Final decision on the future of North and East London Specialised Cancer and Cardiac services

Introduction

1. This paper sets out the final decision required by NHS England on whether to proceed with the preferred service option for specialised cancer and cardiovascular services in north and east London[1] that was approved in part by the relevant CCGs on 25th July 2014.

Recommendation

2. It is recommended that NHS England approves the preferred service model for specialised cancer and cardiovascular services in north and east London, as outlined below:

   Cardiovascular services - the proposal is to consolidate services currently at the Heart Hospital to the new unit being developed at St Bartholomew's Hospital.

   Cancer services - the proposal is to reduce the number of units where specialised surgery or intensive treatment takes place. Services for the specialist treatment of some cancers would be consolidated into a centre at University College London Hospital, with some specialist services continuing at The Royal London Hospital, St Bartholomew's Hospital, The Royal Free Hospital and Queen's Hospital. The number of consolidated units varies for each type of cancer. The proposals affect the following cancers:

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

Decision making

3. NHS England is responsible for commissioning the following services:

   Specialised cancer - All the services are solely commissioned by NHS England, with the exception of acute myeloid leukaemia (AML) services. The key commissioners impacted by the recommendations for AML services include the following four CCGs: Enfield, Barnet, Haringey and Camden, due to the proposed transfer of services to ULCH from other locations. The above four CCGs approved the preferred service model for AML services at a meeting in common on the 25 July 2014.

   Specialist cardiovascular care - Around 59% of spells at the Heart Hospital (mainly general cardiology) are CCG commissioned with the remainder commissioned by NHS England. Of the CCG commissioned activity more than 70% is from six CCGs (Haringey CCG, City and Hackney CCG, Enfield CCG, Islington CCG, Camden CCG, Barnet CCG). The above six CCGs approved the preferred service model at the meeting in common on 25th July 2014.

[1] North and east London for the purposes of this proposal 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.

4. The final decision by NHS England will be taken by Anne Rainsberry, NHS England Regional Director for London, in line with the scheme of delegation. Specifically, the commissioning of specialised services in London falls under the delegated authority of the designated Area Director, which is in this case is combined with the role of Regional Director. The scheme of delegation can be found on the following link: http://www.england.nhs.uk/wp-content/uploads/2013/04/item6-3.pdf

Background

Case for change

5. In 2010 a clinical review made recommendations for improving cancer and cardiovascular services in London concluding that fewer specialist high-volume units would improve clinical outcomes, accelerate the uptake of new technologies, achieve greater quality and optimise efficiency: http://www.londonhp.nhs.uk/wp-content/uploads/2011/03/Cancer-case-for-change.pdf and http://www.londonhp.nhs.uk/wp-content/uploads/2011/03/Cardiovascular-case-for-change.pdf

6. The case for change (attached at Annex A) has been subject to extensive consultation and engagement. Initially, NHS England and CCG partners consulted on the case for change under section 13Q and 14Z2 of the Health and Social Care Act 2012. During the phase one engagement, regular meetings and dialogue were conducted with the three Joint Health Overview and Scrutiny Committees (JHOSCs) and Westminster Overview and Scrutiny Committee (OSC) before and during the engagement to understand their views and any requirement for further engagement or consultation. The JHOSCs concluded the proposals did not represent substantial variation or development in services and formal consultation with local authorities is not required under section 244 of the NHS Act 2006.

7. Based on the consultation feedback, preferred options for change were developed. NHS England and CCG partners undertook further engagement between 23 May 2014 and 27 June 2014 on the preferred options with a wide range of local stakeholders and residents to gain their views.

Discussion

Engagement

8. NHS England and its CCG partners have engaged extensively on the case for change and the clinical recommendations to arrive at the current preferred option. This commissioning led engagement was done in two phases. The first phase of engagement, referred to in paragraph 6, consisted of a 38 day engagement exercise that was conducted on the case for change between 28th October and 4th December 2013. This was followed up with a further five week period of engagement from Friday 23 May 2014 ending on Friday 27 June 2014. Both phases involved a wide range of local stakeholders and residents to gain their views on, and experience of, current services and to listen to their aspirations for future health services. The reports detailing the feedback from both phases can be found in annexes B, C, D and E.

9. The majority of responses received were supportive of the individual proposals. The stakeholders who were supportive agreed with the general principle of consolidating specialised services:

   "Like many of my colleagues, I support the principle of concentrating complex and specialised cancer services into larger centres, where high volume integrated care ensures the delivery of the highest quality care and the best outcomes for patients." Clinician (Phase 1 engagement)

10. However, there were also concerns expressed such as the impact on travel, particularly for patients who live in outer north east London:

    "Speaking quite selfishly, it would increase travel problems especially for the elderly and they are also a number of people who need heart and cancer treatment. Does it mean frequent visits to different centres? I'd like to emphasise that the availability of care locally is very important." – Individual (Phase 2 engagement)

11. Other concerns included the possible impact on co-dependent services (such as the Major Trauma Centre at the Royal London Hospital):

    "To note one of the lessons learnt from the vascular hub being based at the Royal Free is the importance of clarity as to how non elective or urgent support is provided to the spoke sites for non-vascular services during the normal working day." NHS manager (Phase 1 engagement)

12. The move of prostate services from BHRUT to UCLH and consequent increase in travel were also sources of concern:

    Other concerns re the proposals are the implications on patients and their families having to travel to UCLH. It has been suggested by London Cancer that the operations to be held at UCH will only require one night in hospital and so upheaval caused by travelling further afield will be limited. However, we have members who have pointed out that they needed hospital care for up to four nights due to complications following their ops. Has this been taken into consideration? Association of Prostate Patients In London and Essex (Phase 1 Engagement)

13. The programme has responded to these concerns and has obtained robust mitigations from the relevant proposed providers. Further detail on the proposed mitigations can be found in the phase two engagement feedback report at annex E. For example, with respect to increased travel times, providers have plans in place to help mitigate the potential impacts on patients which includes: providing clear information about travel and transport options; immuno-compromised patients will continue to be eligible for NHS Transport; making disabled car parking bays available; and increasing blue badge parking. Further detail can be found on pages 3-5.

Process

14. Taking the UCLPartners clinical recommendations as its starting point, a comprehensive options appraisal and impact assessment was applied to develop an agreed set of preferred options for how to consolidate specialist services delivered by providers in the area. The methodology, the stakeholders consulted and the findings of the appraisal are described in detail in the business case that was developed: http://www.england.nhs.uk/london/engmt-consult/

15. NHS England assured itself that the programme met the four tests, as set out in the guidance on delivering services changes published by NHS England, culminating in an Internal Assurance Report. In addition, the Department of Health conducted a gateway review. The London Clinical Senate with expertise relevant to each of the pathways and with no known conflict of interest provided external clinical assurance. The scope of this assurance review was to test whether a sufficiently robust clinical process was adopted by lead commissioners to arrive at the recommended options, considering the clinical involvement and evidence used. The London Clinical Senate in their overview report concluded a robust clinical process had been undertaken to arrive at the recommended options (annex G).

16. Further to the review of the clinical process, the London Clinical Senate also provided advice to inform a recommendation on the future model and location(s) of radical prostatectomies in north central and north east London. This independent review was conducted in response to engagement feedback on the proposed options. Following the review, the London Clinical Senate concluded a single site model at UCLH was preferable (annex F).

Considerations

17. In taking this decision there are a number of important considerations:

Specialised cancer services

18. Feedback from the engagement raised the issue that the cost of prostate surgery for UCLH is higher than for BHRUT (the incumbent). This is due to the market forces factor (MFF) which is applied to the tariff. The MFF for UCLH is 1.2976 whereas BHRUT is 1.1744, a difference of 0.1232. NHS England acknowledges the marginal higher difference in the MFF. However, MFF is not included in the economic analysis of preferred options in Public Sector Business Cases. It is technically a circular flow of public money, also known as a transfer pricing issue, and therefore derives no overall economic benefit to the wider system. As a result, in line with the treasury's (HMT) green book for public sector business cases, NHS England does not use the MFF as a factor in its decision making: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/190603/Green_Book_guidance_checklist_for_assessing_business_cases.pdf

19. To aid further understanding, even though we did not take MFF into account, the specific changes proposed involve the movement of very small amounts of revenue, calculated to be between £0.2m - £1.8m (p63 of the business case) depending on the service. For example, the size of the prostate service moving is £0.6m. The impact of the higher MFF is therefore considered nominal:

Worked example:
UCLH: 1.2976 x £0.6m = £0.78m
BHRUT: 1.1744 x £0.6m = £0.70m

A difference of £0.08m

20. The engagement feedback also highlighted concerns that the proposals would impact on the ability for UCLH to achieve the cancer 62 day wait performance standard. Assurance was sought from UCLPartners on this point. We are confident that the action plan they have put in place will lead to the performance improvements required.

Financial considerations

21. Developing these proposals has required each party to agree in principle the required funding to sustainably support the proposed implementation. Following a meeting on the 7th July, the national Finance and Investment Committee of NHS England expressed their support for the capital requirements and transitional funding for the preferred option. This was communicated to the CCGs on 25th July 2014 to support their decision making. It was also communicated to the board of NHS England (attached at annex H).

Commissioning for outcomes

22. NHS England as lead commissioner of specialised services has considered carefully the best approach to improve outcomes, in compliance with procurement regulations (2013). The process was commissioner led, with NHS London developing the London Models of Care in 2010. This included establishing *London Cancer* in 2012, an integrated cancer system to cover the area affected by these proposals. As set out in the case for change, the emphasis is on integrating and consolidating existing services, where for historic reasons, the north central and north east London and west Essex population is split between many smaller specialist centres. Many of these centres do not achieve national standards and most do not achieve the London Model of Care recommendations. The emphasis behind the preferred service model is to move to world class specialist centres supporting the overall system for both cancer and cardiac:

    'This case for change is part of a UK-wide strategy to bring fairness and excellence to specialist services, and to strengthen the NHS's status as a pioneer of medical innovation. In developing their ideas, clinicians have been guided by the Department of Health's national outcome strategies and NHS England's national service specifications.' (Case for Change, p4)

23. In May 2013 London Cancer and UCLPartners made recommendations to NHS England on these proposals. In response, NHS England carried out an options appraisal process to review all potential options to deliver the ambitions set out in the case for change.

24. NHS England considered alternative commissioning approaches taking the recommendations from the 2010 Model of Care to consolidate existing services as the starting point. The key concern was to ensure that the commissioning approach would support the future system to integrate further in order to provide full benefits of clinical leadership, with coordination across the pathway and protection of key patient interests.

25. NHS England wrote twice (at beginning and end of the phase one engagement) to all providers across all of London seeking views on different ways to deliver the service improvements but no alternative approaches were suggested. The options appraisal process (see paragraph 15) was designed to ensure that all options were considered and to identify the provider(s) most capable of meeting patients' needs whilst improving quality and efficiency and deliver value for money. The options considered included those intended to accommodate concerns raised by patients and providers, such as a hybrid two site radical prostatectomy proposal based at BHRUT, with UCLH acting as the lead provider.

26. NHS England undertook competition and market share analysis and presented this, along with the commissioning process set out above, to Monitor for informal review in February 2014. No significant concerns were raised by Monitor. For a significant number of services more than one provider is proposed and the choice only reduces where the overall clinical outcome benefit outweighs this. Even then alternative specialist providers remain in London and the surrounding area. In addition, there are a number of other patient choice considerations which are not adversely affected through creating world class specialist centres of excellence, in particular:

    - Choice of primary and secondary care will not change
    - More patients will have access to world class services
    - Patients will be better able to make informed choices

27. NHS England asked the London Clinical Senate (see 15 above) to undertake a review of both the process it had undertaken in reaching its conclusions, and to separately review the radical prostatectomy proposals in response to engagement feedback (as per paragraphs 15 and 16).

28. In addition to unanimous support from the relevant CCGs, there is also strong support from all the lead providers of specialist services in north central and north east London. This includes:

    - A letter of support from Stephen Burgess, Medical Director at Barking, Havering and Redbridge University Hospitals NHS Trust
    - A letter of support for the specialist cancer and cardiovascular proposals from Steve Ryan, Medical Director at Barts Health
    - A letter of support for the specialist cancer and cardiovascular proposals from Stephen Powis, Medical Director at the Royal Free London NHS Foundation Trust
    - A letter of support for the specialist cancer and cardiovascular proposals from Gill Gaskin, Medical Director at University College Hospitals NHS Foundation Trust

29. Copies of these letters can be found at Annex I.

Equalities and inequalities considerations

30. The proposed cardiac and cancer service changes concern all communities in north and east London. NHS England in line with the public sector equality duty (as set out in the Equality Act 2010), has conducted an analysis of the likely impact on different groups in the community, in particular the protected groups as defined under the Equality Act 2010. These groups include race, gender, age, disability, gender reassignment, marriage and civil partnership, sexual orientation and pregnancy and maternity as well as socio-economic duty and human rights of vulnerable people. NHS England also 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.

31. For cardiovascular services, the analysis identified that the proposals will result in care for a significant number of patients (c 5,000 per annum) moving 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. 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.

32. For specialised cancer services, the analysis identified that the changes will result in fewer providers of services but that 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. The proposed providers will seek to minimise the impact of increased travel times for the patients affected (as outlined in paragraph 13 above). Furthermore, the primary aim of the changes is to improve health outcomes resulting in a positive impact on all patients. The changes should also help to reduce early deaths caused by heart disease and cancer and positively impact the inequalities in mortality rates between London and the rest of England.

33. Further detail can be found in the equalities analysis and health inequalities assessment – these are attached as accompanying annexes J and K.

Implementation framework

34. NHS England has developed a proposed outline framework for implementation which has been developed. This will ensure that any proposed change will be managed carefully and in a controlled manner. The framework is based on feedback received throughout the engagement period with stakeholders including CCGs, providers and UCLPartners.

Conclusion

35. Subject to your agreement on whether to proceed, NHS England (London) will work with CCG partners and the relevant providers to implement service change safely, in a timely fashion and accompanied by a clear plan to achieve the expected benefits envisaged.

Annexes (list of documents accompanying this paper)

I. **Annex A** - Case for change
This is already available on the following link: http://www.england.nhs.uk/london/wp-content/uploads/sites/8/2014/03/cncer-crdio-case-change.pdf

II. **Annex B** - Phase 1 engagement overview report
This is already available on the following link: http://www.england.nhs.uk/london/wp-content/uploads/sites/8/2014/03/cacr-crdio-ovrviw.pdf

III. **Annex C** - Phase 1 engagement feedback report
This is already available on the following link: http://www.england.nhs.uk/london/wp-content/uploads/sites/8/2014/03/engmnt-rpt-appen-e.pdf

IV. **Annex D** - Phase 2 engagement Report Summary
This is already available on the following link: http://www.england.nhs.uk/london/engmt-consult/

V. **Annex E** - Phase 2 engagement Report Feedback
This is already available on the following link: http://www.england.nhs.uk/london/wp-content/uploads/sites/8/2014/07/er-app-e.pdf

VI. **Annex F** - London Clinical Senate review of prostate cancer services
This is already available on the following link: http://www.england.nhs.uk/london/wp-content/uploads/sites/8/2014/06/prostate-rev-rep.pdf

VII. **Annex G** - London Clinical Senate overall review
This is already available on the following link: http://www.england.nhs.uk/london/wp-content/uploads/sites/8/2014/06/overall-rev-rep.pdf

VIII. **Annex H** – Copy of NHS England Board paper containing FIC support
This is already available on the following link: http://www.england.nhs.uk/wp-content/uploads/2014/09/item8d-board-0914.pdf

IX. **Annex I** - Provider correspondence
This is already available on the following link: http://www.england.nhs.uk/london/wp-content/uploads/sites/8/2014/07/er-app-g.pdf

X. **Annex J** - Equalities analysis (published alongside)

XI. **Annex K** - Inequalities assessment (published alongside)