used (some were not consistent with the message they were intended to illustrate). Whilst this needs to be commissioner led, clinical review may have been helpful.
3	Did the process demonstrate that the options considered will be **deliverable and sustainable**?	Deliverability in terms of physical and clinical capacity and infrastructure has been taken into account during the options evaluation and the work behind this appears to be thorough given the stage that the process is at. It was felt that staffing and bed capacity had been acknowledged but that ICU dependencies had not been fully explored to date. Activity modelling to inform final capacity plans was not yet complete but will be included in the business case for this scheme. The critical link between capital investment and full delivery of the recommendations did not appear to be appreciated by all stakeholders and some were unclear about plans for future use of current premises (the panel was given two contradictory views about the future of the Heart Hospital at UCLH). The sustainability of organisations with decommissioned services has had some but not extensive investigation undertaken though again there is evidence that related work is underway. Some but not extensive patient involvement had taken place to shape the implementation of the proposals. It is important to patients that this continues.
4	Were **clinicians sufficiently engaged**?	Clinical leadership and engagement has largely been responsible for driving development of the proposals. This has particularly involved many specialist clinicians in the surgical pathways across organisations. The process has included some peer challenge. Overall there is strong clinical support and enthusiasm for the proposals and where some clinicians may be disappointed about changes to their services they are reported to support the principles behind the proposals and are committed to delivering them. Clinicians are working together across pathways in both cancer and cardiovascular services to begin to develop plans for implementing the proposals. Clinicians who have opposed changes have been able to raise concerns and these appear to have been taken seriously with efforts made to explore issues objectively. Some engagement activity has been targeted accordingly.

#	Robustness Test Criteria	Conclusions
		The model of care for radical prostatectomies remains a concern for some clinicians, including clinical commissioners in outer north east London. Pathway Boards were key vehicles for clinical involvement in the development of proposals, including GPs and representatives from all trusts involved. However there does not appear to have been extensive engagement of GPs in general through the engagement process. This has mainly happened in isolated pockets (though included areas where concerns have been raised). There are exceptions to this and some CCG GP Cancer Leads have been very involved. Whilst the evidence session did not indicate significant engagement with non-specialist clinicians e.g. in district general hospitals the engagement report does show that events were held for staff and that many took up the opportunity. There was some, though limited, reference to engagement with non-consultant and non-medical staff. The Programme Director confirmed that the London Ambulance service has also been engaged.
5	Were **patients sufficiently engaged**?	The panel concluded that efforts have been made to engage with patients and this had happened most successfully where the hospital trust service had close link with disease specific groups and charities. The flip side to this is that the patient groups which have been engaged may not have been representative of the whole patient group potentially affected by these proposals, for example the panel did not see evidence of how “general” users of cardiac services were involved (the patients met by the panel had an interest in specific conditions). Although efforts were made to engage with the public, turnout at some meetings was very low. Different methods may need to be considered going forward. For some events not enough notice was given to patients to allow them to plan to attend. Generally patients had a very good understanding of the rationale behind the proposed changes, which demonstrated a certain level of successful engagement. However there are lessons to be learnt from the process to date, for example: ensuring early engagement and giving good notice of meetings and events; use of language and defining terms; ensuring clinicians are available at key meetings. Patients would have liked more clarity at the outset about the overall process and how decisions would be made; this is good practice. The fact that the new commissioning system was at an early stage of development and maturity whilst this work was taking place may have impacted on this. Patients who were opposed to proposals, or who had concerns, were able to raise these through the process though did not always feel they were being heard and there was some frustration that solutions have not been identified at a faster pace (which in part links to the point above). Travel and access and related support is a very significant concern.
6	Did the process demonstrate that specialist cancer and cardiac services are seen as	There is evidence that specialist services are not being considered in isolation. London Cancer’s overall programme and the service specifications developed for each tumour site take a whole pathway approach. Examples of work across the pathway were also provided for cardiovascular services.

#	Robustness Test Criteria	Conclusions
	part of the **broader pathway?**	Some efforts had been made to consider aspects of the broader, non-surgical pathway demonstrated by consideration of joint work with CCGs and local authorities.
7	Did the process consider **potential risks and unintended consequences** of the proposals?	Different professional groups have come together to consider implementation of the recommendations and through this they are sighted on, and have highlighted, potential risks and unintended consequences. It is also clear that work to investigate and mitigate these is, for the most part, at an early stage. • Some work has been carried out regarding the potential impact on the Royal London major trauma service but these needs to be developed further and is clearly a high priority; it is not clear how the significance of this featured in the options appraisal criteria • Although consideration had been given to understanding patients', carers' and relatives' transport needs the lack of visible plans to address this remains a significant cause of concern to patients and the reference group. Early evidence and discussion of specific proposals rather than acknowledgement of the issue in general is needed to address this; the next step is to develop a visible plan • The strong co-dependency with capital development does not appear to have been clearly acknowledged through the process • There are small sustainability concerns around the future workforce of decommissioned services which need to be addressed • There is a lack of clarity around the state of readiness (beds) at Barts before the changes would be implemented. Activity modelling to inform capacity plans has not yet been completed • Significant concerns, and diverging views, remain about the model of care for radical prostatectomies (the Clinical Senate's advice to assist commissioners in addressing this is provided in a separate report) It is not clear whether there has been an overall risk assessment.
8	Did the process consider the options objectively using **criteria aligned to the stated benefits and evidence**?	The overall options evaluation processes were objective and commissioner led. The appraisal of options for cancer services involved views from outside of north central and north east London to create the long list and the appraisal of shortlisted options involved patients, clinicians (including clinical commissioning advisors) and specialised commissioners and involved some peer challenge. Final recommendations were subject to a sensitivity analysis. Independent advice has been sought to assist commissioners in developing recommendations on the model of care for and options for radical prostatectomies, where there is opposition to previous recommendations and the recommendation for OG was modified in recognition of the wider impact in Essex. Criteria for both the long list and short list appraisal were aligned to benefits and evidence set out in the 'Case for Change'. The short-listing criteria considered: clinical quality and outcomes and patient experience and also deliverability and research, education and training.

#	Robustness Test Criteria	Conclusions
		The Programme Team was able to describe how the process discriminated between options where the difference in consolidated weighted scores appeared relatively small though this appeared harder to understand from the written report. It is intended to publish the options appraisal report so that the process and decision-making are transparent Some patients whom the panel met who were involved in the evaluation process did not feel this was the case.
9	Did the process consider the opportunities to support **better integration of services**?	The process did consider that consolidated services at larger sites could offer better integration of services and ways of enabling integration between the consolidated centre and local services (which would continue to provide all non-surgical care) has also been considered, with at least one example of cross site working operating in practice. Generally, though practical working arrangements that enable integration need to be developed. For example, there was concern that integration across sites, especially with regard to the sharing of patient records, did not appear to have been given much consideration. There was also a concern that strong engagement with primary care had not yet been achieved. Engagement with GPs to ensure a flow of information and communication as the coordinator of patients' care is important.
10	Did the process consider **the impact of the proposals on the wider health and care system**?	The impact of proposals on the wider system has been considered to some extent particularly at the provider level. The impact on the Major Trauma Centre is being considered in this context.

5.1.3 Summary conclusion and recommendations

Delivering a process to improve quality and outcomes by transforming the way that NHS services are provided is often complex. It requires a carefully planned approach, with multiple teams and organisations working together, and in full partnership with patients and the public[2]. Considering all of the findings from the documentation reviewed and discussions held, we believe the criteria that the Reference Group identified have largely been met and our conclusion is that the process through which NHS England (London) has developed commissioning recommendations was, overall, a robust one. We have identified aspects of the process that could have been stronger and where learning can be drawn for the next stage. We have also identified several areas where a greater focus will be required in the next stage, some of which are already acknowledged. Our recommendations are noted below:

- Engagement should be strengthened to encompass a broader range of patients and the public, GPs and front line clinicians affected by the proposals. GPs are a particularly important group who need a robust flow of information to inform patients

- The improvements in quality and outcomes that the proposals are intended to deliver should be made explicit and plans should be developed to evaluate whether improvements have been achieved and to make outcome data publically available

- Recommendations about primary angioplasty activity volumes in the ‘Case for Change’ document should be checked for accuracy and consistency with national guidance

- Patients’ concerns about travel, access and associated support need to be resolved as soon as possible. Beginning to discuss concrete proposals will demonstrate to patients that their concerns are being heard and that there is a commitment to finding a workable solution.

- Patients and clinicians concerns about the model of care for radical prostatectomies need to be addressed through a transparent process in which all evidence for recommendations is openly discussed and shared. The Clinical Senate advice’s on the relevance of outcome data and recently published NICE guidance to assist commissioners in addressing this is provided in a separate report.

- The impact of the proposed service changes on the Major Trauma Centre at the Royal London Hospital should be fully assessed and robust plans developed to mitigate risk. Early assurance about the solution and its deliverability should be a high priority.

- Further work should be undertaken to ensure risks associated with other unintended consequences that have a negative impact on delivery of care are identified and plans developed to mitigate them. These should be reflected in the risk log which should be accessible to all stakeholders.

- Ownership and accountability for the process of delivering the changes should be made explicit and encompass planning, implementation and transition. This should be supported by a process of assurance to ensure that all plans are aligned at pathway, organisation and system level.

- More thought should be been given to the seamless and easy sharing of clinical patient information across sites and organisations and with GPs.

- It is important that all stakeholders understand the co-dependency between major, linked capital development and the delivery of the proposed service changes and associated clinical benefits. Finalising activity plans and giving assurance that sufficient capacity will be in place is an important part of this. The future use of the Heart Hospital at UCLH should be clarified to address contradictory views.

- Every opportunity should be taken to improve integration across the whole pathway of care. Developing stronger links between specialised commissioners and Clinical Commissioning Groups will be important in ensuring effective integration between the specialised and the non- specialised parts of the pathway.

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6 Appendices

6.1 Glossary of Acronyms

Acronym	Expansion
ANP	Advanced Nurse Practitioner
BAUS	British Association of Urological Surgeons
BICS	British Cardiovascular Intervention Society
BHRUT	Barking Havering and Redbridge University Hospitals NHS Trust
CFC	Case for Change
CNS	Clinical Nurse Specialist
EOI	Expression of Interest
GUCH	Grown-Up Congenital Heart
HDU	High Dependency Units
HWB	Health and Wellbeing Board
ICS	Integrated Care System
MOC	Model of Care
MSKCC	Memorial Sloan Kettering Cancer Center
NHS	National Health Service
NICE	National Institute for Health and Care Excellence
NYU	New York University
PCI	Primary Coronary Intervention
PIW	Pathway Integration Workshops
PROMS	Patient Reported Outcomes Measure Score
SMDT	Specialist Multi-Disciplinary Team
STEMI	ST segment elevation myocardial infarction (a type of heart attack)
TFL	Transport for London
UCLH	University College London Hospitals NHS Foundation Trust
UCLP	University College London Partners
UK	United Kingdom
UPB	Urology Pathway Board
UPG	Urology Pathway Group
UTG	Urological Technical Group

6.2 NHS England's request for advice

Template to request advice from the London Clinical Senate

Name of the lead (sponsoring) body requesting advice: NHS England (London)

Type of organisation: Assurance & external clinical review for specialised commissioning

Name of main contact: Nigel Littlewood

Designation: Deputy Head of Service Reconfiguration

Email: Nigel.Littlewood@nhs.net Tel: 020 7932 9005 (internal 3005) Date of request: 25/11/13 (updated 14/01/14)

Please note other organisations requesting this advice (if more than the lead body noted above):

Please state as clearly as possible what advice you are requesting from the Clinical Senate.

1. Clinical review of the programme to consolidate, mainly specialised, cancer and cardiac services in north central and north east London, prior to formal final engagement on commissioner recommendations. The scope of this assurance review is to test whether a sufficiently robust clinical process was adopted by NHS England to arrive at the recommended options, considering the clinical involvement and evidence used.
2. In addition, a specific focus of the review is requested relating to future model and location(s) of radical prostatectomies, including consideration of the recent clinical outcomes data for robotic and non-robotic radical prostatectomies conducted by UCLH and BHRUT respectively. This advice should support a decision to determine where radical prostatectomies should be conducted recognising that engagement with some clinicians and patients in outer north east London and West Essex has suggested strong desire to retain a radical prostatectomy service at BHRUT, if clinically viable ((UCLH as sole provider and UCLH as a lead bladder / prostate provider with BHRUT performing some non-robotic radical prostatectomies). This advice should compare current outcomes data, consider the implications of NICE prostate guidance (published 8th Jan 2014) and recommend which outcome measures should be used to compare radical prostatectomy performance. This advice will be shared with key stakeholders, and needs to demonstrate an independent view, it is expected to utilise expert urology clinical advice from outside of London, with links to the national clinical reference group.

Please state your rationale for requesting the advice? (What is the issue, what is its scope, what will it address, how important is it, what is the breadth of interest in it?).

Significant time, effort and money have been invested in developing the scheme which clinicians believe will save lives and improve the quality of life for many others across north and east London. The Case for Change has been shared with national leads, and is broadly supported by James Palmer, Sean Duffy and the clinical reference groups. The Case for Change has recently gone out to initial engagement (5 weeks) ending on 4th December with over 540 stakeholders.

There has been some interest shown by patient groups (prostate in particular), which has led to correspondence between a local MP and NHS England CE, as well as a number of written exchanges between the groups and the London Director of NHS England.

External assurance mitigates the risk of successful challenge to making these changes.

The rationale for the prostatectomy advice is to provide a clear independent report, which includes a review of recent audit data (attached) on clinical outcomes has been queried, and the commissioner led options appraisal has identified a relatively small difference between the overall scores for the two options. Given the contention around this option, further clinical advice is sought, in the context of future NICE guidance and current national specifications.

What is the purpose of the advice? (How will the advice be used and by whom, how may it impact on individuals, NHS/other bodies etc.?).

NHS England is the significant majority commissioner of these specialised services. Assurance of the scheme is being led by the Reconfiguration Team within the Transformation Directorate with a 'Chinese wall' between it and the regional direct commissioning function of NHS England which is leading the scheme.

The Reconfiguration Team is seeking external clinical assurance of the robustness of the process in evaluating the ULCP proposals by NHS England (the non-financial options appraisal), in line with best practice and likely required by forthcoming national guidance for service reconfiguration. This will form part of an overarching assurance exercise.

The prostate review will be published and shared with key stakeholders, and targeted engagement is planned in mid February 2014, to share the outcomes of the review, which will be used to inform the commissioner recommended option for radical prostatectomies.

Please provide a brief explanation of the current position in respect of this issue(s) (include background, key people already involved, relevant data and supporting information, views on methodology to be applied).

The case for change was published in October 2013 and is attached to this request form. This is a result of clinicians within UCL Partners considering their response to the London models of care for cancer and cardiovascular services, published in 2010.

NHS England's London Medical Director approved the case for change prior to publication.

The Senate is requested to provide a desk-top review of the case for change, the scope of this assurance review is to test whether a sufficiently robust clinical process was adopted by NHS England to arrive at the recommended options, considering the clinical involvement and evidence used.

Depth of clinical involvement and support is also requested to be tested and while a small number of telephone interviews may be required to support the review, it is expected that this would mainly be a paper-based exercise.

Clinicians with expertise relevant to each of the pathways and with no / no perceived conflict of interest are requested as essential. For the prostate advice, it is desirable if some of these clinicians could be seen as external to the London system.

When is the advice required by? Please note any critical dates.

The business case is due to be completed by the middle of February and further engagement on this is aimed to begin at the end of March, with approvals undertaken during March 2014. Full assurance, including external clinical assurance, will need to be completed prior to approval. The advice therefore is requested by the middle of February 2014.

Has any advice already been given about this issue? If so please state the advice received, from whom, what happened as a consequence and why further advice is being sought?

Described above

Is the issue on which you are seeking advice subject to any other advisory or scrutiny processes? If yes please outline what this involves and where this request for advice from the Clinical Senate fits into that process (*state N/A if not applicable*)

Service change is subject to scrutiny by local authorities, the local authorities have confirmed that they do not require formal section 244 consultation, they do wish to undertake scrutiny of the business case and future engagement. While not directly part of this process, the Senate's advice will be included / referred to in engagement with local authorities.

If the issue on which you are requesting advice relates to a provider organisation please note: (*state N/A if not applicable*)

(a) What action the provider Board has already taken to address it?
n/a

(b) Whether discussions have taken place between the provider Board and CCG(s) to address the issue and action taken as a result
n/a

(Clearly providers and CCGs are part of the programme in working these proposals up)

If the issue on which you are seeking advice relates to the urgent and emergency care pathway please note what action the local Urgent Care Board has taken to address it (*state N/A if not applicable*).

n/a

Please note any other information that you feel would be helpful to the Clinical Senate in considering this request.

The prostatectomy clinical outcomes data collated for both BHRUT and ULCH, along with the initial comparison by London Cancer. National standards, Prostate NICE guidance (Jan 14).

Please send the completed template to: england.londonclinicalsenate@nhs.net. For inquiries Contact Sue Dutch, London Clinical Senate Programme Lead on sue.dutch@nhs.net or 020 7932 9075.

V5.0 January 2014

6.3 Terms of Reference

Request for advice on proposals to consolidate, mainly specialised cancer and cardiac services in north central and north east London

Terms of Reference

Introduction

NHS England (London) has asked the Clinical Senate to provide independent clinical advice on proposals to consolidate, mainly specialised, cancer and cardiac services in north central and north east London. NHS England is the significant majority commissioner of these services and the advice provided by the Clinical Senate will contribute to NHS England's assurance of the scheme. To avoid conflicts of interest, this assurance process is led by the Reconfiguration Team within the NHS England (London)'s Transformation Directorate with a 'Chinese wall' between it and NHS England's regional direct commissioning function which is leading the scheme.

Scope of advice requested

The advice which the Clinical senate has been asked to provide is in two parts:

1. To give advice on whether NHS England adopted a sufficiently robust clinical process to arrive at the recommended options, considering the clinical involvement and evidence used. As part of this, advice on the depth of clinical involvement and support is also requested.

2. To give advice on a specific aspect of the proposals relating to the future model and location(s) of radical prostatectomies which will be used to inform the commissioner recommended option for radical prostatectomies. The request has three elements, specifically to advise on:
    a. A comparative analysis of current outcomes data
    b. Which outcome measures should be used to compare radical prostatectomy performance
    c. Implications of recently published NICE guidance on prostate cancer

Process for formulating advice

Professor Chris Harrison, Clinical Senate Council Vice-Chair, will lead the process. A briefing session has been held with the NHS England team requesting the advice. A range of documentation about the process adopted by NHS England has been submitted and explained and key documents have been reviewed.

1. Review of the overall process NHS England adopted to arrive at recommended options

The following process is proposed:

Step 1: Establish a Reference Group (see proposed composition below)
Step 2: Brief the Reference Group and circulate documentation for desk-top assessment
Step 3: Reference Group teleconference to share desk-top assessment findings, identify issues where further exploration, clarification or validation is required and agree local stakeholders to be invited to discuss these issues.
Step 4: Panel (drawn from the Reference Group) "hearing" session (¾-1 day) to undertake the following:
  a. Finalise key lines of enquiry (issues for exploration, clarification or validation)
  b. Hold an evidence session with stakeholders involved in NHS England's process to seek responses to key lines of enquiry
  c. Debate and finalise conclusions
  d. Agree the process for follow-up of any outstanding issues
Step 5: Prepare a report setting out overall findings and recommendations (shared and tested with the Reference Group)
Step 6: Share the report with the Senate Council, debate and test conclusions
Step 7: Issue the report and advice to NHS England (London)

Reference Group composition

- Professor Chris Harrison, Clinical Senate Council Vice-Chair
- Experienced clinician with expertise in cancer services
- Experienced clinician with expertise in cardiac services
- Two London Clinical Senate Lay Members
- A GP
- A Director of Nursing (drawn from the London Clinical Senate Council or Forum)
- A Medical Director (drawn from the London Clinical Senate Council or Forum)
- A member of another Clinical Senate (either East of England, South East Coast or Thames Valley)

Membership will ensure a mix of teaching hospital/non-teaching hospital perspectives. All London members will be selected from parts of London unrelated to the changes proposed to ensure there are no conflicts of interest. Neighbouring Clinical Senate's will be asked to nominate a clinician with no conflicts of interest bearing in mind that UCL Partners extends into Herts, Beds and Essex.

Outcome

NHS England is seeking external clinical assurance of its process in line with best practice and likely to be required by forthcoming national guidance for service reconfiguration. It is also specifically seeking advice on whether it has deployed a robust clinical process to arrive at the recommended options, considering the clinical involvement and evidence used. There is no agreed definition of what "robust" looks like in this context and requirements of forthcoming guidance can only be anticipated at this stage. The Clinical Senate Council will draw on the Planning and delivering service changes for patients' guidance, published in December 2013 to inform its approach and the formulation of advice; this includes guidance on testing an evidence base.

The outcome will be a judgement on whether the process adopted to arrive at the recommended options is considered to be sound and reasonable in its approach taking account of the extent of clinical involvement, the underpinning evidence and how this was used. Although NHS England (London) has not asked specifically for patient and public involvement to be taken into account, the Clinical Senate Council believes this is an important element of any such process and therefore will consider it. The reference group composition will enable a judgement to be made by involving a mix of experts in the relevant clinical fields, patients, senior health professionals able to take a broader and system view, and an independent clinical perspective from outside of London.

2. Advice on proposals relating to future model and location(s) of radical prostatectomies

The following process is proposed:

Step 1: Establish Expert Reference Group (see proposed composition below)
Step 2: Brief the Reference Group and circulate relevant documentation for review
Step 3: Reference Group teleconference to share views on approach and key issues
Step 4: Panel (drawn from the Reference Group) "hearing" session (1 day) to undertake the following:
   i. Receive a presentation of outcome data followed by Q&A session with each provider site
   ii. Debate and finalise conclusions on comparative analysis
   iii. Debate and agree what outcome measures should be used to compare performance
   iv. Debate an agree implications of the NICE guidance on the proposals considered
Step 5: Prepare a report setting out the review team's findings and recommendations
Step 6: Share the report with the Senate Council, debate and test conclusions
Step 7: Issue report and advice to NHS England (London)

Reference Group composition

- Professor Chris Harrison, Clinical Senate Council Vice-Chair
- Mr Jonathan Ramsay, Consultant Urologist/Andrologist, London Clinical Senate Council Member
- Director, Centre for Clinical Practice, NICE or nominee
- Chair of the Specialised Urology Clinical Reference Group or nominee
- Clinical Audit Lead, British Association of Urological Surgeons (BAUS)
- Statistical support

A discussion with the National Clinical Director for Cancer is also proposed

Outcome

The Clinical Senate will provide advice on: the conclusions that can be drawn from the audit data that has been shared; the outcome measures that should be used to compare radical prostatectomy performance and the implications of recently published NICE prostate guidance on the model of care for radical prostatectomies. The involvement of relevant experts in the reference group will ensure credibility of the advice.

Resources

The Clinical Senate Programme Lead will support Professor Harrison in the overall planning and delivery of the processes to formulate the advice.

NHS England (London) has offered logistical support to assist in organising teleconferences/Reference Group meetings/panel sessions if required. This would be overseen by the Clinical Senate Programme Lead to ensure there is no conflict.

NHS England (London) will fund costs associated with review team members' time/backfill, travel, accommodation and other sundry expenses as necessary.

Timescale

NHS England has requested the advice by the middle of February 2014. The business case for these proposals is due to be completed by the middle of February and further engagement on this is aimed to begin at the end of March 2014, with approvals undertaken during March. Full assurance, including external clinical assurance, will need to be completed prior to approval.

The initial request for advice was submitted on 25 November 2013. It was revised on 11 December 2013 to be clearer about the advice requested and refined again on 14 January 2014 to further clarify the scope. A full suite of documentation, supported by a summary paper to enable clear navigation through it, was also received on 14 January 2014.

It is essential that the process through which the Clinical Senate formulates its advice is robust and the approach outlined is designed to do this. This will have an impact on the timescale. It is anticipated that provisional advice could be provided in mid-March 2014 with final advice provided following discussion by the Senate Council at its meeting on 1 April 2014.

London Clinical Senate
6 February 2014

6.4 Evidence Session Programme

6.4.1 11 March – Mainly Specialised Cancer and Cardiac Services

Process to formulate advice on the robustness of NHS England (London)'s process to arrive at the recommended options for, mainly specialised, cancer and cardiac services in north central and north east London.

EVIDENCE SESSION PROGRAMME – 11 MARCH 2014

Time	**Activity**	**Purpose**
9.30am - 10.30am	Panel preparatory session	
10.30 - 11.20am	Neil Kennett-Brown, Programme Director Nick Kennell, Responsible for the evaluation process Beth Warmington , Communications and Engagement Lead	Overview of the programme including the engagement programme and the options evaluation Explore specific issues relating to these aspects of the process
11.20 – 12.00 noon	Neil Cameron (kidney cancer patient) Pat Jupp (cancer patient participation group) Tina Dugard (Cancer You Are Not Alone)	Explore the process and engagement from the perspective of cancer patients and voluntary sector groups
12.00 noon – 12.20pm	Richard Bird (Heart Hospital at UCLH patient) Robert Hall (The Cardiomyopathy Association) Malcolm Billings (Chair, Heart Hospital at UCLH Patient Group)	Explore the process and engagement from the perspective of a cardiovascular patient and voluntary sector group
12.20 – 12.40pm	Professor David Fish, Managing Director, UCL Partners Dr Kathy Pritchard-Jones, Medical Director, London Cancer Mr John Hines, Urology Pathway Director	Explore the process and engagement from the perspective of services' clinical leads and advisors in north central and north east London
12.40 – 1.00pm	Professor David Fish, Managing Director, UCL Partners Hilary Ross, Head of Strategic Development, UCL Partners Dr Charles Knight, Cardiovascular Lead, Barts Health	Explore the process and engagement from the perspective of cardiovascular services' clinical leads and advisors in north central and north east London
1.00-1.30pm	Lunch break	
1.30 – 2.00pm	Dr Christine Moss, GP (and Medical Director, West Essex CCG) by phone Andy McMeeking (NEL Cancer Commissioning team)	Explore the process and engagement from the perspective of a GP and a commissioner who leads on cancer performance and (both involved in the evaluation process)
2.00 – 2.20pm	Dr Sarah Slater, Cancer Lead, Barts Health Dr Clare Dollery, Deputy Medical Director, Barts Health	Explore the process and engagement from the perspective of a trust that will be impacted by a loss of cancer services
2.20 – 2.40pm	Dr Gill Gaskin, Cardiovascular Lead, University College London Hospitals	Explore the process and engagement from the perspective of a trust that will be impacted by a loss of cardiovascular services

Time	Activity	Purpose
2.40 – 2.55pm	Simon Williams, Acute Programme of Care Lead for Internal Medicine and Blood and Cancer, NHS England (London)	Explore the objectives, process and engagement from the perspective of the commissioner of specialised cancer and cardiovascular services
2.55 – 3.10pm	William Roberts, Director of Strategy and Planning, Camden CCG by phone	Explore the process and engagement from the perspective of a commissioner of other aspects of the cancer and cardiovascular pathways
3.10 – 3.20pm	Neil Kennett-Brown, Programme Director (if necessary)	To provide an opportunity to clarify any issues
3.20 – 4.30pm	Panel debates and finalises conclusions	
4.30 – 5.00pm	Session ends (subject to extent of panel discussion)	

Panel for the evidence session held on 11 March 2014

The Panel included all members of the Reference Group except Dr Bajwa who was unable to attend.

In attendance at the evidence session held on 11 March 2014

- Sageet Amlan, Specialist Registrar and observer
- Sue Dutch, London Clinical Senate Programme Lead, NHS England (London)
- Roger Durack, Head of Quality Improvement, NHS England (London)

6.5 Reference Group Members

6.5.1 Biographies

Professor Chris Harrison is currently Medical Director and Director of Public Health at Imperial College Healthcare NHS Trust and London Clinical Senate Council Vice Chair. Since 1992 he has held a series of senior medical leadership roles in district health authorities, regional offices, strategic health authorities, the Health Protection Agency, foundation trusts, the private sector and Academic Health Sciences Centres in the North West of England and in London. Immediately before moving to Imperial in March 2013 he was medical director of The Christie NHS Foundation Trust Cancer Centre in Manchester and Director of Manchester Cancer, the Cancer Programme of the Manchester Academic Health Sciences Centre. He was also a non-executive director of London Cancer, the Cancer Programme of UCLP.

As a public health physician he has a long standing interest in the practical leadership of health services so as to obtain the best clinical outcomes and support clinicians in providing safe, effective and patient centred care. As a member of the board of the Organisation of European Cancer Centres from 2011 -2013 and chair of its accreditation committee he has been involved in setting and improving standards of cancer care organisation across Europe.

Dr. Rosalind Given-Wilson is Medical Director and Consultant radiologist at St Georges Healthcare NHS Trust. She has board level responsibility for clinical outcomes, research and medical education as well as being Responsible officer and Caldicott Guardian. She has been part of the Clinical Strategy group developing plans for safe and sustainable reconfiguration of health services in South West London.

Rosalind set up the South West London breast screening service in 1991 and was Director of Screening, then Director of Radiology and then Diagnostics and has been Medical Director since 2007. She has research interests in the optimisation of breast imaging and decision making having published over 120 papers and abstracts. She is involved with national QA of breast screening sitting on the DH advisory committee on breast cancer screening. She runs the St Georges National breast screening training centre providing post graduate training and has held the Royal College of Radiologists Breast imaging Professorship, this involved lecturing widely nationally and internationally on breast imaging.

Elizabeth McManus is the Chief Nurse and Director of Quality at Chelsea and Westminster Hospital NHS Foundation Trust. Previously Chief Nurse since 2007 at York Teaching Hospital NHS Foundation Trust, she has extensive leadership experience, having performed a range of senior NHS nursing and operational roles across England.

Elizabeth has participated in significant transactions whilst at York – where the Trust acquired both community services and another acute hospital within a two year period. She has also taken part in significant clinical reviews nationally, including acting as a member on the Clinical Advisory group to The Special Administrator (TSA) for Mid Staffordshire Hospitals NHS Foundation Trust.

With quality as her organising principle, Elizabeth has majored in service and pathway redesign for many years both locally and nationally and has a passion for ensuring patients feel both safe and cared at every stage of their life and journey through healthcare.

Sally Kirkpatrick retired from being a financial business analyst in the City at the end of 2010. Since that time she has been working on a voluntary basis mainly in the health and wellbeing sector and has been a member of the London Clinical Senate Patient and Public Voice since November 2013. Sally is a carer, trustee and company secretary of a mental health charity that gives support to both carers and mental ill health sufferers. She is a champion for the Time to Change anti-stigma campaign and is also on the steering committee for her local anti-stigma campaign. She regularly attends clinical governance meetings. Sally is also member of the South London and Maudsley NHS involvement register and reviews research proposals before they are submitted to the ethics committee. She has participated in several NHS public consultation s and uses her experience to give advice as a patient and public voice.

Wai Pang SHAM

Wai Pang Sham had been working as a senior geophysicist in the oil and gas industry for 25 years before giving up his profession to set up the Chinese Association for Cancer Care in June 2013. The Association is committed to provide care and support mainly to the Chinese cancer patients and their families across the UK. As the chief executive of the Association, he has built up a wide network of volunteers of different professions to help those affected by cancer in the Chinese community. He is keen to keep a partnership relation with NHS, Cancer Research and Macmillan Cancer Support and the like to promote cancer awareness and provide care. Pang was appointed as a Patient and Public Voice representative in the London Clinical Senate in January 2014.

Dr Rachael Liebmann BSc Hons MB BCh BAO FRCPath RCPath Registrar and RCPath Consulting Lead. Rachael is Registrar of The Royal College of Pathologists and a specialist breast pathologist. She has an interest in commissioning quality, regional pathology reconfiguration and clinical leadership. In her role as Registrar she has co-ordinated production of key performance indicators for quality pathology commissioning. In 2011 Rachael helped to establish RCPath Consulting which provides independent authoritative advice on pathology service and commissioning issues.

Rachael chaired the multidisciplinary Kent and Medway Cancer Network Breast Group for several years, before being appointed Clinical Director of the Kent and Medway Pathology Network, with leadership of all pathology services for a population of 1.7 million. Through this she became the clinical lead for a major £8m regional service reconfiguration project. In the field of education Rachael chaired the regional Specialty Training Committee for five years and was the national recruitment lead for Histopathology until 2009.

Rachael represented the College on the Founding Council of the Faculty of Medical Leadership and Management, is an independent secondary care member of a Clinical Commissioning Group and a member of the Clinical Senate Council for South East Coast.

Mr. Anthony Blower MD FRCS is the Executive Medical Director of The Christie NHS Foundation Trust in Manchester and the Director of Manchester Cancer. Anthony was a Consultant General and Colorectal Surgeon at Wrightington, Wigan and Leigh NHS Foundation Trust for 20 years where he was the Clinical Director of Surgery and Trust Cancer Lead. He was also Medical Director of Greater Manchester and Cheshire Cancer Network (GMCCN) from 2012 to 2013. Prior to this he was Chair of the Colorectal Cancer Clinical Subgroup GMCCN from 2006-2012 and Chair of the Head and Neck Cancer Clinical Subgroup GMCCN from 2006-2012. He was a member of The General Surgery Specialist Training Committee for the North West Deanery. He worked with others to establish Manchester Cancer and the Greater Manchester Cancer Services Provider Board.

Anthony is currently a member of the Clinical Reference Group for Healthier Together, a program which is reviewing the way health and social care is delivered across Greater Manchester. Health and Social Care Reform

Dr. David Smith is a Consultant Cardiologist at the Royal Devon and Exeter NHS Foundation Trust**.** David qualified from St Thomas's Hospital Medical School in1977 and trained in cardiology at St Thomas' and Brompton hospitals before being appointed consultant at the Royal Devon and Exeter Hospital in 1990. His main interest is and has been coronary intervention and particularly primary angioplasty for STEMI but he has also had an interest in peer review.

During his time on Council of BCIS (British Cardiovascular Intervention Society) and subsequently as Honorary Secretary he was co author on two iterations of national guidelines for practice and continued competence for angioplasty and also developed a peer review system for angioplasty centres. He continued to sit on the BCIS clinical standards subcommittee until 2010.

As clinical director of the Peninsular Cardiac Network (2002-2006) David was instrumental in developing new commissioning systems across the Network. He was also an active member of the NIAP (National Infarct Angioplasty Pilot) and of the NICE guideline development group for STEMI.

More recently David has been invited to perform peer reviews of angioplasty services and individual operators outside his own hospital and has helped to provide commissioning solutions for a London Clinical Commissioning Group.

Dr Junaid Bajwa is a practicing GP, Board member for Greenwich CCG (where he leads on Mental Health and Informatics), and Council Member of the London Clinical Senate. He has an interest in education, and clinical leadership, and from June 2014, he will be on the Fast track Executive Programme with the NHS Leadership Academy.

6.6 Conflict of Interest Declarations

1. Professor Christopher Harris was formerly Medical Director at the Christie NHS Foundation Trust (until 2013) and knows Mr. Anthony Blower personally.
2. Professor Christopher Harris was a Non-executive Director at London Cancer until December 2013.
3. Dr. David Smith knows Dr. Charles Knight personally.
4. Dr. Rachael Liebmann is a representative on the South East Essex Clinical Commissioning Group (CCG)

6.7 List of Participating Stakeholders

See sections 6.4.1.

7 Contact Details

For information relating to this report please contact:

England.londonclinicalsenate@nhs.net