COMMISSIONER ‘MEETING IN COMMON’ – SPECIALIST CANCER AND CARDIOVASCULAR SERVICES FOR NORTH AND EAST LONDON AND WEST ESSEX
Minutes of the meeting held on Friday 9 May 2014
14.00-16.00
Portland House, Bressenden Place, London, SW1E 5RS

Present:

Chair: Anne Rainsberry, Regional Director (London Region), NHS England (AR)

Voting Members:

NHS England:
Simon Weldon, Director of Commissioning, (London Region), NHS England (SW)

Camden Clinical Commissioning Group
Dr Lance Saker, GP Governing Body member (LS)
William Roberts, Director for Strategy and Planning (WR)

City and Hackney Clinical Commissioning Group
Paul Haigh, Chief Officer (PH)
Dr Gary Marlowe, GP Governing Body member (GM)
Muriel Purkiss, Hackney Healthwatch, Lay member (MP)

Enfield Clinical Commissioning Group
Graham MacDougall, Director of Service Improvement (GMa)

Haringey Clinical Commissioning Group
Dr Gino Amato, GP Governing Body member (GA)

Islington Clinical Commissioning Group
Alison Blair, Chief Officer (AB)
Dr Gillian Greenhough, Chair (GG)
Dr Rathini Ratnavel, GP Governing Body member (RR)

Non-voting attendees:
David Fish, Managing Director, UCL Partners (DF)
Neil Kennett Brown, Programme Director, North and East London Commissioning Support Unit (NELCSU) (NKB)
Stuart Saw, Head of Financial Strategy (London Region), NHS England (SS)
David Mason, Legal Advisor to Programme, Capsticks (DM)
Kathleen Becker, Legal Advisor to Programme, Capsticks (KB)

In attendance:
Alan Shaw, (observing)
Amanda White, Head of Communications, UCLP (observing)
Beth Warmington, Programme team, NELCSU, (minute taking)
Emdad Haque Equality Team, NELCSU (observing)
Neil Davis, Programme team, NELCSU (minute taking)
Ronnie Jacobson, Trustee, Age UK London (observing)
Wendy Mead, Chair, Health Scrutiny Committee, City of London (observing) (WM)
1. Welcome and introduction

Anne Rainsberry (AR) introduced the purpose of the meeting which was to agree whether the commissioners should adopt the recommendations as preferred options and agree to proceed to the next phase of the programme. The commissioners were convened as they are the majority commissioners for these proposals. AR took the opportunity of thanking all clinicians and commissioners across the area, for their work on the proposals so far.

AR explained that each of these commissioners were not meeting as a single committee, and each decision has to be made by each organisation separately. She explained that this is simply because the organisations are not currently allowed to make decisions affecting all of them in a single joint committee. This legal position is being changed, but not within the timescale for this programme.

AR explained that the reason behind these particular clinical commissioning groups (CCGs) meeting together (rather than all North Central and North East London and West Essex CCGs) is because they are the relevant direct commissioners alongside NHS England (who is the commissioner of all specialist services). AR explained that decisions would need to be made on each of the pathway recommendations individually by the majority commissioners for the services under consideration. She then laid out this further as follows:

Cancer: All the services are specialised services solely commissioned by NHS England, with the exception of acute myeloid leukaemia (AML) services which are CCG commissioned. The key commissioners impacted by the recommendations for the AML proposals include the following four CCGs: Enfield, Barnet, Haringey and Camden, due to the proposed transfer of services to UCLH from other locations.

Cardiac: All the specialist cardiovascular services are commissioned by NHS England, with general cardiology commissioned by CCGs. The key CCGs who commission the majority of this activity is from six CCGs (Haringey CCG, City and Hackney CCG, Enfield CCG, Islington CCG, Camden CCG, Barnet CCG).

AR acknowledged that ahead of this meeting all of the CCGs have taken this through their respective CCG governance processes and agreed how they will enact their decision making role. Barnet CCG have confirmed their support for the proposals in writing, and that they are supportive of the other CCGs working alongside NHS England in decision making going forwards. AR explained that if a decision was reached to proceed to a further engagement phase, the programme will of course be discussing proposals and plans with all stakeholders. This includes members of the public, patient and support groups, clinicians, all CCGs, and joint health and scrutiny committees.

AR explained there were three areas for decision making:

1. To agree, as commissioner preferred options, the recommendations regarding proposed changes to specialist cancer services

2. To agree, as the commissioner preferred option, the recommendation regarding proposed change to specialist cardiovascular services

3. Approve the proposals for a further engagement on the commissioner preferred options and implementation issues to inform final decision making.
2. Presentation on the clinical case

Professor David Fish (DF) introduced the clinical case for change

- In London 2/3rds of early deaths are caused by cancer and cardiovascular disease. There are inequalities in the locality (north and east London and west Essex) and the rest of England and within the locality. These proposals represent an opportunity to save upwards of 1,000 lives each year lost due to cancer and cardiovascular disease.

- The process started with commissioner models of care in 2010

- There is currently strong clinical evidence that specialist centres have better outcomes with higher volumes of procedures

- UCLPartners has supported clinicians to respond to the models of care with an aim to improve services and the quality of care across the whole pathway – from prevention and early detection to diagnosis, treatment and long-term care

- Currently not all providers are meeting national standards of minimum volumes

- There is currently poor patient experience for the services in question across London which needs to be addressed

- Not all patients have access to the latest technology and innovations.

AR provided the opportunity for attendees to respond to DF’s introduction:

Gary Marlowe (GM) noted the gap in patient outcomes from those living in west London vs east London is not necessarily due to clinical practice and that wider socio-economic issues are likely to play a significant role. DF acknowledged these inequalities and recognised the importance of providing the best clinical outcomes for everyone.

GM suggested centralisation is not the only option. The Scarborough stroke service for example has similar outcomes yet did not follow a centralised model. DF agreed that different approaches can be used for different settings, however the outcomes from the major trauma networks and hyper acute stroke centres, as an example of centralised services have been impressive in London and that in a densely populated area such as London, a centralised model has performed well.

GG pointed out at the time of developing the case for change for stroke services, there was a significant level of resistance. However the improvements in stroke services over the past 2-3 years is notable following implementing the recommendations and largely in part due to the close working between providers to deliver network based solutions.

GM noted the number of procedures a clinician must perform in order for outcomes to plateau varies pathway by pathway and clinician by clinician. DF agreed that the link between high volumes and better outcomes was only relevant to certain cancers. The cancers within scope will benefit and in many cases the current providers are not delivering the minimum numbers of procedures as set out in the respective NICE guidance. With respect to cardiovascular services, higher volume centres will result in sufficient scale to enable further sub-specialisation e.g. mitral valve repair. This will allow services in the area to reflect the trend in clinical practice globally of sub-specialisation to deliver effective care.

Lance Saker (LS) highlighted that commissioners need to ensure other parts of the pathway are not neglected by focusing on specialist centres. Most of the potential benefits can be
derived from improvements in early diagnosis and out of hospital care. DF reiterated that UCLPartners is committed to driving improvements in early diagnosis and out of hospital care. The cardiovascular improvements in stroke services seen recently are a key example of this. The priority will be to ensure these specialist centres are embedded as an integral part of the pathway.

3. Presentation and discussion on the cardiovascular proposals

DF presented the case for change for cardiovascular disease. DF noted that the London Chest Hospital is already going to move to St Barts as part of previously agreed changes.

The Heart Hospital has c70 cardiac surgery beds and c15 intensive care beds. It is a relatively small standalone specialty site. Due the small scale there are weaknesses including:
- High cancellation rates
- Small ITU (intensive care) facility
- No capacity to increase size due to location
- Poor compliance with single sex accommodation.

The majority of clinicians engaged would prefer a single specialist cardiovascular centre at Barts Health to take advantage of new building at St Bartholomew’s which will offer better patient experience. Given its size (c42 intensive care beds) patients can be admitted quickly and with fewer cancellations. Surgeons will begin to sub-specialise and the specialist centre is seen as a catalyst to improvements across the pathway.

AR invited the attendees to comment on the cardiovascular proposals and no specific concerns were raised.

Wendy Mead (WM), a member of the public confirmed her support for the proposal for a single cardiovascular centre at Barts Health given the close research relationship Barts Health has with the William Harvey Centre at Queen Mary’s Charterhouse Square.

PH asked for clarification around due diligence required for the financial analysis and commissioner sensitivities applied to the modelling. SS noted that each party within the tripartite work (NHS England, University College London Hospitals NHS Foundation Trust, Barts Health) will require that the costs and revenue flows provided are reasonable. With respect to commissioner sensitivities; the modelling included two assumptions. The first was a ‘no growth’ assumption in activity. The second was application of a 20% optimism bias. Both assumptions result in more conservative modelling outputs.

4. Decision making on specialist cardiovascular recommendation

AR invited the CCG and NHS England representatives to each make their respective decisions on whether to take on the recommendation as a commissioner preferred option for further engagement. AR also requested whether commissioners had any specific equality issues relating to the recommendation. A summary of the decisions is presented in the table below.

<table>
<thead>
<tr>
<th>Commissioner</th>
<th>Do you agree to take on the recommendation as the commissioner preferred option?</th>
<th>Are there any specific equality issues?</th>
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<tbody>
<tr>
<td>Camden</td>
<td>Yes</td>
<td>Further work to understand the impact on travel times for specific protected characteristics.</td>
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<tr>
<td>Islington (Note 1)</td>
<td>Yes</td>
<td>No further issues</td>
</tr>
<tr>
<td>Enfield</td>
<td>Yes</td>
<td>No further issues</td>
</tr>
<tr>
<td>Haringey</td>
<td>Yes</td>
<td>No further issues</td>
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(Note 1) Welcome being involved and considers such collaborative working important. Need assurances there is sufficient capacity to implement the change and that quality is maintained

(Note 2) City and Hackney tabled a paper which set out that the CCG supports the case for change, with conditions on the development on commissioner assurances, in particular on Barts Health as the provider. The paper is pasted below

From Paper:

Overall the CCG supports the case for change and the plan to develop a single integrated cardiovascular centre.

The CCG is keen to proceed with the further engagement work as they remain concerned about the choice of Barts Health as the single centre as outlined in their original Board decision on Friday 31 January 2014.

The CCG Board supports the proposal to develop commissioner assurances and requests that:

- Clear KPIs and targets are agreed by NHS England and CCG clinical commissioners for each of the benefits set out on page 56 of the business case;
- These KPIs are used to both measure the delivery of high quality cost effective care and improved outcomes and underpin the pathway work;
- The pathway work ensures a cost effective model of care between DGH and specialist services

The CCG have indicated that in order to inform their support of the next phase and final decision, they expect:

- The explicit agreement to the KPIs and the production of a delivery plan by Barts Health to achieve these;
- The delivery plan to outline the timing and realisation of the benefits for City and Hackney CCG patients and their health economy;
- To contract for the achievement of the benefits should the proposals proceed to mobilisation

5. Presentation and discussion on the cancer proposals

DF provided the context of the proposed changes. Only a small proportion of total cancer spells (2%) are impacted by the recommendations.

DF noted the work of London Cancer which has been set up to identify improvements across the whole pathway. These recommendations are an integral part of these improvements.

DF set out the individual recommendations as presented in the business case.

DF provided anecdotal evidence supporting the need for dedicated wards for patients with brain cancer. Outcomes are typically poor for patients with short life expectancies. The dedicated ward at Queen’s Square (UCLH) provides a calming environment for patients with quick access to health professionals. The aspiration of these proposals is to deliver this high level of patient experience.

GM requested assurances that any adverse impact on the trauma service at Royal London is mitigated. DF noted that joint working relationships between providers was key. The proposals
have received support from the Medical Director at Barts Health and work is underway to address these issues.

LS noted that a potential risk to centralisation is the additional time patients may have to wait from diagnosis to treatment. There is a need to address management plans following diagnosis and for the specialist centre to keep the patients and their primary care clinicians informed. WM also raised similar concerns that currently the system does not perform well at transferring patients back to their local hospital effectively.

6. Decision making for acute myeloid leukaemia (AML) services

AR invited the CCG representatives to decide whether to take on the AML recommendations as the commissioner preferred option for further engagement. AR also requested whether commissioners had any specific equality issues relating to the recommendation. A summary of the decisions is presented in the table below.

| Commissioner  | Do you agree to take on the recommendation as the commissioner preferred option? | Are there any specific equality issues?
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<tbody>
<tr>
<td>Camden (1)</td>
<td>Yes</td>
<td>Need to make sure that we have engaged and involved the protected characteristic groups to better understand their issues and how they use the services</td>
</tr>
<tr>
<td>Enfield</td>
<td>Yes</td>
<td>No further issues</td>
</tr>
<tr>
<td>Haringey</td>
<td>Yes</td>
<td>No further issues</td>
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</tbody>
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(1) Has requested assurances that the hand-offs between specialist and non-specialist services will work particularly in relation to communication of care plans and ensuring high quality of patient experience.

7. Decision making on remaining specialist cancer pathways

AR invited SW as representative for NHS England to decide whether to take on the remaining specialist cancer pathway recommendations as the commissioner preferred options for further engagement. AR also requested whether NHS England had any specific equality issues relating to the recommendation. A summary of the decisions is presented in the table below.

| Commissioner   | Do you agree to take on the recommendations as the commissioner preferred options? | Are there any specific equality issues?
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<tbody>
<tr>
<td>NHS England (1)</td>
<td>Yes</td>
<td>No issues</td>
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(1) Concerns and key issues that have been raised by all commissioners in regards to the proposals have been noted and these will be taken forward and addressed as part of the next stages of the programme.

8. Decision making on whether to proceed to a further engagement

NKB provided an overview of the next phase of the programme which is outlined in chapter eight of the business case. The business case itself will be developed into a short consultation document which was circulated in draft format, feedback is welcome on this. This document will be written with the plain English standard (kite mark) and published on the NHS England
website as part of the launch of the engagement. A series of workshops will be held to address the key issues previously raised by stakeholders in the previous phase of engagement. In parallel, planning for implementation work and associated commissioner assurances raised during this meeting will be further developed.

AR invited the commissioners to decide on whether to proceed to further engagement on the preferred options. The decisions are presented in the table below:

<table>
<thead>
<tr>
<th>Commissioner</th>
<th>Do you approve the business case and consultation document and agree to proceed to phase 2 of engagement on the commissioner preferred options to inform final decision making?</th>
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<tbody>
<tr>
<td>Camden</td>
<td>Yes</td>
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<td>Islington</td>
<td>Yes</td>
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<td>Enfield</td>
<td>Yes</td>
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<td>Haringey</td>
<td>Yes</td>
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<tr>
<td>City and Hackney</td>
<td>Yes</td>
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<tr>
<td>NHS England</td>
<td>Yes</td>
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</table>

9. **Next steps and close**

AR concluded the meeting and thanked people for their attendance. AR reiterated that this is not the final decision and that a final decision on whether to proceed to implementation will only be made after the further engagement has concluded, in similar commissioner meeting towards the end of July.