Report of the six authority Joint Health Overview & Scrutiny Committee

Response to the consultation paper "Investing in Your Health" issued by the Bedfordshire and Hertfordshire Strategic Health Authority as it relates to the future of the non-surgical oncology facility at Mount Vernon Hospital and the related consultation paper from the North West London Strategic Health Authority entitled "Mount Vernon Hospital: The Future of Services for Cancer Patients"

MEMBERS OF THE COMMITTEE

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Cllr Pauline Wilkinson (Buckinghamshire County Council),
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Cllr Ken Coleman (Hertfordshire County Council),
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Introduction

1. This report sets out the formal response of the Joint NHS Scrutiny Committee to the consultation document "Investing in Your Health" issued in March 2003 by the Bedfordshire and Hertfordshire Strategic Health Authority (StHA) and the complementary consultation paper "Mount Vernon Hospital: The Future of Services for Cancer Patients" issued by the North West London Strategic Health Authority in June 2002. It is understood that Bedfordshire and Hertfordshire StHA consultation document was prepared on behalf of the Primary Care Trusts on the future of health services in the Strategic Health Authority area. The North West London StHA document was issued on behalf of the Primary Care Trusts of Harrow, Hillingdon and Brent.

Statutory Basis for this Submission

2. This study was undertaken as a Regulation 4 study under Statutory Instrument 2002 No. 3048, that is:

   "where a local NHS body has under consideration any proposal for a substantial development of the health service in the area of a local authority, or for a substantial variation in the provision of such service, it shall consult the overview and scrutiny committee of that authority."

3. As opposed to a Regulation 2 study, whereby:

   "An overview and scrutiny committee may review and scrutinise any matter relating to the planning, provision and operation of health services in the area of its local authority"

4. The Joint Committee was established under the terms of a Direction issued by the Secretary of State for Health and dated 17th July 2003. A copy of that Direction is shown as Appendix 1. That Direction requires those local authorities consulted by a local NHS Body to appoint a joint committee for the purposes of responding to the consultation, where that consultation concerns a proposal for a substantial development of the health service or a substantial variation in the provision of a service. It was accepted by all those involved that the consultation proposals as they affected Mount Vernon constituted both a substantial development of services and a substantial variation in the provision of service. Accordingly it was appropriate to proceed by way of a Joint Committee.

Composition of the Joint Committee

5. It is important that the mechanisms used to establish the Joint Committee are documented, not only to secure a firm underpinning and legitimacy to its work but also to record the process for those authorities faced with a similar task of establishing a joint committee. This report is probably the first report of a Joint Committee established under the regulations and directions emanating from the local authority NHS Scrutiny powers set out in the Health and Social Care Act 2001.

6. In May 2003, the Department of Health issued policy guidance, "Overview and Scrutiny of Health – Guidance". Paragraph 10.7 of that document anticipated the issuing of a Direction by the Secretary of State. Local authorities which believed that they might be affected by the Direction met at Harrow Civic Centre on Thursday 10th July 2003. Authorities present at that meeting were Hertfordshire County Council, Bedfordshire County Council (also representing Luton Borough Council), London Boroughs of Barnet, Harrow, Hillingdon and Buckinghamshire County Council.

7. At that meeting it was anticipated (mistakenly as it turned out) that the Secretary of State for Health would very shortly issue a Directive to the Bedfordshire and Hertfordshire County Councils, the London Boroughs of Harrow, Hillingdon (and possibly Barnet and Brent) and Luton Borough Council requiring them to establish a joint committee to scrutinise the proposals for the transfer of cancer services away from Mount Vernon Hospital. It was expected that this Direction would be received in the week commencing 14th July 2003. At that meeting it was accepted that each authority could therefore be under an obligation to participate in a joint committee to consider the proposals and respond to the consultations from the two Strategic Health Authorities.

8. While the details of the Secretary of State's Direction were unknown it was thought that each Authority would still have freedom to respond individually by the 1st September consultation submission deadline to the wider Investing in Your Health document and, it would appear, to the specific proposals for Mount Vernon. Accordingly it was agreed that the joint committee would need to focus on the future proposals for Mount Vernon and not the wider proposals for Bedfordshire and Hertfordshire.

9. At that meeting the following issues were raised:

   a) **Timescale**: deep concern was expressed by all over the very short timescale which was available during late July and August to establish the joint committee and to identify the issues and respond to the consultations. The meeting felt that sufficient time should be allowed to consult, consider and respond properly in order to avoid any challenge by judicial review. The process must therefore be transparent and clear and there was a general feeling that it was questionable if this could be done in the timescale available. It was however agreed by all that although the time available was felt to be inadequate, if the StHA decision was delayed by more than a few weeks then they would miss this years bidding round and so delay the whole health improvement process by at least a year. Everyone agreed that this should not be allowed to happen and every effort would therefore be made to meet the consultation deadline.

   b) **Conflicts of interest**: the possibility of (a) minority report(s) was accepted and would only be required if the final submitted report did not reflect all the views and concerns of all members.

   c) **Composition and size of committee**: the meeting felt that the larger the committee, the more difficult it would be to convene the meeting. The meeting considered if there were any political constraints over what would be feasible and possible. It also addressed issues in relation to the political proportionality of the committee, which it was felt may be particularly difficult to achieve. It was agreed that two Members from each of the Local Authorities named in the Direction should be nominated to represent their Local Authority on the joint committee. Other interested Local Authorities could also be invited although voting rights would require further consideration. It was accepted at that stage that the requirement to secure the appropriate political proportionality may necessitate further attention.

   d) **Mechanics**: It was agreed that the joint committee would be advised to seek approval from the Bedfordshire and Hertfordshire Strategic Health Authority to submit the Joint Committee's response to the two Strategic Health Authorities by the North West London Strategic Health Authority's later consultation deadline of 12th September 2003, rather than the Bedfordshire & Hertfordshire Strategic Health Authority's consultation date of 1st September 2003.

   e) **Evidence**: It was agreed that the joint committee would need to ensure that there would be no risk of legal challenge from community groups who felt that

they had been excluded from the consultation process. Representatives of the joint committee must therefore ensure that there would be an opportunity for all interested parties to submit their views. Given the timescale available, the meeting agreed that the best way to achieve this would be for the Joint Committee to be advised that each participant Local Authority would be requested to publicly invite written submissions. At that stage it was envisaged that the committee would proceed by way of a mixture of Written and Oral evidence. It was envisaged that independent appraisal of written evidence would guide the joint committee on which submissions should be called-in for further consideration. The joint committee would also consider which additional witnesses it would wish to invite in order to give evidence, for instance, the Strategic Health Authorities, Mount Vernon Hospital, and a representative able to outline the national perspective on cancer treatment services.

f) **Process**: it was agreed that there would be a requirement to have at least four meetings. Officers would arrange for each Local Authority to identify two nominated Members, representing political proportionality, who could take the process forward as follows:

(i) A meeting to establish the joint committee of those named in the Directive would be arranged to take place at 6.30 pm, 30th July at Harrow Civic Centre, assuming the Directive had been received at least 7 days prior to this date. This meeting would determine the 'Terms of Reference' and decide if, for example, it would be appropriate to co-opt other partners. It was agreed that Bedfordshire County Council would convene the meeting and circulate an Agenda.

(ii) A subsequent meeting to consider the evidence submitted to each Local Authority and agree joint committee response headlines. The joint committee would receive evidence and invite additional representatives from appropriate bodies. This would be a public meeting. Each Local Authority should take responsibility for issuing a local public notice in local newspapers to announce that the joint scrutiny evidence meeting would take place and invite written submissions. It was also suggested that this could also be further promoted on the council websites.

(iii) A meeting to formally approve the response to be submitted to the StHAs

(iv) Possible further meeting to scrutinise the decision(s) of the Strategic Health Authority(ies).

(v) Substitute representatives would be allowed to attend each meeting and any Local Authority which decided not to take part in this process would lose its right to submit a response.

10. In addition, the meeting felt that there was a need to express to the Department of Health that this process of Direction and joint scrutiny was generally felt to be very unsatisfactory, particularly given that no resources had been made available to local authorities to conduct NHS Scrutiny. All authorities undertook to make it very clear to the Department of Health that this was unacceptable and enlist the support of MPs, the LGA, the Democratic Health Network and others to highlight the need for a better system with adequate resources.

11. Once the Direction was issued on 17th July 2003 it became clear that it was general in its nature. It did not specifically address the Mount Vernon issue and specific authorities were not named. This led to a requirement to re-evaluate the composition of the Joint Committee. The Direction required that those authorities which had been consulted by the NHS Body, which was taken to mean the two Strategic Health Authorities, were required to come together to form the Joint Committee. The Bedfordshire and Hertfordshire Strategic Health Authority's 'Investing in Your Health'

Consultation paper did not identify which authorities had been consulted, while the North West London Strategic Health Authority's paper expressed in general terms, identifying in Appendix 4 that the following local authorities had been consulted, "County District and Borough Councils within the catchment area of Mount Vernon Cancer Centre – specifically Chairs of Health Overview & Scrutiny Committee".

12. This raised a number of issues. First, it was not at all clear that the StHAs were mindful (if indeed they were aware) of the implications for local government of them consulting so many authorities. The effect being that all those social services authorities which were consulted by either of the two Strategic Health Authorities became eligible (if not required) to participate in the joint committee.

13. Secondly, it was unclear whether an authority not included in the first tranche of authorities consulted, but which had subsequently requested to be consulted (say because they are aware that patients from their area use the facility) became eligible to join the Joint Committee.

14. Thirdly, it was tacitly understood that authorities that had little or no material interest in the proposition may not wish to participate, for example if no patients from their area have used the facility in the recent past.

15. Fourthly, the local authorities which had been consulted contained a mixture of District Councils and other authorities which were, in the context of the Direction, those identified in Section 7 of the Act – i.e. Social Services authorities. So while the StHAs may have consulted district councils in two tier areas, those districts were not eligible to join the Joint Committee and their County Council would need to represent their interests.

16. Fifthly, the North West London Strategic Health Authority had sent its consultation paper to the Chair of the Health Overview & Scrutiny Committee. In many cases this meant that the local authority officers were unaware that the authority had been consulted and therefore unaware of the authority's eligibility to join the Joint Committee.

17. Sixthly, at the same time that the Direction had been issued, the DoH May 2003 Policy Guidance was superceded by the July 2003 Policy Guidance which included an amended paragraph (10.7.3) which recognised the DoH Direction. At the same time as the new Directive was published so was an amended version of the guidance on involving the Community Health Councils, while they still existed, in the work of the Joint Committee. It was recognised that this was relevant in these circumstances and that it would need to be factored into the Joint Committee's process of decision making.

18. Most importantly, the question was asked whether the relatively late arrival of the Direction and the revised policy guidance meant that the relevant local authorities did not have to do this exercise for Mount Vernon. The matter was taken up with the DoH. Their advice was that the Secretary of State had issued a Direction which was anticipated in the first draft of the Policy Guidance published in May 2003. The advice also reiterated that the Joint Committee should have as its potential membership all of those authorities originally consulted by the relevant NHS body and that all should be eligible to join/be involved in the joint committee - they had a right to be involved - but equally that there was no requirement or compulsion on them to participate. It was also indicated that those authorities not wishing to be involved still had the right to make representations to the joint committee and that the opportunity to make such representations to the joint committee should be made available.

19. While it was recognised that the job had to be done, it was therefore still unclear which authorities should come together to comprise the Joint Committee. As the lead authority, Bedfordshire County Council approached each of the Strategic Health Authorities requesting a list of which local authorities they had each consulted

20. The North West London Strategic Health Authority reported that it had consulted the following authorities:

- Bedfordshire County Council
- Borough of Kensington & Chelsea
- Harrow health and Social Care Scrutiny
- Hertfordshire County Council
- London Borough of Ealing
- London Borough of Hillingdon
- Luton Borough Council
- Borough of Hammersmith & Fulham
- City of Westminster
- Harrow Social Services
- London Borough of Brent
- London Borough of Harrow
- London Borough of Hounslow

(There were three references to Harrow but this was taken as reference to one authority).

21. The Bedfordshire & Hertfordshire Strategic Health Authority reported that it had consulted the following authorities:

- Bedford Borough Council
- Bracknell Forest Borough Council
- Buckinghamshire CC
- Dacorum Borough Council
- Hertfordshire County Council
- Kings Langley Parish Council
- London Borough of Harrow
- Mid-Beds District Council
- Royal Borough of Windsor & Maidenhead
- Sandridge Parish Council
- South Beds District Council
- Stevenage Borough Council
- Watford Borough Council
- Bedfordshire County Council
- Broxbourne Borough Council
- Chiltern District Council
- East Herts District Council
- Hertsmere Borough Council
- London Borough of Barnet
- Luton Borough Council
- North Herts District Council
- Royston Town Council
- Slough Borough Council
- St Albans District Council
- Three Rivers District Council
- Welwyn Hatfield Council

22. From these two lists it was possible to identify that the following fifteen Social Services Authorities were consulted by one or other of the two StHAs:

- Bedfordshire County Council
- City of Westminster
- London Borough of Barnet
- London Borough of Ealing
- London Borough of Harrow
- London Borough of Hounslow
- Slough Borough Council
- Royal Borough of Kensington & Chelsea
- Buckinghamshire CC
- Hertfordshire County Council
- London Borough of Brent
- London Borough of Hammersmith & Fulham
- London Borough of Hillingdon
- Luton Borough Council
- Royal Borough of Windsor & Maidenhead

23. However it was recognised that not all of these authorities had residents who use the Mount Vernon facility. Set out below in Table 1 is information on the place of residence of patients who used the Mount Vernon facility during 2002/03. The table aggregates the information given in the North West London StHA consultation document about the area of residence of the patients who received courses of treatment for either radiotherapy or for chemotherapy. The data relates to the number of courses of treatment which marginally higher than the number of patients, but was regarded as a good-enough proxy of the service provided by Mount Vernon and may therefore be taken as an indication of the reliance of those patients on the service provided by Mount Vernon.

Table 1: Mount Vernon Patients by District of Residence 2002-2003

District of Residence	Courses of Treatment (Radiotherapy)	Courses of Treatment (Chemotherapy)	Total Courses of Treatment
BEDFORDSHIRE HEARTLANDS PCT	140	62	202
DACORUM PCT	186	80	266
HERTSMERE PCT	108	40	148
LUTON PCT	188	92	280
N HERTS AND STEVENAGE PCT	103	37	140
SOUTH EAST HERTFORDSHIRE PCT	57	22	79
ST ALBANS AND HARPENDEN PCT	153	77	230
WATFORD AND THREE RIVERS PCT	202	102	304
WELWYN HATFIELD PCT	82	27	109
Bedfordshire and Hertfordshire SHA	***1219***	**539**	**1758**
BRENT PCT	114	52	166
EALING PCT	32	20	52
HARROW PCT	279	205	484
HILLINGDON PCT	280	245	525
HOUNSLOW PCT	4	7	11
KENSINGTON AND CHELSEA PCT	3	4	7
North West London SHA	***712***	***533***	***1245***
BRACKNELL FOREST PCT	30	15	45
CHILTERN AND SOUTH BUCKS PCT	143	77	220
SLOUGH PCT	118	52	170
WINDSOR, ASCOT & MAIDENHEAD PCT	131	61	192
WYCOMBE PCT	13	9	22
Thames Valley SHA	***435***	***214***	***649***
BARNET PCT	211	128	339
CAMDEN PCT	1	2	3
ENFIELD PCT	11	8	19
HARINGEY PCT	3	2	5
ISLINGTON PCT	1	2	3
North Central London SHA	***227***	***142***	***369***
Sub-total	**2593**	**1428**	**4021**
Other PCTs	55	22	77
TOTAL	**2648**	**1450**	**4098**
Total Patients	**2639**	**1445**	**4084**

(Source: Adapted from Mount Vernon Hospital: the future of Services of Cancer Patients pages 9 and 11)

24. In comparing the content of the list of those authorities which were consulted with those authorities which had residents who were patients at Mount Vernon some interesting observations could be made. These were that:

25. The City of Westminster and the London Borough of Hammersmith & Fulham do not feature in the list of authorities in Table 1 with residents who had attended Mount Vernon for courses of treatment.

26. Other authorities had relatively few residents who were patients receiving treatments at Mount Vernon:

Authority	Courses of treatment
London Borough of Ealing	52
London Borough of Enfield	19
London Borough of Hounslow	11
Royal Borough of Kensington & Chelsea	7
London Borough of Haringey	5
London Borough of Camden	3
London Borough of Islington	3

All have relatively little contact with Mount Vernon.

27. The residents of the Bedfordshire, Hertfordshire and Luton StHA had 1758 courses of treatment at Mount Vernon, making 43 per cent of the total number of treatments. Within the North West London StHA area there were 1245 courses of treatment (including those at Ealing Hounslow and Kensington and Chelsea), making 30 per cent of the total number of treatments. Within that group of authorities in the North West London StHA area, residents from Brent (166 courses of treatment), Harrow (484 courses of treatment) and Hillingdon (525 courses of treatment) had the most contact - 1175 in all making 29 per cent of the total treatments. (It should be noted that this figure of 1175 is included in the figure of 1245 courses of treatment for the whole of the North West London strategic Health Authority area). Buckinghamshire residents had 242 treatments, while elsewhere in the Thames Valley StHA area the major users were Slough (170), and residents from Windsor, Ascot and Maidenhead, (192). In the North Central London StHA area, London Borough of Barnet residents received 339 treatments. It should be noted that in all cases these are Primary Care Trust area figures but equally there is considerable coterminosity between the local authority and the PCT boundaries.

28. On this basis, and mindful of the need for practical politics and practical public administration within a tight and short timescale it was suggested by Bedfordshire, the coordinating authority, that the Joint Committee should comprise representatives of the following authorities.

- Bedfordshire County Council
- Luton Borough Council
- London Borough of Brent
- London Borough of Hillingdon
- Slough Borough Council
- Hertfordshire County Council
- London Borough of Barnet
- London Borough of Harrow
- Buckinghamshire County Council
- Royal Borough of Windsor and Maidenhead

29. The analysis had indicated that these ten authorities had a particular and direct interest in the work of the Joint Committee. If each authority was to nominate two elected members to serve on the committee that would make a committee of 20, which is as big as the joint committee would want to be if it was to do its work effectively.

30. These ten authorities were contacted late on 18 July 2003 inviting them to join the joint committee. Contact with Slough Borough Council was made via the good offices of Buckinghamshire County Council. Otherwise all contacts were initiated by Bedfordshire County Council

31. These ten authorities had the most direct and material interest in the future of services provided by Mount Vernon. By direct and material interest was meant a significant number of courses of treatment being given to their residents. The authorities were identified by seeing which of them were above a cut-off point of 150 Courses of treatment in respect of patients from the area served by any social services authority. This figure of 150 courses of treatment, which represents 3.66% of all treatments, seemed to be significantly above the next lowest figure (Ealing with 52 treatments) and would ensure that authorities with more than 4 per cent of the total number of treatments, such as Brent (166 treatments) Slough (170 treatments), Windsor Ascot and Maidenhead (192 treatments) could participate in the joint committee.

32. It was however recognised that other authorities were eligible to join. If the other authorities wished to be associated with the joint committee then there were a number of options open to them. First, they could exercise their right to be full and active members of the committee. Secondly, they could be invited to join, be formal members and just not attend. Thirdly they could decline the offer of a place on the committee but could nevertheless submit written comments/evidence/views to the joint committee for it to consider. It was recognised that a defect of the second and third options was that the Direction provided for only the Joint Overview & Scrutiny Committee to make comment, secure the attendance of NHS officers and secure the appropriate information. If those authorities were not full participants then that may inhibit their own Health Overview & Scrutiny from responding to the consultation - albeit that, in their community leadership role, the Executives of those authorities could respond.

33. On the 23 July 2003 contact was made with the Overview & Scrutiny functions of those authorities that had been excluded from the list of ten social services authorities most affected. The analysis and the overall position was explained to them in the hope that they would, for the main, recognise that they had a de minimis involvement, although in the email correspondence it was entirely accepted that the interests of every individual patient has equal weight. It was indicated to those authorities that if they wished to be full participants then it was their right to be so. The authorities approached were:

- London Borough of Hounslow
- London Borough of Hammersmith & Fulham
- London Borough of Haringey
- Bracknell Forest Borough Council
- London Borough of Islington
- London Borough of Camden
- London Borough of Enfield
- City of Westminster
- Royal Borough of Kensington & Chelsea
- London Borough of Ealing

34. Each authority was advised that it had been consulted on the transfer of cancer services from Mount Vernon Hospital in North West London to a new facility to be built in Hertfordshire under the Bedfordshire and Hertfordshire Strategic Health Authority's plan for improving health called "Investing in Your Health". It was indicated that they may have been consulted by the Bedfordshire & Hertfordshire Strategic Health Authority or by the North West London Strategic Health Authority which had issued a parallel consultation paper. Each authority was advised that as a social services authority and a NHS consultee it had the right to join the Joint NHS Scrutiny Committee which was to be established under the Direction from the Secretary of State for Health issued on 17th July 2003.

35. Each authority was also advised that it did not have to accept the invitation to join the committee.

36. The authorities were provided with the analysis set out in Table 1 above. They were advised that from that information it was clear that, except in two cases, their residents did use the facility at Mount Vernon, although in very small numbers. Again the

authorities were advised that it was entirely accepted that for those individual patients their involvement with Mount Vernon could, quite literally, be a matter of life or death. Each of the authorities were provided with all of the previous correspondence that the coordinating authority had had with local authorities covering Hertfordshire, Luton, Harrow, Barnet, Hillingdon, Brent, Buckinghamshire, Slough and Windsor and Maidenhead.

37. Each of those authorities were asked to indicate whether it wished to join the NHS Joint Scrutiny Committee. They were also advised that first meeting was set for the following Wednesday evening at 6.30pm at the Civic Centre, London Borough of Harrow.

38. The following authorities chose not to take part in the Joint Committee:

- London Borough of Barnet
- London Borough of Camden
- London Borough of Haringey
- London Borough of Hammersmith & Fulham
- City of Westminster
- London Borough of Hounslow
- Royal Borough of Kensington and Chelsea
- Bracknell Forest Borough Council

39. In addition replies were not received to the invitation from London Borough of Enfield, London Borough of Islington, Royal Borough of Windsor and Maidenhead, Slough Borough Council. Subsequently and after the first meeting of the Committee the London Borough of Islington advised that it too would not be accepting the invitation. In the main authorities reported that their decision not to participate was due to their residents' de minimus involvement. The London Borough of Ealing indicated that it would participate in Joint Committee but subsequently withdrew after attending the first meeting, again citing de minimis involvement. Another reason cited was that the authority did not have a meeting of its Council in the near future and that therefore individual councillors' nominations onto the Joint Committee could not be approved by a meeting of the full Council. Another Council cited pressure of work and absence through annual leave by officers and members during what is traditionally a holiday or recess period and staff and/or members absences would not allow them to participate. Brent's late involvement, and the short timescale (over the August holiday period) meant that Brent Full Council could not participate in the joint committee nor nominate Brent Councillors to it. As such, the Chair and Vice Chair of the Brent Health Overview Panel attended in an informal capacity.

40. The Joint Committee which eventually prepared this submission comprised elected councillors from:

- Bedfordshire County Council
- Buckinghamshire County Council
- London Borough of Harrow
- Hertfordshire County Council
- London Borough of Hillingdon
- Luton Borough Council.
- together with non-voting councillors from the London Borough of Brent (and non-voting representatives of the Community Health Councils from the affected areas who attended and made submissions to the meetings of the Joint Committee).

41. The other issue which needed to be considered was whether the Community Health Councils were to be invited to join the Joint Committee or whether contact would be made in other ways. Each of the participating Councils were requested to consult their local CHC as to how they would wish to take this forward.

42. In order to meet the needs of the Access to Information legislation a common agenda was prepared and provided to each of the participating authorities with a request that each formally published the agenda in accordance with their normal local practice and

procedures. A single point of contact in the coordinating authority was provided for Press and other inquiries that the individual authorities felt that they were unable or unwilling to handle.

43. It was reported that contact with the DoH had secured an agreement for the authorities to review with the Department the arrangements that had been put in place to see what lessons and learning could be gathered for wider dissemination.

Approach Adopted by the Joint Committee

44. In preparing this response to the consultation the Committee met formally on two occasions. The first meeting on 30th July 2003 established the committee – further details are given below. (On the 1st September 2003, the committee met informally to be briefed by the Strategic Health Authorities on the proposals for Mount Vernon). On the 9th September 2003 the committee considered written evidence from Community groups, NHS representatives and staff and others with an interest. At that meeting it also approved this response to the Strategic Health Authorities. Each of the two formal meetings of the Committee were held in public. The briefing on 1st September 2003 was held in private. Appendix 4 gives a list of those who submitted written evidence.

45. At its first meeting on 30th July 2003 the Committee considered how it wished to approach its task. At that meeting officers from all the involved authorities were available to advise and support their elected members. Also present were representatives from the local Primary Care Trust and an officer representing both the Strategic Health Authorities. There was one other elected member attending as a member of the public.

46. The Committee was advised which authorities had chosen not to participate in the work of the Joint Committee. Set out below is a record of the decisions made by the Joint Committee on how it would discharge the task given to it.

Election of Chairman

47. It was agreed that this meeting should be chaired by the London Borough of Hillingdon as the Authority where Mount Vernon Hospital is located and Councillor David Horne took the Chair

Remit of the Committee

48. The lead officer outlined the role of the committee and after discussion it was **AGREED**:

 (i) That this meeting constitutes a Joint Committee for the purposes of responding to the proposed substantial variation to services covering more than one overview and scrutiny committee area in accordance with the directions issues on 17th July 2003. The Committee comprises representatives from the following authorities: Bedfordshire, Buckinghamshire, Ealing, Harrow, Hertfordshire, Hillingdon and Luton. (NB Ealing subsequently indicated that it would withdraw from membership of the Committee. Although Brent Council did not formally appoint members to the joint committee, the Chair and Vice Chair of Brent Council's Health Overview Panel attended meetings and participated in discussions).

 (ii) The Committee wished to record its concern that the time allowed for this consultation had not enabled all authorities involved to properly nominate members to the committee through their own procedures and that due to the urgency of the situation the arrangements made should be seen as acceptable. It should be noted that each authority made its own arrangements for nominating members to the joint committee.

(iii) This Committee would confine its activities to scrutiny of the proposals for Mount Vernon Hospital

(iv) Responses from individual authorities to the proposals for the reorganisation of health services in Hertfordshire, Bedfordshire and Luton – Investing in Your Health – would be appended to the report on Mount Vernon. LB Harrow will seek written confirmation from the Health Authority that they will, in this case, regard this as complying with the direction to go through the joint committee.

(v) The final date for response to both consultations will be 12th September 2003

(vi) It was agreed that reserve/substitute members with full voting rights should be able to stand in for appointed colleagues.

Additional Attendance at the Committee

49. The involvement of CHCs and other interested bodies was discussed and it was AGREED:

(vii) A representative of each of the CHCs in affected areas should be invited to attend future meetings of the committee as observers and have a right to speak but not vote.

(viii) Other interested parties should be invited to provide written evidence to the committee. The meetings would be open to the public and would consider written evidence from stakeholder groups.

(ix) Where it was felt appropriate CHCs may choose to group together to represent a wider area.

Arrangements for Briefing

50. It was AGREED:

(x) It would be helpful for the Health Authorities to provide a general briefing to enable members to fully understand what is being proposed. Lynda Dent agreed to try and identify a person or persons able to give this briefing from the Health Authorities though she felt it would be more appropriate for North West London SHA to do the briefing because it was their consultation specifically on Mount Vernon

(xi) A provisional date (depending upon the availability of a speaker) was set for **1st September 2pm at Mount Vernon Hospital**

(xii) The lead officer agreed to make available electronically the various briefing documents available

Arrangements for Taking Evidence

51. It was recognised that there were some organisations that would want to give verbal evidence to the committee. However, due to the restricted time scale and unfortunate timing (over the holiday period) it was **AGREED**:

(xiii) That written evidence would be considered by the committee

(xiv) That each authority should, if they wished, carry out separate discussions with interested groups in their area

(xv) That Bedfordshire CC would provide a pro forma letter for authorities to send to all parties who might be interested in giving written evidence and that this would be returned to and collated by Bedfordshire CC with a deadline of the 22nd August 2003.

(xvi) That the committee would engage an external consultant to review the evidence and formulate a draft response from the committee to the consultation

(xvii) That all of the written evidence and the draft response would be made available to all Members before the meeting of the committee to agree a response. The London Borough of Hillingdon undertook to circulate the minority report from the Final Report of the Long Term Review of the Mount Vernon Cancer Network and Centre for circulation with the other briefing papers.

(xviii) That the meeting of the committee to formulate a response would be on 9th September 2003, 6pm at Hillingdon Civic Centre.

Relationship to "Investing in Your Health"

52. The Committee decided that the broader issues relating to the "Investing in Your Health" would be dealt with separately by each authority's own NHS Overview & Scrutiny Committee. It was reported that Bedfordshire and Luton, Hertfordshire and Harrow had each concluded their hearings and evidence taking. It was unclear whether, under the terms of the Direction, these individual authorities could formally individually submit their reports to the respective Strategic Health Authorities. Accordingly the submissions from these authorities are appended to this report as Appendices 6, 7, 8, 9, 10, and 11. Those reports should be read in conjunction with this report from that joint committee.

Consideration of the Evidence

53. The Joint Health Scrutiny Committee met at the Civic Centre Hillingdon on September 9th 2003 to consider the written evidence from a wide range of witnesses. The written evidence had been submitted to the coordinating authority and an independent consultant was retained to provide to the committee an independent and thorough analysis of the written submissions. The consultant presented her report of her analysis of the evidence to the committee. This analysis was accepted by the committee and adopted as its own. The letter inviting evidence is set out in Appendix 2.

Summary of the evidence received

54. Under the process approved at the meeting of the Joint Health Scrutiny Committee on July 30th, written evidence was invited by those authorities comprising the committee from interested parties in their localities.

55. This approach was adopted to help the scrutiny committee formulate its response to the Bedfordshire and Hertfordshire and North West London Strategic Health Authorities' consultation documents regarding the future of cancer services at Mount Vernon hospital.

56. A list of those parties who were invited to submit evidence is attached at Appendix 3. A list of those parties who submitted written evidence is attached at Appendix 4.

57. It is clear from Department of Health guidance that the joint committee should produce a consensual report, which reflects the views of all local authority members and that it should represent the interests of the population as a whole.

58. When change on this scale is considered, there will always be pluses and minuses for the individuals. The Committee will wish to arrive at a considered view as to the best way forward for the whole population that is affected. Indeed, one respondent wished to 'urge the OSC to reflect faithfully the variation of views across the large geographic areas that it represents', and another believes that the role of the committee is 'crucial'.

59. Evidence has been received from a wide range of organisations, from health service providers and Local Government committees, from committed community organisations and from experts in the field. Inevitably, with a wide range of interested parties expressing their views, there will be dissension in some areas, but there is also a significant degree of consensus on many issues.

60. For ease of understanding, the evidence submitted is summarised against the questions that have been posed by North West London StHA in their consultation document.

Q 1 - Do you accept the proposition that Mount Vernon needs to change?

61. There was evidence of a wide acceptance that services at Mount Vernon needed to change. Many respondents referred to the changes that were likely to occur in the treatment of cancer over the next ten years, and the need for flexibility to ensure that these advances could be accommodated.

62. From many respondents there was an understanding that it would be impossible for Mount Vernon to become a cancer centre, in the sense that the strategic health authorities use that term, because of the destabilising effect that this would have on services at other local hospitals.

63. It was broadly understood that the consequence of this, in the light of emerging evidence on the best way to treat cancer, meant that change was inevitable on the Mount Vernon site. The quality of services that would be available to local people was considered by many to be of paramount importance, and there was understanding of the need to change in order to meet nationally agreed quality standards.

64. There was an understanding that continuing developments in the treatment of cancer meant that effective functioning of multi-disciplinary teams was crucial to ensuring the quality of cancer care. There was an understanding that this would be impossible to achieve on the Mount Vernon site.

65. Not all respondents, however, understood the need for change, and some called for services at Mount Vernon to remain unchanged. Others pointed out that no change could mean a drop in the quality of the services provided, or a failure for services to continue to improve in quality, as the site could not become a cancer centre under the NHS definition without a damaging effect on other hospitals.

Q 2 - If you accept this proposition, do you accept that Mount Vernon's future is not dependent on it being a specialist cancer centre?

66. There was a widely expressed understanding that the future of Mount Vernon was not dependent on it being a specialist cancer centre. However, it was clear that, for some respondents, they would prefer that it became a specialist cancer centre.

67. For some of the specialist research bodies currently based on the Mount Vernon site, concerns were expressed that their expertise and contribution to services could be lost through a future where Mount Vernon was not a specialist cancer centre. It was noted, however, that it could be possible for some of the services to remain on the Mount Vernon site, with links developing with the specialist cancer centres at the Hammersmith, and in Hertfordshire. Other specialist bodies expressed a wish to

develop their services in conjunction with a cancer centre, as was being proposed in Hertfordshire, or as exists at the Hammersmith Hospital.

68. There was a perception that, despite Mount Vernon not being proposed as a cancer centre under the NHS definition, there was scope for the Mount Vernon site to remain as a facility that was regarded as providing high quality cancer care.

69. The possibility of the proposed centre being regarded as a 'cancer centre plus,' as the vision set out in the consultation paper was developed, was welcomed by many respondents.

70. Many of the respondents warmly welcomed the proposals to develop improved primary and community services on the Mount Vernon site and to improve intermediate care facilities. The proposal to work with existing specialist providers on the site, such as the Lynda Jackson Centre, Michael Sobell House and the Paul Strickland Centre to ensure that the holistic approach to services was maintained was welcomed.

Q 3 - If you believe that Mount Vernon needs to change in another direction, please give brief details.

71. Some of the respondents expressed the wish that Mount Vernon itself become a cancer centre, as well as the centres at the Hammersmith and in Hertfordshire.

72. Others understood, however, that this was not likely to be achievable, and that a move to create a third cancer centre would potentially have a detrimental effect on acute hospital sites both in North West London and in Hertfordshire, with associated loss of services for local people.

Q 4 - Do you support the general proposition of the development of Mount Vernon as a local provider of cancer services, as outlined above?

73. There was strong support for Mount Vernon retaining its role as a local provider of cancer services.

74. Many respondents pointed out that people were prepared to travel for better care, but that access to local services was extremely important, particularly where care involved an extensive series of treatments.

75. A belief was expressed that there may be a possibility for surgery for common cancers to be provided in the Diagnostic and Treatment Centre (DTC) proposed for the Mount Vernon site, and this was welcomed.

76. The view was expressed that the development of Mount Vernon as a local provider of cancer services, coupled with, where possible, the continuation of the holistic model of service provision that singled out Mount Vernon, would help retain the confidence of local people.

Q 5 - Do you support the proposition of the development of an ambulatory radiotherapy service at Mount Vernon, provided all quality and safety requirements are met?

77. This proposition was widely supported by responders, several of whom also emphasised the need to ensure that the quality and safety of the service was assured. Views were expressed that it would have been helpful to have clearer details of the service that could be provided, in order to come to a conclusion on the merits of the case.

78. It was also stated that other options for improving ambulatory cancer services on the site could be explored, where their provision was consistent with safety and quality of service.

Q 6 - Are there any other issues linked to the development of local services at Mount Vernon

79. As already stated, strong support was expressed for the further development of complementary services on the Mount Vernon site that would strengthen the range of health services available to local residents.

80. Particular mention was made of rehabilitation, physiotherapy, minor surgery provided in a DTC, pathology, intermediate care services, primary care services and community services.

81. The holistic care that is currently provided at Mount Vernon is very highly regarded. The view was expressed that it was important, as far as possible, to continue to provide that holistic service.

Other comments:

82. Many respondents expressed concern about the timetable for responding to consultation, particularly since this consultation had broadly been carried out during a holiday period. Some called for the process to be lengthened, and for additional work to take place on possible models of care before a decision was taken. Others welcomed the fact that this additional consultation had taken place.

83. There was a wide acceptance that the residents of Bedfordshire and Hertfordshire needed a cancer centre that would provide services to their residents.

84. Although it was accepted that the NWLSHA proposals would mean that many of the cancer services already provided at Mount Vernon would still be available there, concern was expressed about the increased travel times that might result for some patients. These people would have to visit either the Hammersmith, or the new cancer centre in Hertfordshire for their care or Oxford in the case of residents of Buckinghamshire. The authority was urged to explore the possibilities for ensuring that access was made as easy as possible.

85. The view was expressed that no change could result in a diminishing quality of care.

86. A question was asked as to whether the projected financial flows would support the plans being proposed here.

87. Concerns were expressed that the Government's national cancer standards might themselves be flawed, and that the plans were not based on statistical certainties. There were calls for further work to be done to underpin the development of plans for future services, and for those plans to be made more explicit over a confirmed timeframe.

88. Other respondents expressed the view that on a balance of probabilities, the proposals being put forward were based on the best currently available evidence, and accorded with evidence presented as to the future direction of cancer care in order to ensure continuing improvements in the quality of services.

89. The need to recruit and retain appropriate staff to ensure that services can be adequately provided was also mentioned.

Conclusions from the written evidence

90. The written evidence presented to the committee broadly indicates

- strong support for the staff and services currently at Mount Vernon
- understanding of, and support for the need for change at Mount Vernon
- support for the development of services of the highest quality in the most appropriate place
- support for a continuing and developing role for Mount Vernon as a provider of cancer services
- support for an enhanced role for the site in providing a range of primary, community and other services close to where local people need them
- a wish for specialist services at present on the Mount Vernon site to continue working with the NHS in a sustainable way
- agreement that the residents of Bedfordshire and Hertfordshire should have a cancer centre to meet their needs - most of those who expressed a preference that they would prefer to see the new cancer centre in Hertfordshire at Hatfield, although Watford was also mentioned
- concern that the timescale for the consultation, and the detail available are such as to make it difficult to reach an adequate conclusion
- a wish to see issues of transport and access for cancer patients to their cancer centre taken in to account
- concerns about the planning of the change in service and its practical implementation over the ten year period proposed

91. A number of groups in the immediate vicinity put forward the following points

- a strongly expressed wish from residents and patient representatives local to Mount Vernon that services remain unchanged
- If that proves impossible, a wish for Mount Vernon to be considered for development as a third cancer centre

92. In addition concerns were expressed that

- The National Cancer Plan was flawed, and not based on statistically valid evidence
- That there could be an irreplaceable loss of research opportunities as a result of change at Mount Vernon

Commentary by the Joint Committee

93. The Joint Committee, mindful of the Direction from the Secretary of State issued on July 17 2003, has attached to this report the submissions prepared by the NHS Overview and Scrutiny Committees (or their equivalent) in some of the participating authorities to the Bedfordshire and Hertfordshire Strategic Health Authority in respect of their wide ranging consultation document *"Investing in Your Health".* These submissions are set out in Appendices 6, 7, 8, 9, 10 and 11. The Committee requests

that the relevant Strategic Health Authorities read this submission alongside those separate submissions.

94. The Committee has adopted this approach in recognition of the provision in the Direction *that "only that joint overview and scrutiny committee may…make comments on the proposal consulted on to the local NHS body under regulation 4(4) of the Regulations".* The NHS Overview & Scrutiny Committees of a number of the authorities have also considered the broader range of issues raised in the "*Investing in Your Health*" Consultation Paper and wish to have that work properly considered by the Bedfordshire and Hertfordshire Strategic Health Authority and see this approach as the only positive method of ensuring that their views are submitted, received and properly considered.

95. In this submission the Joint Committee has restricted itself to addressing the issues surrounding the future of cancer services at Mount Vernon. This submission is therefore made to both the Bedfordshire and Hertfordshire Strategic Health Authority and to the North West London Strategic Health Authority. Where it is necessary to do so, recommendations have been addressed to other parties with an interest in the substantive issues and/or the procedural arrangements.

96. The Joint Committee found this piece of Health scrutiny to be a difficult task. It was operating under a new legislative arrangements, with the uncertainty that this brings. The exercise brought together seven local authorities (there were initially eight, but Ealing subsequently withdrew.[1]) each with their own concerns for the communities they serve. In some cases elected members were fully familiar with the arguments surrounding the future of Mount Vernon; in other cases they were not.

97. The Committee invited the representatives from the appropriate Community Health Councils in the seven authorities to join the committee in its deliberations, with speaking but not voting rights. Both these representatives and the overview and scrutiny members from each of the authorities had different traditions and approaches to the organisation of meetings, debating protocols and approaches to scrutiny. In addition it was the first time that Strategic Health Authorities, or indeed any other local NHS body, had consulted on a major service development or variation under the new legislative arrangements.

98. The Strategic Health Authority representatives were helpful in providing information and advice and for that the Joint Committee is grateful. The Committee would however wish to place on record the potential difficulties of partnership working with bodies they have the obligation to scrutinise. In an area as complex as this, with strongly held views, with complex information and analysis requirements and where there are challenges to the clinical and policy orthodoxy upon which the proposals are based, there will be tensions between the scrutineers and those they scrutinise. To that extent all of the parties were breaking new ground. There were passionately held views from all of the participants, local authorities, health authorities and the Community Health Councils, reflecting their interpretations of what was best for the communities they serve. These views did not necessarily coincide.

99. The Committee had three main concerns about the procedural aspects of this piece of work. First there was the issue of the evidential base. Secondly, there was the issue of the timescale for undertaking such an exercise. Thirdly there was concern about the procedural arrangements for establishing and operating the Joint Committee. Each of these is dealt with separately.

100. The Committee believed that in some respects the evidential basis for the Mount Vernon proposals was deficient. It believes that this hampered the quality of its work.

[1] Similarly, members from Brent participated in the committee but did not wish to be identified as full members of the committee and did not wish to exercise their vote, therefore this report stands in the name of the six remaining authorities whose details are given on the front cover

The Committee believes that there were five principal weaknesses. First, there was insufficient information about the relationship between the minimum size of the catchment population necessary to support a top quality integrated cancer centre. The estimates seemed to vary between 1 million and 1.5 million population, although it is understood that minimum population sizes could very well be slightly different for each different type of cancer. In the context of the smaller number, some members of the committee believed that there could be a different configuration to the number and distribution of cancer centres. Secondly, there was a concern that there was insufficient information about the relationship between catchment area size, concentration of clinical expertise and positive outcomes in terms of individual patients' health. This runs to the foundations of the thinking in the proposals and while references to some of the evidence were given in the consultation paper from the North West London Strategic Health Authority, this issue was insufficiently explored in the information and evidence submitted to the committee, nor, in the joint committee's view was it fully addressed in the consultation papers. Thirdly, there were concerns that insufficient information was made available about the catchment areas and patient flows to other existing or planned cancer centres or supporting facilities in adjacent Strategic Health Authority areas. Fourthly, and this was an issue faced by the Joint Committee itself as well as by the health bodies, was the interpretation of the statistics about where the patients who use Mount Vernon come from. It was both possible to assert that the largest number of users came from the Bedfordshire and Hertfordshire Strategic Health Authority Area and also that a majority of users did not come from that area, but from other Strategic Health Authority areas. Finally, there was a significant absence of proper financial and other resource information covering the existing running costs of the Mount Vernon Cancer services, the cost of short to medium term service improvements and where these were capital or revenue, the capital and operating costs of a new facility and the costs of any transfer to a new facility. Similarly the issues relating to the recruitment, retention, development and transfer of all grades of staff, while touched on is not explored in any detail. The Committee expects to see these issues addressed specifically in the decision-making papers considered by the Strategic Health Authorities.

101. The Joint Committee noted and understood that the Strategic Health Authorities' plans would come to fruition over the ensuing decade. It also noted and understood that therefore Strategic Health Authorities believed that these proposals should be viewed as a direction of travel rather than a detailed blueprint and implementation plan. Some members of the Joint Committee believed that this approach led in part to what they perceived to be deficiencies in the overall evidential base. Other members believed that it was important to secure agreement to the principle of any changes before their detailed implementation were drawn up.

102. The Committee was unsure as to whether there would be a requirement to consult on the detail of any substantial development or variation in service once the principle had been established. The Committee believes that it is incumbent on the relevant local health authorities and bodies to undertake further consultation on such matters if the current proposals are eventually implemented in whole or in part. The Committee envisages that this would be a consultation with the Overview and Scrutiny Committees of the authorities which represent the affected communities. To the extent that the current ministerial Direction applies, those authorities may need to come together to form a joint committee, but it is unlikely that this current joint committee would be reconvened for that purpose.

103. The Second main area of concern to the committee was the timescale under which it had to undertake its work and produce this response. The Secretary of State's Direction was issued on 17th July 2003. The Joint Committee met on 30th July, the first realistic date that it could have met having regard to the Access to Information legislative requirements. At that meeting, it decided to call for written responses from community and patient groups and others. These were to be returned to the coordinating authority by 22nd August. A briefing meeting was held on 1st September and the Joint Committee met formally on 9th September. The Committee was required

to make its submission to the Strategic Health Authorities by 12th September. The Committee was of the view that this did not represent a best practice model for public administration in that the consultation was undertaken during August, a traditional holiday period, and that this may have affected the extent of the responses. Secondly, there was no time for the committee to hold public hearings where experts, patient and public representatives and other stakeholders could give their evidence to the Joint Committee. To that extent the Committee wishes to express its dissatisfaction with the timescale within which it had to operate.

104. The Joint Committee is also mindful of its next task, to ensure that the relevant NHS decision-making bodies have properly consulted and made the decisions in the light of the available evidence, and that it will need to reconvene to examine those decisions. The Committee is however unsure as to the timetabling of the two Strategic Health Authorities' decision-making meetings and would wish to reconvene once rather than twice. The Joint Committee is also unsure as whether the decision is entirely one that falls to the Strategic Health Authority or whether the individual Primary Care Trusts have to approve or ratify a recommendation from the Strategic Health Authority. The Committee would not wish to have to reconvene to scrutinise each of the decisions of four health bodies in North West London and the thirteen (excluding the hospital trusts) in Bedfordshire and Hertfordshire. The Committee would welcome guidance from the Strategic Health Authorities (and other bodies) on this issue and would expect to see this issue addressed specifically in the decision-making papers considered by the Strategic Health Authorities.

105. The third area of concern is the sustainability and viability of the establishment and operation of Joint NHS Overview & Scrutiny Committees. There are significant organisational challenges in establishing such Joint Committees. There are decisions about which authorities should come together and there are concerns about them adequately reflecting the full range of legitimate perspectives where they involve a significant number of councils, as this Joint Committee has. The Committee believes that the current arrangements are not sustainable or viable. They are complicated to organise, sometimes need the support of external consultants or facilitators to act as honest brokers or independent analysts because of the legitimate and separate interests of the participating authorities. These arrangements cost money. Equally, few authorities are adequately funded or staffed to undertake NHS Scrutiny per se. The Joint Committee believes that there is a need for the Government and the parent authorities properly to fund NHS Scrutiny if exercises such as this are to become the norm.

106. The Joint Committee further believes that there are some perverse disincentives in the system in that all of the local authorities that the NHS bodies consult are eligible to participate in the work of a joint committee, and that this may result in either over-large joint committees or, and perhaps even worse, local health bodies restricting the scale, range or coverage of their consultation so that their local authority colleagues are not burdened with over-large Joint NHS Scrutiny Committees. One representative from Buckinghamshire County Council, from whose Strategic Health Authority Area (Thames Valley StHA) 649 out of the total of 4098 courses of treatment (15% of the total) come expressed a particular concern. This was that the Thames Valley Strategic Health Authority should have notified Buckinghamshire County Council, as the relevant social services authority, of the fact of the consultation and should have offered advice to that County Council's representatives on the implications of the consultation proposals on the citizens and patients of Buckinghamshire. Concern was also expressed that the consultation papers and the health bodies' presentation of the issues did not seem to take account of the "ripple effect" of changes in one health area on the services provided in or by a neighbouring health body. There was agreement that any further changes, pursuant to the implementation of the strategy, are the subject of further consultation and that all affected authorities are involved, including those in the Thames Valley Strategic Health Authority area.

107. The Committee also expressed two further concerns about Joint Health Overview and Scrutiny Committees. The first is that there is a need for clarity about how appointments to the joint committee should be made under the terms of the direction. One authority felt unable to participate in the joint committee as their understanding was that the Council of the Social Services authority must approve appointments to a joint committee. If this interpretation is correct it could delay the establishment of Joint Committees, delay their consideration of the issues and at worse prevent them from properly undertaking their Regulation 4 responsibilities.

108. The second was that although each authority has appointed an Overview & Scrutiny Committee with responsibility for Health issues, the Joint Committee had to be established from those authorities consulted by the relevant health body and that only the Joint Committee had the rights set out in paragraph 2 of the Secretary of State's Direction. The Joint Committee was of the view that each authority's own Health Overview & Scrutiny committee should have the right to properly investigate the matters of concern to its local community and to report on those to the relevant health body. The size of such a joint committee (in our case there was representation from seven authorities representing nearly 3 million people) and their concern to produce unanimous reports raises the possibility of bland, consensual reports that in effect represent the lowest common denominator rather than the incisive, sharp analysis that it more likely to come from an individual authority's representation of the valid views and concerns of its own community. There is also the issue of whether, as NHS bodies consult widely, as expected with their new statutory duty to consult, there will ever be a substantial development or variation in service that is only considered by a single authority's Health Overview & Scrutiny Committee. The present arrangements flowing from the Secretary of State's Direction imply the creation of a joint committee for virtually every change and it was the view of the committee that this undermined the local democratic representation and accountability which had been anticipated under the new NHS Scrutiny arrangements.

109. The Joint Committee believes that these are all matters which need to be pursued at the highest level and has instructed the officers supporting its work to do so with the Local Government Association, the Association of London Government and the Department of Health.

110. The preceding paragraphs have set out the views of the Joint Committee on its principal areas of concern as regards procedural matters. There is now a need to turn to the substantive issues as they affect Cancer Services at Mount Vernon Hospital.

111. At the outset, it is important to say that the Joint Committee was unanimous in its view that patients and public in Bedfordshire and Hertfordshire had the right to the highest standards of medical care, including cancer treatment and care. Equally the Joint Committee was unanimous in its view that the people of North West London and the Thames Valley area are not disadvantaged by the transfer of Cancer Services to a new facility in Hertfordshire either at Hemel Hempstead or at Hatfield (depending which option was finally endorsed by the Bedfordshire and Hertfordshire Strategic Health Authority). The Joint Committee supports the provision and development of high quality cancer services for all of the communities served by its constituent authorities. The Joint Committee supports the development of a cancer centre serving the people and patients of Bedfordshire and Hertfordshire. The Joint Committee recognises that the creation of a new cancer centre at a new hospital in Hertfordshire will require the transfer of the Bedfordshire and Hertfordshire NHS funding from the Mount Vernon facility to the new Centre over the coming decade.

112. The Committee is however equally concerned that the needs of Bedfordshire and Hertfordshire should not be met to the disadvantage of the needs of the people of North West London. In that regard the Committee believes that there are different views or interpretations as to the role that Mount Vernon will play in the future.

113. The first is that Mount Vernon becomes a hospital serving the needs of the population of North West London. In this vision it would refocus to be a supportive part of the local NHS infrastructure, supporting and supported by both the local primary care and local acute services provided from the local hospitals. In this vision, the future investment at Mount Vernon would provide for Ambulatory Cancer services (some of which could be quite advanced), a Diagnostic and Treatment Centre, Minor Injuries Clinic, a surgicentre for Elective Surgery and intermediate care, particularly for elderly people. There would not be the facilities or services associated with a district general hospital, Accident and Emergency, Maternity or Paediatrics.

114. The second view is that, in addition to the range of services set out above, Mount Vernon should be developed as a part of a wider cancer network. This view sees the development of the Cancer Network concept. Cancer Services would be based on Mount Vernon and use the NHS and non-NHS resources and assets located there. The services at Mount Vernon would be developed in parallel with the improvement in services at the new Cancer Centre in Hertfordshire, the use of new technology to allow local treatment from remote locations, and by working in concert with the Hammersmith Hospital Cancer Centre and other hospitals where surgery is carried out. The aim would be to see how cancer services could be made as accessible and as local as possible. In this view, it is accepted that Mount Vernon would continue to be a non-surgical oncology centre and would work in partnership with centres and facilities that could offer surgery and surgical after-care. In this context, the aim would be to maximise patient flow, to recognise the place that such a function could play in addressing waiting lists and exploit the geographical advantage that Mount Vernon has in respect of the neighbouring parts of three Strategic Health Authorities' areas.

115. The Joint Committee believes that the future of Mount Vernon should be settled in the context of a full debate about the future of Cancer Services in North West London. The Joint Committee therefore welcomes the proposed consultation on Cancer Services in North West London due to be launched in 2004. It believes that the future use of the Mount Vernon facility should be determined within the context of that work.

Conclusion

116. The Joint Committee has found this to be a difficult piece of work. It is concerned about the deficiencies in the evidential base. It is concerned about the timescale that it had to produce its report. It is concerned about the viability and sustainability of single-issue, time-limited Joint Committees, such as this.

117. On the substantive issue, the Joint Committee supports the development of high quality services for Bedfordshire and Hertfordshire. It supports the development of a state of the art Cancer Centre either at Hatfield or at Hemel Hempstead. It recognises that this involves the transfer of existing funding over time and that in the meantime planned improvements to the services should be pursued.

118. Such a transfer of funding would mean that the role that Mount Vernon plays in the context of serving the communities of North West London and the neighbouring Thames Valley would will need to be reassessed. Two views have developed from the Joint Committee's consideration of the issues and evidence. They have the same basis of the provision of a set of core services at Mount Vernon. One is more ambitious as to the role that Mount Vernon should play in the sub-regional context and seeks to retain what is best on-site while recognising that it will remain a non-surgical oncology facility. . The Joint Committee believes that the future of Cancer Services at Mount Vernon needs to be resolved in the context of a wide-ranging debate, such as the one that will be generated by the North West London Strategic Health Authority's consultation on Cancer Services in early 2004.

119. The Joint Committee is concerned that services, facilities and equipment continue to be maintained and developed over the transitional period. The Committee recognises

the need to keep together effective and well regarded clinical teams and would expect to see that reflected in personnel and other policies. It wishes to see action put in place which will support the continued provision of effective services over that transitional period. The Committee would also expect to see the position regularly monitored and that the relevant health bodies report periodically, but not infrequently, on progress. The role of Mount Vernon in addressing waiting lists and capacity issues and clinical outcomes in North West London, and neighbouring StHAs, should be given proper consideration.

RECOMMENDATIONS

The Joint Committee **RECOMMENDS** that:

1) In future consultation exercises on the development or variation of locally sensitive and well regarded services, the relevant health authorities and bodies produce full argued and reasoned cases with full demographic, technical and financial information. Furthermore, the consultation timetables for similar exercises are the subject of prior discussions with prospective consultees in order that they may properly discharge their own legal and administrative responsibilities in accordance with good practice in public administration.

2) The Bedfordshire & Hertfordshire Strategic Health Authority and the relevant PCTs proceed with their plans for a new cancer centre to be provided in Hertfordshire, principally serving the residents of Bedfordshire and Hertfordshire in line with the proposals set out in “Investing in Your Health”.

3) The North West London Strategic Health Authority and the relevant PCTs consult extensively on the provision of cancer services in North West London and the role that the Mount Vernon Hospital can play in the delivery of cancer and other locally important services.

4) There is continuing dialogue between the three Strategic Health Authorities (Bedfordshire & Hertfordshire, North West London and Thames Valley) and the relevant PCTs and other affected NHS Trusts to address the issues arising out of the development of cancer services in Bedfordshire and Hertfordshire as well as in North West London and the Thames Valley StHA area and that these discussion give equal weight to the future role of the services provided at Mount Vernon Hospital as part of a wider cancer network.

5) The Department of Health, the Local Government Association, the Association of London Government and other relevant bodies receive and consider a copy of this report together with commentary by the lead officer on the experience of operating a joint committee under the Secretary of State’s Direction issued on 17 July 2003 and that in discussions with the Department of Health the issue of funding for local authority NHS Scrutiny is vigorously pursued.

6) The authorities which are a party to this report make it available to their Executive, local MPs and the other stakeholders in accordance with the advice set out in paragraph 5.5.5 of the Department of Health’s Overview and Scrutiny of Health Guidance.

7) The Strategic Health Authorities and the relevant PCTs, in considering the report and recommendations from this committee, address each of the main points and show in their decision-making documentation that they have done so.

And that the Joint Committee **RESOLVES** to reconvene in early December 2003 to consider the decisions of the Strategic Health Authorities and relevant PCTs.

The Secretary of State's Direction

HEALTH AND SOCIAL CARE ACT 2001

DIRECTIONS TO LOCAL AUTHORITIES (OVERVIEW AND SCRUTINY COMMITTEES, HEALTH SCRUTINY FUNCTIONS)

The Secretary of State for Health in exercise of the powers conferred on him by section 8(4) of the Health and Social Care Act 2001(**a**) and regulation 10 of the Local Authority (Overview and Scrutiny Committees Health Scrutiny Functions) Regulations 2002(**b**) and of all other powers enabling him in that behalf hereby gives the following directions:—

Application, commencement and interpretation

1.—(1) These Directions are given to local authorities in England.

(2) These Directions shall come into force on 17th July 2003.

(3) In these Directions—

"the Act" means the Health and Social Care Act 2001;

"joint overview and scrutiny committee" has the meaning given in the Regulations;

"local authority" has the meaning given in the Regulations(**c**);

"local NHS body" has the meaning given in the Regulations;

"overview and scrutiny committee" means an overview and scrutiny committee with functions under the Regulations;

"the Regulations" means the Local Authority (Overview and Scrutiny Committees Health Scrutiny Functions) Regulations 2002.

Consultation of Committees by local NHS bodies

2. Where a local NHS body consults more than one overview and scrutiny committee pursuant to regulation 4 of the Regulations on any proposal it has under consideration for a substantial development of the health service or a substantial variation in the provision of such service, the local authorities of those overview and scrutiny committees shall appoint a joint overview and scrutiny committee for the purposes of the consultation and only that joint overview and scrutiny committee may:—

(a) make comments on the proposal consulted on to the local NHS body under regulation 4(4) of the Regulations;

(b) require the local NHS body to provide information about the proposal under regulation 5 of the Regulations; or

(c) require an officer of the local NHS body to attend before it under regulation 6 of the Regulations to answer such questions as appear to it to be necessary for the discharge of its functions in connection with the consultation.

Signed by authority of the Secretary of State for Health

Flora Goldhill
Date 17th July 2003

Member of the Senior Civil Service
Department of Health

(**a**) 2001 c.15.
(**b**) S.I.2002/3048.
(**c**) *See* regulation 1(3), paragraph (b), for the definition of local authority in relation to regulation 10 of the Regulations.

Appendix 2

Consultation letter sent out by Local Authorities

Your Ref :
Our Ref : nhsscrut/mtver/0803
Please ask for: Bill Hamilton
Direct Line : 01234 228032
E-Mail : hamiltwd@csd.bedfordshire.gov.uk
Web site : www.bedfordshire.gov.uk/scrutiny
Date :

Bill Hamilton
Assistant Chief Executive (Scrutiny)
County Hall
Cauldwell Street
Bedford MK42 9AP

Tel: 01234 363222
Fax: 01234 213006

Dick Wilkinson
Chief Executive

Recipient's name
Address 1
Address 2
Address 3

Dear

Consultation on Mount Vernon Hospital: The future of Services for Cancer Patients

The Joint NHS Scrutiny Committee comprising members from Bedfordshire, Luton, Hertfordshire, Buckinghamshire, Harrow, Hillingdon and Brent would like to receive written submissions from any interested parties on the subject of the Bedfordshire and Hertfordshire and the North West London Strategic Health Authorities' consultation on "Mount Vernon Hospital: The future of Services for Cancer Patients".

If you would like to submit your comments on this consultation, please forward them to me marked for the attention of Katherine Peddie by the 22nd August at the address below. A meeting on this subject will be held on 9th September at Hillingdon Civic Centre at 6pm.

Bill Hamilton
Assistant Chief Executive (Scrutiny)
F.A.O. Katherine Peddie
Room 359
County Hall
Cauldwell Street
Bedford
Beds MK42 9AP

Or via email to: ***nhsscrut@csd.bedfordshire.gov.uk***

I look forward to your responses.

Yours sincerely

Bill Hamilton
Assistant Chief Executive (Scrutiny)

Appendix 3

Circulation list inviting evidence for consideration by the Joint Health Scrutiny Committee

Bedfordshire County Council

Local cancer user groups
Bosom Pals
Cancer aftercare and rehab
The Lawns Carers support group
Can Care Society

Health bodies
Bedford Hospital NHS Trust
Beds and Herts Ambulance and Paramedic NHS Trust
Luton Teaching PCT
Luton and Dunstable Hospitals NHS Trust
Bedford Primary Care Trust
Bedfordshire Heartlands Primary Care Trust
Luton Primary Care Trust
Bedfordshire and Luton Community NHS Trust

Local voluntary sector groups
Biggleswade and District Carers
British Red Cross
Life Cares

Other
Macmillan Day Care Hospice
Macmillan Cancer Relief
Hospice at Home

London Borough of Brent

Local cancer user groups
Cancer Black Care

Health bodies
Brent and Harrow Community Health Projects
Healthwise Project
Healthy Harlesden
Loud and Clear Mental Health Advocacy
Central Middlesex Hospital
Brent PCT
CNWL Mental Health Trust
Local voluntary sector groups
African Women's Care
Age Concern Brent
Arlington Care Association
Asian People with Disabilities Alliance
Association of Muslims with Disabilities
Brent Association for the Blind
Brent Association of Disabled People
Brent Bereavement Services

Brent Carers Centre
Brent Crossroads
Brent Deaf People's Ltd.
Brent Indian Association
Brent Mencap
Brent Mind
Brent Retired Brahmin Association
Brent Triangle
British Red Cross - Harrow Centre
Elder's Voice
Friends of African Caribbean Carers and Sufferers of Dementia
Health from Leisure Wembley Park
Hindu Council for Brent
HIV/AIDs Association of Zambia
Kenya Women Association
Multiple Sclerosis Society
Siri Behavioural Health
The African Child (TAC)
The Disability Foundation
West Indian Self Effort
Women's Health Network
West Indian Senior Citizens
Black Disabled People's Association

Other
St. Luke's Hospice

Buckinghamshire County Council

Local cancer user groups
Chiltern Breast Cancer Support Group
Iain Rennie Hospice at Home
Chiltern Cancer Support

Health bodies
Buckinghamshire Hospitals NHS Trust
Stoke Mandeville Hospital
Churchill Hospital
Chiltern and South Bucks PCT
Vale of Aylesbury PCT
Bucks Mental Health Trust
Thames Valley Health Authority
Wycombe PCT

Local Voluntary Sector Groups
South Bucks Carers Centre
Patient Partnership Group
Other
Chiltern & South Bucks Locality Forum

Other
Marie Curie Cancer Care Area Nursing Office
Macmillan Cancer Relief

London Borough of Harrow

Residents' Associations
Hatch End Association
South Harrow and Roxeth Residents' Association
Pinner Association

Local cancer user groups (based on a list provided by Harrow PCT)
Cancer Black Care
Cherry Lodge Cancer Centre
Bosom Friends
Cancer Information and Support Services
Harrow Carers Centre
Lymphoma Association CAMEO
Trojans Breast Cancer Support Group
Prostate Cancer Support Association (PSA)
Watford Cancer Support Group

Health Bodies (organisations who had given evidence - letter sent advising of the setting up of the Joint Overview and Scrutiny Committee)
Harrow Primary Care Trust
North West London Hospitals
West Hertfordshire Hospitals Trust

Other
St. Luke's Hospice
Michael Sobell House
Baxter Health Care
Hertfordshire County Council

Hertfordshire County Council

Residents' Associations
East Herts Community Council

Health Bodies
East Herts CHC
North Herts CHC
North West Herts CHC
South West Herts CHC
Hertsemere PCT
St. Albans and Harpenden PCT
E & N Herts Trust
Luton & Dunstable Trust
West Herts Hospitals Trust
Mount Vernon Cancer Network
Beds & Herts Ambulance and Paramedic Trust

Voluntary sector bodies
Age Concern
Carers in Herts
POhWER
Herts Action on Disability
Mencap
Alzheimer's Society

Dacorum Hospital Action Group
Mind in Welwyn Garden City
Mind in South West Herts
Mind in St. Albans
Stevenage MindBreath Easy

Other
University of Herts
Dacorum Borough Council
Welwyn Hatfield District Council

London Borough of Hillingdon

Residents' Associations
Community Voice

Health Bodies
Hillingdon CHC
Hillingdon PCT
Hillingdon Hospital and Mount Vernon Trust
Grey Cancer Institute
Mount Vernon Cancer Centre
RAFT
Paul Strickland Cancer Centre
Lynda Jackson Centre
West Herts Hospitals NHS Trust

Other
University College London

Luton Borough Council

Voluntary Bodies
Voluntary Action Luton

Health Bodies
Luton and Dunstable Hospital
Luton PCT
South Beds CHC

Appendix 4

List of Written Submissions of Evidence

Written submissions of evidence were received from the following organisations:

A	Trojans Breast Cancer Support Group
B	Hatch End Association
D	Community Voice
E	Paul Strickland Scanner Centre
F	Hillingdon Primary Care Trust
G	Hillingdon Community Health Council
H	South Harrow and Roxeth Residents' Association
I	Trevor Gash, a representative of South Beds Community Health Council
J	North West London Hospitals
K	Gray Cancer Institute
L	Harrow PCT
M	The Raft Institute
N	The Pinner Association
O	Bedfordshire Heartlands PCT
P	Bedfordshire & Hertfordshire Ambulance and Paramedic NHS Trust
Q	Brent PCT
R	Hillingdon Community Health Council
S	Brent Community Health Council

Appendix 5

Written Submissions of Evidence

Appendix 6

Response from London Borough of Barnet Council

Joint Local Authority Scrutiny of NHS Consultation Paper
'Mount Vernon Hospital: The Future of Services for Cancer Patients'

Issues for the London Borough of Barnet

1. These are initial officers' comments which, owing to the very restricted timescale given to respond to North West London Strategic Health Authority and the time of year, are written in advance of discussion by Members and without the benefit at this point of responses from local voluntary and community groups who have been consulted for their views. As such it does not give a definitive Barnet position on this consultation paper, merely some preliminary comments which the joint scrutiny committee is asked to take into account in reaching its recommendations. Further comments may follow. Barnet PCT is conducting its own local consultation event in mid-September.

2. Patients from the area of Barnet Primary Care Trust (PCT) constituted over 8% of all Mount Vernon's radiotherapy and chemotherapy cancer patients in 2002/03, representing 339 courses of treatment over the year, the third highest number of any individual PCT. Barnet is therefore a major recipient of the cancer services provided by Mount Vernon Hospital.

3. The primary issues for Barnet are (a) how patient flows are likely to change – i.e. where Barnet cancer patients are mainly referred for treatment now and where they are most likely to be referred under the changes proposed; (b) how the quality of care and clinical outcomes are likely to be affected by the changes; and (c) how easy or difficult it will be for Barnet residents to access a new cancer centre at either Hatfield or Hemel Hempstead, compared with Mount Vernon.

4. We have asked Barnet Primary Care Trust to supply us with information on patient flows. While the consultation document shows the total number of treatments for Barnet patients, we also need to establish the proportion of Barnet cancer patients who currently use Mount Vernon for radiotherapy or chemotherapy and where else they currently go. This may give some indication of what the alternatives are for Barnet people if services are moved away from Mount Vernon. The new cancer centre proposed for Hertfordshire may not necessarily be the main option for instance for patients living in the south of the borough. Until we have a clearer picture of the practical impact of the proposals on patients in all parts of the borough and likely travel distances it is difficult for us to give a definitive response.

5. We also need to know more about the policy for patient transfer to and from hospital, who is eligible for patient transport services and the criteria operated, how easy it is to access hospital assisted transport where patients cannot use other means and whether patients can take a carer with them.

6. Nevertheless, there are clearly concerns about the sustainability of cancer services at Mount Vernon including the lack of appropriate on-site support services, a lack of specialist cancer surgery and the deteriorating physical condition of the site. The case for a new fully functioning cancer centre as part of a wider cancer carer network is well made in the consultation document. Quality of care and good clinical outcomes and are

obviously paramount and we have no reason to question the fundamental arguments being put forward.

7. However, the location of a new cancer centre and the ease or difficulty of getting there are crucial considerations for us. Treatments such as radiotherapy and chemotherapy can be very debilitating at the time for those undergoing them. Patients therefore need the shortest travelling time possible.

8. Access to Mount Vernon Hospital from the London Borough of Barnet is difficult. According to Transport for London, the journey to Mount Vernon takes on average between 1½ and 2 hours (varying according to starting point, route and time of day) and in many cases involves a combination of bus and tube train, often with several changes in between. By private car the journey could be up to an hour.

9. Journey times to Hemel Hempstead Hospital would be similar but would involve a combination of bus, tube and mainline rail, with interchanges.

10. Journey times to Hatfield using public transport would vary according to the starting point and the distance from the mainline station to the new hospital site, assuming a convenient bus route. The journey could take between 30 minutes and 1½ hours (rail travel to Hatfield being easy from the east of the borough but difficult from the west). On the other hand, a car journey from the north-west of the borough could take as little as 30 minutes.

11. Therefore, while none of the options is at all ideal, a new cancer centre at Hatfield would on average present the least travel difficulty for the greater number of Barnet residents.

12. At the same time we would strongly urge:

    (a) that less complex cancer treatments are provided as locally as possible, to the extent that this is compatible with the overriding priority of achieving the best possible clinical outcomes;

    (b) that serious consideration is given to extending the eligibility of patients and their carers to hospital-assisted patient transport services, including transport to and from Barnet, where individual patients have no other suitable means of transport.

13. We note that, in an online survey recently conducted by Barnet Community Health Council, 70% of respondents suggested that cancer services should be moved to Hatfield and the remainder wanted to see them stay at Mount Vernon. Barnet CHC have also expressed their concerns about the lack of back-up services at Mount Vernon for cancer patients and their support for providing access to a full acute hospital service on one site at Hatfield.

Rob Mills,
Team Leader, Overview and Scrutiny,
London Borough of Barnet
28 August 2003

Appendix 7

Response from Bedfordshire County Council and Luton Borough Council Joint Scrutiny Committee

Bedfordshire & Luton Joint NHS Scrutiny Committee

Formal Response to 'Investing in Your Health' Consultation undertaken by the Bedfordshire & Hertfordshire Strategic Health Authority

August 2003

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Joint NHS Scrutiny Committee

Response to the 'Investing in Your Health' Consultation

Introduction

1. This report sets out the formal response from the Bedfordshire and Luton Joint NHS Scrutiny Committee to the consultation document 'Investing in Your Health' issued in March 2003 by the Bedfordshire and Hertfordshire Strategic Health Authority (StHA). It is understood that this consultation document was prepared on behalf of the Primary Care Trusts on the future of health services in the Strategic Health Authority area.

Composition of the Joint Committee

2. Following a decision taken in October 2001 by the Bedfordshire and Luton LGA, the Joint NHS Scrutiny Committee was established by Bedfordshire County Council and Luton Borough Council as the Social Services authorities in Bedfordshire, with an invitation to the Bedford Borough Council and the Mid Beds District Council and the South Beds District Council to each provide a representative to join the committee, with full voting rights. An invitation was extended to the two Community Health Councils in Bedfordshire to each provide a representative and this was accepted. The Committee comprises thirteen members, as shown in Appendix A.

Operation of the Committee

3. The Committee met formally on three occasions. The first meeting on 12th June established the committee. At that first meeting the officers were authorised to place an advertisement in two local newspaper groups circulating in Bedfordshire and Luton. The advertisement announced the formation of the Joint Committee. It also called for evidence to be submitted in written form (either electronically or on paper) or for witnesses to come forward to give oral evidence. A copy of the advertisement is included at Appendix B. The committee met informally on the 10th July to be briefed by the Strategic Health Authority on the proposals set out in 'Investing in Your Health'. On the 11th July the committee heard evidence from Community groups, NHS representatives and staff. The Committee met on 11th August to approve this response to the Strategic Health Authority on the 'Investing in Your Health' proposals. All of the Committee's meetings were held in public, except for the briefing on 10th July. Appendix C gives a list of those who gave evidence. Written submissions received by the Joint Committee are set out in Appendix D. The Alzheimers Disease Society's written submission was noted by the Committee as the 'Investing in Your Health' consultation document does not cover mental health issues (this is also included in Appendix D)

Relationship to the Mount Vernon Issue

4. The Committee also noted that the issue of Mount Vernon would be dealt with separately by a separate Joint Committee, involving representation from Bedfordshire, Luton, Hertfordshire, Hillingdon, Harrow, Ealing, Brent, Barnet

and Buckinghamshire. This report should be read in conjunction with the report from that joint committee.

Statutory Basis for this Submission

5. This study was undertaken as a Regulation 4 study under Statutory Instrument 2002 No. 3048, that is:

   "where a local NHS body has under consideration any proposal for a substantial development of the health service in the area of a local authority, or for a substantial variation in the provision of such service, it shall consult the overview and scrutiny committee of that authority."

6. As opposed to a Regulation 2 study, whereby:

   "An overview and scrutiny committee may review and scrutinise any matter relating to the planning, provision and operation of health services in the area of its local authority"

Consideration of the Evidence

7. The Joint Health Scrutiny Committee met at County Hall in Bedford on July 11th 2003 to consider evidence from a wide range of witnesses. Witnesses attended from the voluntary sector, many with a passionate interest in and strongly held views on local health provision. The witnesses came from organisations across the health service in Luton and Bedfordshire, not just the architects of these plans, but many of the healthcare professionals who will have the responsibility for delivering the vision. Other witnesses came from the local authorities concerned both with town planning, and with the provision of social services. In addition, written evidence was received from voluntary and other organisations.

8. As a result of the evidence day, a number of issues clearly arose which the Committee wished to ensure had been adequately taken in to account by the StHA in proposing the major changes in the delivery of health services set out in the document. This paper addresses the broad themes, and sets out the particular areas where further assurances might be sought.

Promoting Health

9. It is clear that the health of a population is determined by much more than health services – evidence was heard that economic well being, environment, public health issues and personal responsibility for lifestyle all contribute to overall health.

10. The people of Luton and Bedfordshire rely upon the adequate provision of services through a variety of providers in both the public and private sectors, and their partners in other agencies to help them maintain their health. The County, District and Borough Councils have significant responsibilities in areas such as planning, transport and social services. The Education Services also have a part to play in ensuring that young people have a full understanding of health, health services and their own choices and responsibilities in accessing these services.

11. The evidence day gave the Joint Health Scrutiny Committee the opportunity to consider the future vision of health services for the area, and the implications that this has for local people. The Joint Health Scrutiny Committee, in both its formal scrutiny and in its community leadership role, is bound to consider the implications of these changes for all the people served by Bedfordshire and Luton. Under either of the two options for change proposed here, there will be pluses and minuses for particular local residents. Although, the Committee's response will deal with the overall strategy, overwhelmingly witnesses to the Committee favoured Option Two in the consultation document.

Strategic Context

12. It was clear from the evidence day that the means of delivering health services to local people have to be planned within the wider constraints of geography, staffing, and finance. Health service strategists need to anticipate future changes in demand, plan for demographic growth, second guess how technology will affect the way services are provided, and anticipate the policies of future governments when proposing changes to local health services. Within those constraints, the health professionals attending made clear that they should always be putting the quality of the service that they deliver to local people at the forefront of what they are proposing.

13. Evidence was heard that a great deal of work has gone into developing these proposals. Care has been taken to gather the views of local people. Members heard something of the scale of consultation that has taken place to gather views before settling on two options, and a commendation that the NHS 'go out of their way' to gather the views of local people.

14. The people of Luton and Bedfordshire need to be able to rely on the quality of their health services. Many of those giving evidence made it clear that change in the way that health services are delivered in the future was both desirable and inevitable. The status quo is not considered to be an option. Indeed the point was made that taking a decision on the future of health services in the area, and moving forward, will do much to raise morale in health services locally. The recent inability to action some necessary change was referred to as 'planning blight', and held to be causing real problems in changing the way health services are delivered to meet the changing needs of local people. In this regard the Joint Committee welcomes the recent announcement that around £800,000 will be made available to the NHS locally to enable the Trusts to assess the implications of the demographic growth on the health services provided locally.

15. Evidence was presented that good health care depends much more on flexible and responsive team working by highly trained professionals than it does on what can be characterised as old fashioned buildings, well below the standards expected by the consumer of the 21st century. We heard from a number of health professionals about excellent collaboration and joint working already taking place in Luton and Bedfordshire: Optometrists locally can refer patients directly to surgeons, shortening the time taken to treatment; GPs are referring between themselves, where they have a specialist interest; PCTs and acute hospitals are showing evidence of working together, with joint Board meetings taking place to consider issues of mutual interest and responsibility.

16. It was clear that there is great support for the vision of providing many services closer to people's homes, through community Diagnostic and Treatment Centres (DTCs), and improved intermediate care. However, until the services that are delivered from existing hospital sites are seen to be being provided elsewhere, it can be hard to understand the reasoning behind proposed changes. Pleas were heard for proper account to be taken of the need to improve provision in primary and community care, before instituting changes in acute services.

17. The vision set out for the future of health services in Luton and Bedfordshire is compelling, and there was wide consensus for the need to move towards delivering much more care for patients in locally accessible centres. The Joint Committee supports the aim of delivering a 'whole health system model' as being one which should provide the highest possible quality of care for people who are acutely ill. This was clearly articulated by the health professionals giving evidence. The vision that is being proposed should also ensure that the majority of the health services that local people need are available to them as close to their homes as possible, and should take advantage of the increasingly rapid advances in technology to do so.

Committee's Comments

18. The Joint Health Scrutiny Committee believes that it will need to seek reassurances in a number of areas – these can broadly be headlined as quality, capacity – both of infrastructure and staffing, accessibility, achievability and affordability.

Quality

19. The needs of the patient should be paramount, and this, together with continuous improvement in the quality of services should be the primary reasons for proposing change. Particularly in the areas of specialist services, maternity and paediatric care, the Committee urges the StHA to ensure that the changes proposed in the consultation document are based on compelling service needs, and are designed to maintain and improve the quality of care available to local residents.

20. Cancer services are of concern to local people. Although the delay in this consultation is not ideal, the Committee understands the requirement to ensure that the outcome of consultations on the future of cancer services in North West London are taken in to account by both StHAs. Members of this Joint Committee have played a full part in the deliberations of that separate Joint Committee. Indeed it is important that this report is read alongside the separate report from the Joint Committee established to scrutinise the issues surrounding the proposed transfer of cancer services away from Mount Vernon. As it is likely that nearly one in three of the population will suffer from cancer at some time in their lives, this Joint Committee urges the StHA to secure centres of excellence that are sustainable. This Joint Committee recognises and welcomes that under either of the options proposed in the consultation document, cancer services will be maintained at the local level, with specialist services moving closer to local residents with the development of a major cancer centre in Hertfordshire.

21. Maternity and paediatric services are the focus of great concern for local people. The Joint Committee believes that in the field of maternity services the needs and aspirations of mothers-to-be require particular attention. Whilst antenatal care should be delivered as locally as possible, the Joint Committee wishes to see a pattern in the provision of services which will ensure that, in Bedfordshire and Luton, maternity services offer a mother-to-be the maximum personal choice, consistent with the safest possible delivery. The Committee also believes that account should be taken of the need to provide a service that will attract midwives to work in the local area.

22. It is proposed that birthing centres may be established on two sites where there will not be specialist newborn baby services. The Committee urges the StHA and the NHS Trusts to provide greater clarity about the benefits that the birthing centre in Hemel Hempstead is offering, and which could be replicated elsewhere. The Committee would also wish to see arrangements put in place whereby, beyond careful selection of mothers, in the event of a problem arising, appropriate care will be delivered to mother and baby. Within the overall doctrine of personal choice and personal responsibility, the Joint Committee wishes to see the practical delivery of the assurances that other agencies will be involved in educating young mothers about their choices and responsibilities in childbirth.

23. The ethnic minority population in Bedfordshire and Luton have specific health needs. Luton has below average life expectancy and a higher than average incidence of both still birth and diabetes. The Joint Committee believe that the absence of any reference to the needs of these communities is a significant omission. The Committee seeks reassurance that the specific needs of these ethnic minority communities will be taken into account in developing and delivering the plans set out in ‘Investing in Your Health’.

24. The Committee is concerned about the emerging health needs of the whole population over the next ten years. It believes that health promotion plays an important part of the vision for the future of health services set out in ‘Investing in Your Health’, and wishes to see the StHA, the PCTs and the NHS Trusts place more emphasis on this approach.

Capacity - infrastructure

25. Throughout the evidence day, both in written and oral evidence, witnesses referred to the significant housing development that is planned for Bedfordshire and Luton. The Committee believes that the StHA, and other agencies, will need to ensure that the necessary revisions to the ‘Investing in Your Health’ proposals take adequate account of the needs of a greatly increased population; that planning for the physical infrastructure needed for the delivery of appropriate health services has been considered and set in train; and that due consideration has been given to financing the identified needs.

26. The impact of the developments envisaged in the Communities Plan will be felt in terms of an increased demand for health services. At one level there will need to be a raft of plans and agreements put in place which will deliver local health service investments as the demographic growth comes on stream, so that there is no gap or lag between the demand for health services and their provision. Such plans will need to be put in place in advance of the delivery of the growth. This will also require that the funding is made available as the growth occurs, otherwise there will be a reduction in the quality and quantity of

services available. Added to the existing historic under-funding of the Health Service in Bedfordshire and Luton this represents a significant challenge to NHS service planning.

27. At another level there will be the need to secure new primary care facilities (e.g. General Practice Surgeries). These considerations will need to be taken into account in framing the Section 106 Agreements with developers and securing the relevant Planning Conditions. It will also be necessary for the developers and planning authorities to ensure that there is adequate provision for affordable housing, whatever the tenure, in order that health service employees (alongside other public and private sector key workers) can afford to live and work in Bedfordshire and Luton.

28. As the proposals in the Strategic Health Authority's plans rely so heavily on the availability of staff in the right numbers and in the right places, this aspect of the impact of demographic growth is particularly important. Accordingly, the Joint Committee will address the local planning authorities in respect of this issue in its recommendations.

29. One of the ways to increase the capacity of the local health services proposed in the consultation document was through the separation of emergency and planned surgery. The location, staffing and management of a surgicentre for Bedfordshire were the subject of lively debate with a number of witnesses. The Committee believes that wherever the proposed surgicentre is ultimately sited it should be the subject of further consultation. At this stage the Committee believes that the issues that need to be addressed are whether it can be adequately staffed; whether it can deliver the quality of care needed for the range of procedures that will be undertaken at the site; and whether it will enhance the ability of local health services to respond to the needs of their residents. The Committee believes that the StHA will also need to address these issues.

30. The proposed changes in Bedfordshire and Hertfordshire also take place within the wider regional context. The Committee wishes to be reassured that factors in neighbouring health economies have also been fully taken in to account. Airport expansion and major development proposals extending in to Bedfordshire, Luton and Hertfordshire may add to the additional numbers accessing local health services within and beyond the planning period of this document. The Committee heard that consultation with neighbouring authorities was underway. It will be looking to see that future population changes in the surrounding areas, as well within Bedfordshire and Luton, have been taken into account in drawing up the delivery plans and mechanisms to implement these proposals.

Capacity - staffing

31. Several references were made by witnesses to issues of recruitment, retention, training and appropriate use of staff within local health services. Although recruitment and retention of key staff appears to be less of a problem in Luton and Bedfordshire than in Hertfordshire, none the less it was made clear that the introduction of the European Working Time Directive in August 2004 will introduce some significant constraints into the system. Without a change in the way that health and other supporting services are organised, it will become impossible to guarantee safe staffing levels for the people in the area who are most acutely ill. It will also be very difficult to optimise the use of resources to

provide the best possible quality of care. The Committee has touched on the issue of recruitment and retention in respect of affordable housing in the previous section. It is important however to restate it in this context.

32. The consultation document talks at length about the changing nature of care, with a much greater emphasis on intermediate care, and caring for residents in their own homes. It is essential that collaborative working with other local agencies, social services and the voluntary sector, to prevent unnecessary admissions to hospital is developed as rapidly as possible. Ensuring that local people spend the minimum amount of time compatible with recovery and rehabilitation in an acute hospital, and are rapidly transferred to a more appropriate care setting should be a high priority for all those responsible.

33. This will require a commitment to joint working across primary and community care, the acute hospitals, social services and the voluntary sector. Even without changes to facilities and staffing, the Committee will wish to seek assurances that everything possible that can be done is being done now to maximise the capacity of current health service facilities. The Committee believes that this is a major challenge and will wish to see it demonstrated that changed ways of working are already helping to support this approach.

34. It will also be important to identify clearly whether any additional accommodation is likely to be needed in the residential and nursing home sector in Bedfordshire and Luton, in order to support these changes, and to understand who has a responsibility for being involved in its provision.

35. The recruitment, training and retention of appropriately skilled staff are issues that are affecting the health service throughout the country. The Committee believes that more work will be needed on the strategies that health and other public sector bodies in Bedfordshire and Luton are pursuing to help train, attract and retain staff in this relatively high cost area. Reference was made to the attractiveness of the proposed service model to staff, and of the potentially positive effects should a medical school be developed in area in the medium/long term. The Committee believes that the StHA will need to focus on new initiatives as well as on measures that are already being taken to try and address these issues, and that it will need to engage with other public sector organisations to share best practice and develop collaborative solutions to a common problem.

36. ‘Investing in Your Health’ offers an exciting prospect, and one which could and should attract staff to play a part in its realisation. It will be essential that the local health community takes advantage of every initiative available from Government to support the innovation that is needed. The NHS needs to work closely with the Commissioners (especially the Learning & Skills Councils) and the providers of education and training to ensure that the staff necessary to deliver the vision are in place.

Accessibility

37. Timely access to health services is very important for local people. Members will wish the StHA to have demonstrated that sufficient attention has been paid to the difficulties that the congested road system in the area, particularly around the major towns, may cause for the delivery of local services. The Joint Committee expressed a wish that emphasis be placed on any work that needs to be done to ensure that adequate parking is available at proposed health

centres; that public transport links are optimal; and that plans have been developed by the emergency services to take account of possible difficulties in the transport of seriously ill patients, particularly those in congested town centres, and in more rural areas.

38. The Ambulance Trust needs to be able to give the assurance that the physical constraints of the road system have been taken into account, and that the service has the capacity needed to cope with the journeys that could be generated by the proposed service changes. It will also be important to ensure that early planning takes place to cope with the potential expansion in the population, with access being give appropriate priority.

39. The Committee heard from the Ambulance Trust of their confidence that they can play a major part in ensuring that either option proposed works well. The Committee wished to have the assurance that the additional staff and ambulances needed, and the appropriate training for front line paramedics will all been provided before major changes are implemented. Patient Transport Services are key to ensuring the ability to take patients to an appropriate care facility, and commissioning needs to reflect this.

40. The demands of an ageing population and the particular access difficulties that elderly people experience must be taken into account in planning services. The Committee heard from local representatives of the concerns of their members in this regard. It is clear that the County and Borough Councils have a role to play in making sure that adequate and appropriate transport links are in place before any major changes in the way services are provided takes place. The Committee wishes to emphasise its view that the Executive functions of the respective local authorities need to demonstrate their commitment to joint working in this area. The Committee believes that the Health Authority needs to demonstrate that it is aware of the high priority that residents place on access to both local and specialist services.

41. The Committee believes that the quality of health care available should not be affected, still less dictated, by the access that patients and the public have to health services, especially specialist services. The Committee is however firmly of the view that quality should not be compromised by availability, rather, it believes that these are twin requirements.

Achievability

42. There are significant proposals for the development of new sites for the local provision of health services within this consultation document. Co-operation between local agencies to ensure that the sites identified for development are affordable, accessible and are available in the necessary time scale for the provision of these facilities is important. Again, District, Borough and County Councils will be able to assist in developing robust plans, and ensuring that all necessary planning matters have been taken into consideration. The development of primary and intermediate care facilities and surgicentres will need to be carefully planned, and the access, transport, topography and other issues equally robustly treated.

43. Many of the changes in the delivery of health services heralded in this consultation document will require significant changes in the working practices of health service and other agencies responsible for the whole pathway of care'.

44. The Committee believes that it will be necessary to adopt a whole system approach to deliver these changes. It believes that assurances from individuals and organisations throughout the health economy will be necessary to ensure that there is support for this vision and that the leadership in place, both clinical and managerial, to carry it forward. The Committee heard some excellent local examples of changed working practices, and supported the view that changes to the training of medical staff will further help to change historical working patterns. There will, however, also need to be significant change management processes put in place if the organisational cultures are to be developed to provide the "organisational glue" to deliver the whole systems approach.

45. This is a vision that will begin developing now, and should be broadly delivered in totality around the end of this decade. Many people working in the health service now are going to have to make substantial changes to the way they work. Visionary leadership is needed to deliver that. The Committee wishes to be assured that the StHA, working with the PCTs and NHS Trusts, are committed to ensuring that this happens.

Affordability

46. There is little reference in the consultation paper to the overall financial context in which these service changes are being proposed, although more detail is available in supporting papers. Luton and Bedfordshire have suffered from under-funding of their health services over many years. There will be further demands on the health service from demographic growth. The Committee notes with regret that the plans set out in 'Investing in Your Health' only aim to bring the area to full funding towards the end of the decade. The Committee believes that this runs the risk of damaging services for local people, and would urge the StHA to do all that it can to influence an acceleration of this timetable.

47. The Committee recognises that Hertfordshire, in common with many of the counties around London, has, in recent years, had significant problems in operating within the financial envelope set out by the Department of Health. During the evidence gathering session, widespread concern was expressed that there was the potential for the financial instability in the NHS in Hertfordshire to affect the proposed move towards adequate funding in Luton and Bedfordshire over the plan period. The Joint Committee wishes to seek further assurances that this cannot be the case.

48. 75% of funding for the NHS has now been passed to Primary Care Trusts, who clearly have a very great responsibility for the delivery of health services to local people. As the consultation document says, 'a substantial shift' of resources from secondary to primary care is needed to deliver this vision. The StHA was clear that primary care trusts will have it in their powers to make that happen. Primary Care Trusts are very new organisations. The Committee expects to see that the PCTs have the full support of the StHA in fulfilling their responsibilities in this area.

49. The Committee also had concerns that the cost of implementing the proposed changes had been fully calculated. Although the proposals for the acute hospitals have been clearly calculated, the picture does not seem to be quite so clear for the developments that would be taking place in primary and intermediate care. Since this vision is based on the need for a substantial shift

of resources, the Committee believes that this is an area that may need more clarity.

50. Further, it was stated that 2% above the 2.5% RPI inflation rate had been used as the figure for calculating the higher rate of inflation that generally applies to health services. The Committee wishes to be assured that this figure has been derived from past experience, rather than future hope, and will look to the StHA to confirm this.

51. Much of the change that is being predicated also needs a substantial investment in equipment and technology. In particular, the compatibility of IT systems in organisations working together needs to be addressed. Again, the Committee wished to be assured that the full cost implications of the plans set out in 'Investing in Your Health' are clearly accounted for, and that adequate ring fenced funding for new IT systems has been identified and the associated staff training would be set in place.

52. Finally, the StHA referred to commitment at the highest level in Government to the vision developed for Bedfordshire, Luton and Hertfordshire, and indeed reported that this vision was pioneering. It was reportedly being followed in other areas that were looking at the future of health services. Realising that vision will take at least ten years. During that time, there will be transitional costs, which can amount to double-running of services. The Committee will be looking to the StHA to ensure that transitional costs have been estimated and included in the financial planning of the proposals.

Conclusion and Recommendations

53. The Strategic Health Authority's consultation document, 'Investing in Your Health' sets out a compelling and attractive vision for the future of health services for the people of Bedfordshire and Luton. Although many of the developments proposed here have been piloted, both in this country and overseas, delivering this vision is going to require the greatest possible commitment from all the partner organisations in the local health economy. It will need courage and goodwill from the Department of Health and from Government. It will need the support of the local planning authorities. If delivered, it will put Bedfordshire, Luton and Hertfordshire in the vanguard of a nationwide drive to develop a sustainable, accessible and high quality health service.

54. The Committee has found this to be a useful initial foray into the field of NHS Scrutiny. The scale of the task of exercising this new role is now becoming clearer. The Committee comprising representatives of five authorities has worked together well. The Committee is grateful to all of those witnesses who gave up time to give it their views on this very important issue.

55. There are few things more important than the health of our communities. The Committee believes that the Strategic Health Authority and the Primary Care Trusts were right in bringing forward these proposals. The Committee believes that their implementation over the next decade will provide an important framework and infrastructure for improving health and the NHS locally.

56. While generally welcoming the thrust of the document the Joint Committee does have specific concerns about the proposals set out in 'Investing in Your Health'. These are set out in this paper. The Joint Committee wishes the

Strategic Health Authority to address these issues and to provide clarity as to how, with the Primary Care Trusts, Hospital Trusts and Ambulance Trust, it will take them forward. In particular the Bedfordshire and Luton Joint NHS Scrutiny Committee **RECOMMENDS** that:

1. **The Strategic Health Authority and the Primary Care Trusts do more to promote the concept of Health and Healthy Living both directly and by working with other statutory, non-statutory and private sector partners and interests.**

2. **The Strategic Health Authority and the Primary Care Trusts specifically reassess the investment strategy and its timing to cope with the significant house building, infrastructure provision and demographic growth in Luton and Bedfordshire arising from the implementation of the proposals being promoted by the Government in the form of the Communities Plan, and in particular ensure that health funding in Bedfordshire and Luton keeps pace with the demographic growth.**

3. **The strategic and local planning authorities in Bedfordshire and Luton be advised that the Joint Committee believes that they have a significant role to play in ensuring that the development process delivers aspects of the vision set out in 'Investing in Your Health' and that the investment to meet the health needs of the community matches the pace of development. In this respect the Joint Committee requests that the planning authorities specifically address the issues of affordable housing and Section 106 planning agreements.**

4. **The Strategic Health Authority and Primary Care Trusts specifically address the financial feasibility of implementing the plan and demonstrate that appropriate sensitivity analyses of the proposals have been undertaken.**

5. **In light of the historical under-capitation in NHS funding in Bedfordshire and Luton, the Strategic Health Authority and the Primary Care Trusts continue to make the case for additional NHS funding for Bedfordshire and Luton to ensure that the area is as well funded as elsewhere.**

6. **The Strategic Health Authority, the Primary Care Trusts and the Hospital Trusts address the need to ensure that adequate and appropriate arrangements are established and put in place to ensure that a whole system approach is secured and maintained. These are complex arrangements requiring "organisational and professional glue" as well as investment in complementary facilities such as intermediate care and social care to make them work.**

7. **The Strategic Health Authority and the Primary Care Trusts be advised that, in line with the overwhelming majority of witnesses it heard from, the Bedfordshire and Luton Joint NHS Scrutiny Committee favours the implementation of option two and in doing strongly urges those bodies to address access issues in respect of the creation of a new cancer centre.**

8. **The Strategic Health authority to continue to consult both the patients and public in respect of implementing specific elements of the strategy and indeed in the way services, especially maternity services, are configured and delivered.**

9. **The Strategic Health authority, the Primary Care Trusts and the Hospital Trusts be advised that the Joint Committee supports the creation of Diagnostic and Treatment Centres and the building of a proposed new surgicentre in Bedfordshire. The Joint Committee would be expected to be consulted on its location. It believes that the decision on where the surgicentre is located should be based on the needs of patients rather than on any other criteria.**

10. **The Strategic Health Authority, the Primary Care Trusts and the Hospital Trusts review the implementation programme for the plan to ensure that it adequately meets the needs of the ethnic minority communities of Bedfordshire and Luton – the Joint Committee believes that this is a significant weakness of the current proposals.**

11. **The Strategic Health Authority and the Primary Care Trusts address each of the specific points made under each of the six headings of this submission:**
    Quality,
    Capacity – Infrastructure,
    Capacity – Staffing,
    Accessibility,
    Achievability and,
    Affordability
    and shows in its decision making documentation that it has done so.

David Reedman
Chairman
Bedfordshire and Luton Joint NHS Scrutiny Committee

Appendix A

Membership of Joint NHS Scrutiny Committee

Councillor Name	Political Group	Authority	Telephone	Email address	Address
Cllr David Reedman	***Conservative***	Bedfordshire County Council	01234 300597	reedmand@bedfordshire.gov.uk	48 Eaton Road Kempston, Bedford MK42 7RP
Cllr Alan Burnage	***Conservative***	Bedfordshire County Council	01462 811681	burnagea@bedfordshire.gov.uk	23 Broad Street Clifton, Shefford Beds SG17 5RJ
Cllr Ralph Hall	***Conservative***	Bedfordshire County Council	01234 268035	hallr@bedfordshire.gov.uk	2 Polhill Avenue Bedford MK41 9DS
Cllr Duncan Ross	***Labour***	Bedfordshire County Council	01582 613313	rossd@bedfordshire.gov.uk	14 Burr Street Dunstable LU6 3AG
Cllr Liz Ledster	***Liberal Democrat***	Bedfordshire County Council	01525 873131	ledsterl@bedfordshire.gov.uk	21 Harlington Road Upper Sundon, Beds LU3 3PE
Cllr Shan Hunt	***Labour***	Bedford Borough Council	01234 852072 07785 532557	shanhunt@ntlworld.com	5 Vyne Close Kempston Bedford MK42 8RH
Cllr Doreen Gurney	***Conservative***	Mid Beds District Council	01767 699391	doreen.gurney@midbeds.gov.uk	Manor Farm, 1 Sandy Road, Everton, SG19 2JU
Cllr Ann Sparrow	***Conservative***	South Beds District Council	01582 512484	ann.sparrow@southbeds.gov.uk	1 George Street Dunstable LU6 1NN
Cllr Anna Pedersen	***Liberal Democrat***	Luton Borough Council	01582 505456	pedersena@luton.gov.uk	45, Repton Close, Luton, LU3 3UL
Cllr Sian Timoney	***Labour***	Luton Borough Council	01582 758902	timoneys@luton.gov.uk	35, West Hill Road, Luton, LU1 3LZ
Cllr John Titmuss	***Conservative***	Luton Borough Council	01582 508674	titmussj@luton.gov.uk	21, Compton Avenue, Luton, LU4 9AX
Anne Villegas / Iris Beazley	***Co-opted***	Community Health Council	01234 212228 01582 391666	anne.northbedschc@dial.pipex.com iris@sbedschc.demon.co.uk	North & Mid Beds CHC 41 Mill Street Bedford MK40 3EU South Beds CHC 4 Bridge Street Luton Beds LU1 2NF

Appendix B

Advertisement in Bedfordshire Local Press

How will the proposals of the Strategic Health Authority affect you?

Bedfordshire County Council, Bedford Borough Council, Mid Beds District and South Beds District Councils and Luton Borough Council have established a Joint NHS Scrutiny Committee under powers set out in the Health and Social Care Act 2001. The Committee invites your views to enable them to respond to the Bedfordshire and Hertfordshire Strategic Health Authority's consultation document "Investing in Your Health".

Councillors on the committee will be responding to the consultation but want to know how it will affect you. If you would like the opportunity to present your views or the views of your organisation to the committee on the proposals, please contact Bill Hamilton, Assistant Chief Executive (Scrutiny) on 01234 228032, alternatively please send comments to:

Joint NHS Scrutiny Committee
Bedfordshire County Council,
County Hall,
Cauldwell Street,
Bedford, MK42 9AP.

Or email on: **nhsscrut@csd.bedfordshire.gov.uk**

The Committee would welcome written submissions and will give the opportunity for those with an interest to give oral evidence to the Committee. Your submission should be received by 1 July. The Committee will be meeting in public at 10am on 11 July at County Hall, Bedford.

Copies of the "Investing in Your Health" consultation are available at libraries, hospitals, GP surgeries and Health Centres and council offices or on the website: www.bhha.nhs.uk

Appendix C

JOINT NHS SCRUTINY COMMITTEE

Witness Schedule - 11th July 2003 – 10am

Committee Room 1, County Hall, Bedford

1.	Presentation of written evidence from Community Groups on 'Investing in Your Health' proposals (See Footnote)
2.	Catherine Williams – National Childbirth Trust: South Beds ***– with written evidence***
3.	Ian Pettit & Peter Brooks – Bedford Association of Senior Citizens
4.	Richard Watts – Head of Environmental Strategy – Bedfordshire County Council – ***with written evidence***
5.	Margaret Stockham – Chief Executive, Bedford PCT
6.	Della Warren, Clinical Support Manager, Bedford PCT
7.	Andrew Reed, Chief Executive, Bedford Hospital NHS Trust
8.	Mr Ed Neale Bedford Hospital NHS Trust
9.	Dr Penny Dash, Strategic Health Authority Director of Service Development
10.	Anne Walker – Chief Executive, Bedfordshire & Hertfordshire Ambulance and Paramedic NHS Trust
11.	John Swain, Chief Executive, Bedfordshire Heartlands PCT
12.	Stephanie Wingrove, Intermediate Care Clinical Support Manager
13.	Stephen Ramsden – Chief Executive, Luton & Dunstable Hospital
14.	John Pickles – Medical Director, Luton and Dunstable Hospital
15.	Paul Brotherton – Director of Public Health, Luton PCT
16.	Chris Brooker – Shared Care Substance Misuse Service Manager, Luton PCT
17.	Paul Jenkins Head of Community Care, Luton Borough Council
18.	Peter Crowe - Bedford Shadow Patients' Forum ***– with written evidence***
19.	Simon Wood – Strategic Health Authority Strategy Director
20.	Alan Warren – Director of Finance, Bedford Hospital NHS Trust
21.	Janette Hoole – SECTA

Written evidence was received from:

Family Groups (Bedford)

Older Peoples Action Group – Biggleswade and District

Mid Beds Alzheimer's Disease Society

Joint response from the 6 Community Health Councils of Bedfordshire & Hertfordshire

Response from the Luton & Dunstable Hospital NHS Trust

Appendix D

National Childbirth Trust Response

National Childbirth Trust
Dunstable and District Branch
DRAFT RESPONSE TO INVESTING IN YOUR HEALTH

8 July 2003

Bedfordshire and Hertfordshire Strategic Health Authority

Dear Madam/Sir

Re: Investing in your health – a consultation document

I am writing on behalf of the Dunstable and District branch of the National Childbirth Trust to respond to your proposals outlined in the above document and in the supporting papers. In particular we would like to address the plans outlined in the **review of maternity services and neonatal care.**

Overall we welcome the move to provide as much care as locally as possible, and we understand the need to provide centralised specialist care though we have some concerns which I will outline further on. We have no particular preference to either option of closure/reconfiguration. We applaud the introduction of birth centres, and believe the unit at Hemel is so far proving the benefits of this type of provision. We are concerned, though, that by closing obstetric units, women choosing/needing this type of care will need to travel further, have more fragmented care, and loose the option of a domino delivery; all of which we have seen from the closure of Hemel, with many women from Harpenden attending the Luton and Dunstable Hospital.

Looking first at the review of **neonatal services**. We are very pleased about the proposal to provide a level 3 neonatal unit at the Luton and Dunstable Hospital, which will mean many parents no longer having to travel to Cambridge or London. We also were pleased to see the emphasis on planned transfers, keeping mother and baby/ies together, and support and information on breastfeeding. (Just a note: who wrote "breast milk pumps", when everyone involved with breastfeeding calls them, simply, breast pumps?). However, facilities and support for parents would need to be extended and there should be an onus on the trust to provide them.

Parents we have spoken to have raised the following **issues that will need to be addressed:** greater privacy, provision for parents to stay for as long as they wish, provision for babies "in air" to be able to be in bed with mum, free car parking (one couple spent over £300 in car parking), transition rooms (like mini flats where parents can spend the first night being "in charge" of their baby, if they wish, with the comfort of knowing the staff are just down the corridor), follow up care involving home visits by paediatric teams and access to counselling. Again and again true support for mothers wishing to breastfeed comes up, because, despite the evidence that breastmilk is ideally suited to preterm babies, mothers tell of their babies given formula to "give you a rest", "save waking you", or …!

In the **review of maternity services**, we like the aims and values outlined, in particular, providing women with a range of options, establishing birthing units, providing high quality specialist treatment, the vast majority of antenatal care provided locally, continuity of care, targeted post natal support, consistent and ongoing support for breastfeeding and care based on evidence and best practice. We see them very much in the same vein as current thinking and approaches in maternity.

We are very unhappy about the whole approach to the actual provision of this service, though; however, there are a number of initiatives we like. I'll address these first.

Firstly, we are pleased to see the priority given to local, flexible **antenatal care** (preferably in the woman's home) and education, with the emphasis on **continuity of care.** We like the proposal that women carry their own notes, and we would like these notes to be in the same format so that women can more easily transfer their care, without rebooking. (Women in Harpenden are currently looking round Watford, the L&D, and Hemel birth centre before their booking visit at 12-14 weeks because the booking procedures are all different).

We welcome the emphasis on providing **information and pre-test counselling** for any screening or testing, and this should include ultrasound scans. **Post-test counselling** is also vital, as is giving women and their partners' time to consider their options.

We are delighted by the apparent commitment to provide a **range of birth options** for women including birth centres, and the recognition that there needs to be more "active promotion of home birth". We are glad to see that midwives are acknowledged to be the lead professional in home births and are professionally accountable. It offers recognition to the midwives and releases GPs unfound fears that they will be called upon. We are pleased to see domino births given a prominence as this is a very popular option for women, and one that can be harder to obtain in some areas of the region than others. It is important that women are given a real choice, baked up by information, education and support from professionals.

We particularly welcome the aim to have **1-1 support in labour** as this is something much desired by women and has also been shown in research to have profound beneficial effects.

Targeted postnatal support is a positive goal. **Consistent advice and support for breastfeeding** is something women want, and that we as an organisation would like to see. However, the half a sentence given I this document to breastfeeding is an indication of the priority given to it.

There are a number of issues we would like to raise:

1. Antenatal care

We would like to see true **continuity of care** in the form of case loading, where the woman has a named midwife, working in a small team, with whom all her antenatal checks are done, unless the woman wants/needs to see her GP or obstetrician. This allows the woman to get to know and trust her midwives and also means she would not see a different person at each appointment as can often happen now.

As stated in the document, though fewer **antenatal checks** could take place on the basis of evidence, women must be given opportunities to discuss any worries. This often takes place while the routine checks are being done. We would be *totally opposed* to these tests being done by a care assistant, as per the example at the end of the maternity section in the main document. This idea seems to have been slipped in, as there is no indication of care assistants taking on this role in the fuller supplement paper, only a vague mention of them, and we would like it removed. Likewise any system where the onus is put on the women to make a separate appointment to see the midwife to air concerns will be less efficient in highlighting problems in pregnancy as women are often reluctant to bother the midwife.

2. Birth

Risk assessment and discussion of place/type of birth – it is not appropriate to do this at initial visit – far better to be done at booking visit with midwife, with place/type of birth being an ongoing discussion. No criteria are given for risk categories, and all cases should be taken individually, with the woman's point of view respected. Women must be trusted. Women have the right to give birth at home. Women should be given the options with balanced information. In maternity world there is a move towards women waiting till they are in labour before they decide where to have their baby.

Home birth has been shown in studies to be at least as safe as hospital for low risk women. It also has many benefits – half rate of cs, half rate of instrumental delivery, less chance of haemorrhage, less perineal trauma, less postnatal depression, higher Apgar scores … and it can save the trusts thousands of pounds. It should not be seen as an add on but an integral part of the provision.

Birth centres are to be welcomed but where's the ones for Bedfordshire. If you want more women to use birth centres they will need to be re-educated away from the medical model that pervades current maternity practises. This can be done through empowering midwives in case loading teams.

Fewer women will be able to have dominos as more will live further from the obstetric units, despite the fact that they are the very women who could do with assessment at home in early labour, as they have a longer journey and don't want to arrive too soon, or too late. Dominos should be the standard with women free and confident to make the decision where to have their baby when they are in labour. Home assessment in labour is something high on women's list of priorities.

I have already mentioned the provision of a level 3 unit at the L&D, and the extra support for parents that would need to be provided. Another concern we have with centralising specialist care, is that the obstetricians, by seeing more mothers and babies with problems, and becoming more proficient at helping them (a good thing), will become more distanced from, and less experienced in, normal birth (a bad thing). This can be addressed by giving midwives, the experts in normal birth, more autonomy and involvement in women's care, which, in turn, will free up the obstetricians for the more complex cases. We would therefore like to see consultant midwives employed by each trust. We are pleased to see the commitment to provide women with 24 hour access to epidurals which is something women want; many more women want access to a birth pool to labour or give birth in which is not mentioned anywhere. We would like to see all labour rooms with a pool, or at least a bath.

Despite the promise at the beginning of the document to extend the choice for women, very little change will be made. Birth centres are only an option for women living near enough, the closure of obstetric units will limit the number of women able to have a domino birth, according to your criteria, and if GPs are making the risk assessments at the initial visits, the number of home births will never increase significantly. So the idea that these proposals increase the options for women is a lie.

3. Postnatal

Scant mention of breastfeeding – all hospitals obtain baby friendly status, promotion of skin to skin and all midwives to be continually trained and up to date so that women are given consistent, evidence based advice and that no woman who plans to breastfeed leaves hospital bottle feeding. Measures must be taken to ensure that

GPs, health visitors and other health workers are giving up to date, evidence based, advice and support consistent with that from the midwives.

Continuity of care should provide women with access to support for mental health or domestic violence problems through a midwife they know and trust.

Conclusion

Don't like the whole approach – no way to plan maternity services. It is very much a medical model with birth seen as inherently risky. There is no mention of measures to keep birth normal, nor that the safest option for the vast majority of mothers and babies is a straightforward vaginal birth ….

What we would like to see … start with the woman … maximise chances of SVB … 1-1 midwifery care … your midwife attends your birth whether home, hospital or elective caesarean. Other areas …

No problem recruiting mw, obs freed up.

Save the trust thousands of pounds e.g. Torbay.

Shadow Patients' Forum Response

Notes for presentation by the Bedford PCT Shadow Patients Forum (SPF) to the Joint NHS Scrutiny Committee meeting at 11th July 2003

Presenter: representing the SPF, Peter Crowe, retired Civil Engineer

Almost four years living in Bedford, previously near Chester.
Involved in voluntary work for 14 years to date, Peter was appointed by SPF as the member to give this presentation. (He is also a member of the 'NSF Monitoring Group for Older People' and the 'Better Government for Older People' Forum)

The Shadow Patients Forum's views on 'INVESTING IN YOUR HEALTH' proposals

As the Forum is part of the Consultation process, we have been preparing our proposals, and (as requested in the documents) we will submit our considered preference for Option 1 or Option 2.

In the meantime a draft copy of our 30 point typescript has been passed to Bill Hamilton and a copy of 'Investing in your Health' to read concurrently with the presentation items.

Also enclosed were five information sheets detailing our role, how we work etc. plus copies of the Secretary of State for Health's draft regulations covering Patients Forums (Membership & Procedure) and (Functions). September 2003 (stated as when these come into force) seems optimistic. Our comments are almost ready for submission.

At a Forum meeting held on 10th July 2003, the following general comments were made:-

31. The Forum feels strongly that we have to accept that the date shown in 'Investing in Your Health' is true and unbiased, and that our comments and proposals are made based on this premise.

32. As a Forum we are universally concerned that the resources employed and the outcome achieved will not dilute Bedfordshire's share of these. (We understand that this was NOT so in the past).

33. The proposals in the document are impressive and we hope that the StHA can live up to these if and when adopted.

34. We have expressed doubts concerning the surgicentre in Bedfordshire. Will there be emergency arrangements to 'back up' the surgicentre in the event of a simple operation being found to be more complex than anticipated? Although the road system is currently poor – especially east to west – we would want to know whether, in the latter situation, the special skills are taken from elsewhere or whether the patient would have to suffer transfer to another 'acute' hospital. We think that the concept should be made clearer.

35. Should the Investments, for the selected Option, after amendments requested consultation, the StHA will have to transfer its vision into reality

by pre-planning and supervision of every function of the health improvements in Bedfordshire and Hertfordshire. This will provide a challenge to ensure that pre-planning, material reserved, job-planning, completion etc – in fact every factor – runs to programme and budget! A big challenge!!

Note: Numbers above follow on after those in the typescript

Peter Crowe
11.07.03

Added Note: Ref 30 of SPF Response: A poll was taken of 10 Forum members, 2 voted for Option 1 and 8 voted for Option 2.

DRAFT

BEDFORD PCT SHADOW PATIENTS' FORUM
RESPONSE TO INVESTING IN YOUR HEALTH
CONSULTATION DOCUMENT

1. The Forum welcomes the concept that more care will be provided outside of major hospitals, along with the development of more home care, more primary care and more intermediate care. Overall it is felt that the aims of "Investing in your Health" are impressive.

2. There are concerns about the Strategic Health Authority's ability to deliver such an ambitious service reconfiguration, given that it will require developments in intermediate and primary care to have been achieved ahead of the changes in secondary care if there is to be no loss in the standard of service provided (particularly during the period of change).

3. The timing of such changes is already open to question, for example, the Archer Unit, which is stated as being open in April 2003, is still not open.

4. It is important to members that Investing in Your Health should not cause a dilution of services in North Bedfordshire.

5. It is important to members that the needs of Bedfordshire should not be dwarfed those of Hertfordshire, and that there should be no diversion of monies from Bedfordshire to Hertfordshire.

Community Diagnostic & Treatment Centres

6. The main concern is whether GPs with the appropriate expertise will always be available at DTCs. It is acceptable for GPs to perform minor surgery, such as removing "lumps and pumps" only if they have been correctly diagnosed as such. A Forum member had a mole removed by a GP which led to unnecessary complications when the mole turned out to be malignant.

7. Existing community hospitals currently provide continuing care and respite care. Where will these necessary services be provided under Investing in Your Health?

Surgicentre

8. The location of the proposed surgicentre for Bedfordshire is the cause of much concern. It must be easily accessible by both public and private transport and, therefore, provide adequate car parking for both patients and visitors.

9. It should be noted that there is no east to west transport link in Bedfordshire.

10. There are concerns that there are not enough surgeons to staff both the proposed surgicentre and the current hospitals in Bedfordshire.

11. The suggestion to site the surgicentre at Bedford hospital could alleviate the problem of staffing.

12. However, if the surgicentre was on the Bedford hospital site it would negate most of the benefits to be gained by locating the surgicentre separately, such as not having planned operations cancelled to accommodate emergency surgery. It would also in no way lessen the parking problems at the hospital site.

13. Investing in Your Health gives the impression that there would be a fast turnaround at surgicentres. It has long been a criticism by patients that they are often "sent out of hospital too soon", in some cases only to be readmitted as an emergency. It would be important that surgicentres' procedures should avoid such practice.

14. It would be essential for surgicentres to be able to provide physiotherapy 7 days a week, in order to effect a successful early discharge after surgeries such as knee replacements. Currently physiotherapy is not available over the weekend at some hospitals.
15. Bedford hospital's old North Wing site has been proposed as a suitable location for the Bedfordshire surgicentre.

Bedford Hospital

16. That a trauma unit is to be developed at Bedford hospital is greatly welcomed.
17. The proposals that Bedford hospital will provide 24 hour consultant led care, and develop increasing specialisation are also supported.

Quality of Care/Treatment

18. The consensus of opinion was that the quality of care/treatment that a patient receives is more important than how far s/he has to travel to receive specialist treatment, and that specialist services such as cancer and rare/serious diseases should be concentrated in major hospitals.
19. There are concerns about birthing centres without neo-natal facilities being provided for "low risk" mothers.
20. There is concern that when current hospital services are carried out outside of the hospital, consultants will be spread too thinly causing the quality of care/treatment to drop.
21. There is concern that because staff at DTCs and Surgicentres will not be treating challenging cases it will lead to a lack of professional development and therefore a "dumbing down" of care provided.
22. There is concern that DTCs and Surgicentres will compromise personal attention in the interests of efficiency.
23. There is concern that small surgeries do not have a broad enough awareness of disability to have the ability to deal with the full range of requirements of disabled people.
24. The proposed developments in primary and intermediate care must be fully supported by Social Services provision to be successful.
25. It is believed that Option 2 will provide improved quality of care in Hertfordshire.
26. There is concern that a teaching hospital in Hertfordshire could cause problems of recruitment/retention of staff in Bedfordshire.

Omissions

27. It is worrying that no consideration of Mental Health or Learning Disability services has been included in this document.
28. Healthy living initiatives and education have not been included.

Choice between Option 1 and Option 2

29. The £150million saving by choosing Option 1 was felt to be significant.
30. New building does not always provide best value for money. ?? ("not always a best bet").
31. In a vote taken by_____members of the forum,___voted for Option 1, _______voted for Option 2 and _____did not express a preference.

Family Groups Bedford Response

Have your say on these important decisions

You have until ~~June 11~~ July 10th to let us know your views. Please fill in the form below.

You can find out more information or consider the issues in more detail by requesting a copy of the full consultation document and appendices. All this information is also available on our website: www.bhha.nhs.uk

- Do you agree that we should invest in more local services, your GP, community hospitals and other services such as Community Diagnostic and Treatment Centres – 'DTCs'?

  Yes ☑ No ☐ Don't know ☐ Has planned increase in population in Bedfordshire been taken into account?

- Some services – in particular paediatrics (children) and obstetrics (maternity) – will need to be reorganised to improve care. This reflects changes in treatment as well as a desire to ensure specialised staff are available 24-hours-a-day. This will mean concentrating some specialist services at major hospitals. Do you agree in principle with the need to concentrate some specialist services in order to provide the best possible treatment for patients – if it means travelling further or not using your nearest hospital?

  Yes ☐ No ☐ Don't know ☑ Depends on no. of factors – public transport being one, dependent family members being another

- We propose concentrating most planned surgery in new 'surgicentres'. Do you agree?

  Yes ☐ No ☐ Don't know ☑

- Are you in favour of a new cancer centre being developed in Hertfordshire based on the move of the Mount Vernon Cancer Centre in north London? Does this have any implications for Bedfordshire

  Yes ☐ No ☐ Don't know ☑

- Of the hospital options please tick your preference for either Option One or Option Two below:

  ☐ **OPTION ONE: To redevelop the Hemel Hempstead hospital to include a new cancer centre.**

  Does this make any difference to Bedfordshire residents? – unless

  ☐ **OPTION TWO: Build a new hospital in Hatfield (to replace the QEII at Welwyn Garden City), together with a new cancer centre.**

  it uses a lot of resources & takes away quality staff from Bedford?

- I have read this summary document and would like to make the following comments:

  How does new Primrose Centre @ Bedford Hospital fit into this?
  Will cancer treatment @ Addenbrookes Hospital for Bedfordshire residents be no longer necessary?
  How easy/difficult would it be for Bedfordshire people to access cancer care in option 1 or 2 – particularly if reliant on public transport?

- Please send me a copy of the main document ☑ *(Please note this is also available online)*

- If English is not your first language, please tick to receive a translation of this summary document:

  Gujarati ☐ Hindi ☐ Punjabi ☐ Urdu ☐ Other (please specify) ______

- This summary is also available in: audiotape ☐ large print ☐

Name Family Groups (Bedford) Co-ordinators

Address Raleigh Centre

Ampthill Road

Bedford Postcode MK42 9HE

Phone (01234) 316801

[Stamp: FAMILY GROUPS (BEDFORD) RALEIGH CENTRE AMPTHILL ROAD BEDFORD, MK42 9HE GUARANTEE NO. 2546[illegible] REG. CHARITY NO. 1045275 TEL 01234 316801]

*Please cut out and return this form using the **freepost** address below:*

Bedfordshire and Hertfordshire Strategic Health Authority
c/o Charter House
FREEPOST 145
Parkway WGC

Older People's Action Group – Biggleswade and District Response

OPAG Older Peoples Action Group Biggleswade & District

12 Banks Road
Biggleswade
Bedfordshire
SG18 ODY

Tel: 01767 312578

OPAG Response to "Investing in your Health"

Improved local access to services previously only available in hospital settings is a welcome development. Travelling to hospital is very wearing for all patients but especially the elderly, particularly with inadequate public transport.

The creation of DTCs and Community DTCs could effect a dramatic improvement, but sadly Biggleswade is not among the towns listed on page 4 of the consultation paper, namely Leighton Buzzard, Royston and Hertford, which admittedly, at present, have much larger populations than Biggleswade.

Preventing unnecessary admission to hospital and enabling early discharge are again laudable aims but Intermediate Care must be well funded and resourced. Also, if local nursing homes are to replace hospital beds, they must be of a high standard and inspected regularly and rigorously.

Continuing Care, when required, should be retained in Hertfordshire and reinstated in Bedfordshire.

Improving the health of local people – should include social and emotional health. The dire shortage of public assembly venues in Biggleswade, together with poor public transport (the last town bus leaves the town centre at 5.20) lead to social isolation, especially in winter.

Providing three Surgicentres – This seems an excellent way of providing planned surgery without disappointing, and often repeated, cancellations. It is good that one of the three will be in Bedfordshire which often seems to be the poor relation, with services such as the potential new cancer hospital sites both being in Hertfordshire. Was consideration every given to a site at Luton and Dunstable hospital which is central to both counties?

Options 1 and 2 – Option 2 although more expensive is preferable if it means that a teaching link to the university can be developed which would certainly attract more highly qualified staff. Also, a new "state of the art" hospital would be better than a redeveloped one which might have site and space restrictions which could militate against optimum planning.

Biggleswade Hospital is not shown on the map. It is hoped that this is because the present site, with inadequate and out-of-date buildings and threatened by the proximity of the proposed Eastern Relief Road, is to be abandoned and a new Community Hospital built on a site shared with the proposed new Surgeries. If so, it should be ensured that adequate land for both purposes and generous car parking space be secured at the very beginning of stage one of the project, lest it be unavailable when the time comes for stage two. This is not a case for "Small is Beautiful", rather for "Think Big"!

Hopefully, such a local hospital would include a Community DTC and, if the plans could include a community space for accommodating consultation groups or exercises classes, Expert Patient courses etc., that would be a fine additional facility.

The members of OPAG look forward to improved services and premises in Biggleswade itself and in the two counties. Since we are Older People we hope for the earliest possible realisation of these ambitious but very desirable schemes.

May M Garton (Mrs)
Chairperson 5.6.03

Mid Beds Alzheimer's Disease Society Response

From: Alex Morton
To: NHS Scrutiny Email Account
Subject: investing in health response
Date: 01 July 2003 14:33PM

Unfortunately I have only been able to review past night the summary supplied on line by the Strategic Health Authority.

I am disappointed that as the Mid Beds Alzheimer's Chair I wasn't sent the full report. However here are my comments:

1. Are the objectives of the NSF guidelines being included within the overall options being considered
2. Few plans seem to be included for mental health or patients with dementia.
3. We are still very disappointed at the abandonment of the Weller Wing reprovisioning in Bedford including substantial new build facilities in Biggleswade and Ampthill. Will some of the plans outlined in these proposals go the same way particularly in Bedfordshire
4. What is to be the future status of other sites in Mid Beds e.g. Steppingley Hospital at Flitwick and Biggleswade hospital. Also what will be the future status of Potton House and Orchid Lawn on these sites
5. Biggleswade, Sandy, Potton and the surrounding villages seem to have no provision for Hospital, Surgicentre, or Intermediate Care facilities. Is it assumed that transport facilities will be provided from these areas to Bedford or Stevenage
6. On the whole patients with dementia do not require extensive hospital services but do require day facilities and adequate diagnostic assessment. No provision seems to have been included for this.

Unfortunately due to other commitments I am unable to come to the meeting on the 11th July but would value a reply to the above comments to share with my committee.

Hope all goes well

Alex Morton

Joint Community Health Council Response

Chairman: Margaret Turton
Chief Officer: Tony Tester

Our ref: *IB/I-Jy18* 23 July 2003

Mr Andrew Morgan
Acting Chief Executive
Bedfordshire and Hertfordshire
Strategic Health Authority
Tonman House
63-77 Victoria Street
ST ALBANS
Herts
MK40 2AW

Dear Andrew

INVESTING IN YOUR HEALTH – A CONSULTATION PAPER

A joint response to the above consultation from the six Community Health Councils in Hertfordshire and Bedfordshire has already been submitted and is enclosed for your convenience.

However, North and Mid-Bedfordshire and South Bedfordshire Community Health Councils have some concerns specifically relating to Bedfordshire. These concerns have been incorporated in a supplementary response, which is now enclosed.

In making this response, the Bedfordshire CHCs have taken the Mount Vernon Hospital: The Future Services for Cancer Patients Consultation Paper into consideration as members are aware that the result of this Consultation may lead to the population of North West London being served elsewhere. If this is the case, the Councils need to know the impact on the Plan, bearing in mind the importance of catchment to a cancer network.

Yours sincerely

Anne Villegas Iris Beazley

Chief Officers

Encs

Cc Chief Executives of All NHS Trusts in Bedfordshire
Bill Hamilton, Beds County Council
Geoff Bocutt, Luton Borough Council
Chief Officers, Hertfordshire CHCs

Bedfordshire & Hertfordshire NHS Strategic Health Authority
INVESTING IN YOUR HEALTH – A CONSULTATION PAPER

Response from North & Mid-Bedfordshire and South Bedfordshire CHCs

General

- Concern that the allocation of resources will be heavily weighted to Hertfordshire because that is where all the infrastructure problems are, ie Lister and QEII Hospitals. Money allocated for Bedfordshire **should be spent in Bedfordshire.**
- Concerns that Bedfordshire has apparently been tagged on as an afterthought.
- No comparable plan for Bedfordshire with regard to hospital and cross-boundary links, which is of great concern, ie Bedford's links with hospitals in Buckinghamshire, Northamptonshire and Cambridgeshire. Changes proposed will have little impact on the North of Bedfordshire, as all the tertiary links are east/west rather than north/south.
- Bedfordshire Hospitals do not have the same problems with staff recruitment and retention as Hertfordshire.
- Concerns that Mental Health and Learning Disabilities have not been included in the proposals.
- Palliative care has been completely omitted; this is of particular concern to the CHCs because Bedfordshire has been un-resourced in this area.
- There was no research carried out in Bedfordshire regarding transport problems.
- Confusion over population growth figures for the whole of Bedfordshire and in particular Luton and Dunstable; this is bound to have an impact on the infrastructure.

Surgicentres

- The plans thus far produced are so inadequate that it is impossible to make a proper informed choice.
- The CHCS are not against the concept of a surgicentre for Bedfordshire, however until the proposal is more clearly defined it is not possible to debate this issue and form a considered opinion.

Diagnostic Treatment Centres (DTCs)

- The same considerations apply as set out under surgicentres above.

Community Hospitals

- The same considerations apply as set out under DTCs/surgicentres above.

Intermediate Care

- Intermediate care needs to be addressed before DTCs and surgicentres are implemented.

The Bedfordshire CHCs are generally disappointed at the inadequacy of the proposals for **Bedfordshire** outlined in Consultation Document: Investing in Your Health and are therefore **unable to endorse** Options one or two.

BEDFORDSHIRE AND HERTFORDSHIRE COMMUNITY HEALTH COUNCILS

'INVESTING IN YOUR HEALTH'

(Consultation by Beds & Herts Strategic Health Authority)

This response needs to be read in conjunction with the other ~~attached documents~~ (Not attached)

- *Notes of the Beds and Herts Enquiry Day, 16.05.03*
- *Consideration of issues raised by the StHA discussion paper Investing in Your Health – Autumn 2002*

The Bedfordshire and Hertfordshire Community Health Councils welcome the consultation, and support the need for change in order to develop a modern, high quality, integrated range of health care services in Bedfordshire and Hertfordshire.

In addition, Beds and Herts CHCs agree the following:

1) The CHCs support the continued provision of six major hospitals as envisaged in the consultation document.

2) The CHCs note the ambitious nature of the plan and that it does not necessarily relate to priorities contained in PCTs Local Delivery Plans. What is needed is total commitment and involvement of local authorities, housing authorities and all NHS partners.

3) The CHCs support the fundamental principle of a shift from acute to primary care as proposed in the document. There is a needs to ensure that investment in primary care, led by PCTs, precedes change to acute services.

4) The CHCs support the promise of early action (within 3 years) in respect of investment in 'Diagnostic Treatment Centres' – as made by the Strategic Health Authority at the joint CHCs Hearing held on Friday 16th May 2003. There are concerns around the unresolved provision of surgicentres in Bedfordshire, i.e. on existing hospital sites or on Greenfield sites, and the basis on which staff are contracted. While such a model of care needs to be flexible, there must be a consistent core definition of the services provided by all Diagnostic Treatment Centres (DTC) and Surgicentres.

5) The CHCs are clear that the development of Intermediate Care services is a critical priority in the development of high quality health and social care. They recognise this has implications for Social Services and Housing agencies, NHS organisations, including primary care, and calls upon those agencies to make these issues their highest priority. This has not been so in the past and remains difficult, particularly at operational level.

6) The CHCs support the development of a specialist cancer centre in Hertfordshire. They would like to see it serve a catchment population around two million, and large enough to provide for a full range of specialist cancer services, plus research facilities and full supportive care to create a Centre of Excellence. Mount Vernon should continue to be used as a key resource as part of the network. They also note that the complexity of developing cancer services for Herts & Beds residents is complicated by a lack of a strategic view about developments by other interested Health Authorities, including North West London Strategic Health Authority. This matter needs to be addressed with some urgency. If it is not, it could seriously undermine proposals for cancer service development in Beds & Herts.

7) The CHCs are concerned that the Children's Services Review in its totality is not mentioned in the consultation document. The Health Authority, PCTs, NHS Trusts and Local Authorities need to work on the implementation of the Review. There must be clarity as to who will provide these integrated services in the future, both in the short and long-term.

8) The CHCs are concerned that Mental Health has been excluded from the consultation. There is major concern about future investment in the existing poor infrastructures for Mental Health. This is needed in addition to the Investing in Your Health plans. In order to meet the NSF standards there will need to be considerable investment in infrastructure and services.

9) The CHCs welcome the commitment made at the joint CHCs Enquiry Day held on Friday, 16th May of an integrated transport service for Herts & Beds service with a single contact point, involving all transport voluntary agencies. There are particular concerns about

    a) The less than adequate East to West transport links, in both counties. (Referred to in the joint response discussion document attached.)
    b) More patient journeys will require more parking.
    c) No evidence of research carried out in Beds.
    d) Investment and support for BHAPS needs to be enhanced.

10) The CHCs acknowledge the serious need for capital resources to maintain the existing NHS estate and to improve the current quality of services. CHCs question whether capital plans for 'visionary service development' have understated priorities for other maintenance and NHS capital needs. There is serious concern about funding during the transitional period.

11) The CHCs have noted many concerns raised with regard to the question of how well the plan has been costed. In particular there are concerns about the implications of PFI. A public comparator is needed for benchmarking purpose.

12) The CHCs note that the plan does not accommodate any implications for changes in Trusts status to that of Foundation Trust – should the Governments' proposals for 'foundation' trusts become law.

Not withstanding that the CHCs have these concerns, they wish to emphasise the importance of providing the quality service for Beds/Herts which local people have not had for decades and which is now being proposed.

Luton & Dunstable Hospital Response

Our ref: SR/ams

18 June 2003

Mr A Morgan
Acting Chief Executive
Bedfordshire & Hertfordshire SHA
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e-mail: stephen.ramsden@ldh-tr.anglox.nhs.uk
PA to Chief Executive: Anne Sargent
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Dear Andrew

LUTON & DUNSTABLE HOSPITAL NHS TRUST
RESPONSE TO INVESTING IN YOUR HEALTH (IIYH)

The Luton & Dunstable Hospital NHS Trust welcomes the formal consultation and supports the overall direction contained within Investing in Your Health. Indeed, the broad thrust of acute hospitals in future concentrating more on acute and specialist services and more ambulatory services being developed off the acute hospital site, is consistent with the L & D's own Strategic Direction 2000 – 2005 'Building Pride in the L & D'.

The long term strategy incorporated in IIYH will allow sensible, compatible short term changes to respond to the very urgent workforce issues all hospitals currently face. There will be further piecemeal closures of services in an un-coordinated way if we do not address this urgently. It is important to emphasise again that these short term changes must be planned and implemented corporately, across Beds & Herts, and NOT confined to single NHS Trusts re-distributing services and skilled staff (including trainee doctors) between their own hospitals.

Investing In Your Health gives an opportunity to begin to address the population needs issue, particularly around Luton. Not only is Luton the most deprived population with the poorest health, it is the most under-funded. Many Bedfordshire stakeholders have commented that Investing in Your Health is about resolving Hertfordshire's health services and this perpetuates fears raised during the creation of the Beds & Herts SHA about Hertfordshire financial problems disadvantaging Bedfordshire healthcare. The SHA must show in actions from IIYH and in resource allocation generally that this is not the case.

IIYH can provide the opportunity to show closer working across the whole of Beds & Herts, but single organisations, quadrants and the SHA need to be willing to grasp these opportunities. In addition to some of the specialist services that should be more formally networked across the whole SHA, the prospect of creating a medical school could bring closer working behind a common cause. The L & D have recently been granted Associate Teaching Hospital status and would welcome the opportunity of co-operating with a pan SHA process to link into Hertfordshire University, the University of Luton and Cranfield.

We have some specific comments to make on the re-organisation proposed and then will comment on which of the two options for Hospital Re-configuration the L & D supports.

1. IIYH and supplementary documents forecast the transfer of large numbers of patients for outpatients, therapy and diagnostics from the L & D to other settings (up to 50% of current numbers is quoted). We will work closely with PCTs and other organisations to develop appropriate services to achieve a shift but we do not have sufficient evidence to support the number quoted (50%).

2. Similarly, a large transfer of elderly patients from the L & D to intermediate care settings is predicted (as many as 50 – 80 beds). Again, we will work closely with PCTs, Social Services and other organisations to develop plans for increased intermediate care services, but we do not have sufficient evidence to support the number of beds freed up quoted.

3. IIYH calls for the creation of two Surgicentres in Hertfordshire and one in Bedfordshire. This is not necessarily the best configuration of surgicentres for Beds & Herts and there has been insufficient strategic planning of this proposal. One option would be to aggregate the elective surgery across Beds & Herts into a specification and test the market view on how many there should be and where they should be located. This strategy must take into account the many workforce issues that have stimulated the need for Investing in Your Health in the first place. It would be ironic if the Surgicentre proposals created even more separate facilities for the specialist workforce to staff, thus compounding not resolving the problem. A further difficulty is the dilemma between the need to concentrate specialist surgery into fewer acute centres and the desire to create Surgicentres off acute sites.

4. A number of other specialties need to be centralised on fewer hospital sites, including some cancer surgical services. It is important that these new centres are dispersed around the remaining acute hospitals in Beds & Herts and not all developed on one supra hospital site in the long term. This will ensure equity in resource investment and the avoidance of creating a 'magnet' for skilled staff in one hospital/location only to the detriment of recruitment elsewhere. Proposals to re-organise these specialties across Beds & Herts need to be progressed as a matter of urgency.

5. The creation of a Beds & Herts Neonatal network and the designation of the L & D as a Level 3 NICU is welcomed. Significant revenue and capital investment will be required to comply with national standards contained in the national NICU strategy.

The L & D will pursue a Strategic Outline Case for the creation of a Women's & Children's Centre to accommodate the level 3 NICU status, the likely increase in paediatric and obstetric patients implicit in IIYH and the delivery of the L & D's own Development Control Plan to concentrate women's' & children's services in the same location on site.

6. In view of the Secretary of States decision to close Harefield, it is essential that a Cardiac Centre is developed for Beds & Herts.

The L & D has revised its Development Control Plan and would have a strong case to develop a Cardiac Surgical Centre on site. We look forward to actively participating in the planning group on Cardiac Services.

Turning now to the two options for Hospital Re-configuration. IIYH gives all the reasons why there needs to be fewer acute hospitals and coupled with this is the need for the remaining 4 hospitals to serve larger populations to generate the critical mass to
support the increased specialisation and workforce issues.

Option 1 does not allow this to be achieved particularly for the L & D, as Hemel Hempstead is too close to the L & D. It would also lead to some Herts residents currently using Watford General to travel to North London for treatment. In addition, the long-term review of the Mount Vernon Cancer Centre recommended strongly, the re-location to a new greenfield site co-located with a new DGH, in preference to an extension to an existing DGH such as Hemel Hempstead.

Consequently, the Luton & Dunstable Hospital NHS Trust supports Option 2, which complies with the longer term cancer centre review recommendation and also allows the expansion of the L & D to serve a large population for acute, paediatrics and obstetrics activity. Option 2 makes more sense geographically and strategically, retaining more Beds & Herts patients within Beds & Herts hospitals.

In supporting Option 2, we reiterate the caveat that major centres of excellence are distributed around the remaining acute hospitals and NOT all developed on the new Hatfield Hospital site.

Thank you for giving us the opportunity to comment formally on these far reaching proposals. Please contact me if you wish to clarify any of the above.

Yours sincerely

Stephen Ramsden
Chief Executive

cc: Mr A Reed, CEO, Bedford Hospital NHS Trust
Ms L Burns, Director of Social Services, Bedfordshire County Council
Mr H Dunnachie, Director of Social Services, Luton Borough Council
Mr P Mullin, CEO, Bedfordshire & Luton Community NHS Trust
Ms R Shakespeare, CEO, Luton PCT
Mr J Swain, CEO, Bedfordshire Heartlands PCT
Ms A Walker, CEO, Beds & Herts Ambulance & Paramedic Service NHS Trust
Ms S Childerstone, Acting CEO, Beds & Herts WDC
Ms V Harrison, CEO, West Herts Hospitals NHS Trust
Mr N Carver, CEO, East & North Herts Hospitals NHS Trust

Bedfordshire County Council – Head of Environmental Strategy - Response

Briefing Paper for NHS Scrutiny Committee
11 July 2003

Communities Plan – Implications for Bedfordshire

1. Introduction

1.1 This report brings the Committee up to date on the progress with the Milton Keynes and South Midlands Growth Area and seeks to identify points that are relevant to the NHS

2. **Sub Regional Strategy**

2.1 In the document Sustainable Communities: Building for the Future published in February this year, the Government proposed that an additional 200,000 houses should be built in the four growth areas, including the Milton Keynes and South Midlands area. This number is additional to those currently planned. The whole of Bedfordshire is within the Milton Keynes and South Midlands area. (Copy of the document can be viewed at www.communities.odpm.gov.uk).

2.2 The Sustainable Communities document included no details of the scale and location of the new housing. In order to provide this detail, 5 studies were commissioned from consultants to set out the scale and location of new housing, together with the required transport and community infrastructure.

2.3 These studies were for Corby/Kettering/Wellingborough, Northampton, Aylesbury, Milton Keynes, Bedford and Luton/Dunstable/Houghton Regis. Copies of the consultants report can be viewed at www.southeast-ra.gov.uk/regional_policies/planning/area_studies/milton_midlands.

2.4 The results of the consultants studies have been distilled into a Milton Keynes – South Midlands Sub-Regional Strategy. This Strategy is being considered by the three relevant Regional Planning Bodies – East of England Regional Assembly, East Midlands Regional Assembly and South East England Regional Assembly – at meetings in June and early July. If the Regional Planning Bodies endorse the strategy, it will be submitted to Government. Government will then issue the strategy for public consultation for 12 weeks, beginning 18 July. The consultation will be organised jointly by the three regional planning bodies and Government Regional Offices.

2.5 The Regional Planning Bodies for East Midlands and the South East have endorsed the Strategy for consultation. The East of England Regional Planning Panel considers the Strategy at its meeting on 9 July.

2.6 The current timetable for the Strategy is:

- consultation – 18 July to 13 October
- public examination – 16 to 29 March 2004
- consultation on changes following the Panel Report – 25 October 2004
- ODPM publishes RPG amendments – December 2004

3. Implications for Bedfordshire (including Luton)

3.1 The headlines are:

- Bedford/Kempston/northern end of the Marston Vale to provide 19,000 new dwellings by 2021.
- Luton/Dunstable/Houghton Regis to provide 20,544 new dwellings by 2021. Sites for some of these can be found within the existing built up areas, but development will be

required north of Dunstable/Houghton Regis and Luton, within the alignment of the proposed northern bypass and on the north west edge of Dunstable. A reserve site is proposed on the eastern edge of Luton, in Hertfordshire, if sufficient sites for new dwellings cannot be found from within the built up area.

- No proposals for new dwellings outside of the above areas.
- No proposals beyond 2021
- Requires a significant investment in transport and community infrastructure to support the new housing

3.2 sets out a level of housing provision that is similar to that in the Deposit Draft of the Structure Plan 2016. For comparison, the table below shows the annual housing provision in the Deposit Draft of Structure Plan 2016 and the Sub Regional Strategy.

	Structure Plan 2016	Sub Regional Strategy
Bedford Borough	760	789
Mid Beds	740	162
South Beds/Luton	930	1,027
Total	2,430	1,978

3.3 The Sub Regional Strategy only covers part of Bedfordshire and Luton. Once an allowance is made for new housing in those parts of Bedfordshire that are outside of the growth areas, the planned annual figure will be at least 2,430 per year.

3.4 Further work is underway by the Bedfordshire local authorities to identify housing provision to 2021 in the rural areas of Bedford Borough, Mid Bedfordshire outside of the northern part of the Marston Vale and South Bedfordshire outside of Dunstable/Houghton Regis. This work is required for East of England Regional Planning Guidance and will be completed by November. This work will provide housing figures for the complete County and Luton in the period to 2021, from which it will be possible to produce population projections.

3.5 The following tables show the population and household growth, based on the 2,430 houses per year proposed in the Structure Plan 2016.

Population growth 2001 -2016

	2001	2016	Change
Bedford Borough	144,200	157,900	+13,700
Mid Beds	128,200	146,000	+17,800
South Beds	112,000	128,700	+16,700
Luton	182,800	171,000	-11,800
County	567,200	603,600	+36,400

Household Growth 2001 - 2016

	2001	2016	Change
Bedford Borough	59,800	70,800	+11,000
Mid Beds	52,100	62,700	+10,600
South Beds	47,300	59,200	+11,900
Luton	69,600	71,100	+1,500
County	228,800	263,800	+35,000

4. Healthcare

4.1 The two consultants' studies both attempted to identify what were the implications of the additional housing for the provision of healthcare facilities.

4.2 The Roger Tym growth area study for Luton/Dunstable/Houghton Regis identified the following health infrastructure costs of the proposed housing in the period 2001 to 2021:-

- £3.5mn Primary
- £19mn Intermediate
- £24.8mn Hospital

4.3 The Entec growth area study for Bedford did not set out costs, but noted additional investment would be required at Bedford hospital and issues of funding and establishment of primary care practices at the northern end of the Marston Vale.

4.4 Both studies identified that further detailed work was required to understand the funding, land use and practical implications for the health sector of the additional growth.

5. Communities Plan Funding

5.1 "Sustainable Communities: building for the future" identified £164mn in the 3 years 2003/04 to 2005/06 for projects that would bring forward new housing developments and agreed plans in the 3 growth areas outside of Thames Gateway. The timetable was for projects to be submitted to the Government by end of May. An announcement on which projects are to receive support is expected before the Parliamentary summer recess.

5.2 GO-East and EEDA drew up a list of projects, in consultation with key stakeholders. 25 projects were submitted for Bedfordshire and Luton, totalling nearly £60mn. One of the projects was Bedford Health Strategy – strategy and programme for primary health and hospital care (£0.75mn).

6. County Council views

6.1 The County Council will be considering it's response to the consultation on the sub regional strategy at an Executive meeting on 2 October. In order to inform the County Council's response all stakeholders, including health providers, will be contacted, requesting that they copy the County Council in to any response that they wish to make.

6.2 The County Council has not taken a formal view on the sub regional strategy. However the Bedfordshire and Luton Local Government Association has identified that the step change in new housing delivery will not occur without considerable investment in transport and community infrastructure. Indeed due to the existing infrastructure deficit, the LGA contend that the new infrastructure is required in advance of housing and are seeking reassurances that the necessary funding will be provided.

Richard Watts
Bedfordshire County Council
4 July 2003

Appendix 8

Response from Buckinghamshire County Council

Buckinghamshire County Council

Chief Officer of the Council Chris M Williams BA(Hons), MA, MRTPI, MIMgt
County Hall • Walton Street • Aylesbury • Buckinghamshire • HP20 1UA

Mr W Hamilton
Bedfordshire County Council
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Date 10th September 2003

Dear Bill

Response to the consultation on the future of services for cancer patients at Mount Vernon Hospital

Here, on behalf of Buckinghamshire's Overview and Scrutiny Committee on Health, is Buckinghamshire's response to the consultation for inclusion in the joint committee's report.

Yours truly

Roger Edwards
Lead Officer, Overview and Scrutiny

Buckinghamshire Overview and Scrutiny Committee on Health

Response to the consultation on the future of services for cancer patients at Mount Vernon Hospital

Introduction

The Buckinghamshire Overview and Scrutiny Committee on Health comprises members from the County Council and each of the District Councils in Buckinghamshire. The Committee welcomes the opportunity to be involved in this consultation process and has given as full a consideration of the issues as was possible in the time available. The amount of time has of course been limited largely because of the haphazard way that the consultation has developed. The Committee is very disappointed that the Thames Valley Strategic Health Authority chose not to be involved with the consultation process particularly in view of the number of residents of the Thames Valley area that use the service (approximately 16% of the total service users).

We do not see this consultation as the end of a process but rather as the beginning of a further consultation round once proposals for Mount Vernon have been firmed up. The present consultation paper is too full of phrases such as “we hope” and “it is anticipated” to provide any confidence that what we are being consulted on is anything like the final story.

General comments

First of all the Committee has to make clear its disappointment at the poor quality of statistical data that has been provided. Because of this lack of information it has proved very difficult to come to a fully informed view about the proposals for Mount Vernon. Furthermore, new information introduced at the presentation at Mount Vernon on September 1st, that should have been included in the original document, further confused the issue.

The following examples show just some of the information that should, in our opinion, have been provided:

- Maps showing, for example, planned and existing cancer centres together with the anticipated patient catchment areas.
- Information on the proportion of rare cases (particularly important in view of the fact that the joint committee was told that it would be intended that common cancers would continue to be treated at Mount Vernon).
- Information on the planned future delivery of services (e.g. we were told on Sept 1st that there is a possibility that most chemotherapy could in the future be delivered at GP surgeries). It is very difficult for lay people to be aware of what services are going to be available in 10 years time and the documents provide no guidance on this.
- Data outlining the capacity of proposed and existing cancer centres. It is not possible to know from the data available whether changing Mount Vernon would leave sufficient total capacity within the whole area from which patients would receive services.
- Information on precisely what ambulatory radiotherapy services would continue at Mount Vernon. It is not acceptable to be told that “some” ambulatory radiotherapy services “could” continue but that precisely what is to happen is dependent on a viability study that would not be completed until after the end of the consultation period. How can a decision reasonably be made before the viability study is completed?
- Similarly, being told that “most” chemotherapy would continue at Mount Vernon is not good enough. This issue was confused further by the statement, see above, that GPs

would develop chemotherapy services "by 2010". If that is true then it should have been referred to in the consultation document as it would seem likely that it would have a major bearing on what is required for services in the future.

- No information was available on the possible knock-on effects of the changes on other centres. For example if patients from South Buckinghamshire were diverted from Mount Vernon to Oxford, would Oxford be able to cope? Also, when a new centre is opened somewhere in the Beds. and Herts. region, what would be the effect on the remaining services at Mount Vernon?
- Earlier consultation over the wider affected catchment area

It did seem from the presentation to the joint overview and scrutiny committee at the meeting on September 1st that a fairly comprehensive cancer service would continue at Mount Vernon. We understand that common cancers would continue to be dealt with at Mount Vernon and that these would equate to about 85% of cases. It would be very helpful to have some confirmation of that figure.

So, the initial view of the Buckinghamshire Health Overview and Scrutiny Committee is that the consultation has been poorly presented and that there is insufficient reliable information available to enable proper consideration of the issue. However we are realistic enough to recognize that a decision is going to be made whether or not Buckinghamshire responds to the consultation. Therefore the following comments in answer to the questions asked in the consultation document are the Committee's considered views on the proposals based on the information available.

Response to questions

Q1 Do you accept the proposition that Mount Vernon needs to change?

We recognize that Mount Vernon needs improving and updating and that change will be inevitable once a cancer centre is developed in Hertfordshire. However, we are not convinced that the proposed changes have been fully thought through and are in the best interests of patients. We accept that there is an optimum size of service provision below which it becomes more difficult to provide a competent service that equates to the highest standards of care. However we believe that Mount Vernon Hospital could form part of a cluster of services that would provide an excellent non-surgical cancer service to a sufficient population around the NW London, South Bucks, Berkshire and South West Hertfordshire border area.

Q2 If you accept this proposition, do you accept that Mount Vernon's future is not dependent on it being a specialist cancer centre?

We can only accept the statements made by the NWLHA that Mount Vernon would have a future without it being a specialist cancer centre. We recognize that, using the definition of a cancer centre as promoted by the strategic health authorities, Mount Vernon is not and would not be one. Our concern is that cancer services as provided at present to patients from South Buckinghamshire should be maintained as far as is practically possible. It seems highly likely that the service would deteriorate if the proposed changes were to take place especially if only the more common cancers were to be dealt with as that could lead to a reduction in the quality of staff seeking to work at the hospital.

Q3 If you believe that Mount Vernon needs to change in another direction, please give brief details

We do not feel that we have sufficient knowledge or information to answer this question. Our main concern is to maintain the quality of cancer services for Bucks' residents.

Q4 Do you support the general proposition of the development of Mount Vernon as a local provider of cancer services, as outlined above?

If "local" means that, as suggested, 85% or 90% of cancer cases would continue to be handled at Mount Vernon then the answer would be yes provided that assurances could be given that the remaining patients would be able to find treatment within a reasonable distance of their homes. We agree that a cancer centre should be established in Hertfordshire but this should not be to the detriment of residents of Bucks and Berkshire. Any major transfer of services to Hammersmith or Hatfield would be detrimental to South Buckinghamshire residents. Travel is of course an important issue for people who are unwell and, almost certainly feeling highly stressed. It must be borne in mind that travel from South Buckinghamshire to Oxford where Bucks residents would be expected to go for cancer treatment, is difficult. Hemel Hempstead would be a reasonable alternative even though it would mean additional travel for most people from South Bucks. Hatfield would not be a reasonable alternative.

Q5 Do you support the proposition of the development of an ambulatory radiotherapy service at Mount Vernon, provided all quality and safety requirements are met?

Yes, provided that it fits into an effective overall service. It seems remarkable that such an important issue had not been considered in detail prior to the consultation document being produced. As this still seems to be an idea that is subject to a viability study we would expect to be part of a proper consultation process leading to future proposals.

Q6 Are there any other issues linked to the development of local services at Mount Vernon of which you wish us to be aware?

The proposals as they stand do not in our view take sufficient account of the effect of change on neighbouring areas. If Mount Vernon services were to be changed drastically then it would clearly mean that Buckinghamshire residents would have to go to Oxford for treatment. There is nothing in the consultation documents to suggest that the possible effects on Oxford have been considered. Therefore, a major issue to be considered when developing local services is the possible ripple effect that developments may have on other sites.

Appendix 9

Response from London Borough of Harrow Council

LONDON BOROUGH OF HARROW

Health and Social Care Scrutiny Sub Committee

Response to the consultation paper

"Mount Vernon Hospital: The Future of Services for Cancer Patients"

1. Introduction

Under the Health Act 2002, councils with social service responsibilities are required to scrutinise the operation of the local NHS. This is in pursuance of its role of community leadership and through its duty to consider the health and welfare of its local community as laid out in the Local Government Act of 2000.

In Harrow this duty is discharged by the Overview and Scrutiny Committee's sub committee, the Health and Social Care Scrutiny Sub Committee (henceforth referred to as the "Sub Committee.") The Committee has cross party representation and works on the basis of consensus rather than along party political lines.

The Sub Committee believes that the future of the cancer services in north west London and beyond are of exceptional concern to local people, especially as they are inextricably linked to the future of the Mount Vernon Hospital (MVH), the future of which has been a subject of much local concern over the past few years. Therefore, in response to this concern, the Sub Committee has invested a substantial amount of its available time to examine the proposals for the future of MVH, its cancer services and also other services. We have also considered the other service changes proposed in the Bedfordshire and Hertfordshire Strategic Health Authority (B&HSHA) document "Investing in your health". The full account is set out in the copy of our submission to the B&HSHA which is attached at Appendix B.

2. Scope Of Scrutiny

On receipt of B&HSHA consultation paper and subsequently the North West London Strategic Health Authority (NWLSHA) consultation paper the Sub Committee's primary purpose has been to consider the proposals in both papers from the perspective of the residents of Harrow. The Sub Committee is aware, especially in relation to the cancer service proposals as they affect residents of parts of Hertfordshire and Bedfordshire, that there is a conflict between the interests of residents in different areas. The Sub Committee is bound to express a view that is in the interests of the Harrow residents although this does not necessarily bind the Sub Committee to simply express, without consideration or reflection, all the views passed to it by residents and their representatives. On the last point, it is worth pointing out at this stage that there has been a significant convergence of views presented to the Sub Committee by local interests.
The Sub Committee has separately scrutinised the two consultation papers although always aware of the links and common ground between the two documents.

3. **Methodology**

The Sub Committee has undertaken its scrutiny through a process of evidence gathering. The process has included inviting a number of organisations and individuals to give "evidence" to the Sub Committee as to their understanding of the proposals and where appropriate their views or those of the organisation they represent. These meetings have been held in public and after the "witness" gave their presentation they answered questions put by Sub Committee members. This process was undertaken for both consultation papers and the Sub Committee's findings outlined below are drawn from both public meetings.

Additionally, the Sub Committee has met in public on a further two occasions at which it has reviewed the evidence gathering meetings and agreed on its response. The individuals and organisations that made a presentation to the public meetings are listed at Appendix A, along with those organisations, which submitted a written statement.

The Sub Committee's findings and response are given below by means of answering the questions set out in the NWLSHA consultation paper.

4. **The Sub Committee's Response to the NWLSHA Consultation Paper**

The Sub Committee welcomes the consultation paper in so far as it focuses on the future of the cancer services at MVH and the likely impact on the residents of Harrow. The B&HSHA consultation paper wrapped up the MVH cancer services proposals in a wider range of detail, thus impeding a full understanding of what is being proposed and the implications. The NWLSHA consultation paper does extract the information about the cancer services at MVH and makes them to an extent, more explicit. The Sub Committee also welcomes the fact that the NWLSHA is actively considering the future of the MVH service and the development of cancer services across north west London. The B&HSHA paper, written primarily for residents of those areas gave no indication of this whatsoever.

Although welcoming the consultation paper the Sub Committee supports the almost unanimous view expressed to it by local witnesses and in written statements that the consultation paper does little to reassure Harrow residents as to the future of the cancer service at MVH. The Sub Committee recognises that the development of the service is a complex process, depending on a number of variables in the future over which the NWLSHA has little direct control. However it would be of more assurance to local residents if there was evidence as to how these issues will be addressed and within what time frame. Much of the consultation paper and many of the answers have a provisional quality with statements often prefixed by "it is possible," "we hope," "it is anticipated". Our concern on the evidence before us, is that the NWLSHA has not progressed very far in thinking through and making firm plans for the future of cancer services for Harrow residents in the light of the proposals for the MVH service. Further, we have seen little evidence of strategic collaboration between the NWLSHA and the B&HSHA over the future of the service for north west London. The Sub Committee might almost wonder whether NWLSHA had been unprepared for the B&HSHA proposals to relocate cancer services from MVH and the resulting powerful negative public reaction in Harrow and Hillingdon.

The Sub Committee's detailed observations are contained in the answers to the questions set out below.

5. **Q1 Do you accept that Mount Vernon Hospital needs to change?**

None of our local witnesses suggested that the status quo was a realistic option, nor does the Sub Committee. We support the evidence which suggests that the history of the removal

of services off the MVH site and the fact that the cancer services also serves a large population away from north west London requires planning a future which means some change for the service. We also recognise that even without the complexities and possible conflicts of two or more strategic health authorities having an interest in the service and site at MVH, the future development of cancer services, especially new treatments and the greater involvement of primary care will inevitably lead to different ways of delivering the service. Therefore, the issue for the Sub Committee is not whether change is necessary but the direction of that change and its implications for the service for cancer sufferers in Harrow, now and in the future.

The Sub Committee did hear from local witnesses that the assumption that MVH should not be retained in its present form or developed as a Calman-Hine type cancer centre was advocated in the Varley Report and that this recommendation appears to be the basis of both consultation papers. Despite evidence from NHS representatives that the long term review of the services at MVH was an inclusive process we are disturbed that the proposals were not subject to public consultation and now appear as a given. This has formed a key element in much of the local opposition, especially to the B&HSHA consultation paper. However this does not prevent the Sub Committee from accepting that the service cannot stand still and that some of the developments proposed by the NWLSHA, however tentative, are welcomed.

A further related issue about which we heard is the veracity of the figures used in the Varley report. Eminent independent academics and academic bodies have challenged these. We do not have the expertise or resources to also independently evaluate the data on which the Varley report recommendations are based, nor is it necessary to do so. However it is disturbing that such important material is in dispute and we would welcome a reassurance from the NWLSHA (and also the B&HSHA) that, when they are undertaking the detailed planning of the services, they will take into account those concerns and have the material reassessed. However, pragmatically, we recognise that the challenge is not going to result in a complete review or revision of the Varley findings. We are concerned that there is apparently no information available showing patient flows to neighbouring cancer centres. We believe it is essential that there is a national mapping showing the needs of, and services to, cancer patients so that each cancer centre is not considered in isolation.

6. **Q2 If you accept this proposition, do you accept that Mount Vernon's future is not dependent on it being a specialist cancer centre?**

The Sub Committee understands that in terms of the Calman-Hine definition, MVH cannot be considered as a cancer centre, but is regarded as a "non- surgical oncological centre". Therefore it might be argued that the question we are asked to address is not relevant.

The Sub Committee heard little evidence that MVH should be developed into a full cancer specialist centre in terms of being able to offer the full range of services. We accept that the MVH site does not have these services at present and whatever the previous history, their restitution and expansion would require significant expenditure which would skew NHS capital spending in north west London and elsewhere. We note it would also have a significant impact on three adjacent general hospitals to the point where their viability would be in question. The public reaction to such a possible development can only be imagined.

MVH's current status is one which many of our witnesses would like to see retained. We understand that if the B&HSHA proposals are to be implemented this would mean the closure of the in patient beds in a few years' time, thereby significantly altering the nature of the service on the site. An immediate consequence brought to our attention would be that patients requiring in-patient assessment and treatment would have to go to Hammersmith Hospital or a hospital in Hertfordshire. This raises for us the issue of travelling for patients

and their relatives and runs counter to the objective that NHS services should be local as recently proclaimed by the previous Health Secretary. Additionally, we are aware that public transport from the Harrow area to Hillingdon Hospital is such that one or two changes from bus to train would be necessary. Taking all this into account, we believe that closure of these beds may be short sighted. This may also be the case as we understand that the nature of cancer treatment will change over the next decade.

The reason for the closure of the inpatient beds appears to be based on the proposal to transfer the service to Hertfordshire. In addition we have heard that to continue to provide the beds without the appropriate medical back up may be to provide a less than safe service. We assume, for it has not been made completely clear to us, that the provision of those back up services depends at present on the presence of the burns and plastics unit on the MVH site. This is also scheduled in the B&HSHA proposals to move elsewhere. This is an example of where the provision of services to our residents appears dependent on the decisions of a strategic health authority that has no accountability to the residents of Harrow.

We heard from the representative of the NWLSHA that the retention of the inpatient beds was a "possibility". We understand that this would depend on the "medical view" and the ability to find the funding. Whilst welcoming this statement we do see it as another example of the level of uncertainty that surrounds the NWLSHA plans for the cancer service at MVH.

We have heard much about the danger of breaking up the existing team at MVH with the loss of expertise should the B&HSHA proposals be implemented. We have not seen in the NWLSHA proposals how this would be countered with the exception of providing out patient services at MVH from the two cancer centres (Hertfordshire and Hammersmith) which we welcome. We believe that a move to another site preceded by some years of uncertainty will have a negative effect on the current team. We would hope that over such an extended planning period (quoted as being between 7 to 10 years) it would be possible to plan an orderly migration of staff to the new centre in Hertfordshire or preferably build up a new team in parallel with the MVH team. Opportunities for cross working, secondment, joint development and training should be explored to mitigate the loss to MVH. We believe that maintenance of the research and clinical links is essential to continue the high regard in which MVH is held.

7. **If you believe Mount Vernon needs to change in another direction, please give brief details**

From the evidence presented to it, the Sub Committee has not identified a radically different proposal for the development of the cancer service at MVH. We would wish the existing services to remain intact and that they be added to in the way considered in the answers to later questions below. We did hear from the representative of West Hertfordshire Hospitals NHS Trust that they were considering the possibility of putting an alternative to the B&HSHA proposal that the new cancer centre should be in Hemel Hempstead or Hatfield. The Long Term Review of the Mount Vernon Cancer Network (the Varley Report) identified 5 potential sites for new cancer services to serve Bedfordshire and Hertfordshire. Amongst the sites was Watford General Hospital. The West Hertfordshire Hospitals NHS Trust believes that the decision not to place the new cancer centre at Watford General Hospital should be reviewed in the light of the potential development of that hospital. The Sub Committee endorses this suggestion, as it would seem the next best possibility of offering a full service to Harrow residents without the need to travel further a field. Rail and bus links with Watford are good from Harrow as well as many parts of Hertfordshire. We have already mentioned the difficulties in travelling from Harrow to Hillingdon Hospital. The inclusion in the short term of the cancer centre in the same Trust as MVH must go a long way to reduce the negative impact of taking services off site from MVH. It could also pave the way for a more integrated approach to the service when Hillingdon Hospital Trust eventually assumes

responsibility for the MVH cancer service. We would urge the NWLSHA to support this proposal, as it does not appear to us to conflict with any plans the NWLSHA wish to pursue.

8. **Do you support the general proposition of the development of Mount Vernon Hospital as a local provider of cancer services?**

The key word in this question is local. Much of the evidence we heard concerned the fact that the proposed new cancer services were remote from Harrow and did not enjoy good transport links. In addition, parking at the Hammersmith Hospital is problematic. Also we were reminded by several witnesses of the statements by the previous Health Secretary about the need to keep services local. We accept that generally it is neither cost effective nor clinically desirable to try and provide all NHS specialist services in each health district. Simply there is not enough money to do so and that for some services to be safe and attract sufficient staff there has to a "critical mass" of population and service provision. These are the arguments which we have heard in support of the establishment of cancer centres at Hammersmith and in Hertfordshire for Harrow residents.

We have already indicated that we accept that to develop MVH into a full cancer centre to be the equivalent of Hammersmith is not a practical proposition in terms of current NHS realities. To achieve a more local access to a cancer centre is why we advocate the development of the centre at Watford as an alternative Hertfordshire site.

However, this does not prevent us wishing to support the views of our local witnesses that the MVH site should remain as a significant provider of cancer services with an inpatient facility as well as the developments advocated in the NWLSHA consultation document. The Watford/MVH axis should go some way to answering the strong arguments made by our local witnesses that the presence of a set of services on both sites would provide the best solution in terms of the distribution of the current MVH patients coming, as they do, from large parts of north west London and the Thames Valley region. The benefit of this arrangement would extend beyond our residents in Harrow.

The other aspect of this question, which concerns us, is the notion of the "general proposition." Many of our local witnesses and written submissions drew attention to the general approach in the consultation document which was more aspirational than concrete. We have already commented on the peppering of the text with various tentative phrases and caveats, leading us to believe the document was more of a response to the justifiable outcry to the B&HSHA proposals than a well crafted strategic statement. We appreciated the honesty of the NWLSHA officer who confirmed that the proposals were more of an indication of current thinking and a start to a process of strategic development rather than the "answers." However, as was pointed out at the meeting, this is little comfort to residents who fear that a service that is valued locally is to be down graded or disappear to meet the needs of people in another place.

Too many questions remain to be answered for the Sub Committee to be able to support the general proposition. The main questions which have been brought to our attention and asked of NHS officers without clear result are as follows:

- Virtually no time frame has been put around the proposals. Whilst recognising that at present there are difficulties for the NWLSHA to do this as other SHAs are involved, nevertheless this is one question that local people are asking more than any other.

- The interrelationship between neighbouring cancer networks needs to be addressed to ensure that there is access to, and equality of, care irrespective of place of residence.

- The role of the Gray Cancer Institute is unclear. The consultation document expresses the hope that the Gray will continue to play a full research role. We understand that this is a decision for the Gray Laboratory but believe that the continuation of in patient beds on the MVH site would allow “the bed and bench” link to continue, thereby ensuring that the status of the service at MVH remains high. The submitted evidence from the Gray Cancer Institute highlights a fear that the research laboratory and clinic link would be lost if the cancer services were to be moved and states that no credible proposals have been put forward for rebuilding research facilities on anew site. We note that the cost of relocating the laboratory is estimated to be £15M.

- Similarly the Paul Strickland Scanner Centre faces an uncertain future. We have been impressed by the fact that local people funded the Centre and very much regard it as a local facility for local people. Reassurances are needed that the future MVH site will use to the up most the facilities the Centre provides and when planning for the services on the site this should be a key consideration.

- Patients and their families value the Lynda Jackson Centre but the B&HSHA consultation paper has ignored the role it plays. We are pleased that the NWLSHA paper rectifies this but again the wish for it to continue to provide a service is aspirational. Why isn’t the NWLSHA clearly stating at this point that they will be taking every possible step to work with the Centre to ensure its continued presence?

- The possible development of surgery on the MVH site treating some of the commoner forms of cancers is very welcome. Will the NWLSHA firm up that option and work with the Hillingdon Hospital Trust to ensure that this does happen?

- We note that reference is made to strengthening the links between the MVH cancer service and Hillingdon GPs. Will this extend to Harrow GPs?

- The consultation document does not appear to sufficiently spell out the consequences of the development of Hillingdon Hospital on the overall provision of cancer services.

Overall, the Sub Committee does support the general proposition that cancer services are developed on the MVH site. We have received from the Hatch End Association a comment that well sums up the Sub Committee’s approach to the development. The Hatch End Association argues that the MVH cancer service should be a “Cancer Unit+”. We endorse this concept.

9. **Q5 Do you support the proposition of the development of an ambulatory radiotherapy service at Mount Vernon, provided all quality and safety requirements are met?**

   It is consistent with our previous comments that we support the provision of an ambulatory radiotherapy service. Whilst recognising that several issues have to be explored by the proposed working party we would want that working party to start from the position of “*what do we have to do to achieve this*?” rather than from the position of “*is this feasible*?” We have not heard or received any evidence, which suggests that this proposal is not feasible providing there is a will to make it happen. We suspect that finance and management arrangements will be as equally important as any clinical considerations. It is at this point that the local community will expect both SHAs to take into account the wishes of local people to see as many services provided locally as is consistent with safe practice. Whilst recognising cost must also be a factor we cannot believe that the cost of ensuring the enhancement of the original B&HSHA proposals for the MVH service can outweigh the advantages to local people. In this respect we would again refer to the need to for a review

of all data used in the original review of services at MVH plus the changing demographic trends in north west London.

We would expect some form of representation from local people on the working group and are surprised that how this will be achieved had not been decided prior to the publication of the consultation document. An unequivocal statement to the effect that local views will be effectively represented on the working group would increase confidence in the outcome. Indeed, the arrangements for this study still remain unclear despite requests for updated information on several occasions in August and September 2003.

10. **Are there any other issues linked to the development of local services at Mount Vernon of which you wish us to be aware?**

We believe we have covered all the issues brought to our attention in the preceding response. It remains to comment that we agree the consultation paper can only be viewed as a start in the full consultation process. Local people need to know of firm proposals that are fully costed and presented within a definite time scale. The risks to those proposals also need to be identified with a contingency plan also prepared in the event of a risk materialising. It is crucial that the necessary changes to a service in which local people have a more than usual emotional investment are properly consulted. There needs to be good, accessible, factual information provided, coupled with a willingness for all parties to listen, debate and accept change when the need is demonstrated.

11. **Summary**

- The Sub Committee accepts the need for change in the provision of cancer services at MVH, in the light of current and future thinking about the provision of cancer services. Acknowledging that change is necessary we strongly support the proposal that the option of developing a cancer centre at Watford Hospital, which was an option in the Varley report is pursued further. The 2002/03 patient distribution data for radiotherapy and chemotherapy suggests to us that that this would be a more accurate epicentre for cancer services than central or east Hertfordshire.
- We welcome the generally positive proposals advanced by the NWLSHA for the development of cancer services at Mount Vernon Hospital, in contrast to the reductionist approach of the B&HSHA's proposals. Such proposals should be considered in the light of the possibility of locating the cancer centre at Watford Hospital.
- We endorse the view of local people that the services at MVH should be retained and developed to ensure good quality services that are locally accessible.
- Whilst accepting that it is unlikely that funding will be found to develop a full cancer centre at MVH, even though the arguments for it are attractive, we do want to see an enhanced service described in the comments as a "cancer unit+".
- We are aware that there are many questions outstanding in the consultation paper and these need to be addressed as soon as possible by the NWLSHA and every effort made to achieve the confidence and trust of local people in the process. The risks as well as the objectives should be published and consulted on.
- We will look for evidence that the two strategic health authorities are working collaboratively in planning cancer services and that one authority should not make decisions which negatively impact on the other authority's services.
- We also recommend that the Harrow PCT and NWLSHA undertake close monitoring of the cancer mortality trends, waiting lists and capacity issues from the present and through the period of service reconfiguration. The recent submission

from the North West London Hospitals Trust refers to capacity issues at Hammersmith Hospital.

12. Consultation

The Sub Committee also has a duty to scrutinise whether it believes the arrangements for consultation by the local NHS body responsible for a service reconfiguration are adequate. The Sub Committee has the power to refer to the Secretary of State where it believes this is not the case.

The Sub Committee believes that the original proposal for the changes at MVH are "buried" in the B&HSHA consultation document and as such do not serve as adequate consultation on an issue which is complex and has a high local profile. The NWLSHA consultation paper goes some way to correct this, but, as has already been stated, there are some significant shortfalls in the document in terms of detail and timings. We would expect more detail and a time frame to be developed as soon as possible and shared with local people in an open and inclusive consultation process. We have seen elsewhere how informal consultation can precede the formal statutory process and urge that this method is adopted by the NWLSHA.

We have some concern about the local consultation arranged by the Harrow Primary Care Trust. Only two meetings are to be held, the last of which is only a few days before the consultation period closes. This may be too late for some people to formulate their response although it was suggested to us that a late meeting might allow for new information to be presented. On balance we think that an earlier date should be available and that it does not best serve a consultation process to drop new information into it at the last moment. We also share the concerns put to us about the late notification of the earlier consultation meeting organised by Harrow PCT. This contrasts with the Hillingdon PCT dates which were arranged early enough to be included in the consultation document.

13. Acknowledgements

This has been a new process for the Sub Committee and we have learnt a lot from its conduct. Some of this learning has been at the "expense" of our NHS colleagues and we are grateful for the time and effort they have put in to assisting the Sub Committee. We hope that our NHS partners will feed back how we can improve on the process in the future. We are also grateful to those individuals and organisations that gave verbal and written evidence. We would also welcome a similar feedback on the process from those groups.

We recognise that we have not endorsed everything we have been told or urged to accept. Although representing the general view of the community, the Sub Committee does have the responsibility to take a detached overview of the issues it considers and must be ultimately responsible for formulating its own view to present to the Council for its endorsement.

APPENDIX A

EVIDENCE GATHERING MEETINGS – EVIDENCE RECEIVED

MEETING HELD ON MONDAY 28 APRIL 2003

Witnesses

- Sue McLellen, Chief Executive, Harrow Primary Care Trust
- Dr Ken Walton, Chair of Professional Executive Committee (PEC), Harrow Primary Care Trust
- Owen Cock, Harrow Community Health Council
- Mike Turner, Chair, Community Voice
- Mike Thompson, Head of Performance and Development, North West London Hospitals NHS Trust
- Andrew Morgan, Interim Chief Executive, Bedfordshire and Hertfordshire Strategic Health Authority

Written Responses Received

- South Harrow and Roxeth Residents Association (Neville Hughes, President)
- Cancer Black Care – Brent and Harrow (Natalie Forbes, Project Manager)
- Paul Strickland Scanner Centre (Roger Sale, Director)
- Trojans Breast Cancer Support Group (Virginia Barber, Vice-chair)
- The Pinner Association (James Kincaid, Chairman, Health Sub-Committee)
- Gray Cancer Institute (Prof P Wardman, on behalf on the Management Group)
- Hatch End Association (Paul Samet, Chairman, Hatch End Association)
- Cherry Lodge Cancer Care (Fiona Kiddle, Macmillan Cancer Information Nurse)
- St Luke's Hospice

MEETING HELD ON THURSDAY 3 JULY 2003

Witnesses

- Helen Mellor, Director of Strategic Projects, North West London Strategic Health Authority
- David Law, Director of Planning and Performance, West Hertfordshire Hospitals NHS Trust
- Jennifer Fenelon, National Programme Director for Action on Urology, NHS Modernisation Agency (formerly Cancer Lead for the Eastern Region at the time of the Long Term Review of Mount Vernon Hospital Cancer Centre and Network)
- Neville Hughes, Community Voice
- Owen Cock, Harrow Community Health Council
- Mike Thompson, Head of Performance and Development, North West London Hospitals Trust

Written Responses Received

- The Pinner Association (James Kincaid, Chairman, Health Sub-Committee, The Pinner Association)
- Hatch End Association (Paul Samet, Chairman, Hatch End Association)

APPENDIX B

LONDON BOROUGH OF HARROW

Health and Social Care Scrutiny Sub Committee

Response to the Bedfordshire and Hertfordshire SHA consultation paper

“Investing in Your Health”

1. Introduction

Under the Health Act 2002, councils with social service responsibilities are required to scrutinise the operation of the local NHS. This is in pursuance of its role of community leadership and through its duty to consider the health and welfare of its local community as laid out in the Local Government Act of 2000.

In Harrow this duty is discharged by the Overview and Scrutiny Committee’s sub committee, the Health and Social Care Scrutiny Sub Committee (henceforth referred to as the “Sub Committee.”) The Sub Committee has cross party representation and works on the basis of consensus rather than across party political lines.

The Sub Committee has considered the proposals in the consultation document; in particular those concerned with the future of Mount Vernon Hospital (MVH) cancer services. The future of the cancer services in north west London and beyond is of exceptional concern to local people, especially as they are inextricably linked to the future of the MVH site. This has been a subject of much local concern over the past few years. Therefore, in response to this concern, the Sub Committee has invested a substantial amount of its available time to examine the proposals for the future of MVH, and its cancer services. It has considered the other proposals in the Beds and Herts Strategic Health Authority (B&HSHA), but due to time and resource constraints, not in such detail. The Sub Committee has also responded in detail to the consultation paper on cancer services published by the North West London Strategic Health Authority (NWLSHA). The full account is set out in the copy of our submission to the NWLSHA which is attached at Appendix B.

2. Scope Of Scrutiny

On receipt of B&HSHA consultation paper and subsequently the North West London Strategic Health Authority (NWLSHA) consultation paper the Sub Committee’s primary purpose has been to consider the proposals in both papers from the perspective of the residents of Harrow. The Sub Committee is aware, especially in relation to the cancer service proposals as they affect residents of parts of Hertfordshire and Bedfordshire, that there is a conflict between the interests of residents in different areas. The Sub Committee is bound to express a view that is in the interests of the Harrow residents although this does not necessarily bind the Sub Committee to simply express, without consideration or reflection, all the views passed to it by residents and their representatives. On the last point, it is worth pointing out at this stage that there has been a significant convergence of views presented to the Sub Committee by local interests. The Sub Committee has separately scrutinised the two consultation papers, although always aware of the links and common ground between the two documents.

3. Methodology

The Sub Committee has undertaken its scrutiny through a process of evidence gathering. The process has included inviting a number of organisations and individuals to give "evidence" to the Sub Committee as to their understanding of the proposals and where appropriate their views or those of the organisation they represent. These meetings have been held in public and after the "witness" gave their presentation they answered questions put by Sub Committee members. This process was undertaken for both consultation papers and the Sub Committee's findings outlined below are drawn from both public meetings.

Additionally, the Sub Committee has met in public on a further two occasions at which it has reviewed the evidence gathering meetings and agreed on its response. The individuals and organisations that made a presentation to the public meetings are listed at Appendix A, along with those organisations, which submitted a written statement.

The Sub Committee's findings and response are given below by means of answering the questions set out in the NWLSHA consultation paper.

4. The Sub Committee's Response to the B&HSHA Consultation Paper

In conducting its scrutiny of "Investing in your health" the Sub Committee has been aware that the primary audience for the consultation has been individuals and organisations within Beds and Herts. This is appropriate in terms of the requirement placed on the B&H SHA to provide health care for the residents of those two counties. As the B&HSHA Chief Executive observed in evidence, the SHA must determine which service it requires to meet the health care needs of the population it serves. By implication, this excludes a full consideration of the needs of the residents in surrounding areas and the document clearly reflects this. There is little evidence, in our view, of close collaboration between the B&HSHA and the NWLSHA in considering the impact the B&HSHA proposals will have on residents of Harrow and the rest of north west London, not to mention the Thames Valley region. Also it is apparent that the B&HSHA was unaware or chose to ignore the local concern about the future of MVH and its cancer services in particular. Fortunately, this omission was recognised by the NWLSHA and a more detailed consultation paper published about the MVH cancer service. However, this was only done after, and in recognition of, the public outcry the B&HSHA document provoked.

The B&HSHA consultation paper wrapped up the MVH cancer services proposals in a wider range of detail, thus impeding a full understanding of what is being proposed and the implications. The NWLSHA consultation paper does extract the information about the cancer services at MVH and to an extent, makes them more explicit. The Sub Committee also welcomes the evidence that the NWLSHA is actively considering the future of the MVH service and the development of cancer services across north west London. The B&HSHA paper, written primarily for residents of those areas, gave no real consideration to the implications for the cancer and other services for the residents not living in Beds and Herts.

The Sub Committee is very sympathetic to the view expressed by many local witnesses that the proposals for the cancer service were "buried" in the mass of detail in the document which covers a very wide range of proposals. The Sub Committee also accepts as a valid argument, put forward by local witnesses, that the proposals to move the cancer services from the MVH site were based on the Long Term Review of Cancer Services (the Varley Report.) In view of the importance of the Varley report findings it was put to us that it should have been subject to further public scrutiny and consultation. We are critical that "Investing in your health" presented the findings as a "fait accompli" with no choice being given, or significant supporting argument about the move of the cancer services from MVH.

We do not intend to rehearse here the problems associated with the Varley Report. Our submission to the NWLSHA draws attention to the arguments put to us by our witnesses and can be found there. The Sub Committee recognises on a pragmatic basis that the conclusions of the Varley Report are unlikely to be reversed at this point and that the cancer services at MVH must be developed and moved forward.

The consultation does not make any proposals for an expansion of the cancer services, only an apparent contraction through the closure of the inpatient beds at MVH. Taking into account the views of local residents we believe this to be unacceptable. We are told that West Hertfordshire Hospitals Trust is committed to increased investment on the site but we are unclear what this will support and whether it will be to bring the reduced service up to an acceptable level. It is important that this information is made known to the local community.

As detailed in the response to the NWLSHA document we are urging both SHAs to consider the following:

- Production of timed and costed proposals for the development of the cancer services at MVH as outlined in the NWLSHA document which we welcome and support leading to the development of what has been termed a “cancer unit+”.
- The long term retention of inpatient beds on the site thus offering a more local service for some patients and further enhancing services on the site.

- An early resolution to the uncertainty surrounding the future of the Gray Cancer Institute, the Paul Strickland Scanner Centre and the Lynda Jackson Centre. The B&HSHA proposals are silent as to the future relationship between these services and any relocated cancer service.

- We ask for a review of the Varley Report findings as they affect the position of Watford General Hospital as a future location for a cancer centre. We have heard from a witness from West Hertfordshire Hospitals Trust that the Trust believes that recent local developments would enable it to provide a cancer centre at Watford. This would be more accessible to residents of north west London and the Thames Valley area. We believe it would also mitigate the loss of the existing expertise at MVH by close collaboration between the two units. This should no be problematic for Hertfordshire residents and some Bedfordshire residents as Watford has good road and public transport connections.

- Also we believe a review of some of the statistical assumptions in the Varley Report should take place. We were concerned to learn that eminent academics and academic bodies have challenged the figures on which some recommendations are based. Were the assumptions demonstrated to be incorrect then obviously the B&HSHA would need to review its strategic approach to the future location of a cancer centre. We however, recognise the unlikely event of the main thrust of the Varley report being accepted by the SHA as invalid because of these criticisms.

- We have noted a significant shift in the distribution of patients by districts of residence from the 2000-1 figures set out in the Varley report and the 2002-3 data in the recent NWLSHA document. Patients from Brent, Harrow and Hillingdon receiving radiotherapy and chemotherapy treatments at MVH increased from 20% to 25% and from 21% to 35% respectively. Taking into account the patients from the Watford area as well we remain to be convinced that the epicentre of users of the Mount Vernon Services is some distance north of Watford.

We have considered, but in less detail, the implications for Harrow residents of the proposals for other services provided by NHS trusts in the B&HSHA area. Apart from these particular services and facilities the Sub Committee takes the view that the major thrust of the proposals has little effect on Harrow residents.

5. Watford General Hospital A&E Services

Although we have not been given any statistical detail in the consultation document or from witnesses, we are aware that there is a significant patient flow from Harrow to the A&E service at Watford General Hospital. Any action to downgrade the service currently provided at the hospital would undoubtedly have a negative impact on Northwick Park Hospital. There would be additional demands on the Northwick Park A&E service. We were informed by an officer from North West London Hospitals Trust that this would negatively impact on their performance unless resources were diverted to allow for the additional capacity. The consultation document does not indicate the resources will necessarily follow the diverted patient flow.

We therefore favour option 2, which is to develop a trauma service at Watford Hospital and continue to provide a full A&E service.

6. Watford General Hospital Maternity Services

We note that under option 1 it is proposed to locate a birthing centre at Watford. The Sub Committee would wish to see more detailed information on the implications for the development of the maternity services currently being undertaken by North West London Hospitals Trust. We are aware of the currently increasing patient flow from Harrow for maternity care and we believe that there is a risk that the local development plan could be destabilised if this was further encouraged. Such a development could attract a disproportionate flow of patients from Northwick Park Hospital during the period Northwick Park Hospital is trying to build up the local services. We would suggest that the development of the two services is considered as a collaborative exercise.

7. Burns and Plastics

Witnesses have informed us that there was an earlier “understanding” that as part of the redevelopment of the MVH site these services would eventually be transferred to the Northwick Park site. Some of our witnesses have expressed surprise that no reference is made to this in the consultation document other than the reference to services for Beds and Herts patients being moved to a hospital in Herts. This underlines the problem of the consultation document only referring to the needs of a particular set of residents.

We would welcome further information on the position of services for north west London residents but understand that this should be provided primarily by the NWLSHA and the local commissioning PCTs.

8. Consultation

The Sub Committee also has a duty to scrutinise whether it believes the arrangements for consultation by the local NHS body responsible for a service reconfiguration are adequate. The Sub Committee has the power to refer to the Secretary of State where is believes this is not the case.

The Sub Committee believes that the original proposal for the changes at MVH are "buried" in the B&HSHA consultation document and as such do not serve as adequate consultation on an issue which is complex and has a high local profile. The NWLSHA consultation paper goes some way to correct this, but, as has already been stated, there are some significant shortfalls in the document in terms of detail and timings. We urge for more detail and a time frame to be developed for both consultation papers as soon as possible which are shared with local people in an open and inclusive consultation process. We have seen elsewhere how informal consultation can precede the formal statutory process and urge that the strategic health authorities and PCTs adopt this method.

9. Acknowledgements

This has been a new process for the Sub Committee and we have learnt a lot from its conduct. Some of this learning has been at the "expense" of our NHS colleagues and we are grateful for the time and effort they have put in to assisting the Sub Committee. We hope that our NHS partners will feed back how we can improve on the process in the future. We are also grateful to those individuals and organisations that gave verbal and written evidence. We would also welcome a similar feedback on the process from those groups.

We recognise that we have not endorsed everything we have been told or urged to accept. Although representing the general view of the community, the Sub Committee does have the responsibility to take a detached overview of the issues it considers and must be ultimately responsible for formulating its own view to present to the Council for its endorsement.

Appendix 10

Response from Hertfordshire County Council

REPORT OF THE ADULT CARE AND HEALTH SERVICES SCRUTINY COMMITTEE

Hertfordshire County Council

'INVESTING IN YOUR HEALTH'

Response to the Beds and Herts Strategic Health Authority's consultation

August 2003

1. Introduction

The Adult Care Services and Health Scrutiny Committee has a statutory power to scrutinise the operation and performance of health services in Hertfordshire, including the responsibility for responding to consultations on behalf of the county council. The committee also has the power to refer to the Secretary of State when it considers that changes to health services will not best meet the needs of Hertfordshire residents.

Membership of the Committee comprises 14 county councillors, 5 District councillors appointed by the Hertfordshire Local Government Association and 5 representatives of Patients' Forums.

The Committee have undertaken a large-scale scrutiny exercise in pursuit of its statutory responsibilities in responding to the Beds and Herts Strategic Health Authority's consultation document 'Investing in Your Health' ,which outlines wholesale changes in the organisation and approach to health care provision in Hertfordshire, and will have far reaching implications for users and providers alike.

On 21 May the committee heard the views of local residents, representatives of voluntary and local groups, Community Health Councils, a wide range of health experts, and local authority planners.

A list of those giving oral evidence on 21 May is attached as appendix A

A complete catalogue of written representations considered as part of this process is available for inspection in the county secretary's office (room 223) at county hall, Hertford.

On 22 May the Committee met to hear a summing up of the key issues by Sian Flynn, and independent health expert engaged for this purpose. That summary and subsequent debate formed the basis for a report back to the Committee on 12 June.

This report represents the conclusions from the process outlined.

2. Summary

This report concludes that, having considered the 'Investing in your Health' document; and having taken into account representations made to them on 21/22 May, the Adult Care and Health Scrutiny Committee wish to wholeheartedly endorse the vision that the Strategic Health Authority has put forward for a model of health services in Hertfordshire that:

- **Ensures the Safety and Improves the quality of Health Care accross the whole of Hertfordshire**

  and
- **Shifts the balance of resources to Primary Care**

The Committee further endorsed the thrust of the SHA s message that 'no change' is not an acceptable option.

This report summarises the main areas of discussion by the Committee, and, arising from that, sets out criteria upon which the final proposals will be assessed.

Roma Mills
Chairman

3. Consideration of the SHA proposals - key findings

During their deliberations the Committee focused on the implications of the proposals for all the people in the county, and the issues emerging from that consideration, rather than a specific analysis of the two options for the configuration of major hospital sites.

People in Hertfordshire rely upon the adequate provision of services through a variety of providers across sectors. The committee have drawn particular attention to the following issues :-

3.1 No change

It was very clear during the two-day process that there is strong support for the view that 'no change' to the existing means of delivering health services is not an option. Members accepted that the SHA consultation provided a framework for service development, but that the pace and dynamics of change would not permit a 'blueprint'. Nevertheless they would wish to see a clearer picture of likely service configurations in relation to primary care.

3.2 Flexibility and responsiveness

The vision set out by the SHA is compelling, and there is a wide consensus for the need to move towards delivering much more care for patients in locally accessible centres, taking advantage of the rapidly developing technological changes that will enable this shift.

Attachment to institutions is natural. However, good health care will depend upon responsive and flexible team working by highly trained professionals, and the Committee heard many examples of how this whole health system approach is already making headway in Hertfordshire.

The Committee heard pleas for proper account to be taken of the need to provide appropriate primary and community care facilities, before instituting change in acute services.

3.3 Ease of access

During the Hearing it was apparent that the accessibility of services is extremely important to residents of Hertfordshire, with three main areas of concern.

Firstly, the presumption that services will be delivered as locally as possible consistent with good quality of care in a safe environment is welcomed. The Committee would like to see more detailed proposals for Diagnostic and Treatment centres including the possible locations and (recognising that treatments develop) the needs that they are likely to be able to meet.

The Committee noted the predicted implications of the European Working Time Directive on staffing the service, and that without changes in the way services are configured and delivered staffing pressures would be such that patient care could be jeopardised.

Examples of pilot schemes for imaginative local service delivery were given at the Hearing, and members look forward to these being delivered more widely as the vision becomes the reality for more people.

Secondly, the transportation of patients (notably for accident and emergency services, and those for other seriously ill patients) visitors and staff relies on local transport networks.

This is an area where local authorities and their transport partners have a significant role to play in planning and implementing the necessary infrastructure. The Committee are mindful that the overall strategy for local access to healthcare facilities is predicted to reduce travel distances.

Nevertheless, transportation issues will need to be addressed in the planning and implementation of proposed sites, and the County Council would request the opportunity to discuss the feasibility of proposals prior to publication. The preparation of Travel Plans will ensure that the travel needs of all users of the facilities will be addressed. A joint approach should be developed, building on the Herts Transport Direct project.

Considerations include Ambulance Service capacity and expertise, road networks, public transport operators and adequacy of parking at sites identified for the provision of health services.

Thirdly, shortcomings in the current system result in unnecessary hospital visits. A reduction in the total number of patient movements should become a realistic target, including a reduction in the number of outpatient visits to acute hospitals.

3.4 Quality

The needs of patients are paramount within the service and this must remain above all else the primary focus of change.

It is essential that more collaborative working to prevent unnecessary admissions to hospitals is developed. Ensuring that local people spend the minimum amount of time compatible with recovery and rehabilitation in an acute hospital, and are rapidly transferred to a more appropriate care setting should be a high priority for all those responsible. This will require a commitment to joint working across primary and community care, the acute hospitals, Adult Care Services and the voluntary sector to reduce delayed transfers of care. This will need increased capacity in intermediate care of all types, and improved communication between agencies.

Quality can only be maintained if appropriate staff are in place, and there is some concern that current staff shortages may jeopardise service provision in the short term, and during transition to new arrangements. Recruitment, retention and training will be key issues in ensuring success of any proposed configuration. A medical school based in the SHA area could enhance the reputation of health services locally, and generate increased interest in working in this area. Members heard that this could serve as a boost not just to the recruitment of doctors, but would also be likely to attract many other key staff needed in the health service.

Partnership working with other public sector agencies experiencing similar problems could also help to address these issues.

3.5 Emergency Care

We know that members of the public understandably take great interest in the provision of accident and emergency services. Reconfiguring acute hospital services will help to ensure that the residents of Hertfordshire can be assured of the quality of emergency provision. There is however a need to communicate more effectively on the provision of Accident and Emergency services, and what will be available at each site.

Beds and Herts Ambulance Trust have a major role to play in ensuring that A and E services are appropriately accessed. The Committee heard the Trust express its support for the proposals in the SHA consultation document, and confidence in its ability to respond to the options under discussion, and within the overall vision.

3.6 Cancer Treatment

Members noted that the consideration of the future of Mount Vernon Hospital , currently providing cancer services for Hertfordshire, would have an impact on the area. Whilst it was not ideal that

this had resulted in a slight delay in progressing the proposals set out in the consultation document, it was accepted that the provision should be considered in a holistic way. It was noted that there would be no significant change to the provision of local outpatient services.

(subsequent publication of proposals for Mount Vernon, and consideration thereof, has led to the conclusion that the 'Investing in Your Health' document is not significantly affected, and that the Committee would not be adding to this response)

3.7 Maternity and Paediatric Services

It is proposed that birthing centres be established on two sites where there will not be special care services for babies. This will clearly require appropriate consideration of safety, risk and personal choice.

3.8 Resources

There is little reference in the main consultation paper to the overall context in which these service changes are being proposed, although more detail has been supplied in supporting papers. In common with many of the counties around London, Hertfordshire has encountered significant difficulties in operating within resources made available. With 75% of NHS funding now resting with Primary Care Trusts, the Committee will want to be reassured that these relatively new bodies are able to exercise their powers and responsibilities to ensure that the substantial shift of resources from secondary to primary care set out in the consultation document can be achieved successfully.

Calculations of the cost of changes to the acute sector have been set out in some detail. The picture for primary care seems less clear, and although it is understood that the circumstances are fluid and dynamic, there is sufficient certainty within the proposals to inform a broad calculation now.

The Committee would wish that some account of mental health services be made in the proposals, including possible ring-fencing of resources.

Much of the change being predicated requires substantial investment in new technology and better integration of systems in support of patient care. Members would like to be reassured that this has been adequately costed in the proposals.

While the development of either of the two options will require the purchase of land, it is likely to be possible to release some land currently used for health service provision for alternative uses. This should provide opportunities for ensuring that receipts for released land are re invested in the local health economy for the benefit of the communities in Bedfordshire and Hertfordshire.

3.9 Deliverability

The Committee heard about the challenges of sites identified in the proposed options and in particular noted the planning and transportation issues for any development at Roehyde. They also noted that neither option would preclude a Medical School opportunity.

3.10 Communications

Communities and their residents have to become familiar with services available and their location. It is apparent that the current level of awareness is open to improvement. As the new configuration is implemented it is critical that public awareness campaigns are an integral element of the planning process.

4.. Rural issues (as addressed by all scrutiny within HCC)

In considering the overall strategy proposed by the SHA the Committee have welcomed the principle that services should be local, except where the quality of care can best be enhanced by centralisation/specialisation. Local services for most health needs is supported. In reshaping the services it is important that those patients in rural areas with specialist health needs are assured that any moves to centralise services are taken because of the need to guarantee or improve the quality of care.

It is also worth recording here that the Committee have taken a particular interest in transport and access issues, which include emergency and non-emergency transport services for patients, as well as issues such as public transport and car parking to provide for staff and visitors.

Detailed operational planning will be a matter for case by case consideration. Inevitably there will be great interest in the precise configuration of local services. In any event the committee welcomes the recognition that successful transition will require attention to the quality and range of local provision.

5. Assessing the final proposals

The Committee recognise that service provision is constantly evolving and that any workable proposal will involve some compromises from the optimum.

In considering whether or not to support the final proposals put forward by the SHA this Committee will be looking at the extent to which the proposal meets the following criteria:-.

Quality of Care

The Committee will be looking at the extent to which the chosen option:

- Will enhance the quality of care received by the people of Hertfordshire
- Will enable the development of a centre of excellence in Hertfordshire
- Will address the recruitment difficulties experienced locally
- Recognises the need to plan , and provide wherever possible alternative community facilities before relocating services from acute to primary care

Affordability

The Committee would wish to be assured that the financial calculations on which the option is based are robust and in particular:

- That the commitment to shifting resources to primary care will be maintained and that unforeseen financial pressures in the acute sector should not jeopardise developments in the primary sector
- That the funds needed for transition have been fully accounted for including the need for a period where there may be duplicate provision in some areas
- That the “knock on” financial implications for other services – in particular homecare, therapy and residential care – have been taken into account and that plans in place are being developed with partners to address them
- That the resources needed to address the current backlog in maintenance of existing facilities have been taken into account

- That full account has been taken of the costs to the Beds and Herts Ambulance Service of the transport requirements of the different options and of the changing way that people are cared for

Development of Primary Care

The Committee will be looking at the extent to which the final proposals:

- Demonstrate a commitment to the development of primary care both in terms of resource allocation and shift of focus
- Contain plans and targets for building on the good practise which already exists
- Will result in improved quality and equity of primary care provision

Access

The Committee will be looking at the extent to which the final proposals take due account of:

- Congestion on key routes
- Plans for Public Transport Links
- The accessibility of chosen sites
- Car parking
- The capacity of ambulance services

A key driver for change is the accessibility of services. The Committee will wish to confirm that the issues of equality are adequately balanced.

Deliverability/Timescale

The Committee will be looking at the extent to which the final proposals minimise the risks of the chosen sites being unable to gain the necessary planning consents.

Whilst the development of a Medical School is supported as a long - term vision, the Committee would wish to confirm that the chosen option would be sustainable and achieve the stated objectives, even if the Medical School aspiration were not realised in the foreseeable future.

Communication

The Committee will be looking at how public awareness of change is Maximised for Hertfordshire residents.

6. The way forward

As we hope is clear from our response, the Committee are very supportive of the overall vision for improved health services in Hertfordshire and commend the Health Authority's commitment to making them happen. The Committee also consider that there are areas where they can help to make the proposals a reality, and therefore wish to propose the following:

6.1 Recruitment and Retention

Many of the issues affecting recruitment and retention difficulties are common across the public sector. The Committee would suggest that work to improve recruitment and retention should be done jointly, building on the work that has already started on key worker housing across all of the health, local authority and police organisations in Hertfordshire.

6.2 Transport

Transport issues which the proposals highlight are common across sectors. The committee would urge a joint approach building on the work that has been started by the Hertfordshire Integrated transport Partnership – Herts Transport Direct.

6.3 Monitoring Progress

Monitoring progress in achieving the vision behind 'Investing in your Health' will be a key role for the Scrutiny Committee. The Committee suggest that a short life topic group be set up to work with the Health Authority to agree how this should be undertaken. The remit of the group would be:

1. To explore ways that evaluation can be made of the changes to the whole health economy in Hertfordshire not just individual services.
2. To discuss and agree the nature and content of monitoring information which will enable the SHA and the committee to evaluate progress
3. To agree a programme of monitoring – this may include regular reports on activity, finances and outcomes and/or briefings/visits for the committee
4. To consider other ways that members of the Committee can helpfully engage in monitoring progress – e.g. attendance at meetings and engagement with stakeholders

7. Concluding remarks

There is overwhelming support for the vision set out in 'Investing in your health' and the points raised above should be considered in that context.

Many people working in the health service are now going to have to make substantial changes to the way they work. Those appearing before this Committee were very positive about the direction of the proposals and believe that morale will be lifted by reaching agreement on the way forward.

The challenges are immense, and will require strong leadership, determination and good will. This will involve working closely with, and getting support from, a wide range of partners. The Committee wish to convey that they, and their constituent bodies, will seek to work towards the vision, and look forward, in due course to reviewing the SHA's final decision on the option to pursue.

As implementation of the vision unfolds the Committee will wish to consider the SHA's arrangements for measuring success, and in particular, how the shift towards localised care is progressing.

Appendix A

List of witnesses/ speakers - 21 May 2003

Barrie Taylor	South West Herts CHC
Zena Bullmore	Dacorum Hospital Action Group
Pauline Dye	Director of 02H Campaign and CHC Chief Officer
Mrs Brereton	Service user Bishop's Stortford
Norman Gurney	Chairman, Breath Easy
Toni Horn	Chief Executive, Primary Care Trust.
Wendy Mahaffey	District Nurse, Chorleywood
Dr Mike Edwards	GP –Professional Executive Chair of Hertsmere PCT
Nicola Jones	Physiotherapist, Welwyn Hatfield PCT
Caroline Tapster	Director, Adult Care Services, HCC
Simon Wood	Director of Strategy, Beds & Herts Strategic Health Authority
Dr Steve Laitner	Consultant in Public Health St Albans & Harpenden PCT
Miss Jane McCue	Medical Director - E & N Herts Trust
Mr John Pickles	Medical Director - Luton & Dunstable Trust
Dr Danny Boxer	Associate Medical Director - West Herts Hospitals Trust
Dr Jane Halpin	Cancer Lead, Mount Vernon Cancer network
Prof. Mike Pittilo	Pro. Vice Chancellor, University of Hertfordshire
Anne Walker	C.E. Beds and Herts Ambulance and Paramedic Trust.
Dave Humby/Jon Tiley	Head of Transport Planning and Policy HCC – Strategic planning
Graham Winwright	Dacorum Borough Council
Chris Conway	Welwyn Hatfield District Council
Alan Warren	Director of Finance, Beds & Herts Strategic Health Authority
Ian White	Chairman Beds & Herts Strategic Health Authority

Appendix 11

Response from London Borough of Hillingdon

Mr Hamilton
Assistant Chief Executive (Scrutiny)
FAO Katherine Peddie
Room 359
County Hall
Couldwell Street
BEDFORD
MK42 9AP

Date: 21st August 2003

Dear Mr Hamilton

LONDON BOROUGH OF HILLINGDON COMMENTS ON CANCER SERVICES AT MOUNT VERNON HOSPITAL

I attach a copy of the results of London Borough of Hillingdon's consultation on cancer services at Mount Vernon Hospital, identified following a meeting with a panel of expert witnesses on 31st July 2003. The Committee when reviewing these results identified the following general comments to be read alongside them.

- The whole process is occurring within an overly tight timescale
- It is regrettable that because of this timescale it has not been possible for verbal evidence to be heard by the Joint Committee.
- The Committee was concerned that the formal definition of Mount Vernon Hospital as a Cancer Unit, as opposed to a Cancer Centre (according to the latest definitions used by the Department of Health) did not fully reflect the value of Mount Vernon. It had historically been classed as a Cancer Centre, and locally it is still viewed in that light. Indeed, it considerably exceeds the standards required of a 'Unit', in that it has overnight beds with a high occupancy rate. It is important that the change of definition should not obscure the very high standards of service provided at Mount Vernon – considerably in excess of those required of a Cancer Unit
- The Committee resolved that as well as presenting its findings to the Joint Committee that they should also be presented to the PCT and SHA

Yours sincerely

ANDREW NANKIVELL
Overview and Scrutiny Manager

HEALTH AND SOCIAL CARE OVERVIEW & SCRUTINY COMMITTEE

Meeting held at the Civic Centre, Uxbridge
on Thursday 31st July 2003 at 2.00 pm

Councillors: Catherine Dann (Chairman)

Mary O'Connor (Vice Chairman)

Janet Gardner
Lee Griffin
Shirley Harper-O'Neill
John Major
Jill Rhodes

Also present

Councillor Henry Higgins

Representatives from the following groups:

Hillingdon Community Health Council

Community Voice

Hillingdon Primary Care Trust

General Practitioners

Officers Present

John Doran, Head of Commissioning & Performance Management
Guy Fiegehen, Head of Scrutiny & Members' Services

1. APOLOGIES FOR ABSENCE

Val Harrison, Chief Executive, West Herts Hospitals NHS Trust, sent her apologies.

2. DECLARATIONS OF INTEREST

There were no declarations of interest from Members in relation to the business of the meeting.

3. BUSINESS TO BE CONSIDERED IN PUBLIC

The Committee confirmed that all its business would be conducted in public.

4. CONSULTATION ON CANCER SERVICES AT MOUNT VERNON HOSPITAL

The Chairman opened the meeting by welcoming Members and witnesses. The purpose of the meeting was to hear evidence from expert witnesses concerning the proposals for the future provision of cancer services at Mount Vernon Hospital, in light of the current North West London and Bedfordshire and Hertfordshire Strategic Health Authorities' consultation documents. The evidence heard at the meeting would inform Hillingdon's response to the consultation, through the Mount Vernon Joint Scrutiny Committee. The

views expressed below are based on opinions and evidence submitted to the Overview and Scrutiny Committee on 31st July 2003 by one or more of the four witnesses that gave evidence.

The Committee invited the following witnesses to give evidence to the meeting:

- Joan Davis, Vice Chair, Hillingdon Community Health Council;
- Mike Turner, Chair, Community Voice;
- Elaine House, Executive Director Performance & Commissioning, Hillingdon PCT
- Dr James Kennedy, local GP.

Evidence from Joan Davis – Vice Chair, Hillingdon CHC

Joan Davis had circulated the following documents to Members before the meeting:

- Hillingdon CHC's Minority Report rejecting the recommendations contained in the Final Report of the Long Term Review of the Mount Vernon Cancer Network and Centre;
- Notes of Joan Davis' presentation, which set out her own views on the Beds and Herts SHA and NW London SHA proposals. Other items for reference, quoted at the end of the notes, were tabled at the meeting.

Key points of the presentation were noted as follows:

- Angry public meetings in Hillingdon and Harrow on the Beds and Herts proposals show that local people do not want the Mt Vernon Cancer Centre to move.
- Hilingdon CHC was represented on the Long Term Review and dissented from its recommendations, but minority views were not published in the Final Report.
- Clinical evidence of the Final Report (Rosie Varley Report), published as Report 3 in the Beds and Herts consultation, was rejected statistically by professors from London, Oxford and Cambridge Universities.
- There is no other clinical evidence in support of the Cancer Centre proposals.
- Recent CHC surveys show that the Cancer Centre is very popular with patients and the public.
- There should be three cancer centres, not two, to serve the populations of Bedfordshire, Hertfordshire and NW London.
- Government policy with respect to cancer centres is based on the Calman-Hine report, aspects of which are now out of date.
- There is a strong case for keeping the Cancer Centre at Mount Vernon: long established clinical teams; ethos of patient care; other excellent facilities, including the Paul Strickland Scanner Centre and the Gray Cancer Institute research centre.
- All these facilities would be at risk if the Cancer Centre were moved.
- Joan Davis would circulate the official response of the CHC as soon as it was available.

Questions & Answers

Q. *Given the lack of statistical and research evidence to support the proposals, should the SHAs be considering major changes at this juncture?*

A. Long term decisions should perhaps be delayed until best evidence is available.

Q. *How can you base conclusions on conflicting evidence?*
A. I agree. Some very eminent statisticians have discredited the evidence in Report 3.

Q. *The National Cancer Director considers 1.5 million to be the optimum catchment population for a cancer centre; if we have only 2 centres we'll be over the optimum, therefore will people suffer worse treatment?*
A. It is not really possible to say; it is based on the number of patients needed to enable clinicians to develop the necessary skills. It is however worth noting that we have not seen a single Mt Vernon clinician speaking on public platforms in favour of either the Beds & Herts or NW London SHA proposals.

Q. *Do you support the proposition of the development of an ambulatory radiotherapy service at Mt Vernon, provided all quality and safety requirements are met?*
A. Only as a fall-back option, if the Cancer Centre is removed from Mt Vernon.

Q. *Was there any support at the public meetings for the Beds & Herts or NW London SHA proposals?*
A. Only NHS Administrators supported the proposals.

Q. *Are there any other local issues that we should be aware of?*
A. Many of the proposals for developing the site would benefit local people, but only if the Cancer Centre remains.

Q. *If NW London SHA were responsible for the Cancer Centre, would these changes be being proposed?*
A. Local people would like the Cancer Centre to stay at Mt Vernon and control of it to revert to NW London.

Evidence from Mike Turner – Chair, Community Voice

- Community Voice is the largest organisation of its type in London. The organisation works closely with all political parties and the local MPs; these groups all strongly support the retention of the Mt Vernon Cancer Centre Network.
- Mike Turner spoke about a previous agreement, relating to the status of Watford Hospital, which would be breached if Beds and Herts Option 1 (to redevelop Cancer Centre services at Hemel Hempstead) were followed.
- This would result in the downgrading of services at Watford Hospital, which would impact badly on Hillingdon people. Option 1 should be rejected on these grounds.
- Beds and Herts Option 2 (to develop a new major hospital at Hatfield) would leave Watford services unchanged; therefore this was more acceptable to Community Voice.
- The providers of cancer services at Mt Vernon all oppose the Beds and Herts proposals.
- The NW London SHA proposals were hurriedly prepared and hadn't been properly thought through. A lot of questions are left unanswered, but we are being asked to agree to what amounts to a set of aspirations.
- Community Voice would support the extension of the consultation period to enable NW London SHA to research their facts thoroughly and come up with some proper answers.

- Mike Turner listed the clinical and medical advantages of Mt Vernon. All the cancer service facilities are present at the Mt Vernon site; it's worked successfully for 40 years, so why change?
- Thoracic surgery for Mt Vernon cancer patients is currently carried out at Harefield Hospital. If cancer services are moved from Mt Vernon it is likely that services will also move from Harefield.
- If the Harefield science park goes ahead, Mt Vernon will benefit with respect to research, but only if cancer services remain at Mt Vernon Hospital.
- The Paul Strickland Scanner Centre and the internationally renowned Gray Cancer Institute for research would be threatened if the Cancer Centre were moved. These institutions are funded by charitable donation and not by the NHS.
- Community Voice has collected thousands of signatures for a petition, which will go to the Minister, strongly opposing any proposals for closure of the Mt Vernon Cancer Centre. The 4 local MPs will give the same message to Government.
- Current Government policy recognises that 'biggest isn't always best'; Community Voice would contend that this is an argument in favour of retaining cancer services at Mt Vernon.
- Community Voice's position could be summarised as follows:
    - Reject the closure of Mt Vernon Cancer Centre;
    - Develop and improve cancer services at Mt Vernon
    - NHS should put more money into Mt Vernon to develop services; the hospital should not have to rely on charitable donation.

Questions & Answers

Q. *Do you support the proposition of the development of an ambulatory radiotherapy service at Mt Vernon, provided all quality and safety requirements are met?*

A. Community Voice would support any new equipment to improve services at Mt Vernon

Q. *How would Watford Hospital be affected by Beds & Herts Option 1?*

A. Under Option 1, Watford would be downgraded to a back up service with little or no A&E. It's not clearly spelt out in the consultation.

Q. *How can you base conclusions on conflicting and / or discredited evidence – should the SHAs establish the facts before major decisions are taken?*

A. That would be logical, but we won't have the option because the consultation process is too short. Beds and Herts SHA run cancer services at Mt Vernon at present and it's in their interest to develop services outside London, where their population lives. We say there should be more cancer services at Mt Vernon.

Q. *Are there any other issues that we should be aware of?*

A. I am very suspicious about proposals for grand new hospitals because they often fail to follow through. If they build a new hospital in Hertfordshire, they may have difficulty getting staff.

Q. *How up to date is the Calman-Hine report on which the recommendations are based?*

A. Calman-Hine will be very out of date by the time the Beds and Herts proposals come on stream (in 8 – 10 years time). The majority of patients may not need operations at all; other new treatments are continually being developed.

Q. *What do you think is the optimum catchment population for a cancer centre and on what do you base that view?*

A. As Joan Davis says, we should be looking to achieve proper treatment for patients and three cancer centres would provide more people with local services.

Evidence from Elaine House – Executive Director Performance & Commissioning, Hillingdon PCT

Elaine House had circulated a paper to Members before the meeting, which set out the background to the North West London SHA proposals. Elaine House referred to this document in her presentation and responded to issues raised earlier in the meeting. The main points were as follows:

- The case for change at Mt Vernon was justified by proposed major developments to hospital services in Bedfordshire and Hertfordshire.
- At present the cancer centre for Bedfordshire and Hertfordshire is at Mt Vernon. If plans to develop a new cancer centre in Hertfordshire are realised, Mt Vernon's catchment population would be halved and its continuation as a cancer centre would, over time, become insupportable.
- In NW London, the SHA and PCTs are planning for a flexible service that meets local needs.
- If the NW London SHA and PCTs appear to be 'reacting' to what's happening in Beds & Herts, then in a sense we are. NW London has not yet published its strategy for developing cancer services for the outer west London population.
- Admittedly the Calman-Hine report is old, but it provides a base line for cancer services. We can, in NW London, say that it is an anomaly that Mt Vernon cancer services are managed by Beds & Herts SHA. We are working towards bringing control of local cancer services within the NW London Cancer Network.
- Local people are concerned about the loss of beds at Mt Vernon, but as treatments continue to advance it is expected that more people will be treated as outpatients, so fewer inpatient beds will be needed. There will however be some inpatient beds for people who become ill during radiotherapy or chemotherapy treatment.
- Those patients needing inpatient beds are generally the more serious cases: people who are acutely ill because of their cancer, or have other serious medical problems. These people will need a range of back up services that won't be available at Mt Vernon and will probably need to attend one of the proposed cancer centres (Hertfordshire or Hammersmith Hospitals).
- The most commonly occurring type of cancer in this area is breast cancer and patients with this disease are treated locally, mostly as outpatients or day cases.
- Strictly speaking, Mt Vernon is a cancer unit, not a cancer centre, because it does not have surgical facilities onsite. Under our proposals we are intending to retain a cancer unit in Hillingdon.

Questions & Answers

Q. *Do you accept the proposition that Mt Vernon needs to change?*

A. Yes. Mt Vernon needs to provide services for local people; that's what we're proposing.

Q. *Don't you think that Beds & Herts patients from south of the region would continue coming to Mt Vernon and that a new cancer centre in Hertfordshire would get patients from farther north and east?*

A. It's still all guess work, but I do believe that Mt Vernon would lose half its patients if the Beds & Herts proposals came to fruition. But we do need to do more research on this, through GPs etc. In our proposals we are planning to continue treating the

commoner types of cancer, such as breast, bowel and lung, locally. We must provide the best possible service for our local population.

Q. *Could you please explain the term 'cancer unit?'*
A. It is a non-surgical oncology centre. Mt Vernon is currently not recognised nationally as a cancer centre because it does not provide comprehensive surgery.

Q. *Mt Vernon has 65 inpatient beds – what is the usage of these beds?*
A. The average stay in a bed at Mt Vernon is 3 days. The inpatient beds are for very sick people – people who've become unwell during treatment, or who are having lots of high doses of chemotherapy. At present 97% of the beds are in use most of the time but if the Beds & Herts proposals are developed, we would lose half our patients. In 8 years' time we won't need that many beds.

Q. *What is your impression of the public meetings so far, and what have you taken on board?*
A. I have enjoyed the public meetings. The debate has been useful to us in helping to inform our proposals.

Q. *How can you base conclusions on conflicting or discredited evidence?*
A. I don't believe the evidence is discredited. We are working closely with experts in the West London Cancer network and others as we develop our strategic framework for cancer. We, and the SHA, want the other services to remain on site. It is not true to say that the NHS does not support the Scanner Centre and the other facilities; we and other NHS Trusts commission and pay for their services.

Q. *If beds need to be reduced, shouldn't it be justified by evidence not supposition?*
A. We are looking for decisions that acknowledge that if Beds & Herts build their own cancer centre there will be a knock on effect on the Mt. Vernon network. We can't produce definitive proposals at this point but there will be full public consultation as our plans are developed.

Q. *What about the implications for the workforce?*
A. The workforce will have 10 years to decide on their future and will be supported throughout. Whatever cancer services remain on the site, Hillingdon will be running them.

Q. *What do you think is the optimum catchment population for a cancer centre and on what do you base that view?*
A. 1.3 – 1.4 million is the optimum figure; it's the critical mass that's needed to enable specialists to build the necessary expertise to achieve the best results.

Evidence from Dr. James Kennedy – GP, Hayes

Dr Kennedy spoke to the Committee from the perspective of a GP in the London Borough of Hillingdon. Key points were noted as follows:

- Most people will be affected by cancer, either directly or indirectly, at some stage in their lives and there a number of factors which influence the types of treatment needed.
- Treatments and outcomes are changing; we can do more to treat cancers even if we can't always cure; we can prolong life and improve the quality of life.

- We have a diverse population in Hillingdon; ethnic groups may respond differently to different treatments.
- We have an ageing population with multiple health problems, e.g. most people survive their first heart attack and then go on to have other medical problems.
- Rapid medical advances mean that we'll need to continue to have highly specialist state-of-the-art facilities for cancer treatments, supported by a full range of 24 hour surgical and medical specialities to treat people's other ailments too.
- The UK is not really at the cutting edge of medical science any more; we don't really have the health infrastructure; the costs of carrying out research in London are prohibitively high.
- A number of factors may influence patient outcomes (e.g. depends on the type of cancer being treated and what happens during the course of treatment), but experience suggests that cancer centres that treat higher numbers of patients tend to achieve better results. It is estimated that a catchment population of around 1.3 million is best.
- At the moment in Bedfordshire and Hertfordshire, there is a large population that is without a proper cancer centre; whereas people in this borough have been accustomed to a better than average service. In remedying the situation in relation to services in Beds & Herts, we should be raising their standards to ours, not vice versa.
- Patients want their cancer treated in the best possible way. In order to achieve this locally we need to retain, and develop, the services in our local hospitals. The development of new treatments means that patients will become less reliant on hospitals for their care. Possibly over time we may have mobile GPs and nurses who can treat patients in their own home.
- Development of the ancillary services at Mt Vernon would be welcome.
- The cutting-edge cancer centres will be treating the most complex cases that can't be dealt with in an ordinary district hospital.
- GPs want access to high quality care for their patients and won't accept less but they are pragmatic and accept the need for change. It is important that the Hillingdon/Mt Vernon cancer network retains and develops its clinical links with the most cutting-edge services.

Questions & Answers

Q. *Do you accept the proposition that Mt Vernon needs to change?*
A. Yes. 'No change', staying still, is not an option.

Q. *What would be the effect of chemotherapy treatment at Mt Vernon being reduced to a minimum?*
A. It would affect patients severely and it couldn't be justified; the issue of an ambulatory service is very important. We also need more intermediate care in Hillingdon and the primary care set up in this area is many years behind other parts of the country.

Q. *What is the proportion of complex cases?*
A. The very complex cases are not the majority.

Q. *What about inaccuracies / conflicting evidence?*
A. The key issue is, what is care going to be like 10 – 15 years in the future? We need to look at the big picture and it's therefore hard to justify a case for 3 cancer centres.

- You need facilities for visitors (e.g. parking) as well as patients.
- As many clinical and other services as possible should be based within Mt Vernon, or Hillingdon hospitals, so that they remain as local as possible. We need to develop community services too.

- There are some concerns about the Paddington Basin developments: the location is difficult for patients to get to; medical staff train in central London and then move on to work elsewhere.

Q. *Do you think Mt Vernon services should remain as they are?*
A. Patients should have access to treatment locally. We need to:

- Improve the health of the local population;
- Provide good primary care for local people; this includes good cancer care;
- Commission the best services we can for our patients. PCTs should be reviewing this locally and continually pushing for improvements.
- We want the best quality cancer services for Hillingdon's population but not at the expense of other areas.

Q. *There's an emotional attachment to Mt Vernon – has communication* [of the proposals] *been a problem?*
A. The important thing is the service, not the site. We've been used to above average services in this area; we want to see the service kept and improved.

Q. *What about Calman-Hine?*
A. The Calman-Hine recommendations are reasonable.

Q. *What do you think is the optimum catchment population for a cancer centre?*
A. Whether it's 1.3 or 1.5 million is debatable, but it's a quibble. From the point of view of the individual patient, if you've got cancer, you want the best care for yourself, available locally. You want your individual needs to be met.

Q. *Are there any other issues that we should be aware of?*
A. Primary care services in this area, in terms of infrastructure and staffing, are about 2 decades behind other parts of the country. It is difficult to get primary care premises developed; a large proportion of our GPs and nurses are nearing retirement and it is vital that younger, high calibre people are recruited. I would urge LB Hillingdon to look at this issue seriously.

Following the evidence, all witnesses were thanked for their valuable contribution to the consultation.

5. COMMITTEE DISCUSSION

The Head of Scrutiny and Members' Services summarised the discussion that had taken place at the Mount Vernon Joint Scrutiny Committee meeting on the previous evening. The Joint Committee would be inviting interested parties to submit written comments on the consultation on cancer services by 22nd August 2003, and members would meet again on 9th September to consider the responses received.

AGREED:-

1. The health and social care overview & scrutiny committee had set a series of questions on which to base its conclusions. Initial observations of the committee were noted as follows: -

Q1. Do you accept the proposition that Mount Vernon needs to change?

- 'No change' is not an option; some progress is necessary as medical science advances;

- it is important to build upon and improve the existing cancer services at Mount Vernon;
- the population of Bedfordshire and Hertfordshire deserves a better service than is currently available, but this should not be to the detriment of the people of Hillingdon;
- Mount Vernon cancer services should be run by NW London SHA
- The 65 in-patient beds for cancer patients at Mount Vernon are needed currently.

Q2. <u>Do you support the proposition of the development of an ambulatory radiotherapy service at Mount Vernon, provided all quality and safety requirements are met?</u>

- The Committee supported the proposition.

Q3. <u>Are there any inaccuracies in the consultation documents that you are aware of?</u>

- The Committee perceived that there were some inaccuracies in the documents.

Q4. <u>What is your impression of the public meetings so far, and what have you taken on board?</u>

- No one was in favour of the Beds and Herts proposals for the future of Mount Vernon;
- Meetings were well attended and very supportive of Mount Vernon;
- Many of the delegates were from organisations representing large numbers of people (residents associations, etc.);
- No one was convinced of the need to reduce cancer services at Mount Vernon.

Q5. <u>What do you think is the optimum catchment population for a cancer centre and on what do you base that view?</u>

- About 1.3 million;
- Noted that 2 expert witnesses were in favour of 3 cancer centres to serve the populations of Beds and Herts and NW London, while 2 expert witnesses favoured 2 cancer centres.

Q6. <u>How up to date is the Calman-Hine report on which the recommendations are based?</u>

- The Calman-Hine report, published in 1995, was based on 1980s data;
- Noted that NW London SHA would be using other data in developing its strategic framework for future cancer services.

2. The Committee noted that some primary care services in Hillingdon were reported to be, in terms of infrastructure and human resources, 1-2 decades behind other parts of the country, and it was important that this issue be addressed.

3. The Committee agreed to meet again on **20th August** (2.00 p.m. start) to agree a report that will inform Hillingdon's representatives to the Joint Committee. This report to be circulated to Joint Committee members and the two SHAs, along with notes of the evidence and questioning.

The meeting closed at 5.25 p.m.