Appendix E: Engagement feedback report (Phase two engagement)

Appendix E: Engagement feedback report

Introduction

NHS England undertook a second phase of engagement on the case for change for specialist cancer and cardiovascular services in north and east London and west Essex, which ran formally between 23 May and 27 June 2014, although responses continued to be accepted until 4 July 2014.

Overall, support was demonstrated for each proposal and an understanding of the need for the consolidation of specialist services within an integrated system, and the need to improve outcomes across the area. The key concerns raised include the possible impact of the proposals on other services, and on travel and transport, many of which had been raised during earlier engagement.

A number of key themes emerged from the engagement exercise. At the individual proposal level, the majority of responses were supportive. Stakeholders who were supportive, agreed with the general principle of consolidating specialised services and willingness for patients to travel for the best services available.

A number of specific concerns were raised however, including the impact on travel, particularly for patients residing in outer north east London, the possible impact on co-dependent services (such as the Major Trauma Centre (MTC) at the Royal London Hospital (RLH)) and the move of prostate services from Barking, Havering and Redbridge University Hospitals NHS Trust (BHRUT) to University College London Hospitals NHS Foundation Trust (UCLH). The programme has responded to these concerns which are outlined in this report and sought to identify sufficiently robust mitigations from the relevant parties.

Engagement activities

The engagement overview report and this feedback report describe the engagement activities undertaken as part of the second phase. In summary, over 600 stakeholders were contacted as part of the programme, a series of public workshops were held, and programme representatives attended existing public and patient meetings to seek feedback on the proposals.

Feedback

In total, there were 254 responses from individuals and organisations including:

- Clinicians across the area
- Public and patient groups and service users (including PHASE and ProActive)
- NHS organisations
- Clinical Commissioning Groups (CCGs)
- Healthwatch

In addition, the programme team received letters of support for the proposals from the following providers; Barking, Havering and Redbridge University Hospitals NHS Trust, Barts Health, Royal Free London NHS Foundation Trust and University College London Hospitals NHS Foundation Trust. These can be viewed in Appendix G: Provider correspondence.

Responses ranged from emails requesting detail on the public events, to hard and soft copy survey responses, which allowed respondents to comment on each proposal individually. Comments raised during the public workshops were also captured.

The table below presents the total responses to the survey received for each of the service proposals, and what proportion of the responses were supportive. Not everyone who responded to the survey included a response for each of the proposals. Where concerns were raised during the engagement process, this has translated into a smaller percentage of respondents supporting the proposals.

A total of 159 responses were received from a range of stakeholder groups including clinicians (115) patients and patient representatives (26), and various other local representative bodies. The results of the clinicians are however skewed towards from representatives from Bart's Health (88).

Response Group	Brain	Head & neck	Bladder & prostate	Renal	Haematopoietic stem cell transfer	Acute myeloid leukaemia	Oesophago-gastric	Cardiac
Yes	107	88	110	97	133	128	89	131
No	45	59	38	42	12	17	54	22
Total	152	147	148	139	145	145	143	153
% in support	70%	60%	74%	70%	92%	88%	62%	86%

The results of the online survey indicated a majority support for each of the pathways. Some pathways received stronger support than others however. Both the haematology and cardiac pathways received the most support with in excess of 80% of all responses supporting proposals.

Of the remaining pathways, while on balance respondents are supportive there is notable concern raised by some clinicians working at RLH, Barts Health. For example, 59 respondents were not supportive of the head and neck proposal. Over 95% of these respondents were clinicians at Barts Health and a significant proportion of those were part of the anaesthetic profession at RLH. This feedback is consistent with the feedback received through the other engagement activities and the programme continues to work with Barts Health to develop sufficiently robust mitigation strategies in response.

For the specialist bladder and prostate proposals just under three quarters of the 38 respondents who were not supportive were from Barts Health on the basis of retaining surgical expertise at the trust for services such as major trauma. Very few unsupportive responses were received from patients and clinicians in outer north and east London. The prostate support group PHASE also responded separately in a letter to the programme.

For the specialist renal proposals, a similar response pattern to bladder and prostate is observed. Typically those resistant to the proposals are from Barts Health stating the need to retain surgical expertise and the burden of travel on local RLH patients.

For the specialist oesphago-gastric cancer proposals, those not in favour were from Barts Heath. A number of clinicians questioned the need to move the service from Barts Health given the strong outcomes the service is currently achieving.

In summary while the survey revealed overall support for each of the proposals, it is clear there are still concerns from a sub-set of clinicians at RLH, Barts Health. Subject to final decision making, implementation will need to take this into account and ensure there is strong clinical leadership and agreed mitigations to address these concerns. The foundations of this work is described below in the response to the MTC issue.

The table below identifies the key themes from the other engagement events that were held across the area and how the programme intends to address them going forward.

General themes

Summary of feedback	Response
Support for the proposals and the need to consolidate specialist centres, giving patients the best access to excellent care and improved outcomes.	Support for the proposals is welcomed
Support for the concept of integrated cancer systems and centralisation where appropriate, balanced with the need to ensure that the patient remains the priority and at the centre when planning provision of services.	Support for the proposals is welcomed. All proposed changes are clinically driven and are intended to improve patient outcomes and experience.
The requirement to focus on the importance of prevention and early diagnosis.	NHS England fully agree this is a priority and is working with the transferring cancer services teams and London Cancer on this. We recognise the need to improve prevention and earlier diagnosis. Projects are underway to address this including understanding why so many people are only diagnosed with cancer when they are admitted to A&E. In addition to their work and involvement with these proposals, a large part of UCLPartners' work is focussed on early prevention and diagnosis.

Travel, transport and geography

Summary of feedback	Response
A few respondents stated they felt that patients would be happy to travel for the best possible treatment and outcomes.	Support welcomed; the proposals are focussed on ensuring that patients only travel extra distances when necessary – for specialist treatment or treatment. Diagnosis and follow up will continue to be delivered locally.
Comments were received from patients who were prepared to travel for the best available service. Concerns were raised by approximately 25 stakeholders regarding the ability of patients and their families/ carers to travel to specialised centres and the lack of parking available at some central sites.	Providers have plans in place to help patients mitigate these potential impacts and at the stakeholder workshops held as part of the engagement phase, representatives from each provider outlined more information about these plans which are in development, and on which attendees were invited to comment. A large number of patients already travel for treatment from across the country. <u>UCLH</u> • Commitment to providing clear information about travel and transport options to staff in referring hospitals so that this information can be passed on to patients

Summary of feedback	Response
	• Immuno-compromised patients will continue to be eligible for NHS transport and will not have to share this with other patients • Ten free-of-charge disabled car parking bays. Commitment to increasing blue badge parking in vicinity. Also local street parking and nearby car parks. • Option of hotel accommodation prior to specialised surgery/ treatment. • Assessment of suitability/ quality of existing hospital patient transport service. Tender for new transport contract: - A patient centric service - A prompt timely service - Good customer service - Quality vehicles suitable for patient needs - New features of service specification include; on the day reminder service of estimated pick up time, reduction in providers and commissioned for journey requirement rather than region <u>Barts Health</u> For cardiovascular care, based on patient data by borough, over three-quarters of outpatients and two-thirds of inpatients would have less distance to travel to the new centre at St Bartholomew's Hospital, if proposals are implemented: • Current transport service for eligible patients; trust is considering its current travel arrangements. • Patients would only have to travel when absolutely necessary • Large public car park available opposite proposed new site. <u>The Royal Free</u> • Draft patient information leaflet for specialised renal centre. Copies were made available at engagement workshops; feedback was welcomed. • Provision of patient navigator, whose main role is to provide advice on a range of issues including transport, parking, accommodation arrangements as well as appointments • Commitment to provide free parking for patients undergoing renal surgery. • Patient transport available for eligible patients • Patients who travel for surgery can choose if they would prefer to stay overnight prior to accommodation; room provided for the patient and immediate carer. <u>BHRUT</u> • Free parking for all cancer patients undergoing treatment regardless of their home address

Summary of feedback	Response
	• Discussion of possible improvements to local bus services • Patient transport available for eligible patients Copies of travel information leaflets provided by the trust can be viewed in Appendix C: Event material Work will continue between commissioners, UCLPartners and providers as part of the ongoing planning for implementation work to ensure that travel issues are identified and addressed prior to implementation.

Specialist prostate cancer services

Summary of feedback	Response
Some respondents (~30) expressed concern about the proposals to consolidate specialist bladder and prostate cancer services to one site based at UCLH, therefore transferring the specialist services away from BHRUT and the geographic area. Two of these respondents included PHASE and ProActive. Concerns encompassed issues such as the loss of provision and skills away from outer north east London and the potential impact on patients (travel) from these areas (including west Essex). Respondents wanted to be reassured that there would be robust systems in place to support urology patients in the area having both benign and malignant complex colorectal and gynaecological surgery. One respondent asked why the prostate proposals could not be amended to retain two centres for the next few years, as is the case with proposals for specialist oesophago-gastric cancer services.	These proposals are about the creation of an integrated service which would be of significant benefit to patients. Currently, four centres across the area currently serve over 3.2 million; services do not always meet national standards. Following the first phase of engagement, NHS England requested an independent review led by the London Clinical Senate who in turn called on national experts from outside the area. The London Clinical Senate reviewed the proposals for provision of specialist prostate cancer. It concluded that NICE guidance, recommending volumes of at least 150 robotic prostatectomy procedures per year per centre, should be followed. As a result of this, there can only be one compliant service in the area. A potential second site offering open or laparoscopic surgery raises equity concerns for the populations at each site. Based on advice from and taking into consideration the options appraisal undertaken by NHS England during the first engagement phase, UCLH is proposed as the single centre for specialist bladder and prostate surgery The programme engaged on this outcome and facilitated a dedicated workshop held at Romford to present the findings. Supporting this engagement were key members of the London Clinical Senate and the clinical leadership at BHRUT. The workshop was a useful question and answer session providing attendees with an opportunity to ask questions and raise concerns. These queries were addressed by clinicians from across the area including senior clinical leadership at BHRUT who support the proposed changes. Key outputs from the workshop include, the prostate support group PHASE continuing to oppose the proposals for specialist prostate cancer reiterating their previous concerns relating to the support for the service at BHRUT

Major trauma services

Summary of feedback	Response

Queries included the possible impact on co-dependent services, if specialised services were to be centralised. A significant cohort of Barts Health clinicians responded to the potential impact on the Major Trauma Centre at the Royal London. This included concerns about specialised surgery for brain cancer transferring from the site.
Concerns included questions regarding the potential impact on recruitment, retention and training (particular for anaesthetists) of high quality staff and clinicians.
Comments included support for current services e.g. ear, nose and throat services, and therefore questions about the rationale for change.
	The proposals aim to replicate the success of major trauma centres and stoke units by ensuring the small number of cancer patients who require specialist treatment receive world class care.
	
	The potential implications on the major trauma centre have been recognised and a significant amount of work has been undertaken to address this at a trust level and with commissioners as part of the planning for implementation work. On review of the work undertaken to date the programme recognises that while there are a number of challenges and risks, these risks are not unsurmountable and can be addressed within the timeframes stated.
	
	The below is summarised from a letter from Barts Health Medical Director Steve Ryan dated July 2014 (which can be read in full in Appendix G: Provider correspondence). This letter sets out the approach that Barts Health have adopted to develop cross provider solutions to the risks raised by a number of Barts Health clinicians. Key activities have included:
	
	Setting up of effective governance to ensure all key experts are involved. This is being considered within a wider review of emergency standards
	
	• *Seeking expert advice from London Cancer on options and recommendations*
	
	• *Establishing a dedicated core clinical advisory group which meets weekly and contains the Medical Director, at Barts Health, leading surgeons and anaesthetists. The group is responsible for ensuring risks are adequately defined and mitigations are appropriate*
	
	• *Key clinical issues have been identified including:*
	  ○ *Neurosurgery: Surgeon availability: theatre staff skills*
	  ○ *Head and neck: Surgeon availability, managing the complex airway*
	  ○ *Upper GI: Surgeon availability, anaesthetic skills*
	  ○ *Renal: Surgeon availability*
	
	• *Establishing of a wider reference group which has met twice since May containing a wider pool of clinicians across the relevant specialties*
	
	• *Developing a business plan for trauma neurosurgical posts*
	
	• *Informing the business planning meetings have been held at UCLH covering research, education (including postgraduate training) and risks to debate outputs from the reference group*
	
	The merger of the cancer and surgery clinical academic groups is nearing completion with the appointment of a surgeon as its substantive director. The major trauma centre at The Royal London Hospital was subject to a

Summary of feedback	Response
	recent peer review where need for improvement was noted in the area of rehabilitation and a business case has been developed. *Barts Health is considering its current emergency service standards as they apply to trauma and other acute services* • *Major team job planning is underway across all services with a focus on the 7 days a week imperative, daily consultant ward rounds, more direct engagement of consultants in delivering and shaping the emergency care response* • *Transforming Services, Changing Lives is the sector wide transformation process, beginning in spring 2014 with acute and specialised emergency care being one of its key workstreams. An associate medical director has been appointed to support the medical director and the clinical academic group director for emergency and acute care in delivering this agenda* • *The clinical director for emergency care is conducting a ward by ward audit of adherence to the Trust's standards. The system design and baseline forms a major CQUIN (Commissioning for Quality and Innovation payment) this year (value>£2.0m).* *The Director of Integrated Cancer for London Cancer is now working with the Barts Health's Medical Director on a 3 month programme which will deliver recommendations and options to deliver the relevant mitigations and make recommendations to build on service excellence and standards. This work began in early July and is systematically working through issues from the bottom up. This week the work has focused on head and neck cancer, with key inputs from both the cancer and trauma surgical leads. Real opportunities to develop further trauma excellence have been identified.*

UCLPartners

Summary of feedback	Response
Comments were received supporting the excellent academic back up provided through UCL Partners.	These comments are noted and welcomed

Workforce

Summary of feedback	Response
~20 respondents raised issues around the potential effects of the proposals on training for staff, as well as on morale of staff.	The aim of the proposals is to become world-class leaders in cancer and cardiovascular care. It is not to cut costs across services, but to improve services to patients both locally and nationally. The proposals would support the development of specialist teams through education and training improvements and more opportunities for sub specialisation

Summary of feedback	Response
Concerns were raised the proposals would result in clinical staff cuts and downgrading. Respondents raised the importance of ensuring that plans were in place to retain key staff, keeping them motivated and committed. The importance of ensuring across-site working was managed effectively was also raised.	It is expected there will be a need for some changes to staff roles and locations. As part of the planning for implementation work, commissioners are working with providers to ensure that HR processes are in place to mitigate potential impacts on staff. With regards to the proposed creation of an integrated cardiovascular centre at St Bartholomew's, there are no planned redundancies and staff will be transferred over to Barts Health, with full support and complying with NHS Terms and Conditions.

Capacity and current performance at Barts Health

Summary of feedback	Response
Six respondents raised concerns about capacity within the current system, including performance at the Barts Health with regards to Referral-to-Treatment (RTT), administration and management issues. Comments around capacity included the requirement for trusts to be able to support an increased volume of activity, e.g. laboratory support and ITU (intensive care unit) facilities with activity transferring from the London Chest and Heart Hospitals.	A major performance improvement programme is in place at Barts Health. The below is summarised from a letter from Barts Health Medical Director dated 10 July 2014 (which can be read in full in Appendix G: Provider correspondence) There are a number of factors which are believed to have contributed to issues around Referral to Treatment standards at the trust, all of which are now being addressed and corrected. Through the use of waiting list initiatives and other methods, capacity has been created in the short term whilst longer term solutions are secured These proposals are expected to significantly assist in improving the trust's Referral-to-Treatment (RTT) performance: • Head and neck – the proposed reconfiguration involves the largest number of patient episodes, in the order of 400 annually. A large proportion of these patients require critical care as part of their pathway of care and therefore this will free up critical care (usually HDU (high dependency unit)) capacity. This will improve flow for patients needing these pathways for other complex surgery. In addition, significant theatre capacity will be made available at The Royal London Hospital • Neurosurgery – a significant number of patients (~100 a year) needing treatment result in the neurosurgery ward being very often full. This prevents flow out of critical care and access for patients awaiting spinal surgery. The high demand of emergency pathways places a strain on the elective pathways which is often reflected in RTT difficulties in neurosurgery. Again, significant theatre capacity will also be made available • It is also expected that there will be a benefit in relation to urology patients, with more than 50 surgical episodes a year beginning to be relocated to the Royal Free Hospital.

Summary of feedback	Response
	• With regards to the proposed changes to specialist oesophago-gastric cancer services, this will significantly improve flow in and create additional capacity in theatres which again can be used to improve RTT performance Overall the proposed changes are expected to have a cumulative beneficial effect on in-patient flow and RTT in the trust.

62 day wait performance at UCLH

Summary of feedback	Response
A few respondents raised the current poor 62 day wait performance at UCLH and the impact the proposals will have on the ability for UCLH to achieve this important performance metric	The programme has sought a letter of assurance from UCLH and an action plan to address this point. More detail on these proposals can be found in Appendix G: Provider correspondence The current underperformance against the 62 day cancer standard has received considerable focus at executive, divisional and team levels. UCLH have as a result undertaken a range of improvements cutting across all tumour pathways. These include: • Developing a protocol to help us understand all drivers of any breach of the 62 day standard • Consolidating all learning from these breach analyses into a rolling improvement plan, along the lines of a urology action plan • Establishing a new role to strengthen corporate validation and monitoring, for example through the development of a trust-wide training programme and leading a systematic approach to the identification and dissemination of best practice and learning from breaches. • Setting up a new daily reporting and escalation process for patients on two week wait referral pathways to reduce the time taken to book their appointments.

Volume of service

Summary of feedback	Response
Queries were made as to the actual volume of service likely to transfer.	The case for change and the Business Case reported on activity volumes based over the period Feb 2012 – Jan 2013. Given the volumes for cancer are relatively small, the exact numbers are inherently variable year by year, however, local clinicians working on the planning for implementation work are in general agreement regarding the approximate size of services transferring.

The clinical case

Summary of feedback	Response
There was strong support for the clinical case to support Barts Health as	The clinical case for change recognised a number of constraints of the current facilities for cardiovascular services, a number of which are the result of limited capacity within The Heart Hospital. With limited scope to

Summary of feedback	Response
the provider of specialist cardiovascular services	expand due to physical constraints The Heart Hospital is unlikely to be able to achieve the volume required to meet recommended standards of care for both elective and non-elective care. Capacity at The Heart Hospital is limited as it is in a central London location with no room to expand. As a result there was no option to retain The Heart Hospital. (The decision to move services from The London Chest Hospital was made some time ago and does not form part of this review) • Barts Health currently provides good outcomes with regards to cardiovascular services and the creation of a new integrated cardiovascular centre at the trust will bring more activity to the site strengthening the trust overall. • A robust options appraisal was conducted by NHS England during the first phase of engagement to assist in developing commissioners' preferred options for change. Further detail on this can be found from page 51 of the Business Case available online: http://www.england.nhs.uk/london/engmt-consult/

Expected benefits, quality of care and patient choice, patient pathway

Summary of feedback	Response
A few respondents requested assurance that private patients would not be treated to the detriment of NHS patients.	The proposals would seek to significantly improve outcomes and experience for NHS patients, not place them at a disadvantage. Any such departure from this ethos would be investigated by trust boards and the appropriate measures would be taken to prevent this from happening
A few respondents asked for further clarification about the patient benefits of the proposals, querying whether higher volumes would be more beneficial to surgeons as opposed to patients.	The benefits of the proposals are focused on improving outcomes for patients. The programme team have worked with national health analysts to examine the benefits. We are also conscious of the importance of developing effective and accurate metrics and are therefore using international benchmarks in our work with clinicians.
Respondents queried about the availability of clinical trials for patients.	If implemented, the changes would mean much better access to the latest treatments and technology through more access to clinical trials for patients. The aim is to offer the majority of patients the option of joining a clinical trial. It would also result in specialist care available 24/7, and shorter waiting times.
Some respondents expressed concern about the quality of care at some sites across the area and asked that these be addressed as part of the ongoing work.	The vision of these proposals is to create world class services as part of an integrated system of care. Currently, care is fragmented and varies across hospitals. This is because specialists, technology and research are spread across too many hospitals to provide the best round the clock care to patients. The model of care that was developed by commissioners in 2010 found that these inconsistencies could be addressed by concentrating specialised services in fewer, larger centres in order to deliver world class standards of care and address fragmentation of services.

Summary of feedback	Response
Concerns were expressed by some respondents that the transfer of some specialist services would result in a lack of care for patients, placing some at a disadvantage.	The aim of the proposals is to improve outcomes and access to excellent care and treatment for all, not to place patients at any disadvantage.
A small number of respondents queried whether the proposals would run contrary to the NHS' principle of providing free, local care to those who need it.	The NHS will remain free at the point of need for all. All specialist services being looked at as part of this review, would remain free to all who need them
Respondents were keen to ascertain the process that would be adopted with regards to the patient's journey through the system. This ranged from queries about follow up care and appointments to discharge procedures, to avoiding possible duplication of pre-op assessments.	The majority of care would continue to be provided locally. Patients would only travel to a specialist centre for specialist surgery or treatment. Across the system, patients will only be discharged from the centre when they are fit to leave. A discharge summary would be sent to a patient's GP, local hospital and clinical nurse specialist. In most cases, follow up appointments would be limited to one follow up appointment at the specialist centre with all other follow-up taking place locally. As part of the planning for implementation work, providers are each developing their plans to ensure a coordinated pathway from diagnosis through to treatment and aftercare. This will form a key part of the on-going commissioner assurance framework.
One respondent queried the potential arrangements for patients diagnosed with more than one cancer.	The ultimate aim of the proposals is to save lives through the creation of centres of excellence for specialist surgery and treatment for some cancers and cardiovascular service. The vast majority of all care and treatment would remain local, including diagnosis and care after any surgery. Every patient is an individual, and therefore each patient's journey through treatment, including the location, would be developed between the doctor, specialist and the patient, to deliver the best clinical outcomes in line with the patient's wishes.
Some respondents were concerned that the recommendations did not reflect some of the current excellent outcomes from providers across the area.	There are some excellent examples of outstanding care being delivered across the area for patients with cancer and heart disease. However, outcomes for patients in London are not as good as the rest of the country. The aim is to achieve a consistently high standard of care, not dependent on where people live. By concentrating services in dedicated centres of excellence, clinicians believe it is possible to improve outcomes for patients – not only survival rates but also improving the quality of life for people after specialist treatment or surgery. NHS England has looked at international evidence that demonstrates that centres seeing higher volumes of patients generally achieve better patient outcomes.

Patient records

Summary of feedback	Response
Some respondents wanted to know how the different hospitals would be able to access patient records and how	We recognise it is vitally important that patient records are transferred safely and efficiently.

Summary of feedback	Response
the records would be transferred through the system. Queries were received regarding how communication between different parts of the system would work. What systems have been devised to ensure that each team at each site from GP to local hospital to specialist centre knows what is happening?	One of the workstreams of the planning for implementation work is dedicated to ensure that this is managed properly. This is already working successfully for other services that people have to travel for, such as radiotherapy and these proposals would seek to emulate successful arrangements that are already in place. An example of the system that is already in place across trusts is the 'cloud system' which is used by urology pathway clinicians. This involves the immediate uploading of scan images which are then transferred to ensure they travel with the patient through the system. UCLP are currently expanding on this work. The aims of this are to: • Make the best use of available data across the partnership ensuring that information is managed safely and patient confidentiality is protected • Develop a single system approach so that there are consistent approaches to information sharing across the partnership and information can be used to drive improvement across whole pathways of care • Promote connectedness to ensure care providers have the information they need to deliver safe and effective care irrespective of their care setting or geography.

Finance

Summary of feedback	Response
A few respondents were interested in whether cost is taken into consideration when planning proposed service change. These respondents were keen to ensure that no trust is financially compromised by the proposed service changes and that there is active engagement now with commissioners, patients and patient groups outside London about the changes being planned. One respondent queried why individual costs (i.e. cost of radical prostatectomies) are not included in the Business Case. Comments were received about the investment undertaken at individual sites for cancer pathways and whether this now represents a waste of money if services are to be transferred	The key driver for the proposed changes is clinical with the focus being to save lives and improve outcomes. In order to facilitate a funding agreement for proposals, a financial advisor was jointly appointed to work with all parties to agreed terms of reference. All financial analysis has shown that the proposals are affordable, including the costs of implementation. Changes which would, most importantly, help save over 1200 lives a year also represent value for money for the taxpayer and all organisations involved. The Business Case is not intended to go into procedure level detail. The analysis shows the differential cost impact, through the market forces factor of different providers. All financial analysis has shown that the proposals are affordable for providers. All investment in individual sites is still current and will be utilised by providers and result in benefits for local patients

Scope

Summary of feedback	Response
One respondent questioned the scope of the maps used in the Case for Change, asking what would happen to patients living outside the areas shown on these maps.	The maps used in the Case for Change (available here: http://www.england.nhs.uk/london/engmt-consult/) aim to show the geography of the 12 trusts across the area only. The maps used are not designed to show catchment areas for treatment. Patients can be referred for treatment who live outside these areas, which will be dependent on patient choice and doctor's advice.

Engagement process

Summary of feedback	Response
Some respondents queried why formal consultation was not undertaken on the proposals and the length of time given for engagement and notice of events.	The programme has undertaken a robust approach to engagement including two engagement phases and continued dialogue at all stages Following the first phase of engagement, all three Joint Health Overview and Scrutiny Committees (JHOSCs) for the area agreed that the proposed service changes did not represent significant service change and did not therefore require formal consultation. Phase two engagement activities included: • Collation of commissioners' preferred options into a high level, Clear English Standard approved, summary. This was distributed via email and made available in hard copy at eight locations across the patch and at all engagement events, and at CCG and Healthwatch engagement events across the area (full details can be viewed in Appendix D: Promotion and publicity). This was also made available on the programme's dedicated page on NHS England's website and alternative formats of this were available on request • Letters were distributed including details of the second engagement phase to ~600 stakeholders and follow up phone calls were made to all local branches of Healthwatch and Age UK/Age Concern to ask them to publicise the engagement and events • In addition, the programme team made contact with all clinical commissioning groups (CCGs) and providers with several of these publishing information on their websites • Three public events were held across the locality to give attendees the opportunity to provide feedback on the proposals. Clinicians and staff from the trusts presented at each event and were available for questions. • A dedicated workshop discussing the results of the London Clinical Senate review into proposals for specialised prostate cancer services, was held in the outer north east London area • Details of these engagement events were advertised in 14 local newspapers

Summary of feedback	Response
	• UCLPartners, London Cancer and participating trusts and CCGs ran information on the engagement process and events with UCLP tweeting the event details to over 700 followers • Partner trusts received updates and information about the engagement process and events to cascade to their staff and stakeholders • Updates were provided by the programme team to London Cancer patient partnership group and The Heart Hospital Patient and Carers Information Group (full details can be viewed in Appendix B: Communications and activity log) • A reminder article was posted on NHS England's website to encourage feedback and responses • Feedback on the commissioners' preferred options was encouraged to be submitted by Friday 27 June 2014, however feedback continued to be accepted after this date (until 4 July 2014) All the data in the Case for Change and supporting materials was sourced from London Cancer, UCLP and by using information gathered by Public Health England and North and East London Commissioning Support Unit (NELCSU)

Decision to include specialist cancer and cardiovascular services in one review

Summary of feedback	Response
Some respondents queried the rationale of grouping together proposed changes to specialist cancer and cardiovascular services	It was decided to combine the proposed changes to specialist cancer and cardiovascular services as two thirds of premature deaths in people under the age of 75 in London are as a result of cancer and heart disease. There is an urgent need to improve the way services for both are delivered.

Cancer specific

Summary of feedback	Response
Support shown for the concept of an integrated cancer system. An area of concern raised at the stakeholder workshops for cancer patients related to late diagnosis and this should be prioritised as part of any planning for implementation going forward.	Support is noted and welcomed. NHS England fully agree this is a priority and is working with the transferring cancer services teams and UCLP (London Cancer) on this. We recognise the need to improve prevention and earlier diagnosis. Projects are underway to address this including understanding why so many people are only diagnosed with cancer when they are admitted to A&E. In addition to their work and involvement with these proposals, a large part of London Cancer's work is improving earlier diagnosis, reducing variation in services and improving patient experience. This work includes:

Summary of feedback	Response
One respondent asked why OG was not collocated with major thoracic surgery at Barts Health to obtain the best results.	• Understanding root causes of why one in four cancer patients present at A&E • Improving uptake in bowel screening by 14% in Camden • Interactive case-study GP and practice nurse education led by local MDTs • New model of rapid access to specialist opinion and diagnostics for bowel symptoms • Workshops to reduce inter-trust delays and sharing clinical and performance data • A single process for assessing patients' holistic needs • Interactive maps to help patients to navigate care locally Further work is currently required to determine the best provision for lung cancer patients and as such, thoracic surgery is not included in this review. London Cancer is currently undertaking work to develop a detailed specification for this pathway.

Cardiovascular specific

Summary of feedback	Response
Respondents stated the importance of acute treatment centres in the area that were able to treat patients with heart attacks as quickly as possible. Comments included the requirement for capacity for patients with Cardiac Diseases and Adult Congenital Heart Disease.	The new centre at St Bartholomew's Hospital will be a Heart Attack Centre for the area along with the Royal London Hospital. The majority of patients would live closer to the proposed integrated centre at St Bartholomew's Hospital.

Next steps

The feedback the programme team received over the engagement phase has been fed into this report and will inform the planning for implementation work, should the proposals be approved to proceed.

A second commissioner 'in common' meeting will be held on 25 July 2014, where the majority commissioners of these services will discuss the themes and decide on next steps.

Should the proposals be approved, the trusts would continue to work with the local community and key partners to develop detailed plans to communicate the reconfiguration.

Further detail about this process can be viewed in the Engagement overview report available online at: http://www.england.nhs.uk/london/engmt-consult/