NHS England

Health Inequalities Impact Assessment: Specialist cancer and cardiovascular services in north and east London

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Health Equity Tool

This tool has been developed to help you to think through the implications of your work on addressing health inequalities. It aims to help you take the right steps to make sure that the policy, commissioning and/or procedure you are developing has the best chance of reducing health inequalities. This will support NHS England in meeting its legal duties.

Health Inequalities

Health inequalities have been defined as “Differences in health status or in the distribution of health determinants between different population groups." [World Health Organisation Glossary of terms]

Health inequalities exist across a range of social and demographic indicators, including socio-economic status, educational attainment, area deprivation, gender, age, occupational group and vulnerable groups and those with special needs. Avoidable health inequalities "arise because of inequalities in society and in the conditions, in which we are born, grow, live work and age, and the systems put in place to deal with illness. The conditions in which people live and die are, in turn, shaped by political social and economic forces.” [WHO Commission on the Social Determinants of Health, 2008].

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The evidence tells us that up to 20% of the life expectancy gap between the most and least deprived communities can be accounted for by health care. NHS England therefore has a key role in addressing health inequalities.

Legal Duties

The Health and Social Care Act 2012 established the first specific legal duties on NHS England to have regard to the need to reduce inequalities between patients in access to, and outcomes from, healthcare services and in securing that services are provided in an integrated way. These duties had legal effect from April 1st 2013.

The duties require that NHS England give regard to the need to reduce health inequalities in all decision making, to integrate services where this might reduce health inequalities and has evidence of compliance with the duties. Publishing guidance or policies without demonstrating how you have complied with these legal duties may leave the organisation open to legal challenge, primarily judicial review of the decision.

NHS England must therefore be able to demonstrate it had evidence on the potential impact of policies and practices on addressing health inequalities, including opportunities to reduce them, and has used this to inform its decision making. The legal duties apply to any decision made, any policy developed, any programme implemented and any practices driving activity. They also apply to functions and services provided by others on behalf of the organisation. Both new policies and decisions and existing policies and decisions, when reviewed, come within the duties.

What is meant by “…have regard to…” in the duties?

- Lawyers advise that “have regard to the need to reduce” means health inequalities must be properly and seriously taken into account when making decisions or exercising functions, including balancing that need against any countervailing factors.

- Part of having due regard includes having a robust evidence base about the relevant health inequalities and accurate record keeping of how the need to reduce health inequalities have been taken into account.

The decision maker within NHS England must be able to demonstrate that:

- they are fully aware of the duty;
- the duty was considered during the appropriate stages of work, from the beginning of the decision making process and throughout;
- the appropriate amount of weight has been given to factors which would reduce health inequalities in the decision making process.

HIA Tool:
This tool has been developed to help you to take the right steps to make sure that the policy, commissioning decision and/or procedure you are developing has the best chance of reducing health inequalities and to ensure that you are meeting our legal duties. This includes ensuring that the duties were considered during the appropriate stages of work.

The process of using the tool and working through the questions is as important as the outcome. The process is an opportunity to evaluate your evidence base and involve stakeholders and allow them to take ownership of the analysis. Answer those questions in the tool that are appropriate to your work. For each question, refer to the best available evidence and identify stakeholders who can be involved in the discussion of each question. If the evidence is not readily available or gaps are found, a proactive approach may be needed, such as commissioning new research. Finally, keep records and note where the evidence can be found for each answer in the space provided.

Policy Development Process and self-assurance for Gateway:
Regard to health inequalities is embedded within NHS England's policy development process under, and it is encouraged that this tool is adopted at this early stage to guide you through the policy development process. The evidence and record keeping will help the responsible officer to self-assure themselves on compliance with the duties.

As part of complying with the legal duties, NHS England must consider whether any policy or documentation it develops might reduce existing health inequalities, exacerbate them and/or create new inequalities. For example, when looking at a specific outcome consider how it is distributed across society and across different demographic indicators, rather than looking just at average outcomes. This requires identifying and using robust data and considering ways of mitigating any negative impacts.

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INTRODUCTION

NHS England, together with a number of CCGs, is proposing a reconfiguration of specialised cancer and cardiovascular services in north and east London[1]. The details of the reconfiguration are more fully described in the business case that accompanies the Equality Impact Assessment and in the sections that follow.
For cardiovascular services the proposal is to consolidate services currently at the Heart Hospital to the new unit being developed at St Bartholomew's Hospital.
For cancer services the proposal is to reduce the number of units where specialised surgery or intensive treatment takes place. The number of consolidated units varies for each type of cancer and this is detailed in the sections that follow. The proposals affect the following cancers:

- Brain cancer
- Head & neck cancer
- Urological cancers (kidney, bladder and prostate)
- Acute Myeloid Leukaemia
- Oesophago-gastric cancer

In all cases it is only the specialist element of the treatment pathway that is affected by these changes. Outpatients, chemotherapy, radiotherapy and non-specialised surgery are all unaffected by these proposals.

This report is intended to highlight to stakeholders, patients and the public the groups of patients that will be affected by the proposed changes and suggest the impact that the changes will have. The report is slightly limited by the availability of data about the patients that currently use the service.

Questions:

1. **What health inequalities exist with regard to your policy/procedure?**

   1.1 What health inequalities currently exist with regard to the health issue that your policy/procedure aims to address?

Cancer and cardiovascular disease cause two-thirds of early deaths in London. If the NHS in north and east London were to improve local survival rates for heart disease and all cancers in line with at least the rate for England over 2,000 lives a year would be saved. The document Improving specialist cancer and cardiovascular services in north and east London: The case for change sets out the case being made to introduce these changes. This proposes that fewer specialist high volume units would improve clinical outcomes, accelerate the uptake of new technologies, achieve greater quality and optimise efficiency.

[1] For the purposes of this document "north and east London is defined as the London Boroughs of Barnet, Enfield, Haringey, Camden, Islington, Tower Hamlets, City of London, Hackney, Newham, Waltham Forest, Redbridge, Barking & Dagenham and Havering.

NHS England has examined how these services are provided in north and east London and has developed a vision for how they could be improved. Through an engagement exercise to consider these proposals NHS England have heard that patients want to have health services that are locally accessible where possible, but when they are critically ill they want the best specialists, with the best equipment, to give them the best chance of recovery. North and east London has some of the best cancer and cardiovascular experts in the country but specialist services are not organised in a way that gives patients the best chance of survival and the best experience of care. So the proposals are:

- For cardiovascular care, to combine services currently provided at The Heart Hospital, The London Chest Hospital and St Bartholomew's Hospital to create a single integrated cardiovascular centre. With The London Chest Hospital closing next year and The Heart Hospital having limited capacity, clinicians have recommended consolidating into a centre in the new building at St Bartholomew's Hospital (which is 2.5 miles from The Heart Hospital). The Royal Free Hospital and the integrated cardiovascular centre at St Bartholomew's Hospital would act as heart attack centres for the area.
- For five complex or rare cancers, to provide specialist treatment in four centres of excellence across the area with a hub at University College Hospital. There would continue to be services provided locally for other types of cancer and general cancer services, such as diagnostics and chemotherapy.

The primary aim of the changes is to improve health outcomes for patients. This will have a positive impact on all patients and by helping to reduce early deaths caused by heart disease and cancer should also have a positive impact on the inequalities in mortality rates between London and the rest of England.

1.2 What factors have created, maintained or increased the health inequalities?

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

1.3 What are the full demographics of the population that your policy/procedure addresses?

Profile of north and east London

General Profile

The area covered by this reconfiguration includes the London Boroughs of Barnet, Enfield, Haringey, Camden, Islington, City of London, Tower Hamlets, Hackney, Newham, Waltham Forest, Redbridge, Barking & Dagenham, and Havering.

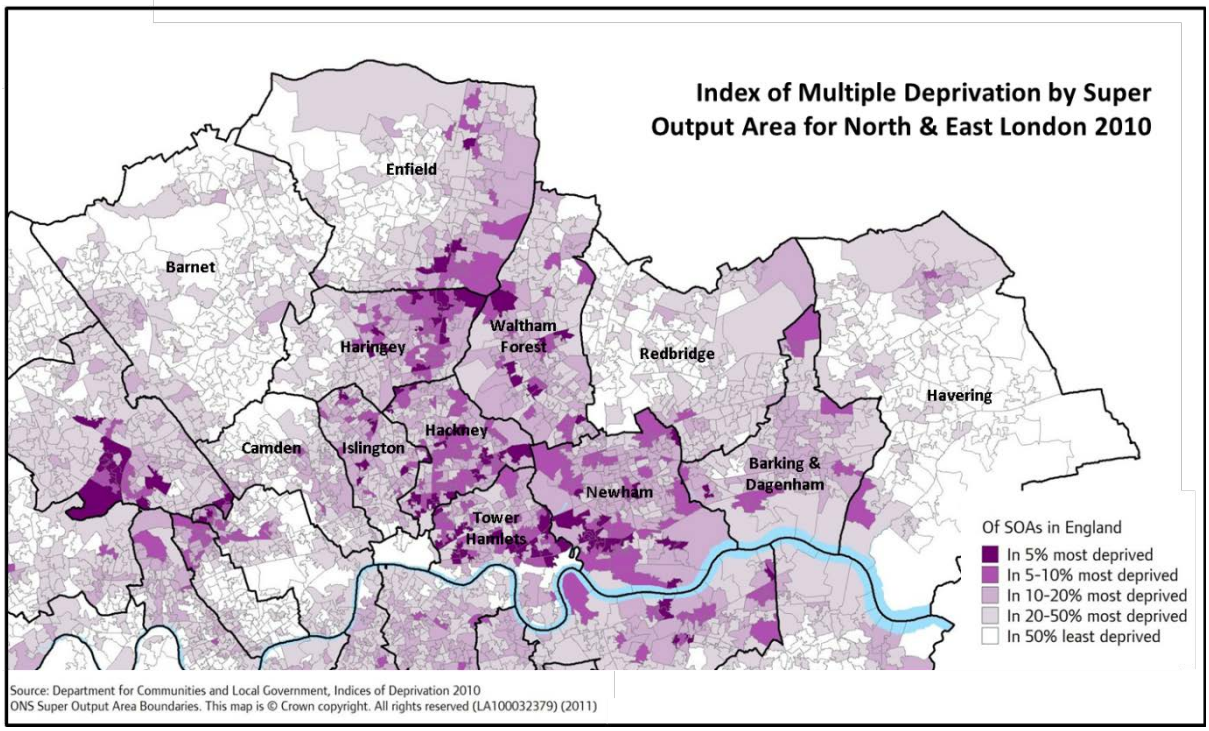
Estimates of the population of this area vary. The GLA estimates the population to be 3.3m, however the number of people registered with General Practitioners in the area is 3.5m.

The area is ethnically diverse; of the seven London Boroughs only Havering has less than 20% of its population from a non-white BME group.

There are seven NHS trusts in the area providing specialist cancer and cardiovascular services from a number of hospital sites. In addition some of these hospitals are the designated provider of some specialised cancer services for West Essex.

Deprivation in north and east London.

The map shows areas of high deprivation in north and east London. This shows that Newham, Hackney and Hackney are amongst the most deprived Boroughs in England; in addition parts of Waltham Forest, Islington, Haringey, Enfield and Barking & Dagenham also have areas of high level of deprivation.



1.4 How is the health issue that your policy is aiming to address distributed across different population groups and across different geographical locations?

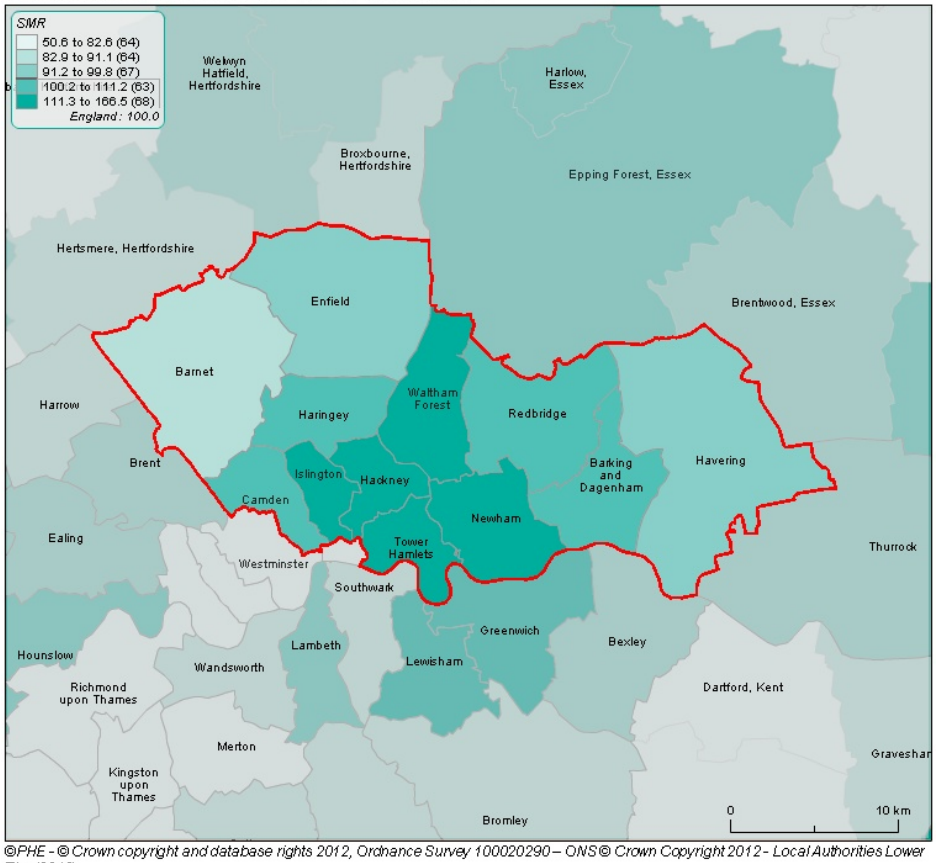
Incidence of cancer and heart disease in north and east London

From local and national evidence it can be shown that there are serious health issues and health inequalities in north and east London which are closely linked to poverty and deprivation and which impact on life expectancy. Cancer and cardiac conditions are predominantly issues of poverty, age and lifestyle i.e. smoking and drinking alcohol. We have highlighted some key facts about cancer and cardiovascular health from local Joint Strategic Needs Assessments (JSNA) and national organisations:

- Smoking is the leading cause of premature deaths in all communities but more so amongst minority communities and working class populations. Smoking accounts for nearly one-fifth of all deaths from cardiovascular disease.
- Much of the area has poor survival and high mortality from cancer. Evidence suggests that late diagnosis is a significant contributor to this.
- Lack of physical exercise and poor diet increase the risks of cancer and cardiovascular diseases.
- Prostate cancer is one of the top causes of cancer death in men.
- Cancer occurs predominantly in older people, and therefore as life expectancy increases so the number of cancers diagnosed each year will also increase.

- Evidence suggests that people with learning disabilities, mental health issues and those who are housebound have high risks of developing cancer and cardiovascular conditions due to life style and socio-economic factors.
- The prevalence of Coronary Heart Disease (CHD) is higher amongst Indian, Pakistani and Bangladeshi men. From those who are dying in England and Wales but born in South East Asia, CHD accounts for about a quarter of all deaths.

Deaths from coronary heart disease, all ages, standardised mortality ratio, 2006-2010 - *source: PHOs (now part of Public Health England), produced from ONS data © Copyright 2011*



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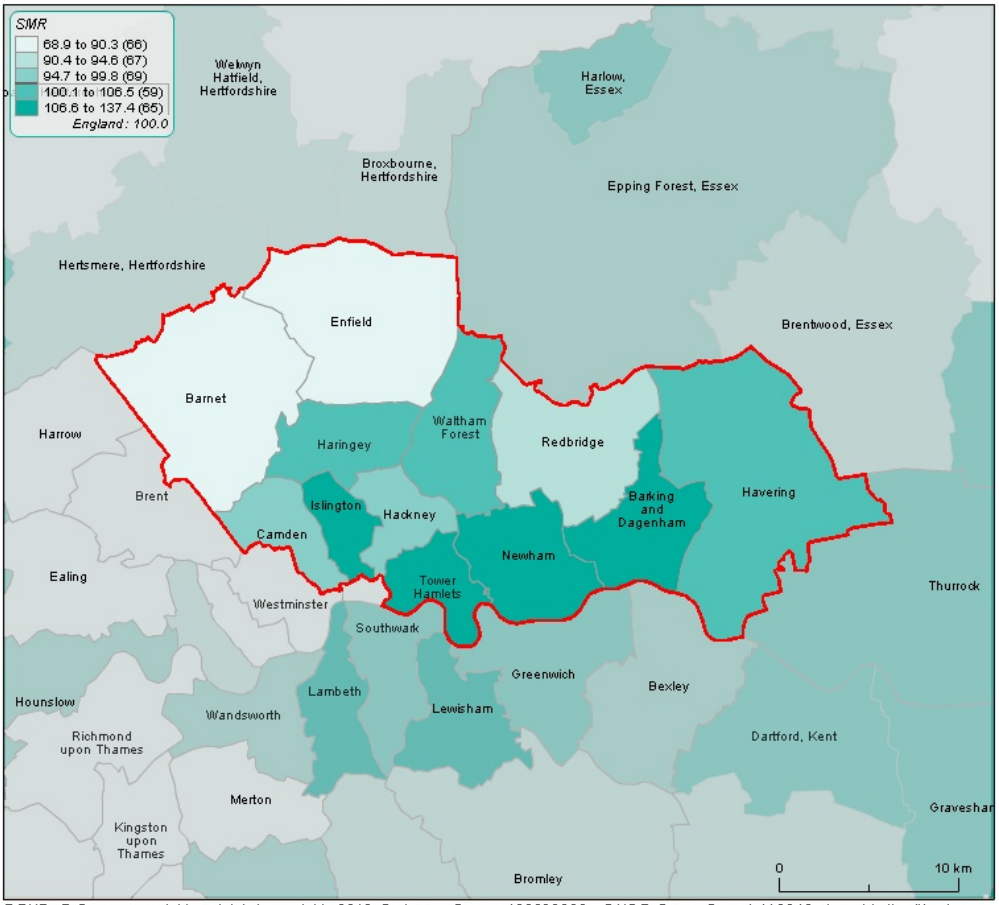
The map above shows deaths from CHD across the north and east London area, standardised for the age of the population. The map shows that CHD deaths are higher than average in all areas except Barnet, Enfield and Havering. CHD deaths are particularly high in Islington, Hackney, Tower Hamlets, Waltham Forest and Newham.

Deaths from all cancer, all ages, standardised mortality ratio, 2006-2010 - *source: PHOs (now part of Public Health England), produced from ONS data © Copyright 2011*



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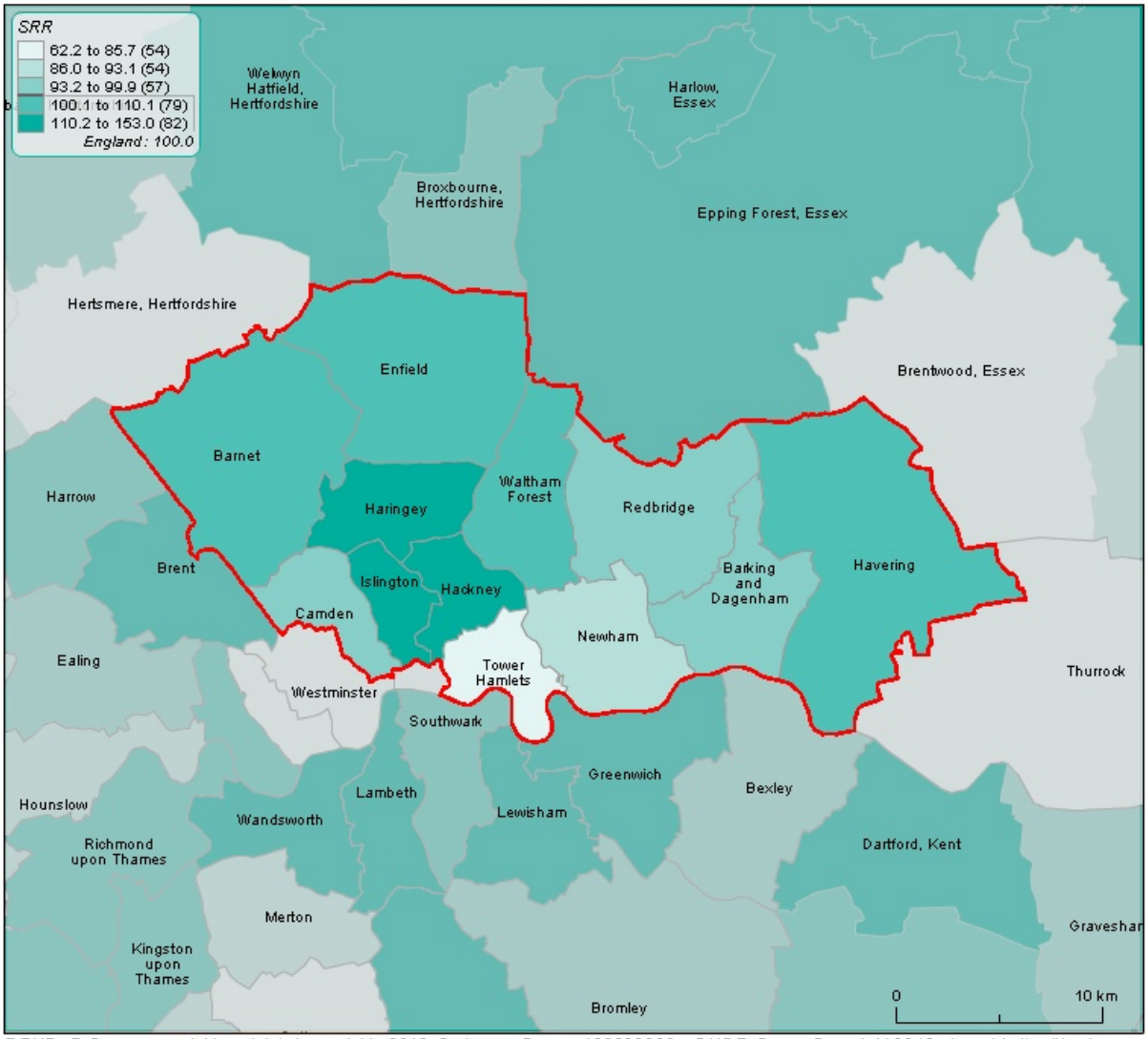
The map above shows deaths from all cancers across the north and east London area standardised for the age of the population. The map shows higher than average numbers of deaths across much of the area, with the highest numbers of deaths in Islington, Tower Hamlets, Newham and Barking & Dagenham. However this is data for *all* cancers, each tumour type can have a different pattern of incidence.

Of the tumour types covered by this programme (brain cancer, head and neck cancer, renal cancer, bladder cancer, prostate cancer, acute myeloid leukaemia and oesophago-gastric cancer) only prostate cancer data was readily available. The map below shows the incidence of prostate cancer in north and east London. This shows that there is higher than average incidence across much of the area with the highest incidence in Islington, Haringey and Hackney.

New cases of prostate cancers, standardised registration ratio, 2005-2009 - *source: UK Association of Cancer Registries (now part of Public Health England), National Cancer Data Repository*



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2. What is the potential impact of the policy/procedure on health inequalities?

2.1 How will the policy/procedure affect health inequalities?

NHS England has examined how these specialist cancer and cardiovascular services are provided in north and east London and has developed a vision for how they could be improved. Through two engagement exercises to consider these proposals, NHS England has heard that patients want to have health services that are local accessible where possible, but when they are critically ill, they want the best specialists, with the best equipment, to give them the best chance of recovery.

The primary aim of the changes is to improve health outcomes for patients. This will have a positive impact on all patients and by helping to reduce early deaths caused by heart disease and cancer should also have a positive impact on the inequalities in mortality rates between London and the rest of England.

2.2 Can you demonstrate through evidenced based consideration how the health outcomes, experience and access to health care services differ across the population group and in different geographical locations that your policy/procedure applies to?

2.3 Will the policy/procedure address need across the social gradient or focus on specific groups?

2.4 Will the policy/procedure have an unintended differential impact on different population groups and across different geographical locations?

Analysis undertaken

The analysis that follows has looked at recorded data by the hospitals affected over the last three years. The hospitals record the age, gender and ethnicity of the patients treated. Using this data a profile has been created of the patients that are currently being seen at the hospitals where the proposal is to decommission a service. This represents the patients that will be most affected by the proposals.

In each case the profile of the affected group has been contrasted against patients treated at a wider range of centres. The analysis seeks to address the following issues:

- What is the nature of the patients affected by the proposed changes:
    - How many patients are affected?
    - Where do they come from?
    - What is the age, ethnicity and gender profile of the group?
- Is the profile of the group of patients affected by the changes any different from the profile of patients in general? If so the changes could have an impact on equality of service provision or access to services.

Possible impacts

Whilst the analysis described above goes some way towards identifying whether one group may be affected disproportionately over another it is harder to assess whether the impact could be neutral, positive or negative.

Possible impacts could include:

- Changes lead to better clinical outcomes for the affected group
- The new provider is more difficult for patients from the affected group to access; possibly because of a combination of the age of the patient group affected and the increased distance to travel.
- The new provider is better or worse at responding to the particular needs of a specific patient group; for example if the access to translation services is better under the new provider.

The changes proposed are to tertiary services, so patients have already started on a treatment pathway before they are treated by the specialist centre. By implication, access to the patient pathway is not affected by the proposals.

Impact on people with disabilities

Currently there is no data collected on the numbers of patients treated with a disability. Consequently it is difficult to assess the numbers of patients with disabilities that might be affected by the proposed changes. However the impact should be negligible because all the hospitals involved in the reconfigurations:

- Are routinely assessed by the Care Quality Commission to ensure that their services are responsive to the needs of patients with a disability
- Operate special transport arrangements for patients with mobility problems.

So it is reasonable to conclude that there should be no material negative impact on patients with a disability. However there remains an onus on all the providers involved in the project to ensure that the implementation of the changes is done in a way that the needs of disabled patients are considered.

The scoping exercise concluded that, of the protected characteristics:

- The changes proposed would have the greatest effect on the elderly as cancer and cardiovascular disease most commonly affect older people.
- There was likely to be no impact on marriage/ civil partnerships or pregnancy.
- It is difficult to measure the impact on inequalities in the areas of disability, religion/ belief, sexual orientation or gender reassignment as data was not collected by the Trusts on these groups.

The focus of the analysis that informs the assessment in this report has concentrated broadly on race, gender and age, as there is existing data from the former PCTs on these characteristics. The second phase of engagement was then used to make every effort to engage with groups with protected characteristics on which there was limited data for the analysis, this included engaging with newly identified groups of stakeholders who had not previously engaged in the programme, including branches of Age UK and local LGBT charities.

2.5 Would providing services in an integrated way reduce health inequalities?

The proposals are:

- For cardiovascular care, to combine services currently provided at The Heart Hospital, The London Chest Hospital and St Bartholomew's Hospital to create a single integrated cardiovascular centre. With The London Chest Hospital closing next year and The Heart Hospital having limited capacity, clinicians have recommended consolidating into a centre in the new building at St Bartholomew's Hospital (which is 2.5 miles from The Heart Hospital). The Royal Free Hospital and the integrated cardiovascular centre at St Bartholomew's Hospital would act as heart attack centres for the area.
- For five complex or rare cancers, to provide specialist treatment in four centres of excellence across the area with a hub at University College Hospital. There would continue to be services provided locally for other types of cancer and general cancer services, such as diagnostics and chemotherapy.

3. How can you make sure that your policy/procedure has the best chance of reducing health inequalities?

3.1 What can you do to make it more likely that the policy/procedure reduces health inequalities?

3.2 What have you done to mitigate against any failure to reduce health inequalities?

3.3 Are there any dependencies or interdependencies that may impact on the work's ability to address health inequalities? For example, are delivery partners sufficiently engaged in addressing health inequalities? Are there any resource implications that may affect the delivery?

3.4 Will the policy/procedure be equitably delivered to all population groups, with a scale and intensity proportionate to the level of disadvantage?

See detailed Impact Analysis for Cardiovascular Services and Cancer services sections below (3.4.1 to 3.12.17).

Impact Analysis: Cardiovascular services

3.4.1 Current service

Currently there are cardiovascular centres in NE London providing cardiology, catheterisation and cardiac surgery at the Heart Hospital, St Bartholomew's Hospital and the London Chest Hospital, although plans are already well advanced to move all services at the London Chest Hospital to St Bartholomew's Hospital.
There are heart attack centres at St Bartholomew's, the Heart and the Royal Free Hospitals.

There are some service issues associated with the current service:

- Patients are waiting unacceptably long for treatment
- Too many patients are having their surgery cancelled
- Hospitals cannot deliver 24/7 care by specialist teams without sufficient patient numbers

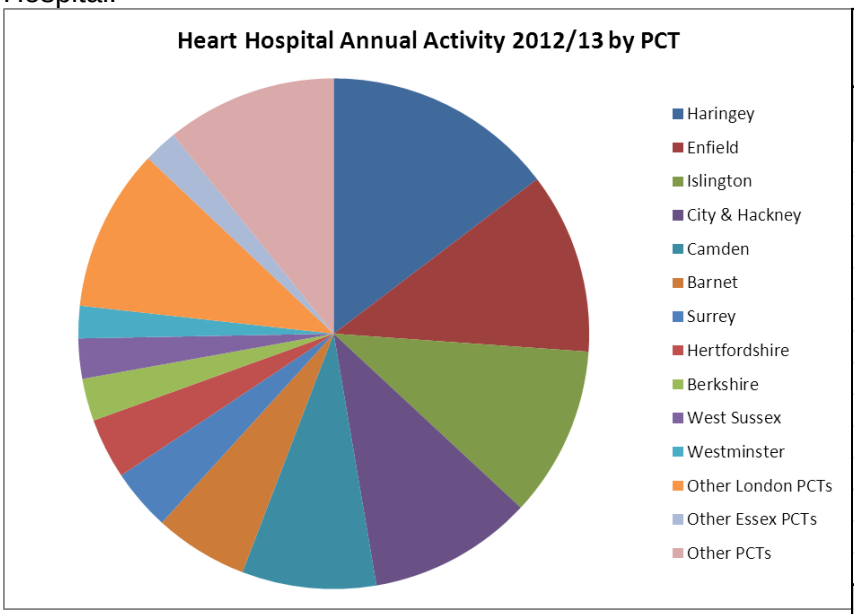
Not all our services are delivering the national standards for care and patient outcomes could be improved.

3.4.2 Proposed service

All services currently at the Heart Hospital will be consolidated to the new development at St Bartholomew's, thereby creating one world-class integrated cardiovascular centre and two heart attack centres for the north and east of London.
The aim is to develop a comprehensive, joined-up network of care spanning from prevention and earlier diagnosis through to treatment of disease.
The majority of care would continue to be provided close to people's homes.

3.4.3 Patients affected

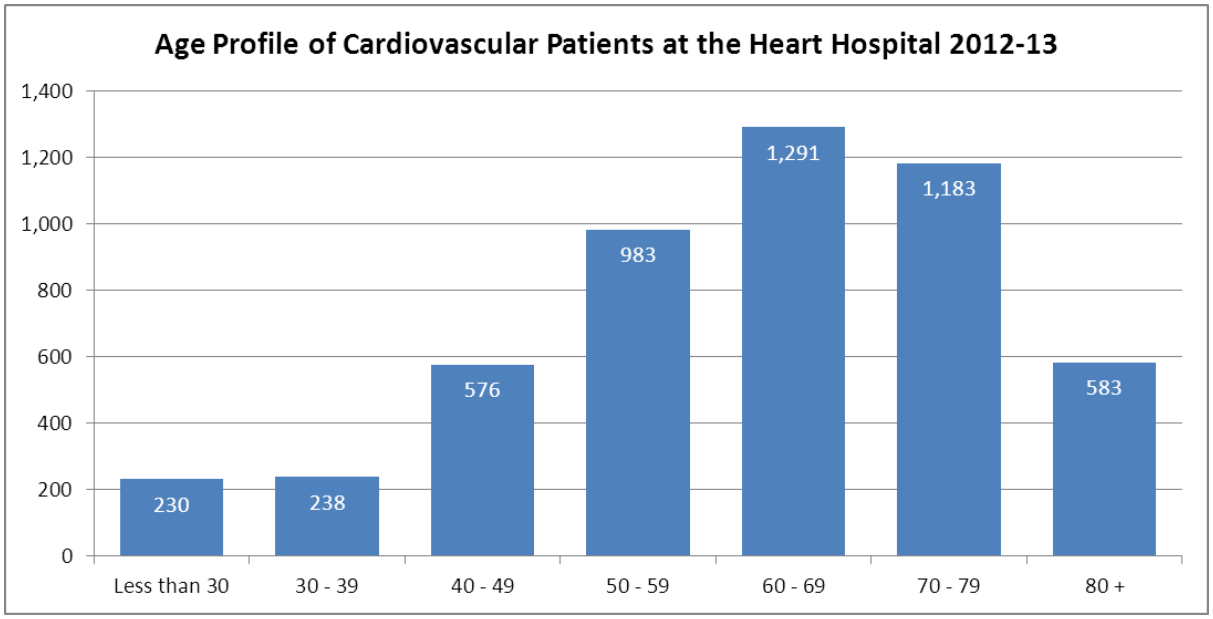
The patients using the Heart Hospital predominantly come from the North Central London area and Hackney. The table and pie chart below show that around 60% of patients come from this area. Within this area, the public health analysis shows that Islington and Hackney are areas of high mortality for CHD. However there are patients using the Heart Hospital from across London and south east England. The current assumption is that 95% of the activity currently going to the Heart Hospital would in future transfer to St Bartholomew's Hospital.



Heart Hospital Annual Activity 2012/13 by PCT		
PCT	**Value**	**Proportion**
Haringey	739	14.7%
Enfield	578	11.5%
Islington	545	10.8%
City & Hackney	524	10.4%
Camden	428	8.5%
Barnet	299	5.9%
Surrey	197	3.9%
Hertfordshire	193	3.8%
Berkshire	136	2.7%
West Sussex	128	2.5%
Westminster	103	2.0%
Other London PCTs	520	10.3%
Other Essex PCTs	108	2.1%
Other PCTs	545	10.8%
Total	**5,044**	**100.0%**

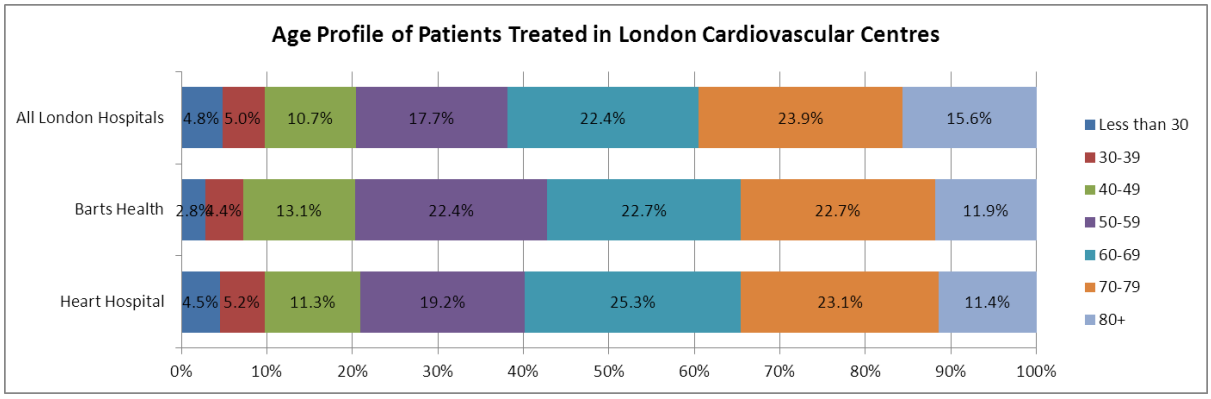
3.4.4 Age Profile

The tables below show the age profile of the patients using the Heart Hospital in 2012-13. This shows that the patients using the Hospital tend to be middle-aged or elderly, which reflects the profile of cardiac heart disease.



This profile has been contrasted to the age profile of patients using cardiovascular services across all the units in London and at Barts Heath. This analysis indicates that the Heart Hospital has a younger mix of patients than London as a whole but that it is broadly the same as patients treated at the two units in Barts Health. A number of factors are contributing to this:

- The Heart Hospital focuses on interventional cardiac services where the patients tend to be younger and fitter. Patients requiring non-interventional cardiology are treated at UCLH rather than the Heart Hospital.
- The congenital heart service at the Heart Hospital has a younger case mix than conventional cardiovascular service.
- Demographic factors effecting the boroughs served by the Heart Hospital



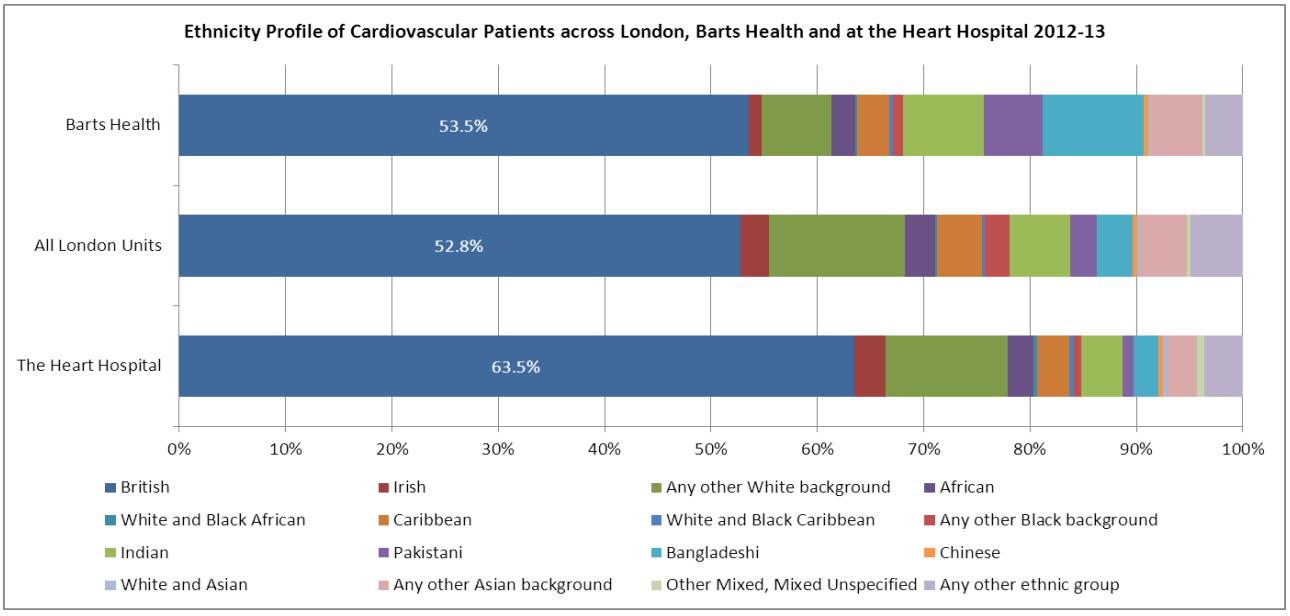
3.4.5 Ethnicity

The table and graphs below show the ethnic mix of patients using the Heart Hospital[2]. The information is contrasted with the ethnic mix of patients at Barts Health (St Bartholomew's Hospital and the London Chest Hospital) and all cardiovascular centres across London. Each of these show a different profile that to a large extent reflects the ethnic mix of the local

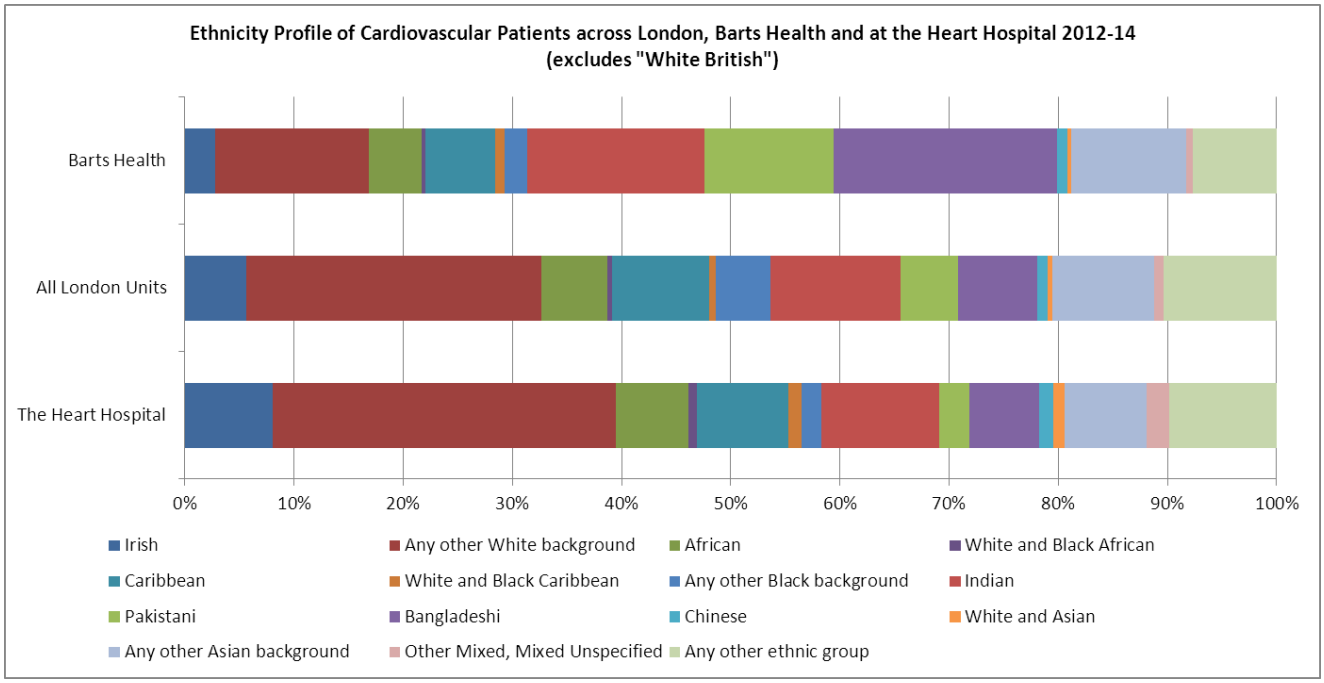
[2] The source of this is the data collected by trusts and where a patient's details have not been collected this has been excluded.

population served. In particular it is worth noting that the 63.5% of the patients at the Heart Hospital are classified as “White British” compared to 52.8% for London providers as a whole. It is also worth noting that the number of patients seen in some of the ethnicity categories is small so it is difficult to reach definitive conclusions about these groups.

	The Heart Hospital	All London Units	Barts Health	The Heart Hospital	All London Units	Barts Health
British	2,642	32,399	4,164	63.5%	52.8%	53.5%
Irish	122	1,630	100	2.9%	2.7%	1.3%
Any other White background	478	7,835	509	11.5%	12.8%	6.5%
African	101	1,750	175	2.4%	2.9%	2.3%
White and Black African	12	136	14	0.3%	0.2%	0.2%
Caribbean	127	2,569	232	3.1%	4.2%	3.0%
White and Black Caribbean	18	172	29	0.4%	0.3%	0.4%
Any other Black background	28	1,459	76	0.7%	2.4%	1.0%
Indian	164	3,452	587	4.0%	5.6%	7.5%
Pakistani	42	1,534	430	1.0%	2.5%	5.5%
Bangladeshi	97	2,089	740	2.3%	3.4%	9.5%
Chinese	19	272	34	0.5%	0.4%	0.4%
White and Asian	16	142	12	0.4%	0.2%	0.2%
Any other Asian background	114	2,701	383	2.7%	4.4%	4.9%
Other Mixed, Mixed Unspecified	31	252	20	0.7%	0.4%	0.3%
Any other ethnic group	150	2,995	278	3.6%	4.9%	3.6%
Sub-Total	**4,162**	**61,386**	**7,782**	**100.0%**	**100.0%**	**100.0%**



The table below shows the same information but without the “White British” Category. This allows the mix of other ethnicities to be seen more clearly.



This shows that Barts Health already treats a wide ethnic mix of patients. The one group that features at the Heart Hospital that is less represented at the two Barts Health sites is the "Other White" category. Barts Health should investigate whether there are any special arrangements that should be put in place to accommodate this group.

3.4.6 Travel implications

The Heart Hospital and St Bartholomew's Hospital are around 2.5 miles apart. Both are located close to underground stations and both are within two underground stops from the main rail termini for north London (Kings Cross, St Pancras & Euston). The travel times analysis that for the large majority of patient that currently use the Heart Hospital journey times would be unaffected by the move to the Barts site.
A similar conclusion was reached regarding emergency ambulance journeys in discussion with the London Ambulance Service.

3.4.7 Conclusions

Key points:

- The proposals will result in care for a significant number of patients (c 5,000 per annum) shifting from the Heart Hospital to St Bartholomew's Hospital.
- The patients affected predominantly come from north central London and Hackney, although 40% of patients are spread across the rest of London and the South East.
- There is no evidence of any group being disproportionately affected by the proposals.
- The improved outcomes forecast for these changes will contribute to closing health inequalities for deprived populations that have higher mortality rates for CHD.
- The location of the two sites is such that there are unlikely to be any access implications from the change of site. This will be tested further in the transport impact report.
- The ethnic mix of patients currently seen in the Heart Hospital is different from that seen at the two Barts Health sites; with the Heart Hospital having a smaller proportion of patients from black and minority ethnic (BME) groups

3.5 Impact Analysis: Specialised cancer services

3.5.1 Specialised cancer services in general

3.5.2 Proposed changes

The changes proposed are concerned with:

- The treatment of rarer cancers (with the exception of prostate cancer)
- Specialised treatments or operations that are not appropriate or necessary for the majority of patients that are diagnosed with the specific type of cancer
- One element of a patient's treatment pathway. Much of the patient's care (outpatients, chemotherapy, radiotherapy) will take place in a more local unit

As a consequence the number of patients affected by these changes is small when considered next to the total number of patients being treated for each type of cancer.
The sections that follow describe in more detail the impact of the proposed changes to each specialised cancer pathway.
In each pathway, the proposal is to reduce the number of sites that provide specialised cancer services and consolidate these into one or two centres. These consolidations will allow specialist centres to develop where the best clinical outcomes can be achieved. The map shows that specialised cancer services are currently provided at a number of sites across north and east London and west Essex.

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

Barnet and Chase Farm Hospitals NHS Trust

1 Chase Farm Hospital

2 Barnet Hospital

North Middlesex University Hospital NHS Trust

3 North Middlesex University Hospital

Barts Health NHS Trust (Barts Health)

4 Mile End Hospital

5 Newham University Hospital

6 The London Chest Hospital

7 The Royal London Hospital

8 St Bartholomew's Hospital

9 Whipps Cross University Hospital

Princess Alexandra Hospital NHS Trust

10 Princess Alexandra Hospital

University College London Hospitals NHS Foundation Trust (UCLH)

11 University College Hospital

12 The National Hospital for Neurology and Neurosurgery (NHNN)

Royal Free London NHS Foundation Trust

13 Royal Free Hospital

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

14 Queen's Hospital

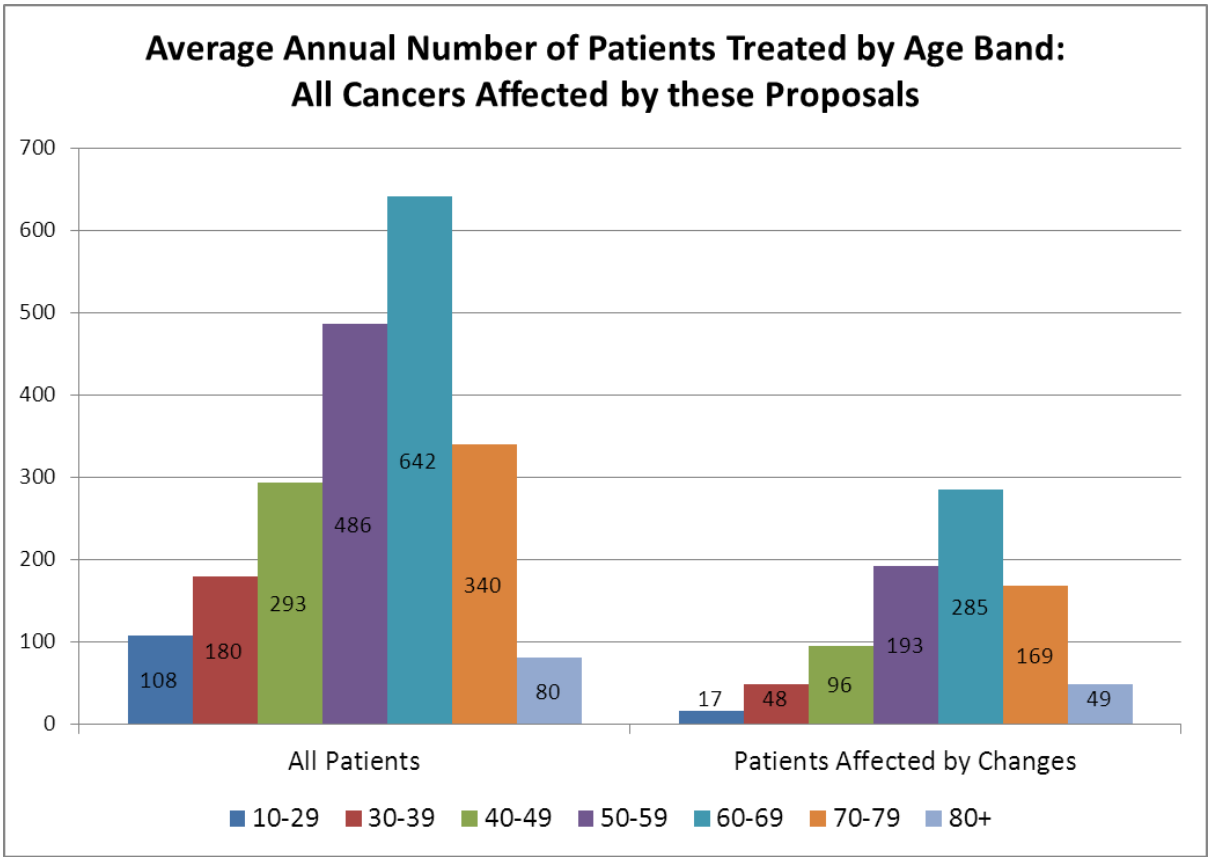
15 King George Hospital

Homerton University Hospital NHS Foundation Trust

16 Homerton University Hospital

3.5.3 Age profile

The graph below shows the patient numbers receiving these specialised treatments in age bands. Around 30% of patients are aged 60 to 70 and 75% of patients are aged 50 to 80.

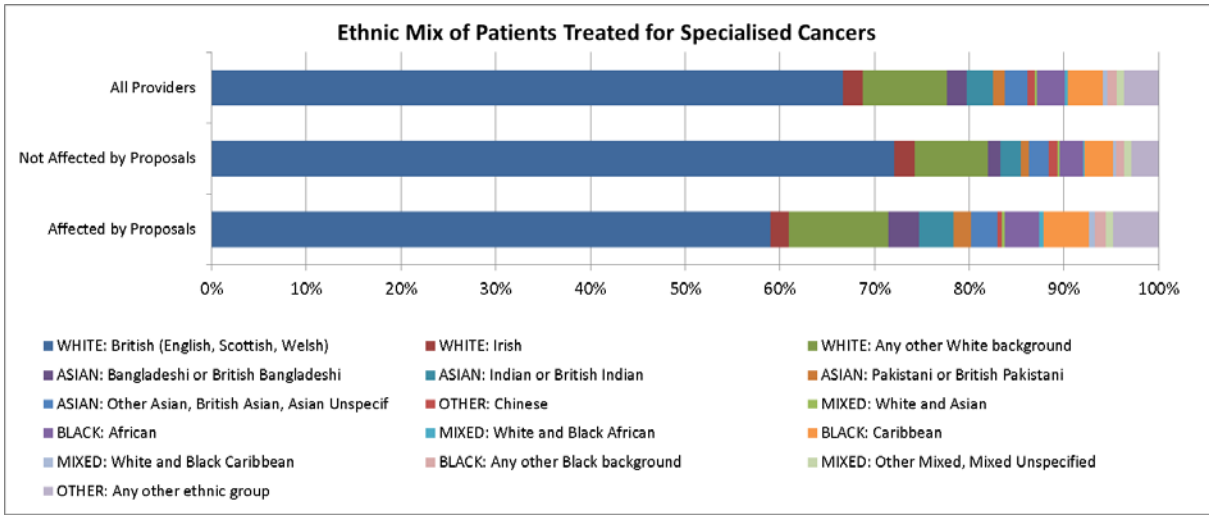


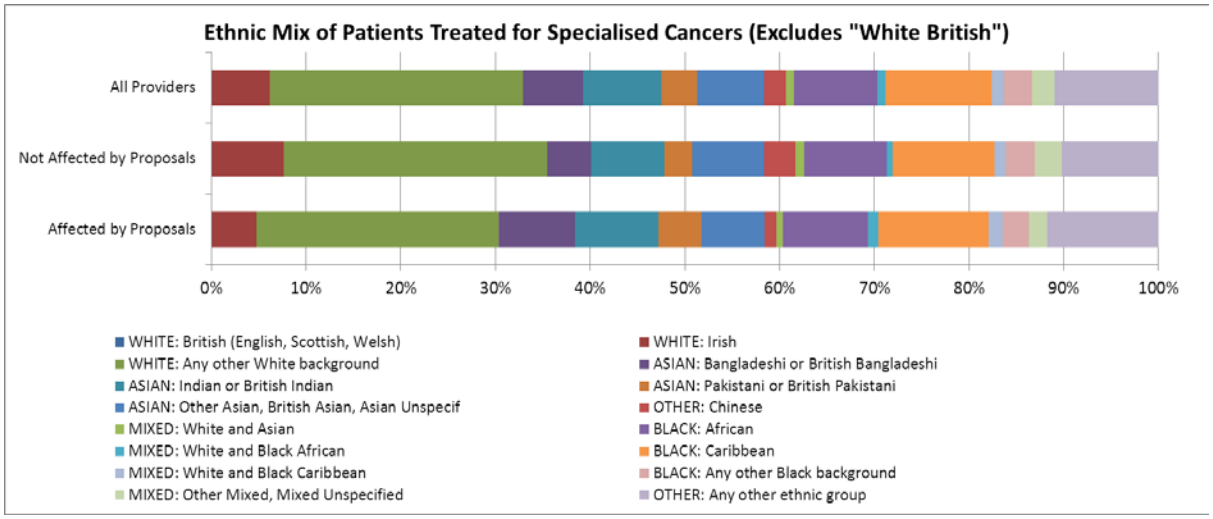
3.5.4 Ethnicity

The number of patients affected by the changes in each cancer pathway are relatively small which makes analysis of the ethnic mix of each pathway difficult. The table below shows the ethnic mx of all patients treated in the specialised cancer treatments under review.

Ethnic Mix of Patients Treated for Specialised Cancers
Average Annual Spells 2010-11 to 2012-13

All Specialised Cancers Affected	Affected by Proposals	Not Affected by Proposals	All Providers	Affected by Proposals	Not Affected by Proposals	All Providers
WHITE: British (English, Scottish, Welsh)	489.5	857.3	1,346.8	59.0%	72.1%	66.7%
WHITE: Irish	16.2	25.4	41.6	2.0%	2.1%	2.1%
WHITE: Any other White background	87.2	92.5	179.6	10.5%	7.8%	8.9%
ASIAN: Bangladeshi or British Bangladeshi	27.2	15.2	42.4	3.3%	1.3%	2.1%
ASIAN: Indian or British Indian	30.0	25.8	55.8	3.6%	2.2%	2.8%
ASIAN: Pakistani or British Pakistani	15.5	9.9	25.4	1.9%	0.8%	1.3%
ASIAN: Other Asian, British Asian, Asian Unspec	22.6	25.1	47.6	2.7%	2.1%	2.4%
OTHER: Chinese	4.2	10.9	15.2	0.5%	0.9%	0.8%
MIXED: White and Asian	2.5	3.2	5.6	0.3%	0.3%	0.3%
BLACK: African	30.4	28.9	59.3	3.7%	2.4%	2.9%
MIXED: White and Black African	3.9	2.1	6.0	0.5%	0.2%	0.3%
BLACK: Caribbean	39.5	35.6	75.2	4.8%	3.0%	3.7%
MIXED: White and Black Caribbean	4.9	3.9	8.8	0.6%	0.3%	0.4%
BLACK: Any other Black background	9.5	10.2	19.8	1.1%	0.9%	1.0%
MIXED: Other Mixed, Mixed Unspecified	6.7	9.5	16.2	0.8%	0.8%	0.8%
OTHER: Any other ethnic group	39.9	33.9	73.8	4.8%	2.8%	3.7%
Grand Total	**829.8**	**1,189.4**	**2,019.2**	**100.0%**	**100.0%**	**100.0%**



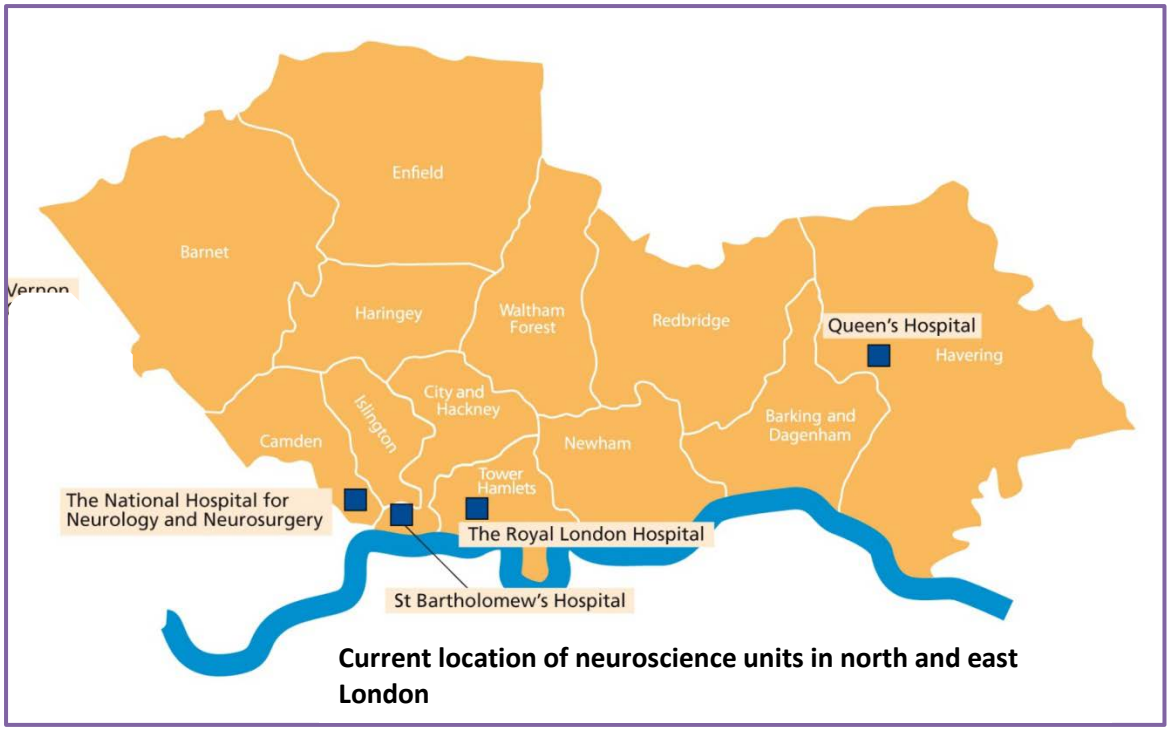


The tables above show that the majority of patients receiving specialised cancer treatment are in the “White British” category; reflecting the ethnic mix of the population served. The group affected by the proposals have a higher proportion of patients from ethnic minority groups than the group not affected by the proposals. This is probably a consequence of the geographical spread of the changes. In general the hospitals that are losing services are in the Boroughs in the east of London with a higher level of ethnic diversity.

3.6 Brain cancer

3.6.1 Proposed change

Currently there are three neuro-oncology centres in north and east London at the Royal London Hospital (Barts Health), Queen’s Hospital (BHRUT) and the National Hospital for Neurological Diseases (UCLH) serving a population of over 3.9 million covering north and east London and Essex.



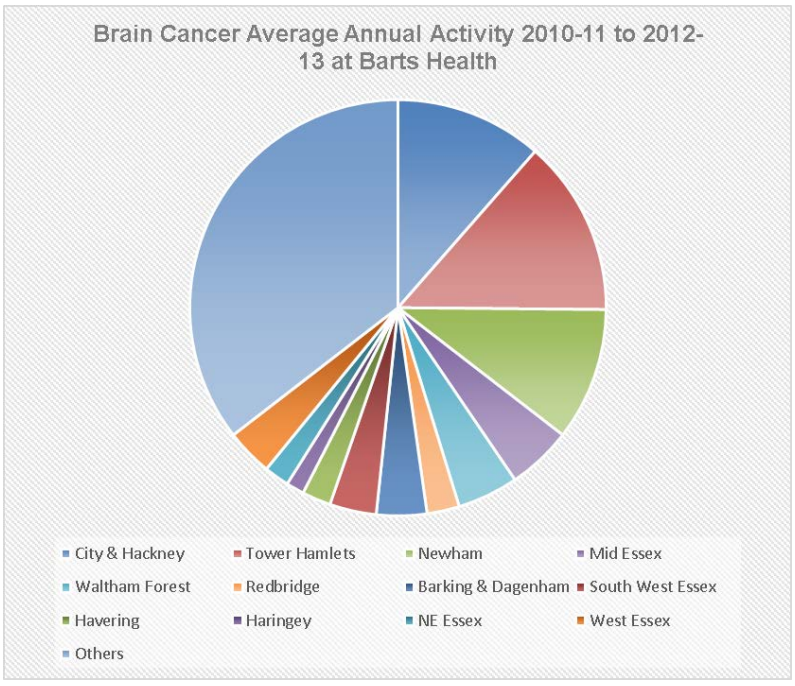
Current location of neuroscience units in north and east London

The proposal is for the service at the Royal London to be decommissioned with activity transferring to the other two units.

3.6.2 Patients affected

The Royal London Hospital treats around 126 patients a year for brain cancer. The pie chart below shows that 60% of these patients come from north east London although the Trust receives small numbers of referrals from across London and the Home Counties.

Brain Cancer Average Annual Activity 2010-11 to 2012-13 at Barts Health		
Responsible PCT	Spells	%
City & Hackney	14	11.5%
Tower Hamlets	17	13.7%
Newham	13	10.3%
Mid Essex	6	5.0%
Waltham Forest	6	4.7%
Redbridge	3	2.5%
Barking & Dagenham	5	3.9%
South West Essex	5	3.6%
Havering	3	2.2%
Haringey	2	1.4%
NE Essex	2	2.0%
West Essex	5	3.6%
Others	45	35.5%
Total	**126**	**100.0%**

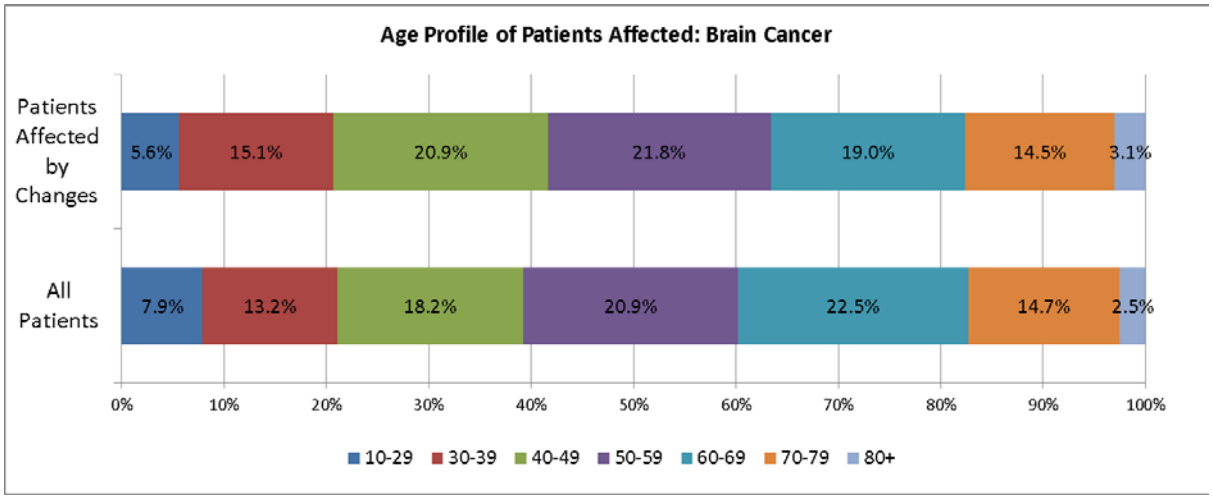


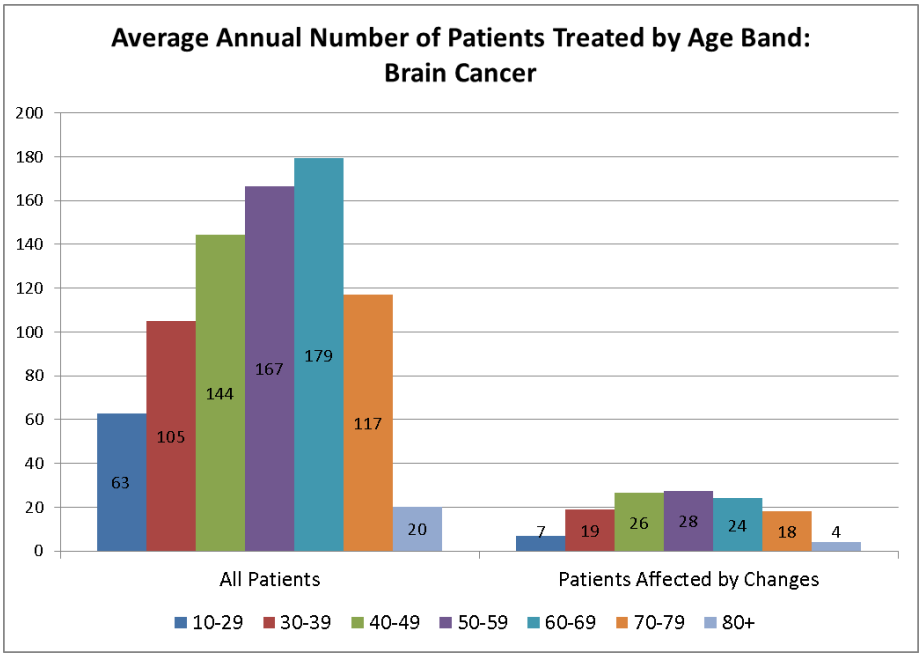
It is anticipated that 25% of patients currently receiving brain cancer surgery at the Royal London (those from Essex, Barking & Dagenham, Havering and Redbridge) will in future

receive their treatment at Queen's Hospital (Romford) and the balance will transfer to the National Hospital for Neurological Diseases.

3.6.3 Age profile

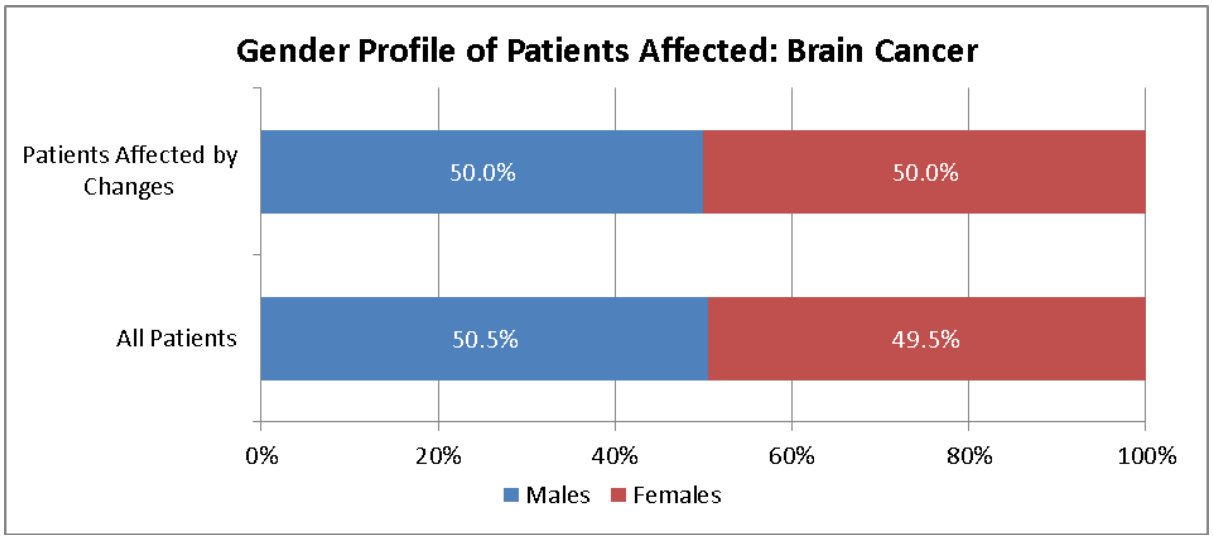
The graph below shows that the age profile of the patients affected by the changes are broadly the same as the whole group receiving care.
Around 17% of patients receiving specialised treatment are aged 70 or older.
16% of patients currently being treated will be affected by the changes.





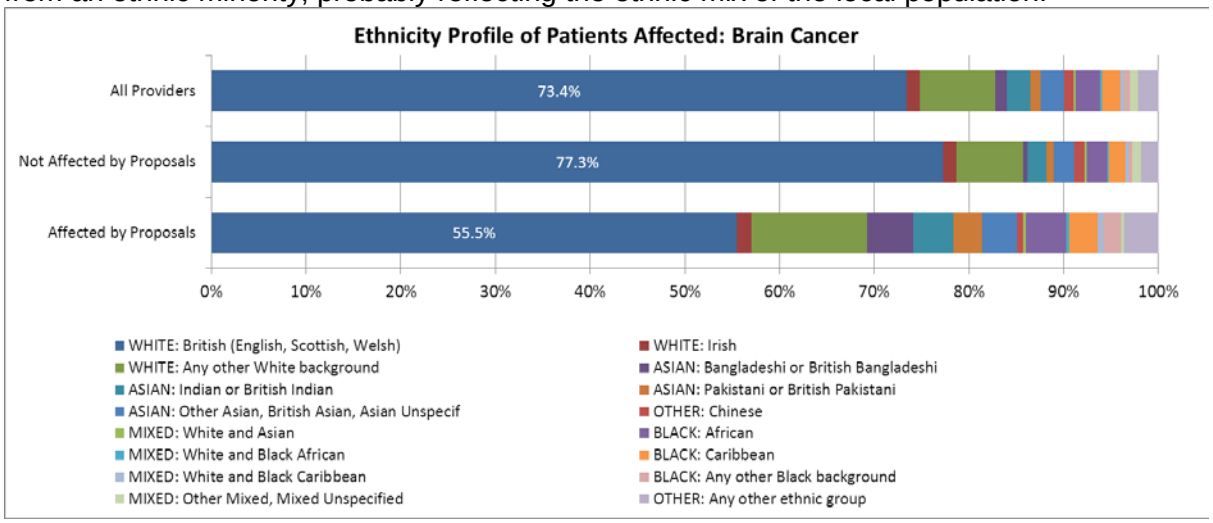
3.6.4 Gender

The graph shows that the gender profile of patients treated and the patients affected by changes is the same.



3.6.5 Ethnicity

The table below shows the ethnic mix of patients being treated at Barts Health that are affected by the proposals. This shows that patients at Barts Health are more likely to be from an ethnic minority, probably reflecting the ethnic mix of the local population.



3.6.6 Travel implications

The National Hospital and the Royal London Hospital are around 4 miles apart. Both are located close to underground stations but neither have parking, apart from disabled bays. For patients travelling from Hackney, Tower Hamlets, Waltham Forest and Newham, which make up 40% of the activity at the Royal London, there will be small increases to journey times; average journey time increases vary from 1 minute (Hackney) to 16 minutes (Waltham Forest). Twenty percent of patients currently being treated at the Royal London Hospital live to the east of the hospital and are likely to be treated at Queen's Hospital in Romford in future. For these patients journey times are likely to be shorter and parking is available.

For other patients that currently travel to the Royal London from further afield journey times will be increased.

3.6.7 Conclusions

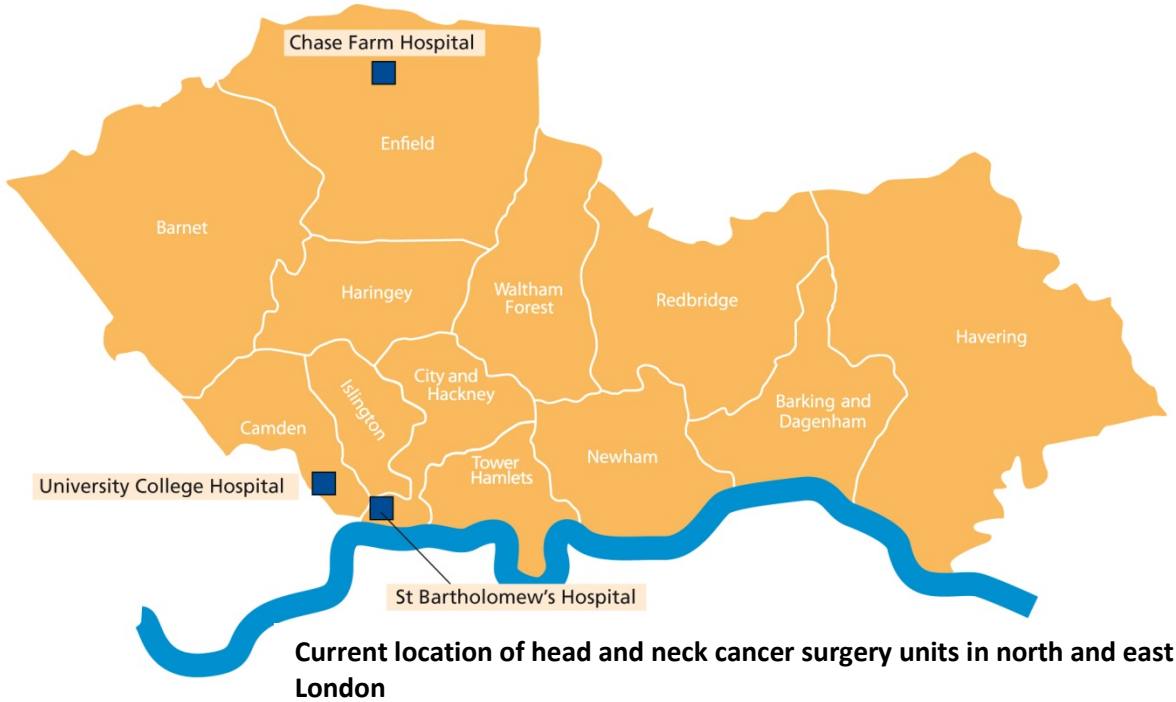
Key points:

- The proposals will result in care for a small number of patients (c 126 per annum) shifting from the Royal London Hospital. Around 75% of these will see their care move to the National Hospital and the balance shifting to Queen's Hospital (Romford).
- The patients affected predominantly come from north east London, although 40% of patients are spread across the rest of London and the South East.
- There is no evidence of any group being disproportionately affected by the proposals.
- The location of the sites is such that there are unlikely to be any significant access implications from the change of site.
- There is a greater proportion of patients from BME groups currently seen at the Royal London Hospital.

3.7 Head and neck cancer

3.7.1 Proposed changes

Specialised head and neck cancer surgery is currently taking place at three centres; Chase Farm Hospital (Barnet & Chase Farm Hospitals Trust), UCLH and the Royal London Hospital (Barts Health Trust).



Current location of head and neck cancer surgery units in north and east London

The proposal is to consolidate services to one site at UCLH. This will allow the national standard to be met of each unit serving at least 100 operations per year. This will allow for a number of improvements to the patient pathway:

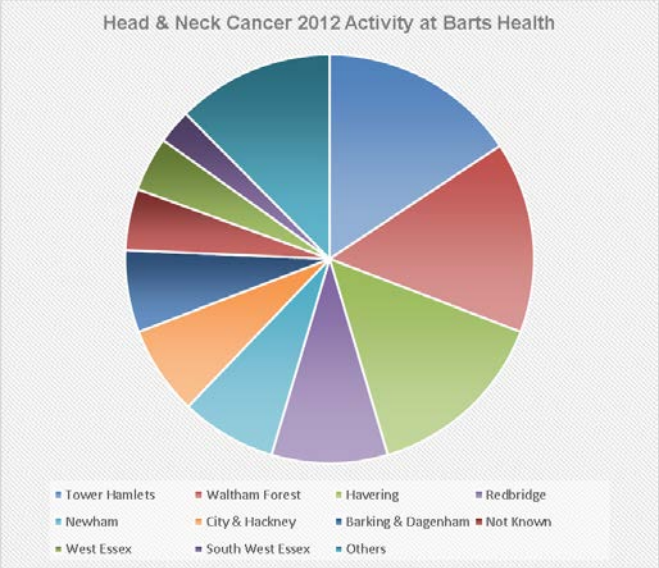
- Sustaining dedicated facilities, 24/7 specialist medical, nursing and therapy support teams

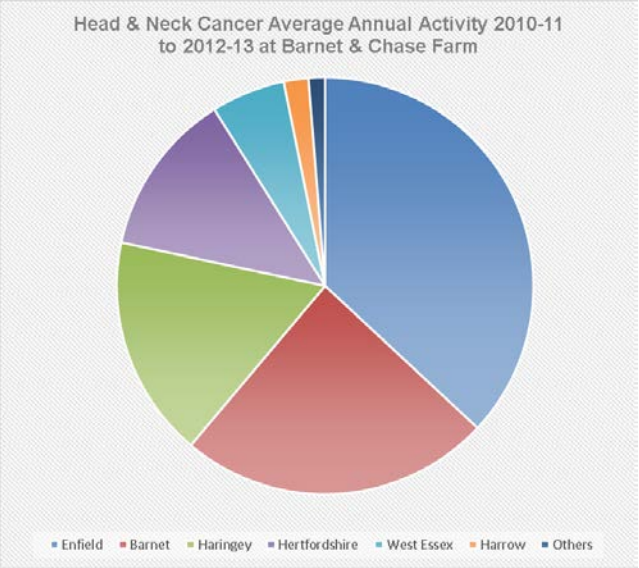
- Faster diagnosis and screening
- Patients offered all suitable treatment options and reconstruction
- Access to cutting-edge radiotherapy
- Local follow-up and enhanced recovery programmes

3.7.2 Patients affected

Patients currently being treated at the Royal London Hospital (Barts Health Trust) and at Barnet & Chase Farm Hospitals will be affected by this change.
Barts Health treat on average 206 patients annually. The majority of these (85%) come from north east London and west Essex. It is anticipated that most of this activity will transfer to UCLH.
Barnet & Chase Farm Hospitals treat 55 patients a year on average with 90% of this coming from the local area. It is anticipated that most of this activity will transfer to UCLH.

Head & Neck Cancer Average Annual Activity 2010-11 to 2012-13 at Barts Health				
Responsible PCT	Spells Barnet & Chase Farm	Spells Barts Health	Total Spells	Proportion
Tower Hamlets	0	41	41	15.6%
Waltham Forest	0	31	31	12.0%
Newham	0	28	28	10.8%
Enfield	20	1	22	8.2%
City & Hackney	0	18	18	7.0%
Havering	0	18	18	6.9%
Redbridge	0	18	18	6.7%
West Essex	3	11	14	5.3%
Barnet	13	0	13	5.1%
Hertfordshire	7	4	11	4.3%
Barking & Dagenham	0	11	11	4.2%
Haringey	10	1	11	4.0%
Not Known	0	5	5	1.9%
South West Essex	0	4	4	1.3%
Others	2	16	17	6.6%
Total	**55**	**206**	**262**	**100.0%**

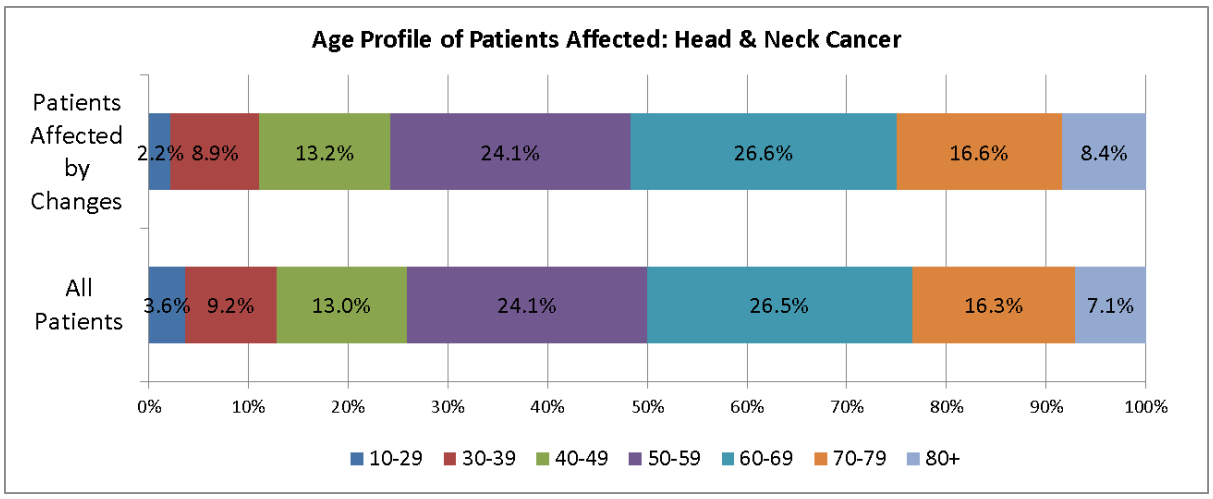


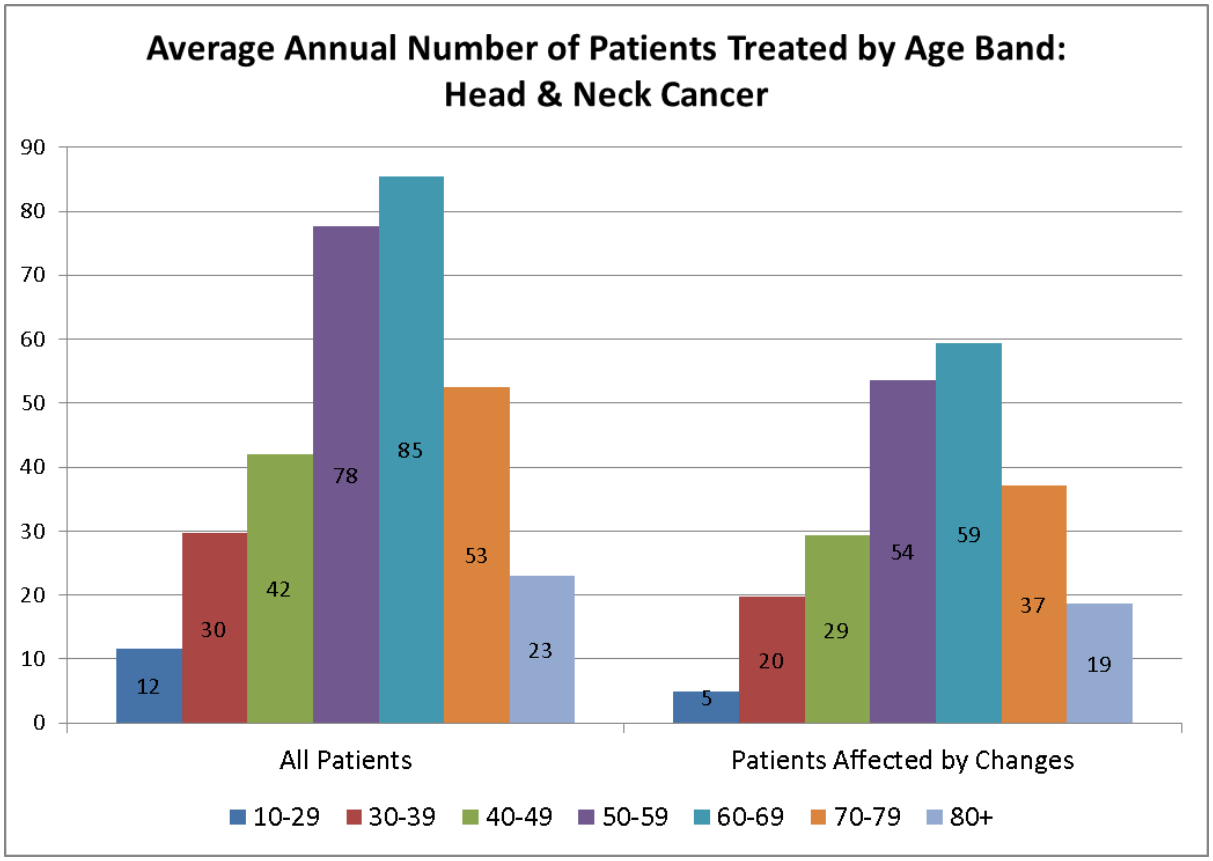


Taking the changes at both providers together, the changes will affect around 70% of all patients in north and east London that undergo specialised head and neck cancer surgery.

3.7.3 Age profile

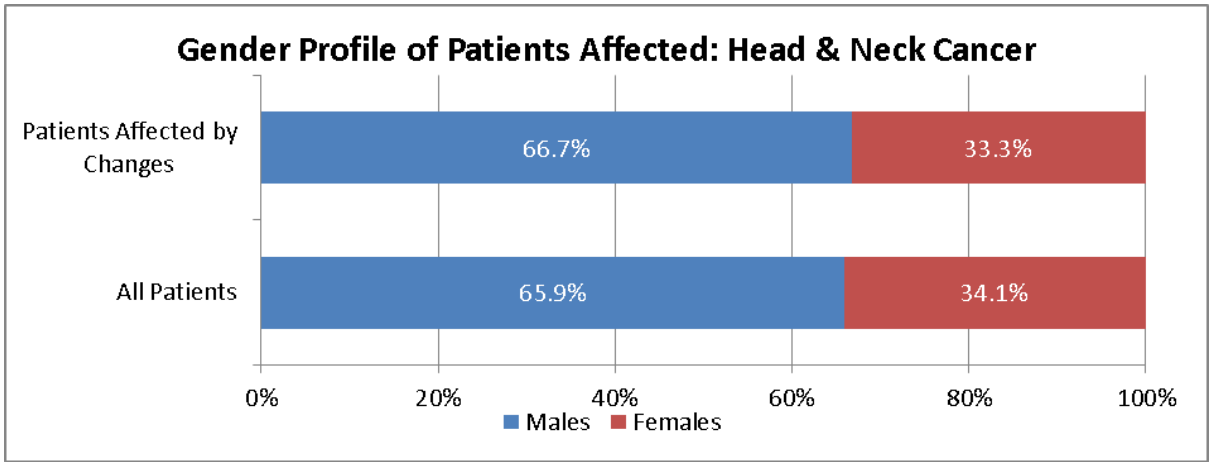
The tables below show that the age profile of the patients affected by the changes is broadly the same as the age profile of all patients in north and east London that undergo specialised head and neck cancer surgery.
Around 60% of patients treated are over 60 years of age.





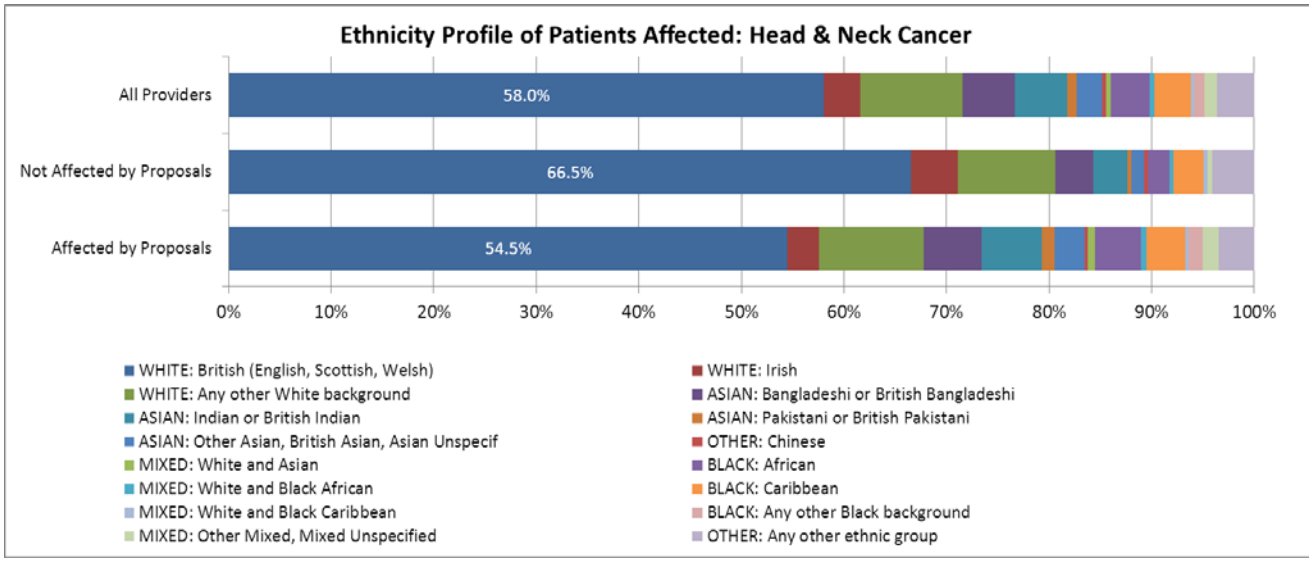
3.7.4 Gender

The table below shows that two thirds of the patients receiving specialised head and neck cancer surgery are men. This proportion is the same in the patients affected by the changes.



3.7.5 Ethnicity

The graph shows that 45% of patients that are affected by the proposed changes are from an ethnic minority. This compares to 32% at UCLH where the service will be consolidated. However the 45% represents 118 patients per year.



3.7.6 Travel implications

UCLH and the Royal London Hospital are around 3 miles apart. Both are located close to underground stations but neither have parking apart from disabled bays. For patients currently receiving care at the Royal London Hospital there will be small increases in travel times. The estimate is that these patients will experience an average increase in public transport journey times of 9 minutes. The impact is greater for patients who are local to the Royal London (Newham and Tower Hamlets) than for those who are already travelling from further afield.

For the patients who currently receive their care at Chase Farm Hospital who will journey to UCLH there is a greater impact on travel. With most of the patients living locally and parking at UCLH limited to disabled bays, travel by private transport will be more difficult and take on average 25 minutes longer. Travel by public transport is less impacted as rail links into central London are good and journey times increase on average do not change.

3.7.7 Conclusions

Key points:

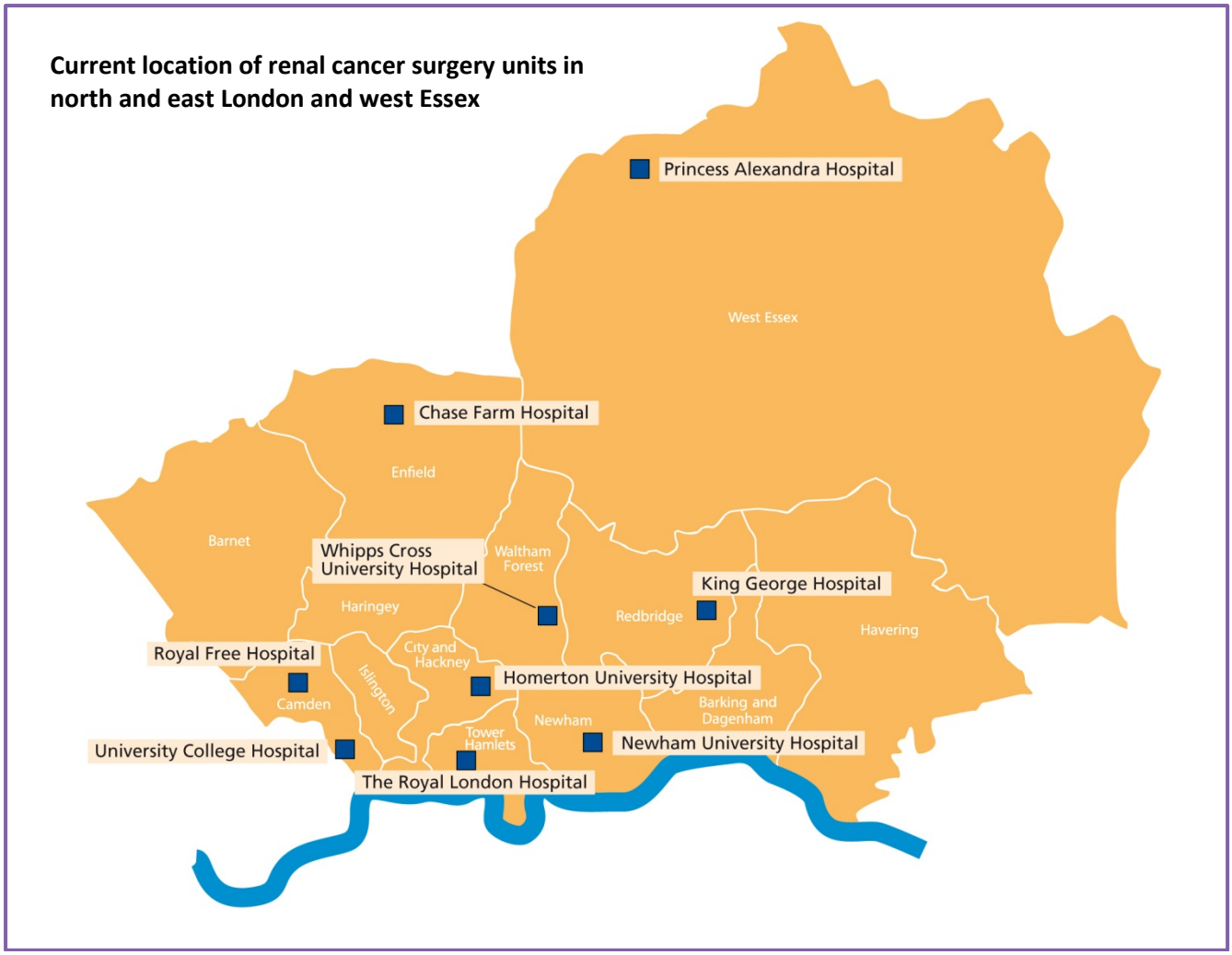
- The proposals will result in the care of a small number of patients (c 260 per annum) shifting to UCLH from the Royal London Hospital (c 205 per annum) and from Chase Farm Hospital (c 55 per annum)
- The patients affected predominantly come from north and east London.
- There is no evidence of any group being disproportionately affected by the proposals.
- For those patients currently being treated at the Royal London Hospital, the location of the sites is such that there are unlikely to be any significant access implications from the change of site. For the smaller number of patients currently travelling from Enfield, Barnet and Hertfordshire to Chase Farm Hospital there will be longer journeys by private transport. This will be tested further in the transport impact report.
- There is a greater proportion of patients from BME groups currently seen at the Royal London Hospital than at UCLH.

3.8 Urological cancer: Renal

3.8.1 Proposed changes

There are currently around 400 new cases of renal cancer in north and east London each year; 300 of which need complex surgery. Renal cancer surgery has not been performed under the management of a Specialised Multi-Disciplinary Team (SMDT) so most acute hospitals with a urological specialty perform removal of cancerous kidneys.

There are nine hospitals in north and east London and west Essex that currently perform renal cancer surgery. The numbers of procedures done at each centre ranges from 10 – 72. Not all units perform partial kidney removal: a more complex procedure. Not all hospitals have access to the latest technologies or have a full range of complementary services on site such as renal medicine or dialysis facilities.



The proposal is to consolidate all services onto one specialist centre at the Royal Free Hospital. The Royal Free has a full range of necessary supporting specialities including:

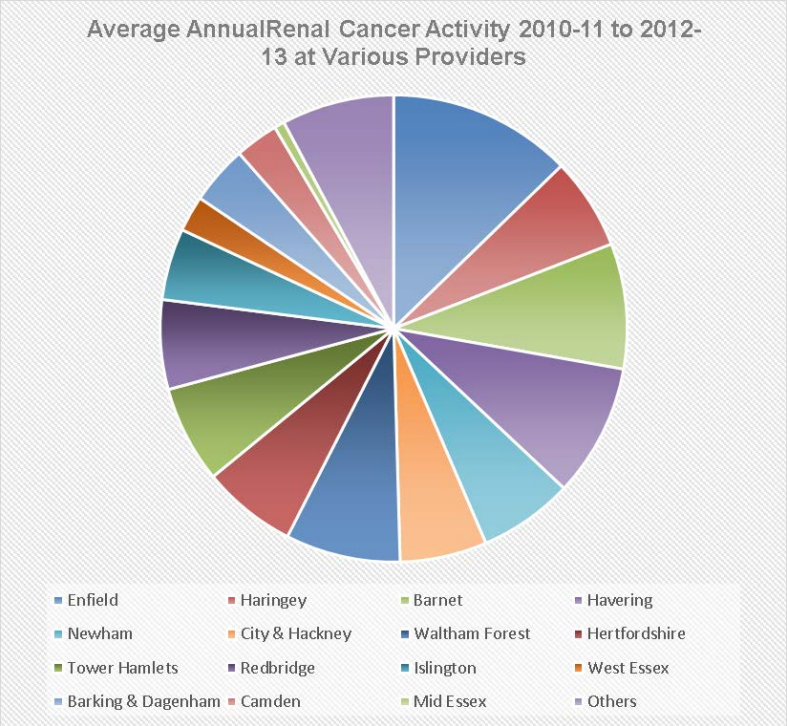
- Vascular surgery
- Liver and pancreatic surgery
- Renal medicine and dialysis
- 24-hour interventional radiology

The Royal Free also has the ability to expand facilities in line with its strategy for renal diseases.

3.8.2 Patients affected

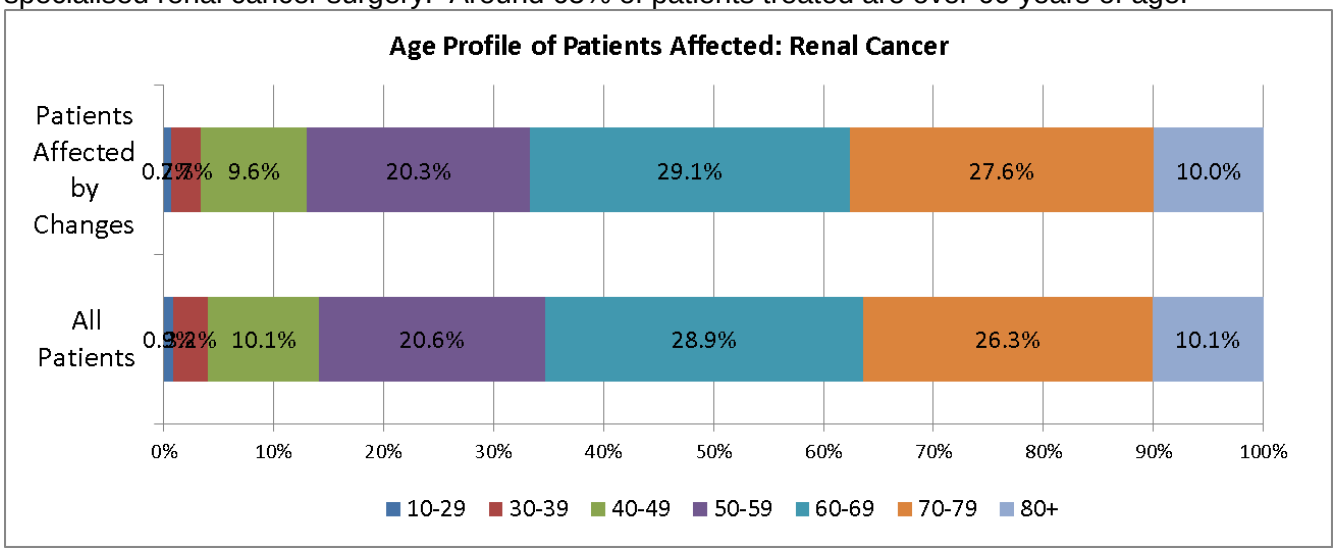
Only patients currently being treated for specialised renal cancer at the Royal Free Hospital are not affected by this change. The table below shows that based on the average number of operations over the last three years, around 200 patients a year will be affected by this change, which is 84% of all patients treated in the sector. These patients are spread across all of the Boroughs in the sector.

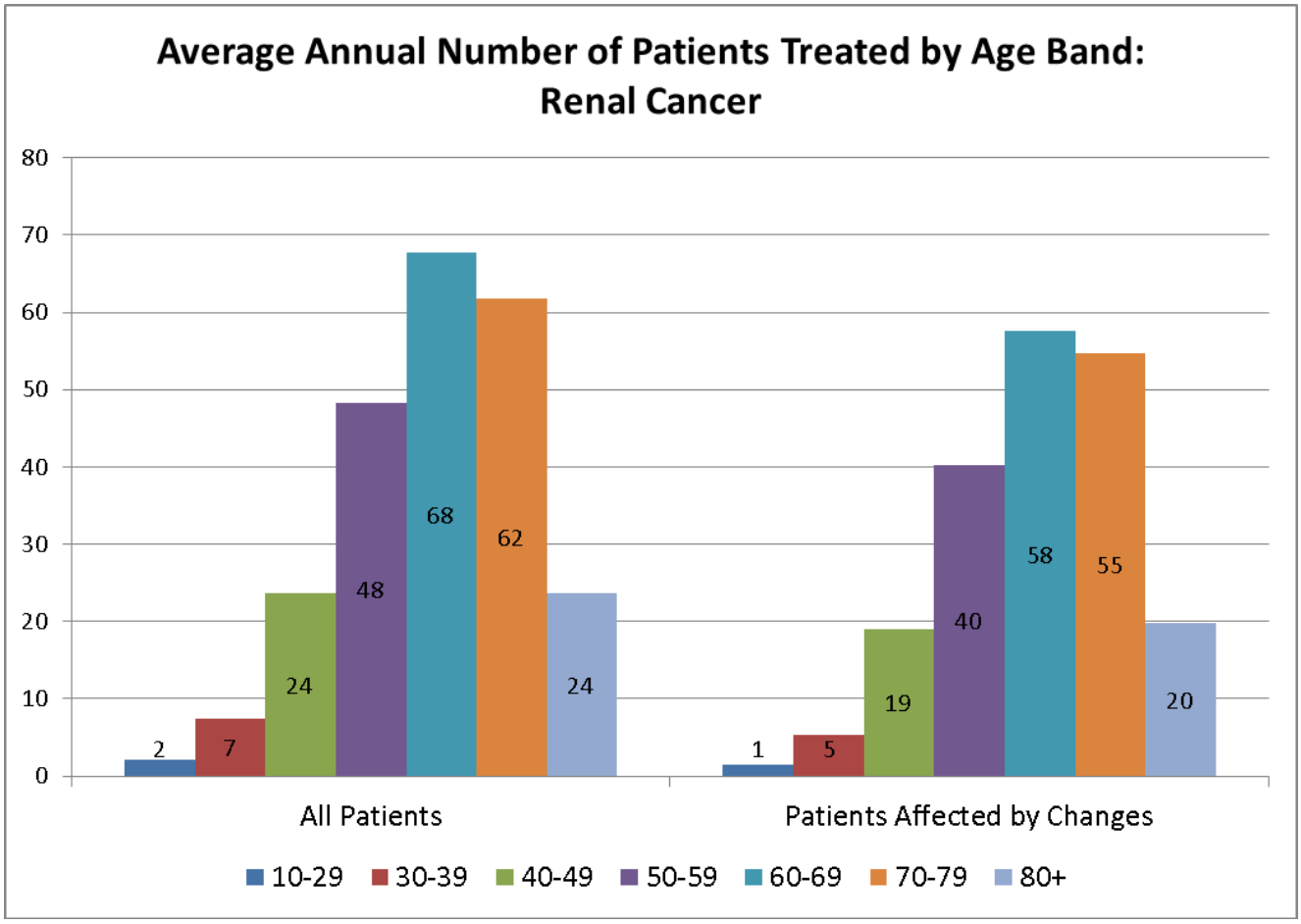
Average AnnualRenal Cancer Activity 2010-11 to 2012-13 at Various Providers		
Responsible PCT	Spells	%
Enfield	25	12.7%
Haringey	13	6.4%
Barnet	17	8.7%
Havering	18	9.2%
Newham	13	6.5%
City & Hackney	12	6.0%
Waltham Forest	16	8.0%
Hertfordshire	13	6.5%
Tower Hamlets	13	6.7%
Redbridge	12	6.2%
Islington	10	5.0%
West Essex	5	2.5%
Barking & Dagenham	8	4.1%
Camden	6	3.0%
Mid Essex	1	0.7%
Others	16	7.8%
Total	**199**	**100.0%**



3.8.3 Age profile

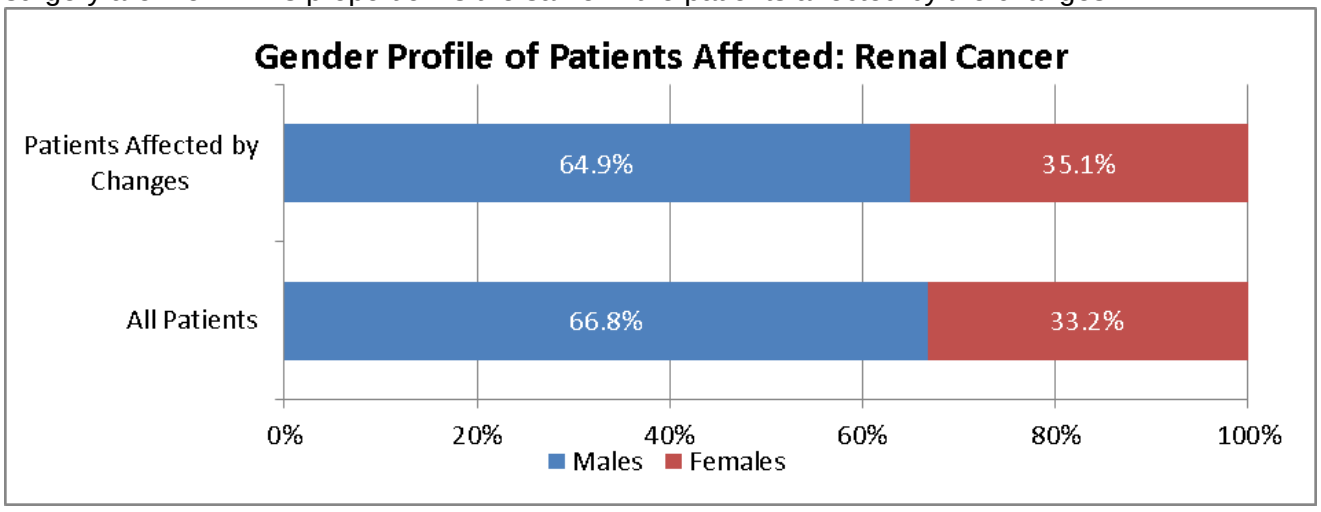
The table below shows that the age profile of the patients affected by the changes is broadly the same as the as the age profile of all patients in north and east London that undergo specialised renal cancer surgery. Around 65% of patients treated are over 60 years of age.





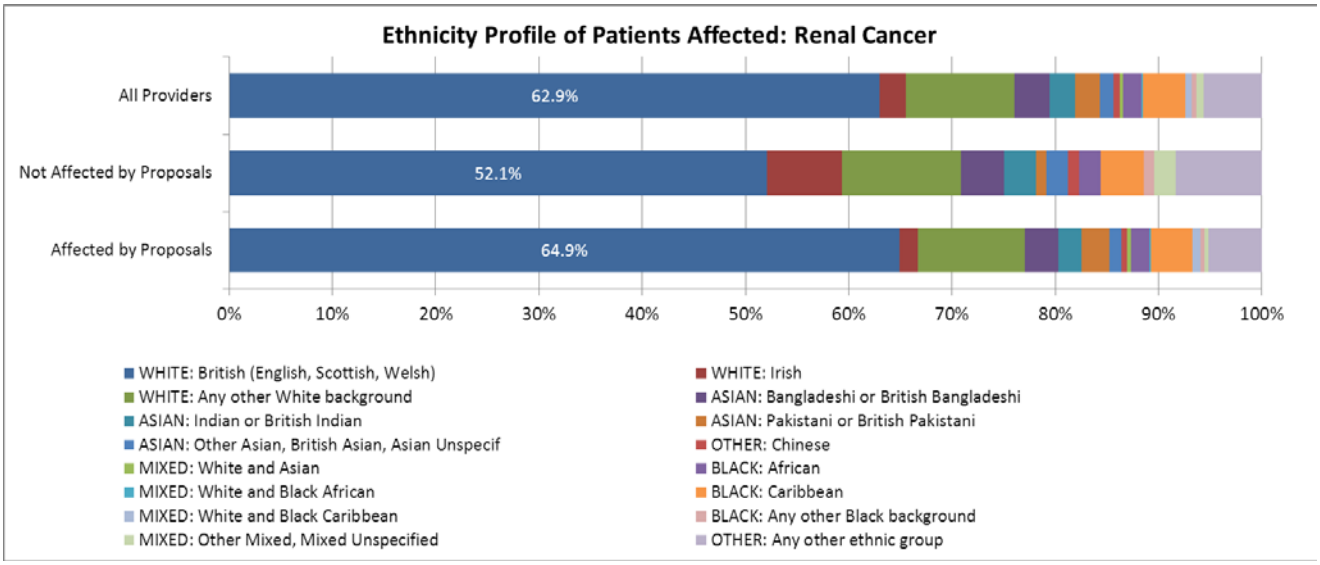
3.8.4 Gender

The table below shows that two thirds of the patients receiving specialised renal cancer surgery are men. This proportion is the same in the patients affected by the changes.



3.8.5 Ethnicity

The graph shows that 35% of patients affected by these changes will come from an ethnic minority. This compares to 48% of patients being treated at the Royal Free Hospital.



3.8.6 Travel implications

Around 200 patients a year that currently would receive surgery at hospitals throughout north and east London will have their care transferred to the Royal Free Hospital. The Royal Free Hospital is located in Hampstead; it is close to underground and overground stations and a number of bus routes. The hospital also has public parking.

The travel impact for patients living in the west of the area is relatively minimal, so for the 50 patients a year that are currently treated at Chase Farm Hospital the average increase in journey time is about 7 minutes. This increases as one moves east; the 30 patients a year travelling from Redbridge, Barking & Dagenham or Havering, that currently use King George Hospital, will see journey times by increase by an average of 30 minutes by public transport and 60 minutes by private transport.

3.8.7 Conclusions

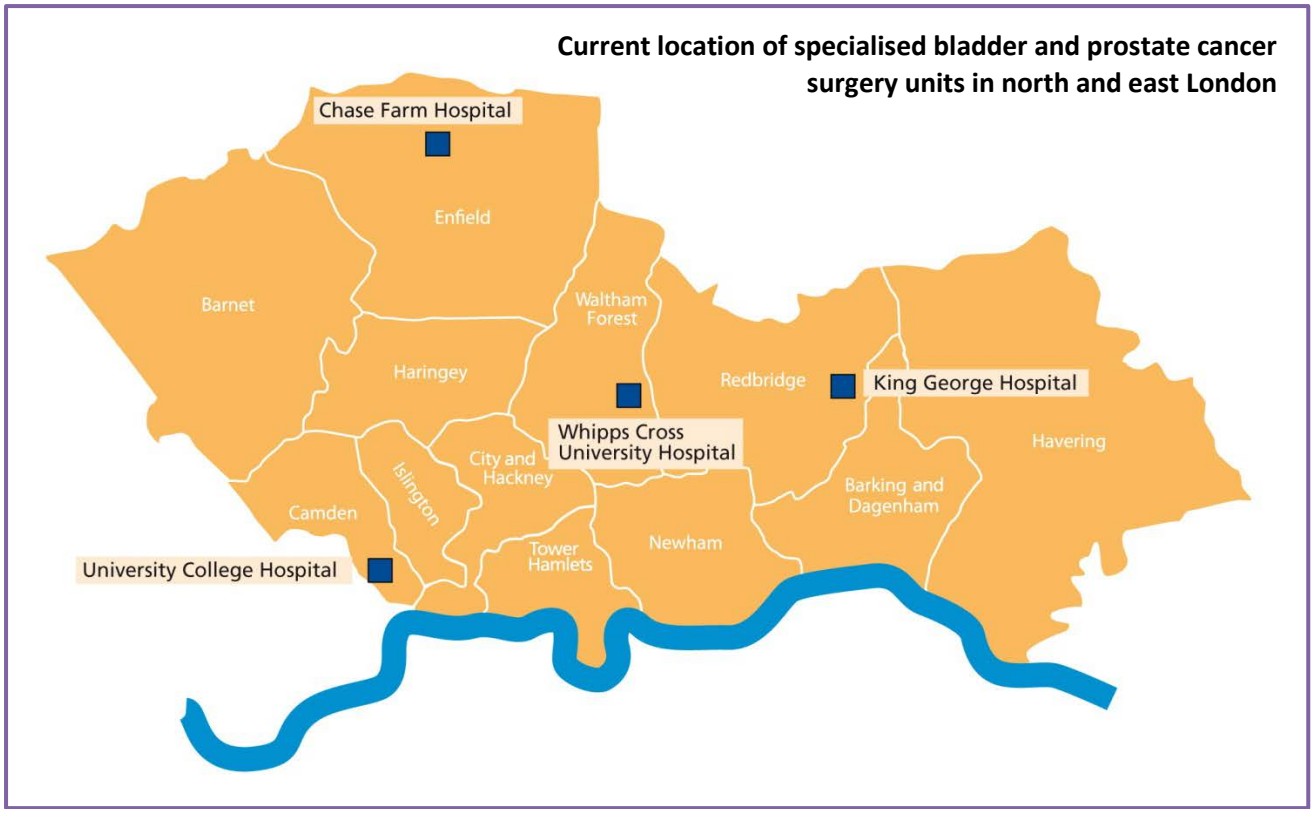
Key points:

- The proposals will result in the care of a small number of patients (c 200 per annum) shifting to the Royal Free Hospital from a number of hospitals across the sector.
- The patients affected predominantly come from north and east London.
- There is no evidence of any group being disproportionately affected by the proposals.
- Some patients from the east of the sector will have their public transport journey times increased by up to 30 minutes, and private transport journey times increased by up to 60 minutes.

3.9 Urological cancer: Specialised bladder and prostate surgery

3.9.1 Proposed changes

There are currently around 100 bladder cancer patients and 220 prostate cancer patients requiring complex surgery a year in north and east London. There are currently four centres in the sector, although the service at Chase Farm Hospital is closed on safety grounds. The centres at Whipps Cross, King George and UCL hospitals each do between them 54-89 complex operations each year. Not all of these centres meet the national standards of performing more than 100 operations each year and serving a population of 1m people.

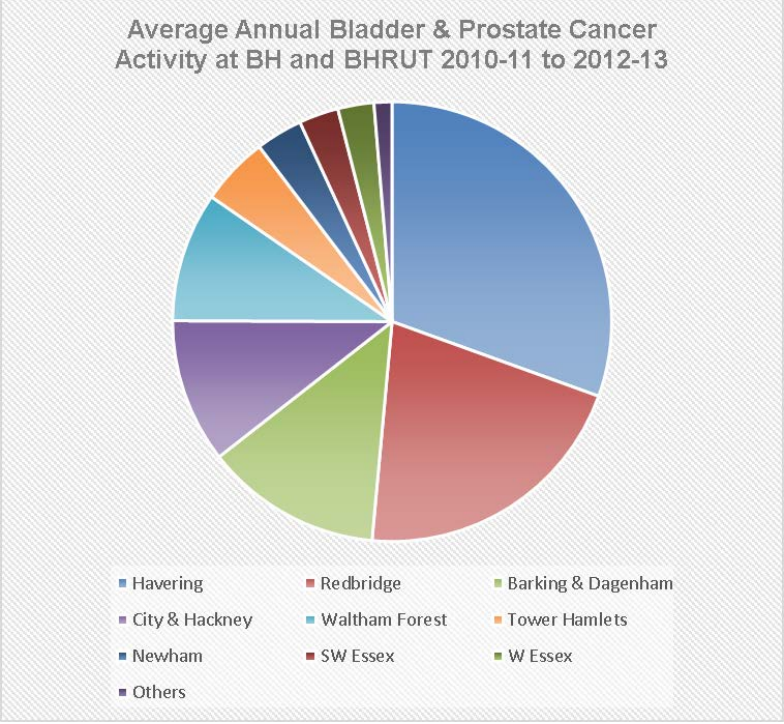


The proposal is to consolidate services at the King George Hospital (Ilford, BHRUT), Whipps Cross Hospitals (Barts Heath Trust) and Chase Farm Hospital (Barnet & Chase Farm Hospitals Trust) to UCLH.

3.9.2 Patients affected

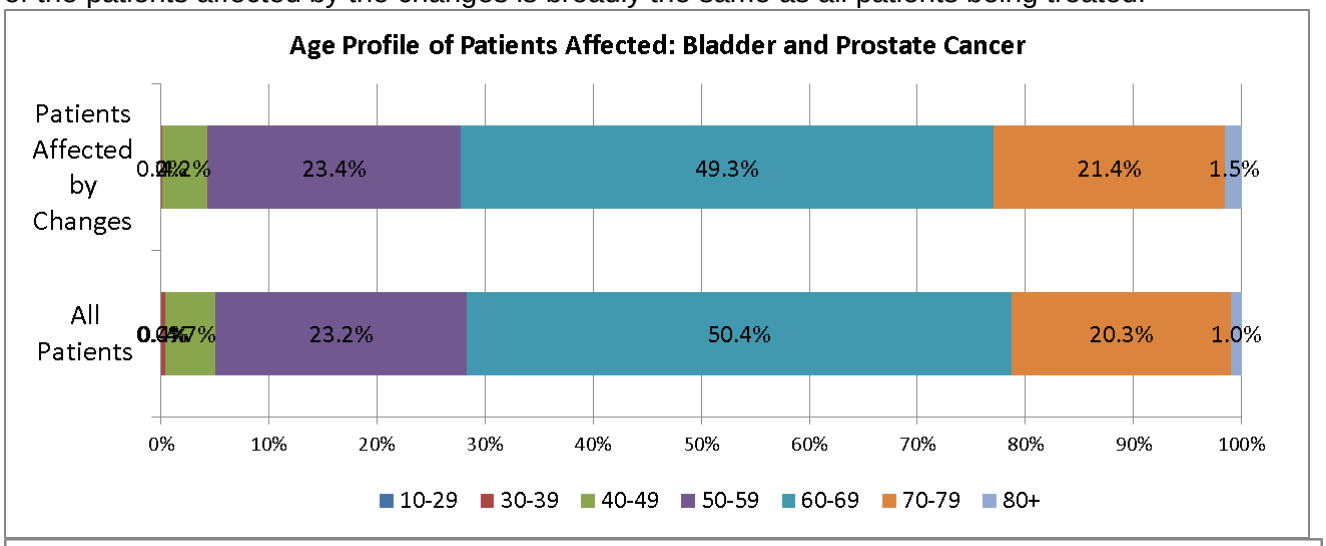
The tables below show that around 133 patients a year will be affected by these proposals. This represents 64% of the patients currently being treated. These patients predominantly live in the Boroughs of north east London particularly Havering and Redbridge. Of the Boroughs that are particularly affected by these changes only Hackney shows high incidence of prostate cancer.
It is anticipated that around 98% of these patients will be treated at UCLH in future.

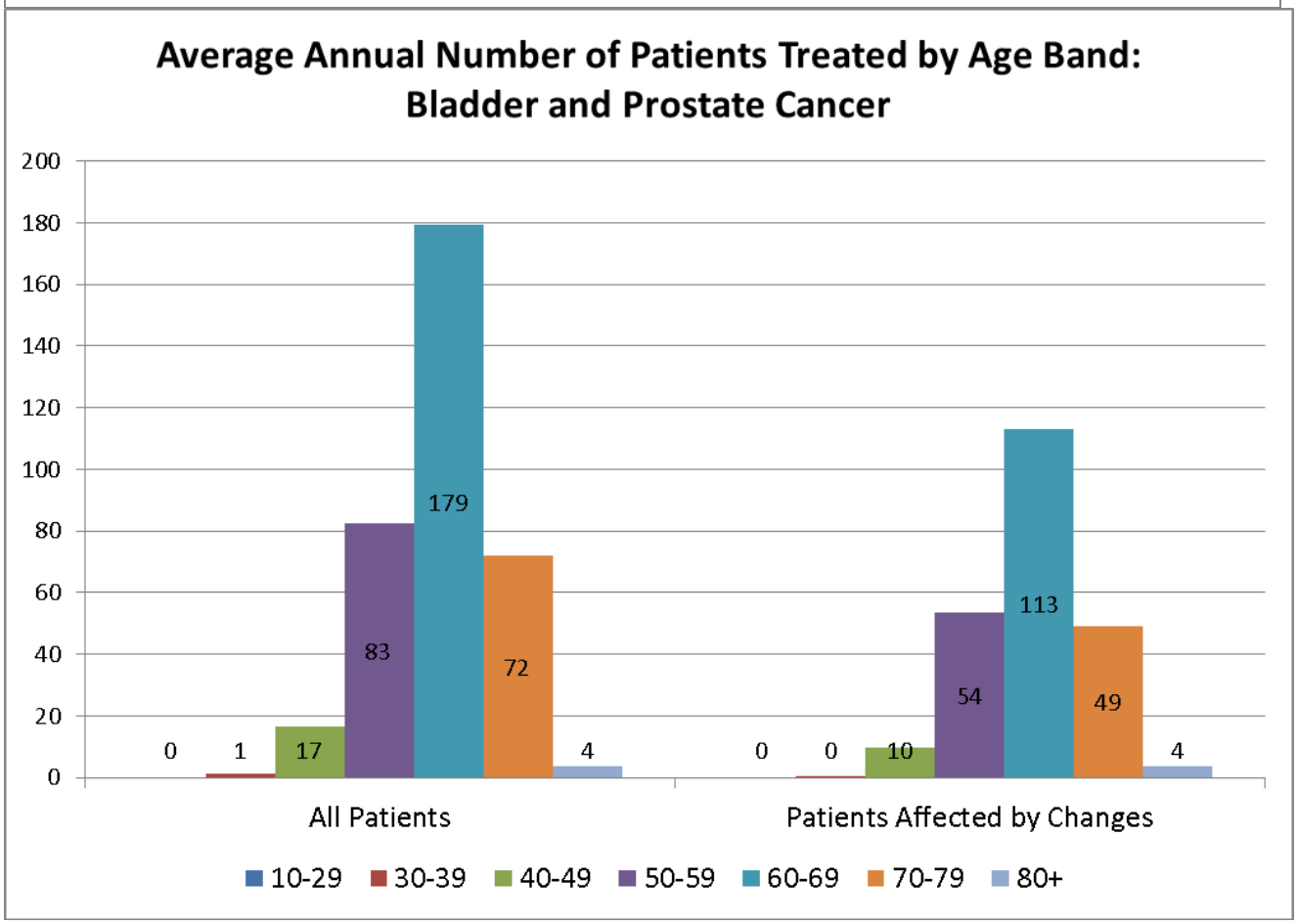
Average Annual Bladder & Prostate Cancer Activity at BH and BHRUT 2010-11 to 2012-13		
Responsible PCT	Spells	%
Havering	41	30.5%
Redbridge	28	21.0%
Barking & Dagenham	17	13.0%
City & Hackney	14	10.6%
Waltham Forest	13	9.5%
Tower Hamlets	7	5.0%
Newham	5	3.4%
SW Essex	4	2.9%
W Essex	4	2.7%
Others	2	1.3%
Total	**133**	**100.0%**



3.9.3 Age profile

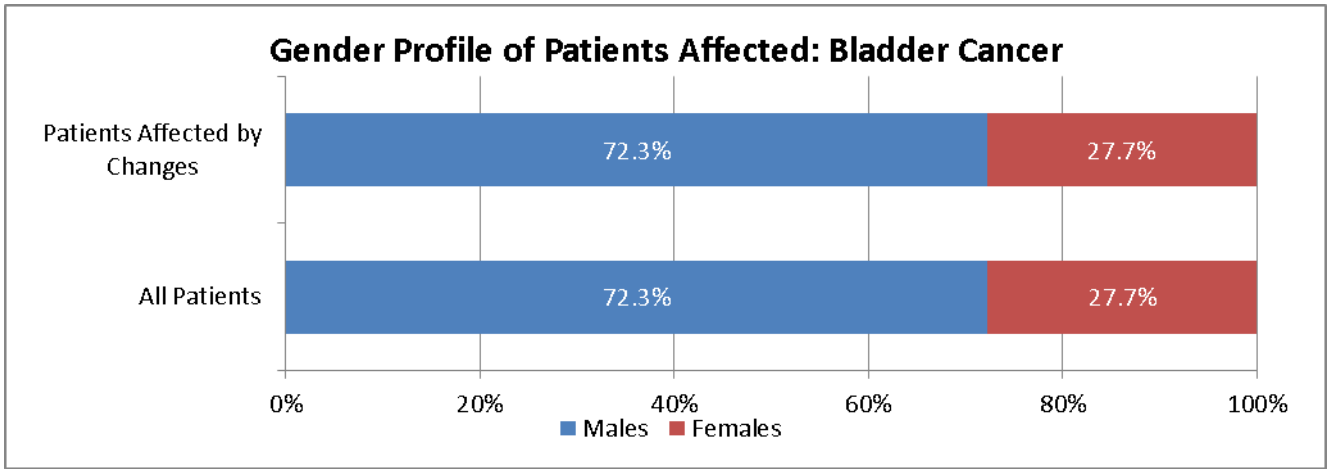
The table shows that 95% of patients receiving specialist surgery for prostate or bladder cancer are in the age band of 50 to 80; 50% are aged between 60 and 70. The age profile of the patients affected by the changes is broadly the same as all patients being treated.





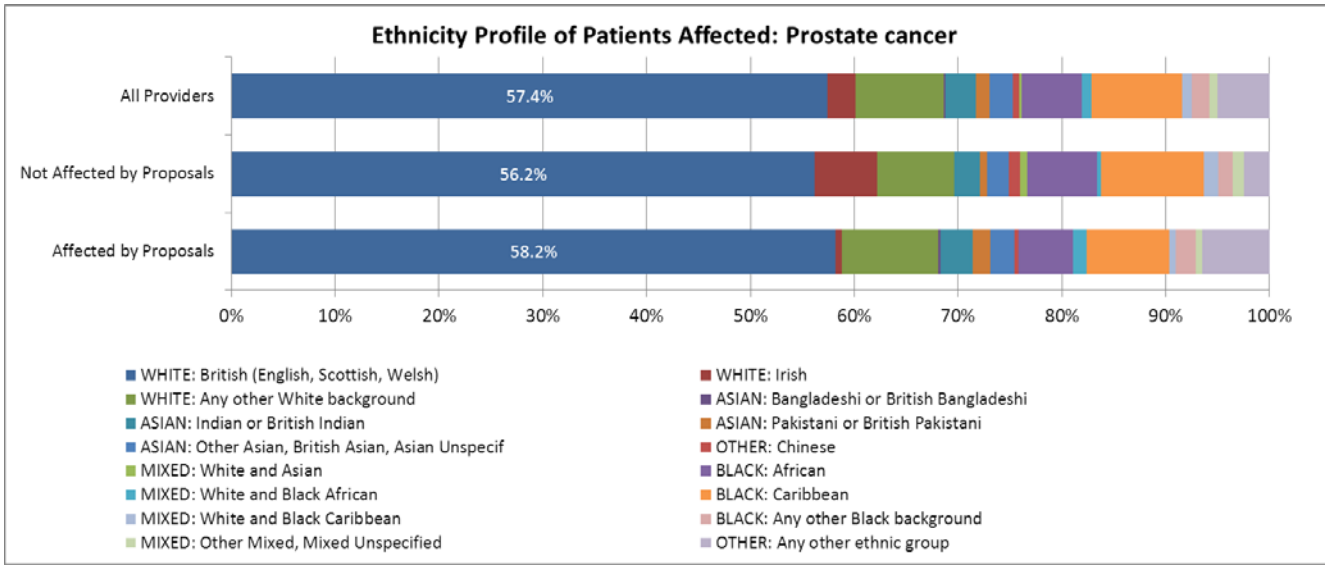
3.9.4 Gender

Prostate cancer affects only men. Additionally 72% of patients receiving specialist surgery for bladder cancer are men. The table shows that the gender profile is the same for all patients and the group affected by the proposals.



3.9.5 Ethnicity

The table below shows the ethnic mix of patients receiving specialised prostate cancer treatment. It shows no material difference between the group affect by the proposals and those not affected.



3.9.6 Travel implications

Around 90 patients that currently receive surgery at King George Hospital will have their care transferred to UCLH. Most of these patients live in Havering, Barking & Dagenham or Redbridge and these patients will have average increased journey times of 17 minutes by public transport or 60 minutes by private transport. The patients travelling from Havering will have the greatest increase in journey times.
A smaller number of patients (around 45 per annum) currently receive surgery at Whipps Cross Hospital and their care will transfer to UCLH. These patients mostly live in Waltham Forest and City & Hackney and these patients have only small increases to journey times. The average journey time increase for these patients is 4 minutes by public transport and 20 minutes by private transport.

3.9.7 Conclusions

Key points:

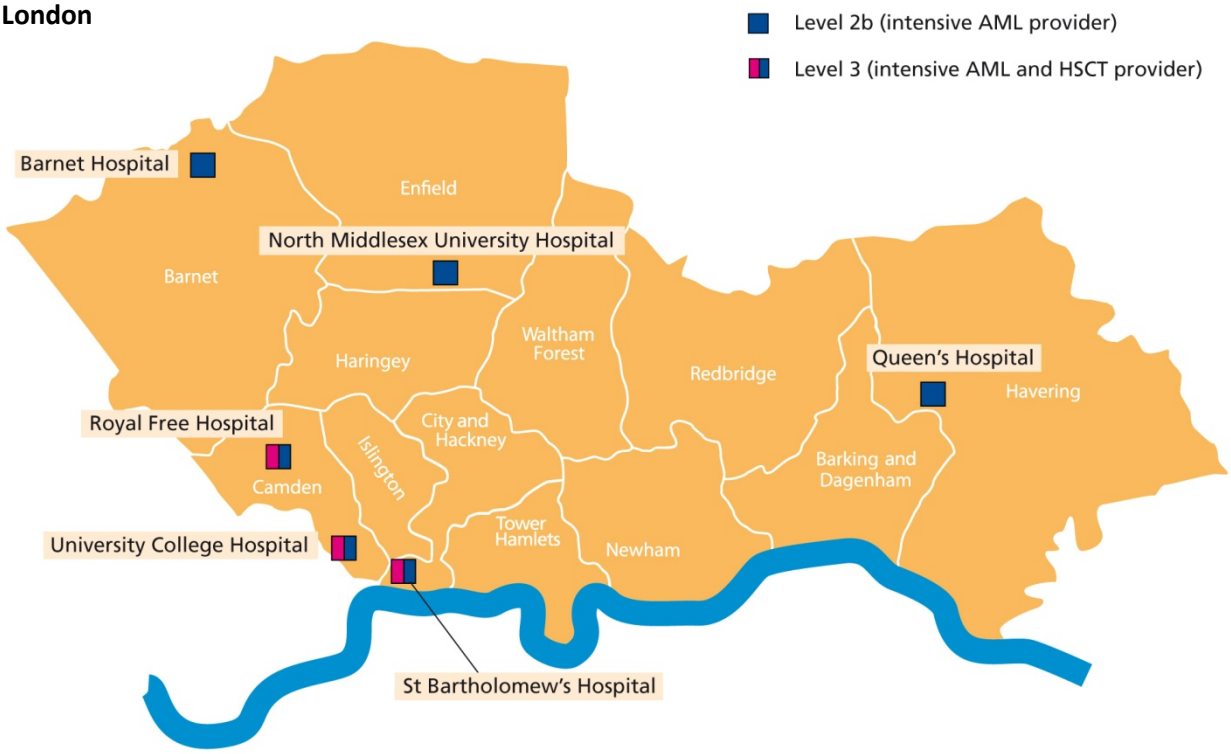
- The proposals will result in the care of a small number of patients (c 130 per annum) shifting to the UCLH from Whipps Cross and King George Hospitals.
- The patients affected predominantly come from east London (Havering, Redbridge, Barking & Dagenham and City& Hackney).
- There is no evidence of any group being disproportionately affected by the proposals.
- Some patients from the east of the sector will have their public sector journey times increased by an average of 17 minutes (public transport) or 60 minutes (private transport).

3.10 Haematopoietic stem cell transplantation

3.10.1 Proposed changes

Currently north and east London has three centres; the Royal Free Hospital, UCLH and Barts Health, each treating between 50 and 130 new patients each year with stem cell transplants. The recommended standard is that a centre should do 100 transplants each year.

Current location of units providing specialised services for patients with Acute Myeloid Leukaemia in north and east London

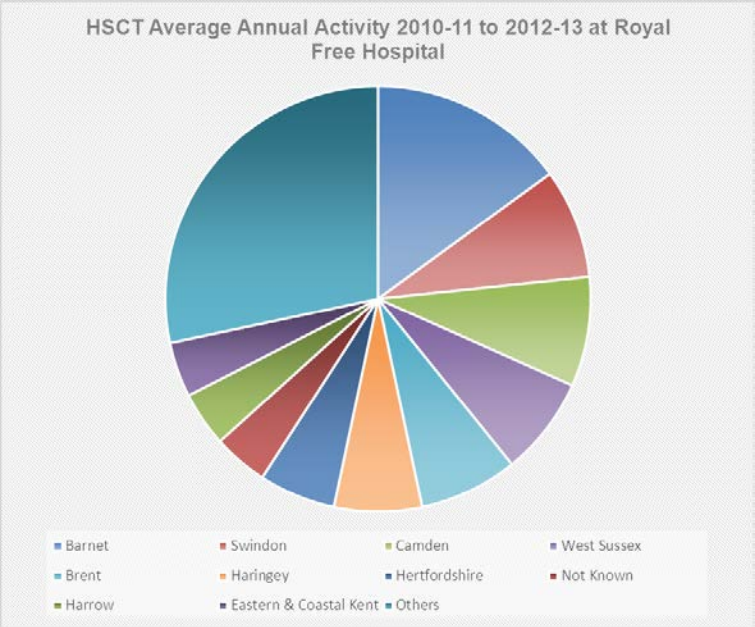


The proposal is to decommission the service at the Royal Free Hospital with activity shifting to the other two units.

3.10.2 Patients affected[3]

The tables below show that the Royal Free Hospital attracts patients from a wide geographical area: the 120 patients treated over the last three years came from 30 different PCT areas from as wide afield as Dorset, Cheshire and Kent.

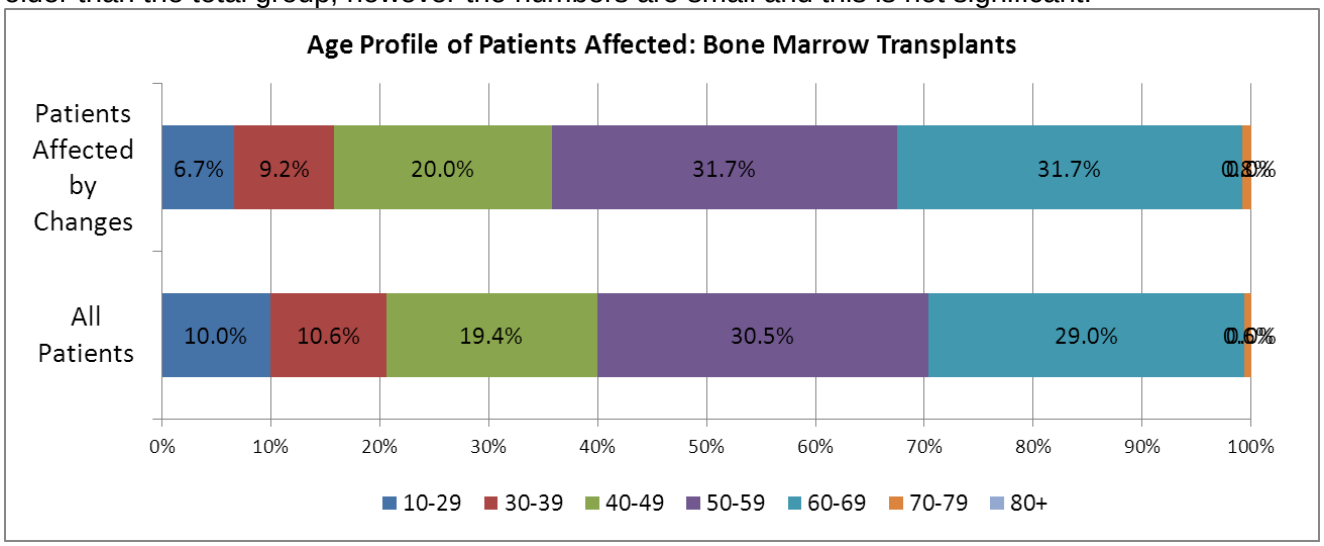
HSCT Average Annual Activity 2010-11 to 2012-13 at Royal Free Hospital		
Responsible PCT	Patients	%
Barnet	6	14.6%
Swindon	4	8.7%
Camden	4	8.7%
West Sussex	3	7.4%
Brent	3	7.8%
Haringey	2	5.6%
Hertfordshire	2	5.5%
Not Known	2	4.3%
Harrow	2	4.3%
Eastern & Coastal Kent	2	4.3%
Others	12	28.7%
Total	**41**	**100.0%**



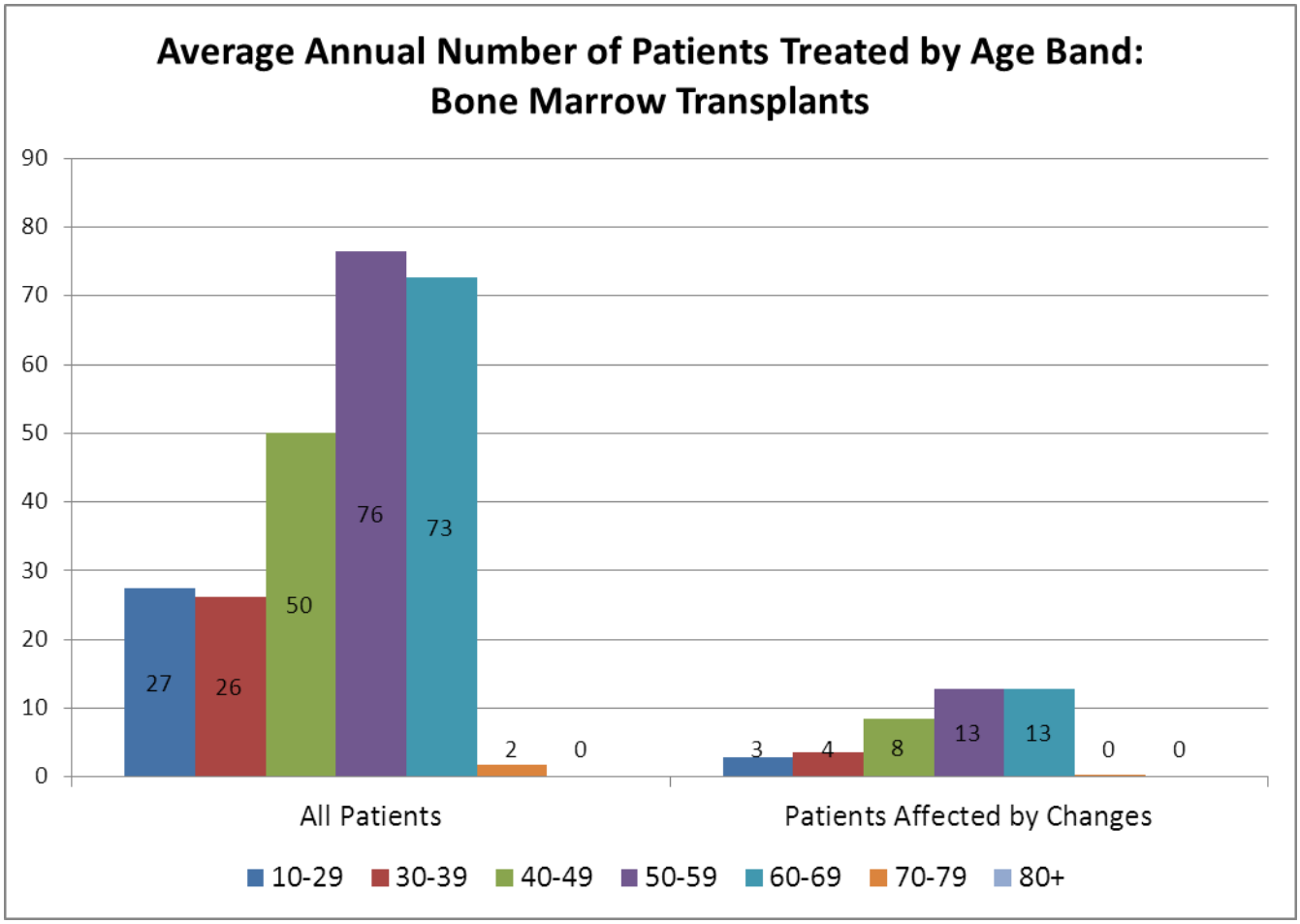
The average of 41 patients a year represents 16% of the patients treated in the three north and east London centres. Current estimates are that 64% of this activity would transfer to UCLH and 24% to Barts Health.

3.10.3 Age profile

The age profile shows that 80% to 85% of the patients treated for HSCT are aged between 40 and 70. The table shows that the age profile of patients at the Royal Free is marginally older than the total group, however the numbers are small and this is not significant.

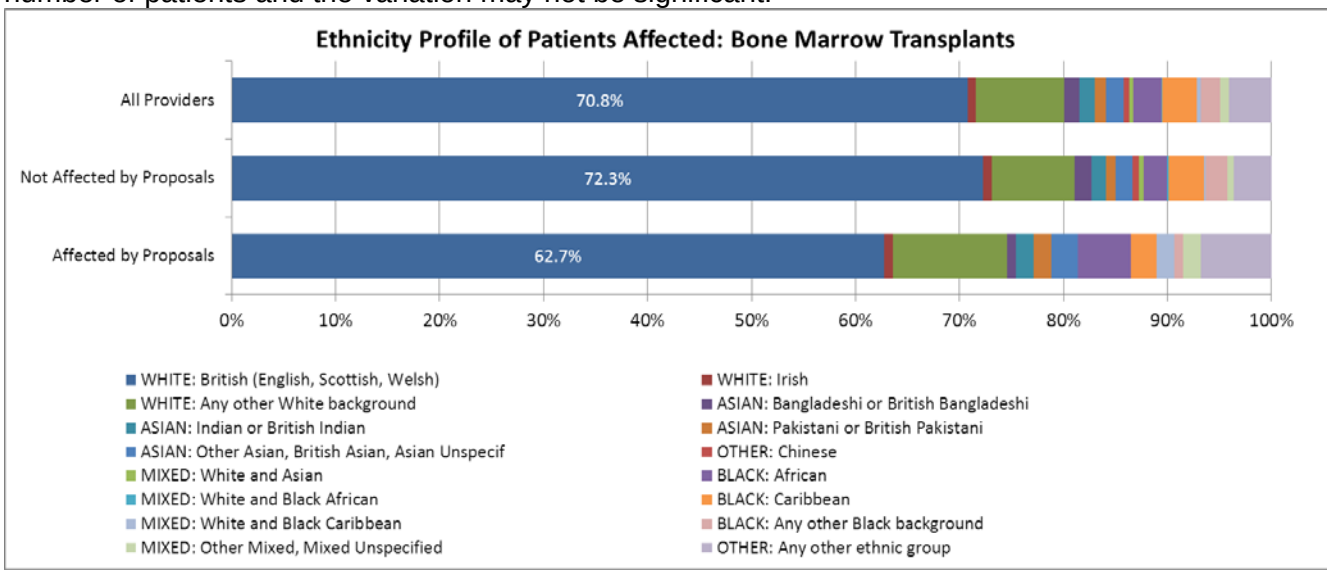


[3] Data used is the number of new *patients* treated in a year. Elsewhere *spells* have been used as the units of data, however treatment for blood cancers can often involve several spells in hospital for each patient.



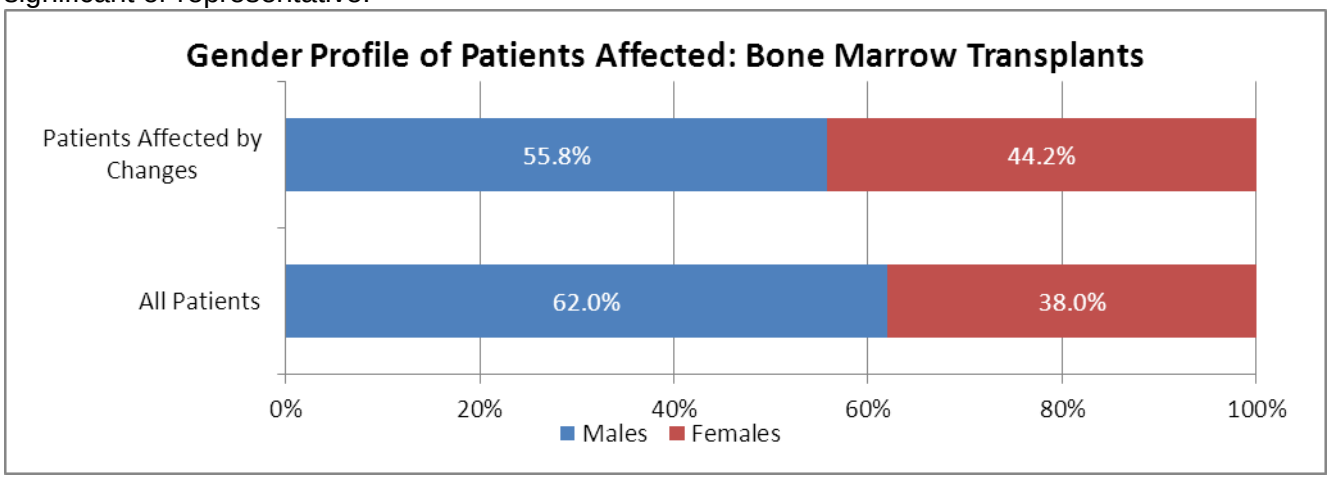
3.10.4 Ethnicity

The graph shows that 33% of patients affected by the proposals are from a minority ethnic group, which compares to 29% for patients as a whole. However this represents a small number of patients and the variation may not be significant.



3.10.5 Gender

The table shows that 62% of patients treated for HSCT are men. The proportion is slightly lower for the Royal Free Hospital although the total number is small so this may not be significant or representative.



3.10.6 Travel implications

Around 40 patients a year that currently have their treatment at the Royal Free Hospital will transfer to either UCLH or St Bartholomew's Hospital. These patients come from Boroughs all over London and the Home Counties so it is difficult to predict what the impact on travel times will be. However UCLH and St Bartholomew's are both well located in central London and accessible by public transport from all of London. The travel impact will be minimal for most patients.

3.10.7 Conclusions

Key points:

- The proposals will result in the care of a small number of patients (c 40 per annum) shifting from the Royal Free Hospital to either UCLH or St Bartholomew's Hospital.
- Based on the activity of the last three years the patients affected come from across London and the Home Counties
- There is no evidence of any group being disproportionately affected by the proposals.
- There will be only minimal impact on journey times.

3.11 Acute myeloid leukaemia (level 2b)

3.11.1 Proposed changes

There are currently six level 2b acute myeloid leukaemia centres providing intensive treatment (see map in section 5.6.1). The six units are:

- Queens Hospital (BHRUT)
- North Middlesex Hospital
- Barnet Hospital (Barnet & Chase Farm)
- St Bartholomew's Hospital (Barts Health)
- The Royal Free Hospital
- UCLH

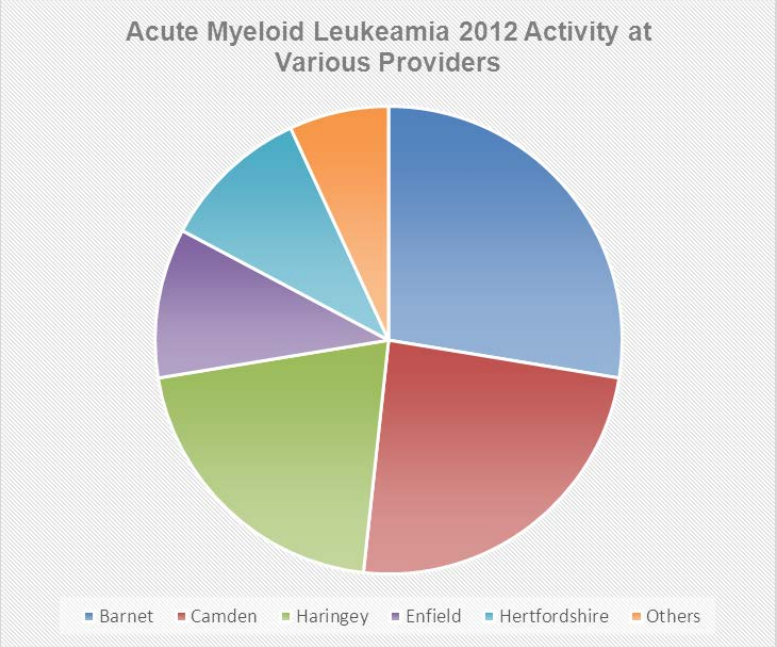
The numbers of new patients a year treated at each centre varies from 1 a year (NMH) to 50 a year at Barts Health. The recommended standard is that each unit should be treating

10 new patients a year. The proposal is that the units at North Middlesex, Barnet and the Royal Free Hospitals should be decommissioned.

3.11.2 Patients affected[4]

Taken together, the three units to be decommissioned treat 20 new patients a year. Most of these patients come from five areas and are local to the units affected. The 20 patients a year represent 19% of the patients treated in units in north and east London. Current estimates are that most of the activity would transfer to UCLH with 2 patients a year going to Barts Health or another provider.

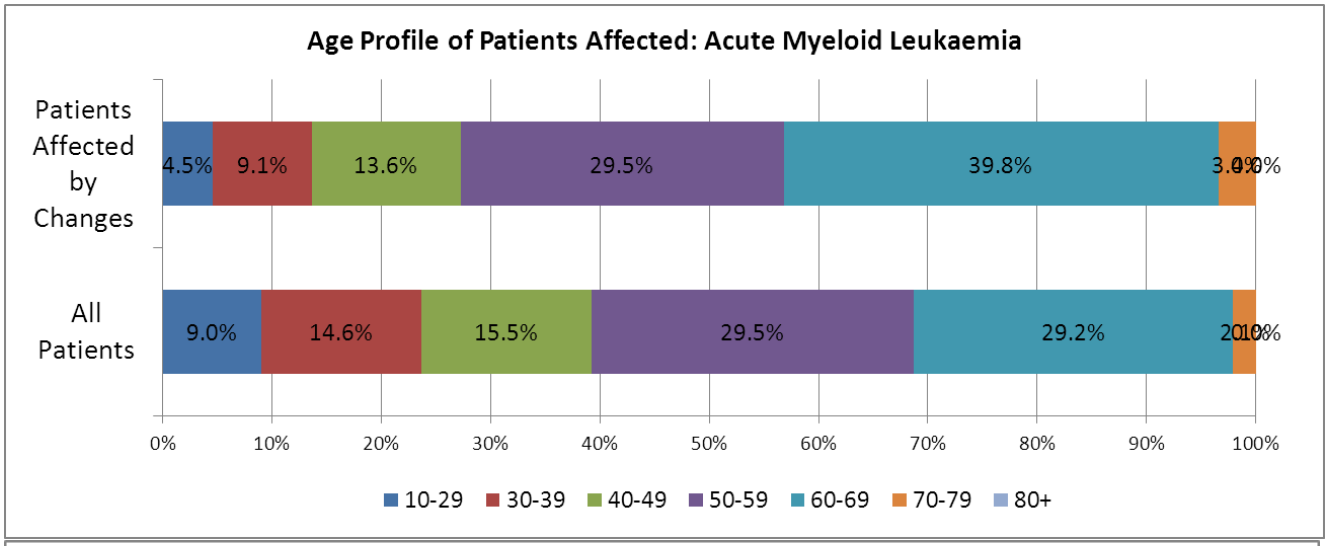
Acute Myeloid Leukeamia Average Annual Activity 2010-11 to 2012-13 at Various Providers		
Responsible PCT	Patients	%
Barnet	5	27.2%
Enfield	3	16.1%
Camden	3	16.1%
Hertfordshire	2	11.9%
Haringey	3	13.4%
Others	3	15.2%
Total	**20**	**100.0%**

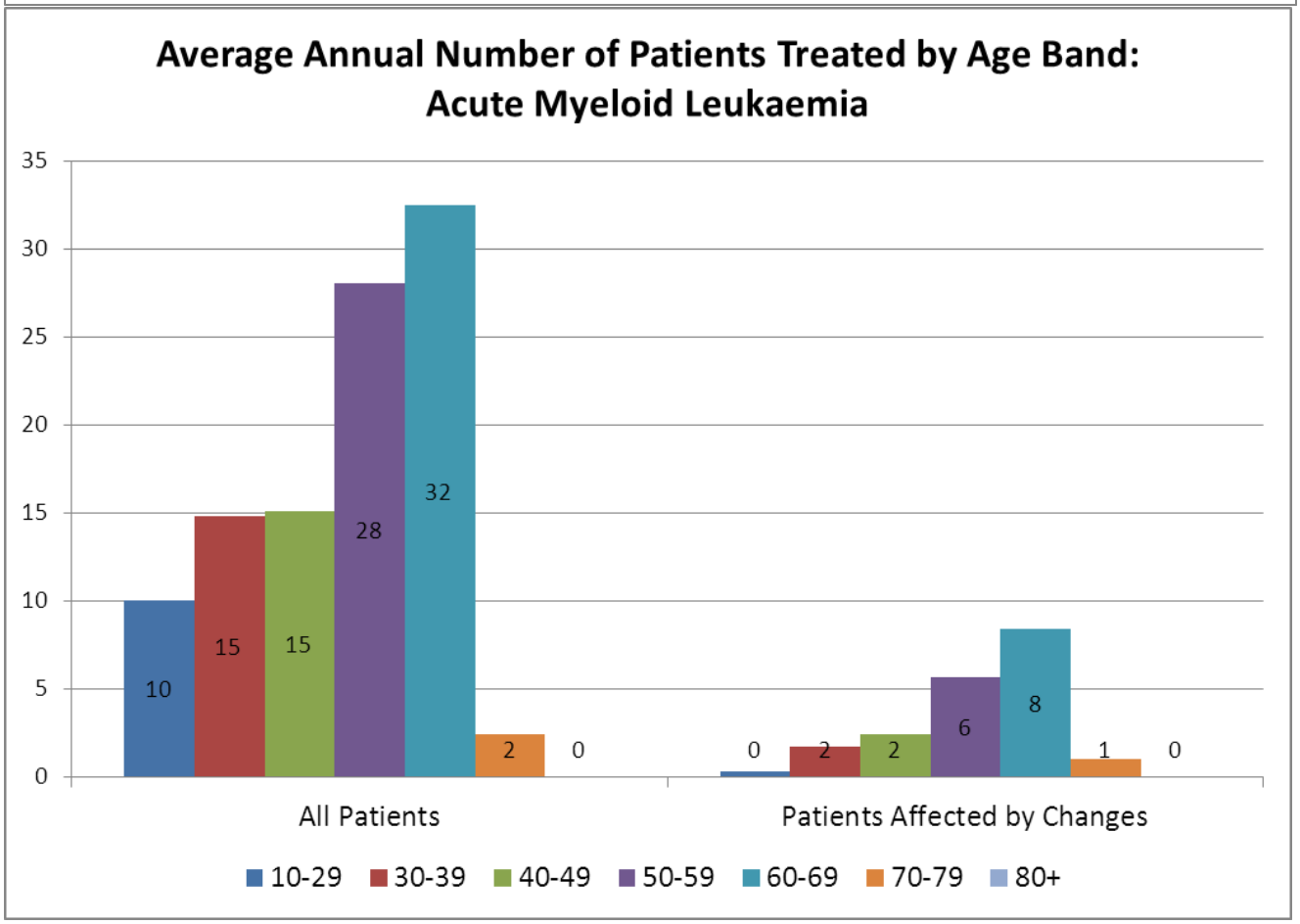


3.11.3 Age profile

The table below shows that across all units the age profile shows that around 60% of patients treated intensively for AML are aged 50 to 70. The profile for the group of patients affected by the proposals would indicate that there are slightly more patients in the 60 to 70 band. However the numbers are small and this is not a significant variation and may not be representative.

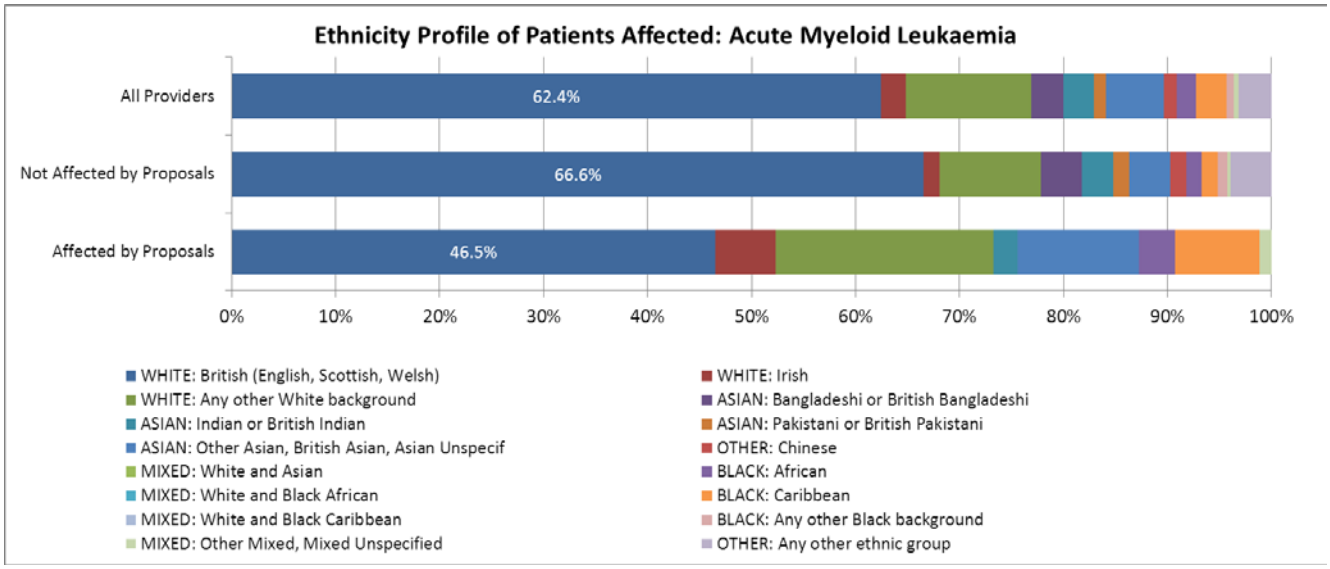
[4] Data used is the number of new *patients* treated in a year. Elsewhere *spells* have been used as the units of data, however treatment for blood cancers can often involve several spells in hospital for each patient.





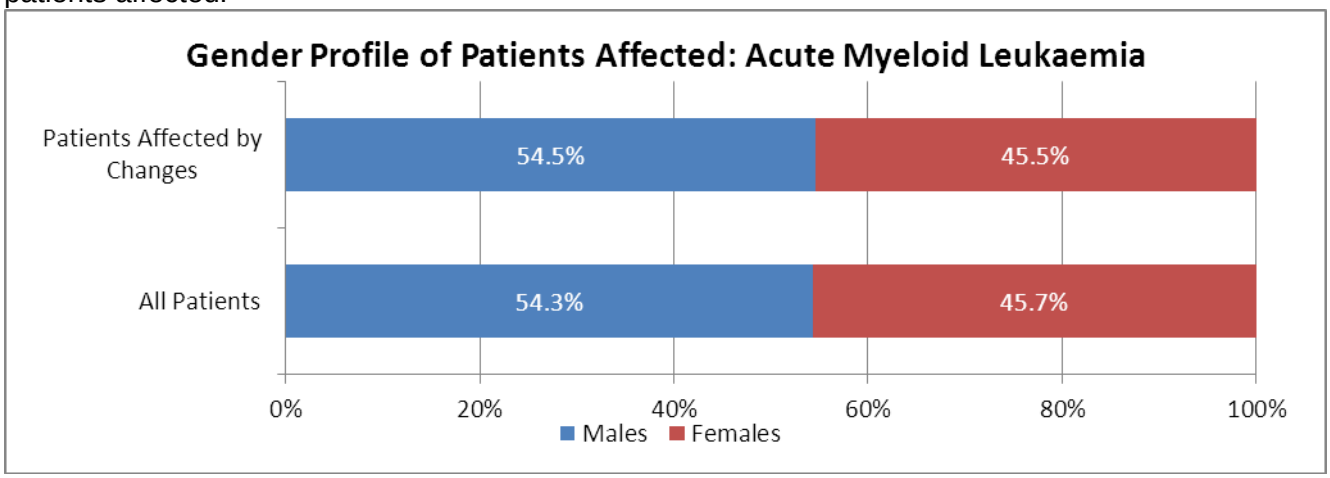
3.11.4 Ethnicity

The graph shows that 54% of patients affected by the proposals are from an ethnic minority group compared to 33% for the group not affected. However the numbers involved are very small and this may not be statistically significant.



3.11.5 Gender

The table below shows that 55% of patients treated are men. The profile is the same for the patients affected.



3.11.6 Travel implications

The proposals affect around 20 patients a year who live in the north of the sector. Care for these patients will transfer to ULCH or St Bartholomew's Hospital. The impact on journey times will be small with many journeys not increasing at all and the average public transport journey time increasing by less than 10 minutes. However with such a small number of patients it is difficult to be accurate in this assessment.

3.11.7 Conclusions

Key Points:

- The proposals will result in the care of a small number of patients (c 20 per annum) transferring to either UCLH or St Bartholomew's Hospital.
- Based on the activity of the last three years the patients affected come from north London and Hertfordshire
- There is no evidence of any group being disproportionately affected by the proposals.
- There will be only minimal impact on journey times.

3.12 Oesophago-gastric cancer

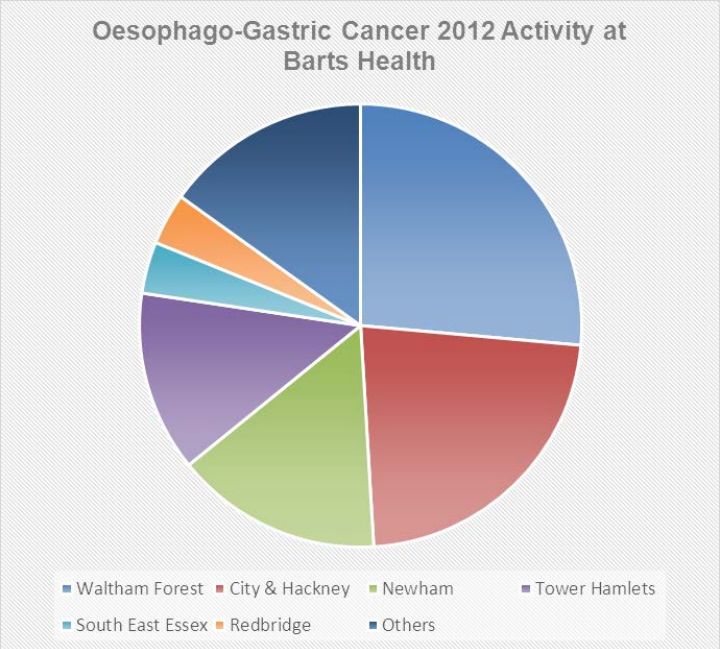
3.12.1 Proposed changes

Around 25% of patients with oesophago-gastric cancer will require specialist surgery. Currently there are three centres in north and east London offering this type of surgery, Queen's Hospital (BHRUT), UCLH and the Royal London (Barts Heath). On average, in the last three years there were around 130 patients a year requiring this surgery at the three units, with each unit treating 35 to 55 patients each year. The recommended standard is that each unit should be performing at least 60 operations a year. The proposal is that in the medium term there should be two centres and the service operated by Barts Health should be decommissioned.

3.12.2 Patients affected

The unit at St Bartholomew's Hospital treated 53 patients in 2012[5]. 75% of these patients came from the four PCTs local to the Royal London. These 53 patients represent 39% of the patients treated at the three units.

Oesophago-Gastric Cancer 2012 Activity at Barts Health		
Responsible PCT	Spells	%
Waltham Forest	14	26.4%
City & Hackney	12	22.6%
Newham	8	15.1%
Tower Hamlets	7	13.2%
South East Essex	2	3.8%
Redbridge	2	3.8%
Others	8	15.1%
Total	**53**	**100.0%**

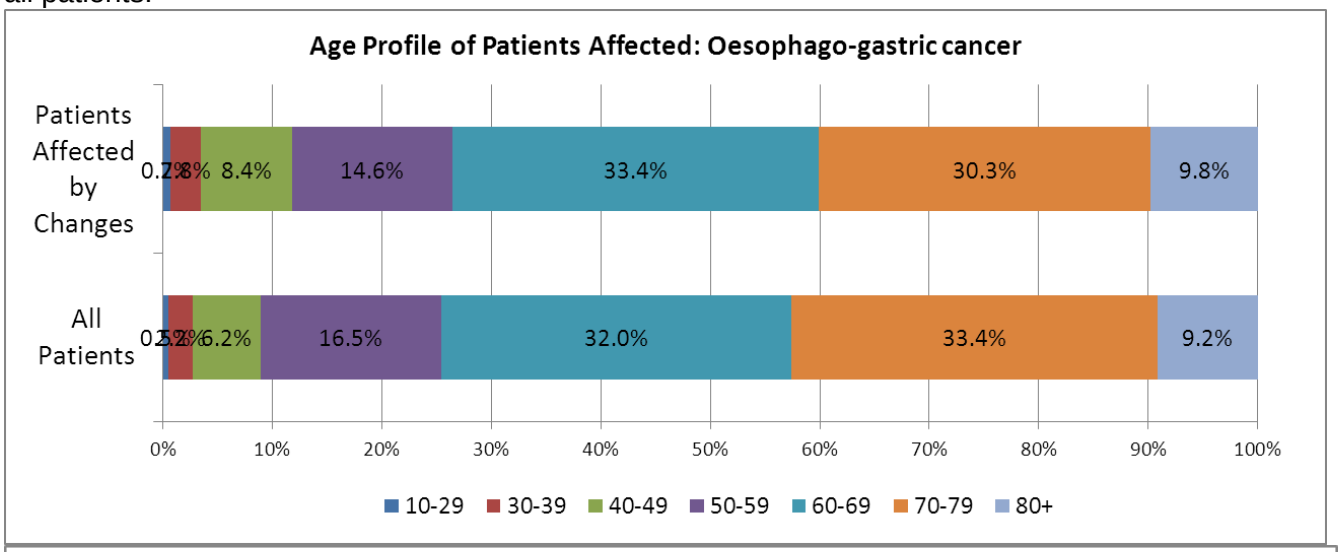


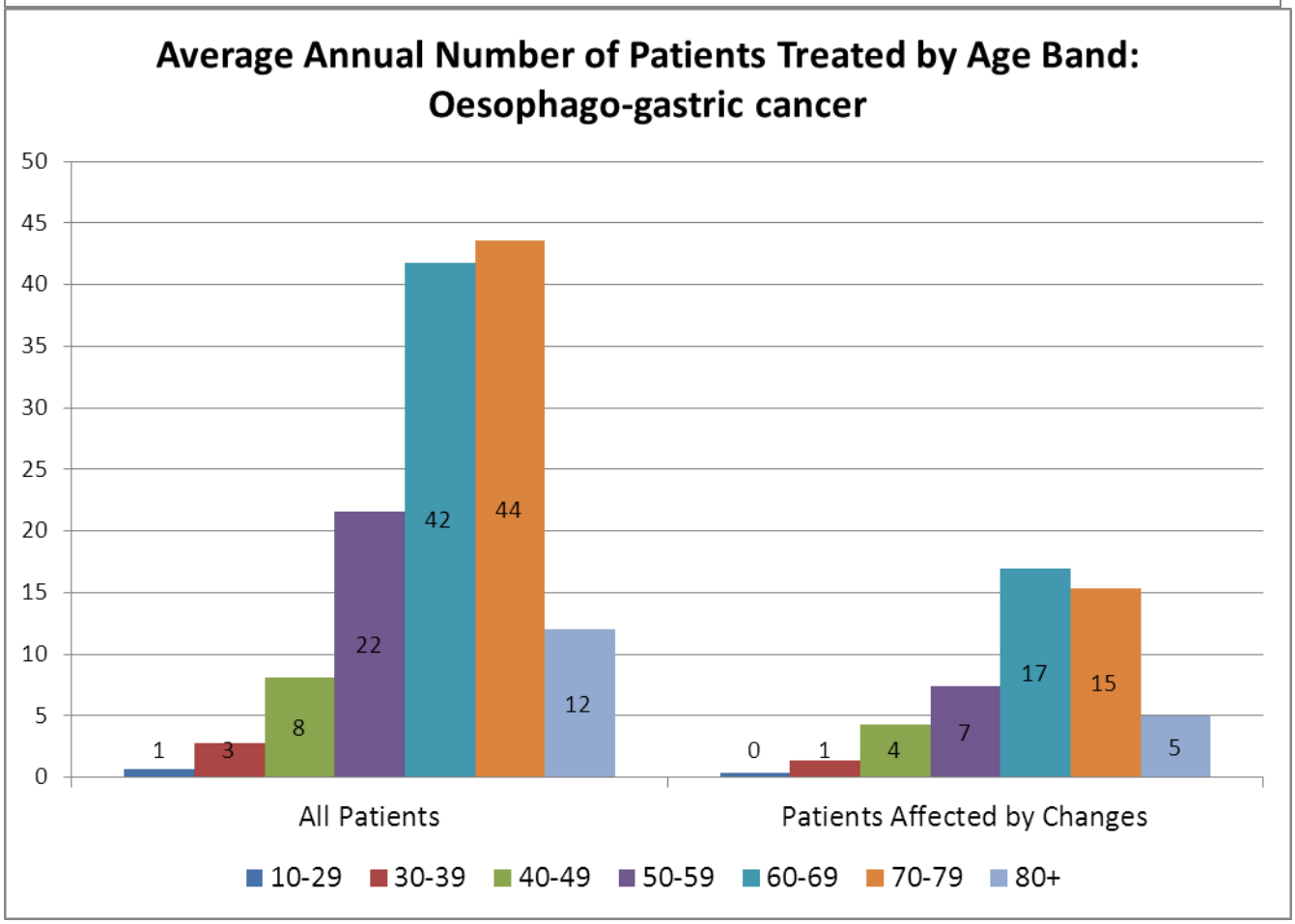
Estimates are that around 90% of the patients affected will in future be treated at UCLH and 6% at BHRUT.

[5] Numbers shown are for the last calendar year rather than the average of three years that has been used for the other tables. Numbers of patients treated changed significantly in 2011-12 when the new unit in Colchester opened. Prior to that patients from Essex formed a large proportion of the patients treated at the Royal London.

3.12.3 Age profile

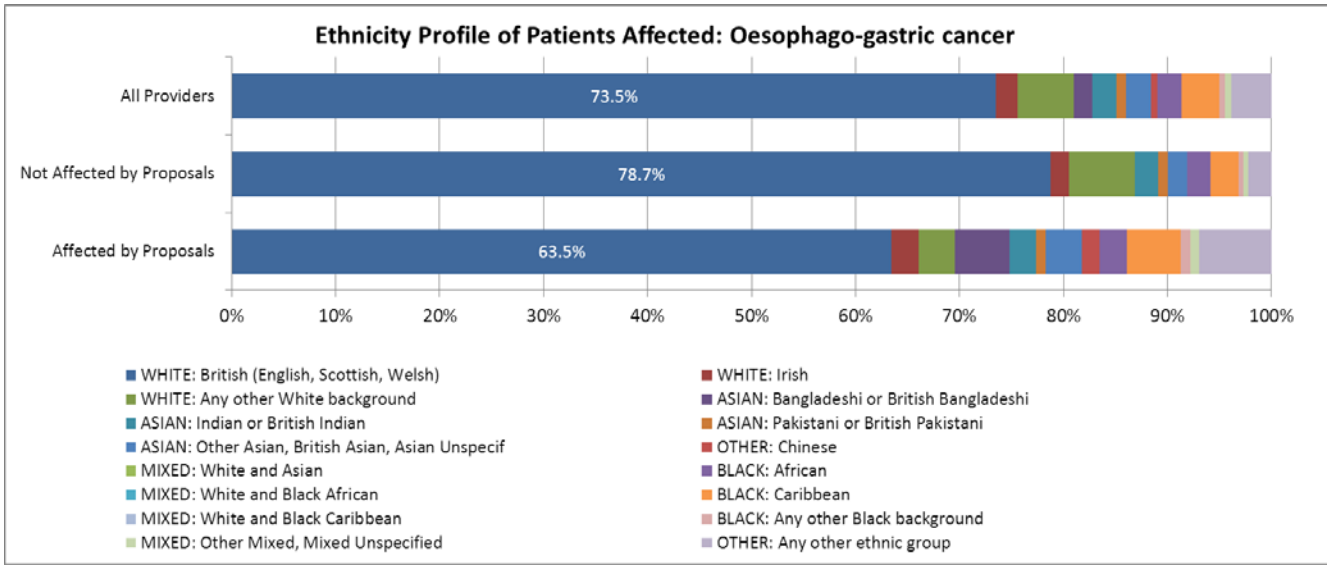
The table shows that 75% of patients undergoing specialised surgery for oesophago-gastric cancer are 60 or older. The profile for the patients at Barts Health is broadly the same as for all patients.





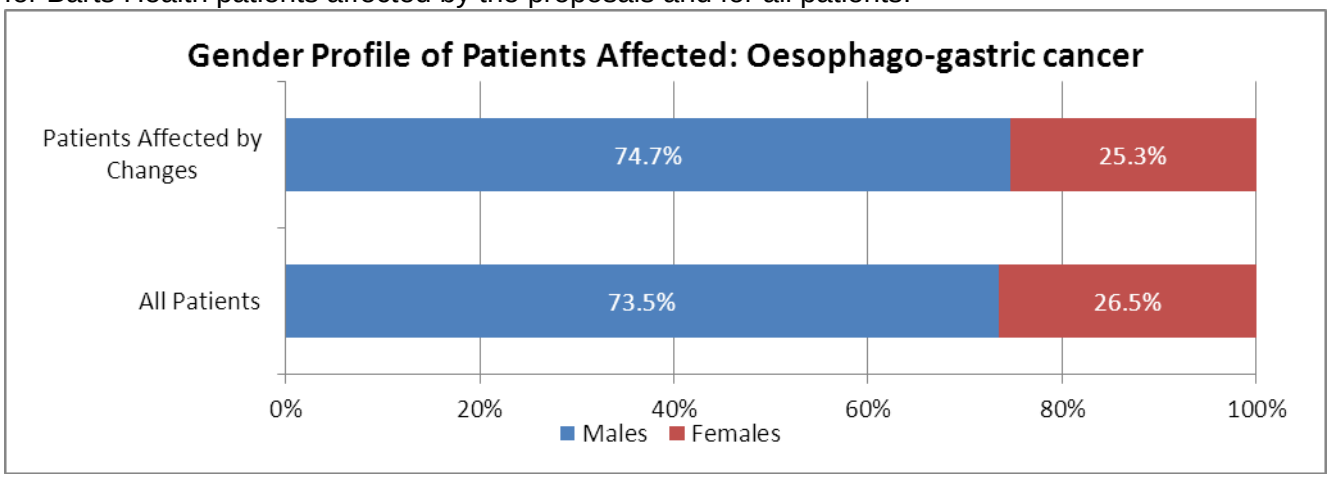
3.12.4 Ethnicity

The graph shows that 46% of patients affected by the proposals are from an ethnic minority group compared to 22% for the group not affected. However the numbers involved are small.



3.12.5 Gender

The table shows that around 75% of patients treated are men. This is the same proportion for Barts Health patients affected by the proposals and for all patients.



3.12.6 Travel implications

In 2012 53 patients received surgery at the Royal London Hospital. Under the proposed changes 45 of these would have been treated at UCLH and eight patients would have been treated at Queen's Hospital (Romford). UCLH and the Royal London Hospital are around 3 miles apart. Both are located close to underground stations but neither have parking apart from disabled bays. For patients currently receiving care at the Royal London Hospital there will be small increases in travel times. The estimate is that these patients will experience an average increase in public transport journey times of 6 minutes. The impact is greater for patients who are local to the Royal London (Newham and Tower Hamlets) than for those who are already travelling from further afield.

The small number of patients whose care will transfer to Queen's Hospital are residents of Essex or Redbridge and their average journey times will not change.

3.12.7 Conclusions

Key Points:

- The proposals will result in the care of a small number of patients (c 50 per annum) from the Royal London Hospital to either UCLH or Queen's Hospital.
- Based on the activity of the last three years the patients affected come from east London and Essex
- There is no evidence of any group being disproportionately affected by the proposals.
- There will be only minimal impact on journey times.

4. How will you know the effect of your policy/procedure on addressing health inequalities?

4.1 Can you produce both whilst developing this work and at the end of the work, for assurance and risk mitigation, accessible records of all decisions and the decision making processes?

The business case outlines the expected benefits; the primary driver of this programme is to improve patient outcomes across the area by delivering world class services and this can be translated into a number of specific commissioners benefits derived through a more efficient health system.

These include the following measurable high-level benefits for patients and the system:

- Lower readmission rates - Reducing the number of cases with complications, through greater patient volumes and therefore increased familiarity with conditions, will result in lower readmission rates
- Reduced number of outpatient visits - Better joined up working across the pathway will lead to reduction in unnecessary or repeat diagnostic testing
- High cost drug savings - Larger centres that can attract more clinical trials will result in savings on high cost drugs where they are provided free as part of the trials

- Improvements in primary and secondary prevention - World class specialist centres that offer high quality care will encourage system improvements, in terms of primary and secondary prevention.

These commissioner benefits sit alongside a broader range of benefits for patients and providers. These are illustrated in the benefits map and detailed table in the full business case (sections 2.4 and 3.4) The development of detailed outcomes measures and programme key performance indicators (KPIs) would be explored as part of developing a benefits management strategy and would be measured through a system-wide assurance mechanism.

5. Have I captured the evidence and recorded how the need to reduce health inequalities has been taken into account in the development of the policy/ procedure?

5.1 How can I provide evidence that I am aware of and am working in compliance with the legal duties on NHS England regarding health inequalities?

The NHS recognises that cardiac and cancer services concern all communities. Under the NHS Act 2006 the NHS has a duty to reduce inequalities in accessing services and in clinical outcomes, and to ensure that services offer same outcomes and same experience to patients regardless of their backgrounds.
Under the public sector equality duty (PSED), when a public sector organisation is planning to re-configure a service it must give 'due regard' to equality. The Equality Act 2010

mandates an integrated Equality Duty on all public bodies and those discharging a public function to consider how they can:

- Eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under the Act;
- Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;
- Foster good relations between persons who share a relevant protected characteristic and those who do not share it.

Due regard is demonstrated by considering the likely impact of the change on different groups in the community, in particular the protected characteristics as defined under the Equality Act 2010. These characteristics include race, gender, age, disability, gender reassignment, marriage and civil partnership, sexual orientation and pregnancy and maternity.

In addition to the protected groups highlighted in the Equality Act, the NHS is also concerned that inequalities are reduced between groups from different social backgrounds. This is of particularly relevant to the NHS in north and east London where there are areas with high levels of social deprivation that correlate strongly to populations with high incidence of heart disease and shorter life expectancy.

Through analysis the organisation must ensure there is no negative or disproportionate impact; and all measures have been considered to eliminate or at least minimise any likely negative impact of the reconfiguration. 'Due regard' is not only a legal duty, it can help the services make good business decisions and provide services in an equitable manner which will reduce inequalities and foster good relations between groups as well as good health outcomes.

From the NHS Constitution:
The NHS provides a comprehensive service, available to all *irrespective of gender, race, disability, age, sexual orientation, religion, belief, gender reassignment, pregnancy and maternity or marital or civil partnership status. The service is designed to diagnose, treat and improve both physical and mental health. It has a duty to each and every individual that it serves and must respect their human rights. At the same time, it has a wider social duty to promote equality through the services it provides and to pay particular attention to groups or sections of society where improvements in health and life expectancy are not keeping pace with the rest of the population.*

5.2 How can I demonstrate and provide evidence that I have analysed and determined whether there will be an impact on health inequalities from the outset of any decision making process, i.e. prior to commencing the work?

5.3 How can I demonstrate and provide assurance that this is a proportionally co designed and co-produced piece of work, fully involving the whole stakeholder range of expertise?

See Equality Impact Assessment (focusing on equalities and inequalities) and phase 1 and 2 engagement activity logs (appendices 3 and 4).

5.4 Am I able to demonstrate that I have the robust data and evidence needed to inform my thinking? Where are the gaps?

A full equality impact assessment was undertaken, but there are some groups where there is little or no data available to reach any conclusions as to the impact of changes on that group. It is difficult to measure the impact on inequalities in the areas of disability, religion/belief, sexual orientation or gender reassignment as data was not collected by the Trusts on these groups.

See section below – Impact on people with disabilities. Also see individual sections of this report: Impact Analysis: Cardiovascular Service and Specialised cancer services in general.

The approach taken to the Equality Impact Assessment is in three stages:

Stage 1: Scoping. Aim is to decide where the focus of the impact analysis should be. This takes account of:

- The proposed changes
- Initial view of the communities likely to be most impacted
- The availability of data: there are some protected characteristic groups where there is little or no data available to reach any conclusions as to the impact of changes on that group

A report on the scope of the analysis was taken to the Programme Management Team 20 January 2014.

Stage 2: Impact Report. The aim of this report is to provide an assessment of the impact of the proposed changes. This informed the engagement exercise that took place from May 2014. The analysis in the report was predominantly a desktop exercise looking at the profile of the patients most affected by the changes proposed.

Stage 3: Engagement. During the second period of engagement, every effort was made to get views on the proposals from groups identified as likely to be the most impacted by the proposals prior to the final decision being made. Also the engagement process was used as an opportunity to obtain views from groups where the analysis in this report was limited by a shortage of information (impact on people with disabilities, religion, sexual orientation and gender reassignment). See also programme Engagement Report appendix 2.

The scoping exercise concluded that of the protected characteristics:

- The changes proposed would have the greatest effect on the elderly as cancer and cardiovascular disease most commonly affect older people
- There was likely to be no impact on marriage/civil partnerships or pregnancy

- It is difficult to measure the impact on inequalities in the areas of disability, religion/belief, sexual orientation or gender reassignment as data was not collected by the Trusts on these groups.

The focus of the analysis that informs the assessment in the report has concentrated broadly on race, gender and age, as there is existing data from the former PCTs on these characteristics.

Engagement – phase 1

An extensive engagement programme was undertaken to bring the Case for Change to the attention of stakeholders and the public. Specific attention was given towards making representatives of affected groups aware of the Case for Change.

- The case for change summary document was translated on request into Bengali
- Letters inviting responses to the engagement were sent to 540 stakeholders including local Healthwatch committees, patients groups, community groups and voluntary sector groups representing a wide range of the population.
- Five public engagement meetings were held at locations across north and east London and west Essex. Advertisement of these meetings included 14 local newspapers and electronic media.

Full details of the engagement processes and the findings can be found in the engagement reports. We have not been able to gain any further insight on the impact of proposals from the engagement exercise.

A second engagement exercise took place May-June 2014. The findings of this report were tested with stakeholders. Every effort was made to get views on the proposals from groups identified as likely to be the most impacted by the proposals, such as contacting local LGBT groups and charities and Age UK. The engagement process sought to obtain information about groups such as people with disabilities, where there was limited information.

5.4.1 Analysis undertaken

The analysis that follows has looked at recorded data by the hospitals affected over the last three years. The hospitals record the age, gender and ethnicity of the patients treated. Using this data a profile has been created of the patients that are currently being seen at the hospitals where the proposal is to decommission a service. This represents the patients that would be most affected by the proposals.
In each case the profile of the affected group has been contrasted against patients treated at a wider range of centres. The analysis seeks to address the following issues:

- What is the nature of the patients affected by the proposed changes:
  - How many patients are affected?
  - Where do they come from?
  - What is the age, ethnicity and gender profile of the group?
- Is the profile of the group of patients affected by the changes any different from the profile of patients in general? If so, could the changes have an impact on equality of service provision or access to services?

5.4.2 Possible impacts

Whilst the analysis described above goes some way towards identifying whether one group may be affected disproportionately over another, it is harder to assess whether the impact could be neutral, positive or negative.

Possible impacts could include:

- Changes lead to better clinical outcomes for the affected group

- The new provider is more difficult for patients from the affected group to access; possibly because of a combination of the age of the patient group affected and the increased distance to travel.
- The new provider is better or worse at responding to the particular needs of a specific patient group; for example if the access to translation services is better under the new provider.

The changes proposed are to tertiary services, so patients have already started on a treatment pathway before they are treated by the specialist centre. By implication, access to the patient pathway is not affected by the proposals.

5.4.3 Impact on people with disabilities

Currently there is no data collected on the numbers of patients treated with a disability. Consequently it is difficult to assess the numbers of patients with disabilities that might be affected by the proposed changes. However the impact should be negligible because all the hospitals involved in the reconfigurations:

- Are routinely assessed by the Care Quality Commission to ensure that their services are responsive to the needs of patients with a disability
- Operate special transport arrangements for patients with mobility problems.

So it is reasonable to conclude that there should be no material negative impact on patients with a disability. However there remains an onus on all the providers involved in the project to ensure that the implementation of the changes is done in a way that the needs of patients with disabilities are considered.

6. Conclusions and recommendations

6.1 Cardiovascular services

Key findings:

- The proposals will result in care for a significant number of patients (c 5,000 per annum) shifting from the Heart Hospital to St Bartholomew's Hospital.
- The patients affected predominantly come from north central London and Hackney, although 40% of patients are spread across the rest of London and the South East.
- There is no evidence of any group being disproportionately affected by the proposals.
- The improved outcomes forecast for these changes will contribute to closing health inequalities for deprived populations that have higher mortality rates for CHD.
- The location of the two sites is such that there are unlikely to be any access implications from the change of site.
- The ethnic mix of patients currently seen in the Heart Hospital is different from that seen at the two Barts Health sites; with the Heart Hospital having a smaller proportion of patients from black and minority ethnic (BME) groups.

6.2 Specialised cancer services

Key findings:

- The changes will result in fewer providers of services.
- The numbers of patients affected are relatively small.
- The patients affected by these proposed changes are spread across London and Essex. For those services that involve moving the provider from an outer London provider (Queen's Hospital, Chase Farm Hospital) to an inner-London provider (UCLH, Royal Free) there will be a travel impact on patients. However the numbers of patients affected are small.

- Most of the patients affected are in the age band 50 to 80 years of age.
- For most of the patients pathways the group of patients affected have a greater proportion from BME groups although this reflects the different populations served.
- There is no evidence of any group being disproportionately affected by the proposals.

6.3 Recommendations

The findings of the EqIA were tested with stakeholders during the second phase of engagement. Every effort was made to get views on the proposals from groups identified as likely to be the most impacted by the proposals. If the proposals are approved, providers will need to ensure that the needs of diverse populations are met under their public sector duties.

7. ADDITIONAL INFORMATION PROVIDED BY NHS ENGLAND IN SEPTEMBER 2014

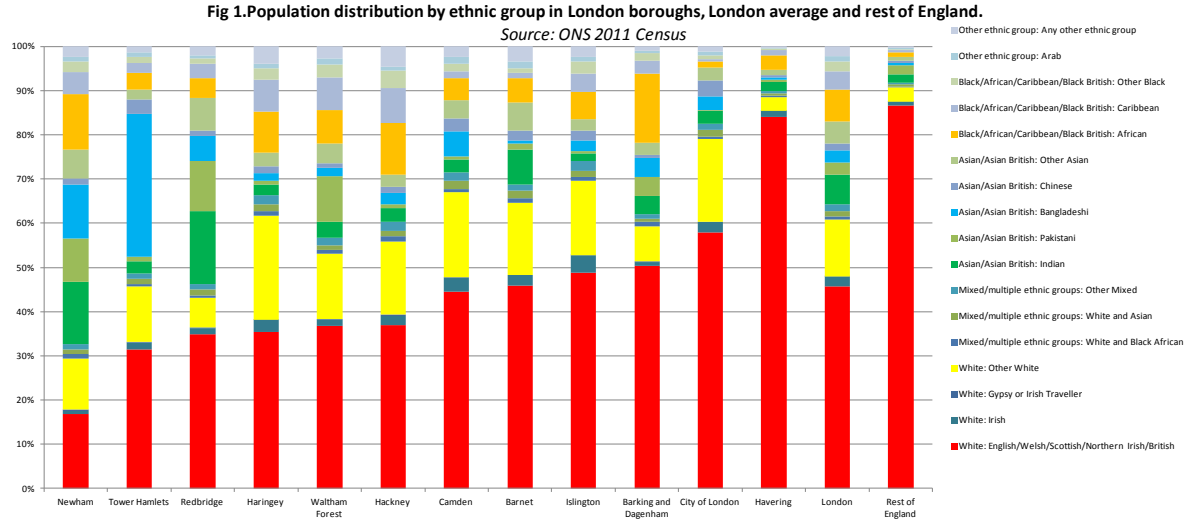
Socio-demographic variation of patient experience in patients with cancer and cardiovascular disease

Introduction

The section below aims to provide evidence in terms of patient experience variation for cancer and cardiovascular services in north and east London.

Fig 1.Population distribution by ethnic group in London boroughs, London average and rest of England.

Source: ONS 2011 Census



1) Variation of Patient experience in patients with cancer

Aggregated data from the CPES (Cancer Patient Experience Survey) related to three years (2010-2011, 2011-2012 and 2012-2013) were analysed with the objective of identifying variation of patient experience in patients treated for cancer, accordingly socio-demographic variables.

The scores of the survey question related to the *Overall experience of cancer services* were analysed. The score express the proportion of surveyed population who reported a **positive** *Overall experience.*

Cases were selected considering a selection criteria which was based on the referring PCT and the type of cancer.

The analysis included cases where the referring PCT areas were related to the London Boroughs of Barnet, Enfield, Haringey, Camden, Islington, Tower Hamlets, City of London, Hackney, Newham, Waltham Forest, Redbridge, Barking & Dagenham and Havering.

The types of cancers considered in the analysis were:
1. Head & neck cancer
2. Urological cancers (kidney, bladder and prostate)
3. Haematological (as an approximation of Acute Myeloid Leukaemia)
4. Osophago-gastric cancer

The variation of scores according socio-economic variables was studied. These variables were the following: sex, age, ethnic group and deprivation.

1.1) Scores variation

As a summary and pattern:
-The younger, the poorer the patient experience, although scores slightly decreased in the oldest age band. (table 2)
-The more deprived, the poorer the patient experience, although there were slight differences among the most deprived quintiles. (table 4)
-Males have a slightly better patient experience than females (table 1)
-There are differences in terms of patient experience according to ethnic groups. African, Chinese, Mixed White and Black Caribbean, Mixed White and Black African, Caribbean and Irish ethnic groups presented the poorest patient experience. (table 3)

Please note that there were low numbers in some ethnic categories.

Differences of scores according cancer type were also fund. Since only bi-variate analysis was developed, this effect was not controlled when analysing socio-economic variables.(table 5)

2) Variation of patient experience in patient with CVD

There is not data available to analyse this variation.

4) Variation of patient experience in general population

Analysis based on the 2012-2013 GPPS (GP Patient Experience Survey) scores by socio-demographic variables concluded as the following:

- For all the GPPS questionnaire items studied, the older the age group, the higher the item scoring in London and in the rest of England. Differences were statically significant.
- For most of the studied items, the more deprived the population band, the lower the item score in London and in the rest of England. In London the least deprived band scored higher than the most deprived band in all studied items.
- There were significant differences in scoring between ethnic groups. Caribbean, Other White and Other Black /African/Caribbean scored the highest in London, and Other White, White British, Caribbean and Other Black /African/Caribbean scored the highest in the rest of England. Bangladeshi, Chinese, Other Asian and Pakistani scored the lowest in both London and rest of England.
- Regarding variation by gender, the findings were not completely consistent. Males scored higher than females in 12 out of the 17 studied items in London, and in 10 items in the rest of England.

5) Variation of other health outcomes

There are evidence of incidence and prevalence differences as well as poorer cancer and cardiovascular health outcomes in certain ethnic minorities, which are prevalent in the project reference area. (Figure 1)

Example for Cancer:
-"Cancer Incidence and Survival by Major Ethnic Group, England, 2002 – 2006". Cancer Research UK

Example for Cardiovascular disease:
"Ethnic differences in Cardiovascular Disease."2010 Edition. British Heart Foundation and University of Oxford.

Table 1. Positive overall experience of cancer services by sex.

Sex	Number cases	% Overall positive experience cancer services
Female	4173	61.18%
Male	3317	63.52%
Total	7490	62.24%

Table 2. Positive overall experience of cancer services by age bands.

Age band	Number cases	% Overall positive experience cancer services
21-30	95	65.00%
31-40	278	57.54%
41-50	797	57.72%
51-60	1448	62.35%
61-70	2150	62.83%
71-80	1890	63.90%
81+	806	62.01%
Total	7464	62.20%

Table 3. Positive overall experience of cancer services by ethnic groups.

Ethnic group	Number cases	Overall Positive experience cancer care
African	241	52.53%
Any other Asian background	158	63.54%
Any other Black background	71	67.50%
Any other ethnic group	262	52.98%
Any other mixed background	29	62.50%
Any other White background	699	63.38%
Bangladeshi	81	65.38%
British	4448	63.34%
Caribbean	343	56.63%

Chinese	56	52.78%
Indian	219	69.92%
Irish	198	59.65%
Pakistani	79	65.45%
White and Asian	17	83.33%
White and Black African	20	53.85%
White and Black Caribbean	21	53.33%
Not stated	548	60.90%
Total	7490	62.24%

Table 4. Positive overall experience of cancer services by deprivation quintile.

Deprivation Quintile (1)	Grand Total	% Overall positive experience cancer services
1	154	71.21%
2	483	66.00%
3	828	63.92%
4	1246	62.90%
5	2335	62.42%
Not Known	2444	61.09%
Grand Total	7490	62.24%

(1) The higher the more deprived

Table 5. Positive overall experience of cancer services by type of cancer.

Type of cancer	Number cases	% Overall positive experience cancer services
Brain/Central Nervous System	111	63.83%
Haematological	1250	64.64%
Head and Neck	290	57.74%
Upper Gastrointestinal	403	58.93%
Urological	781	63.39%
Grand Total	2835	62.68%