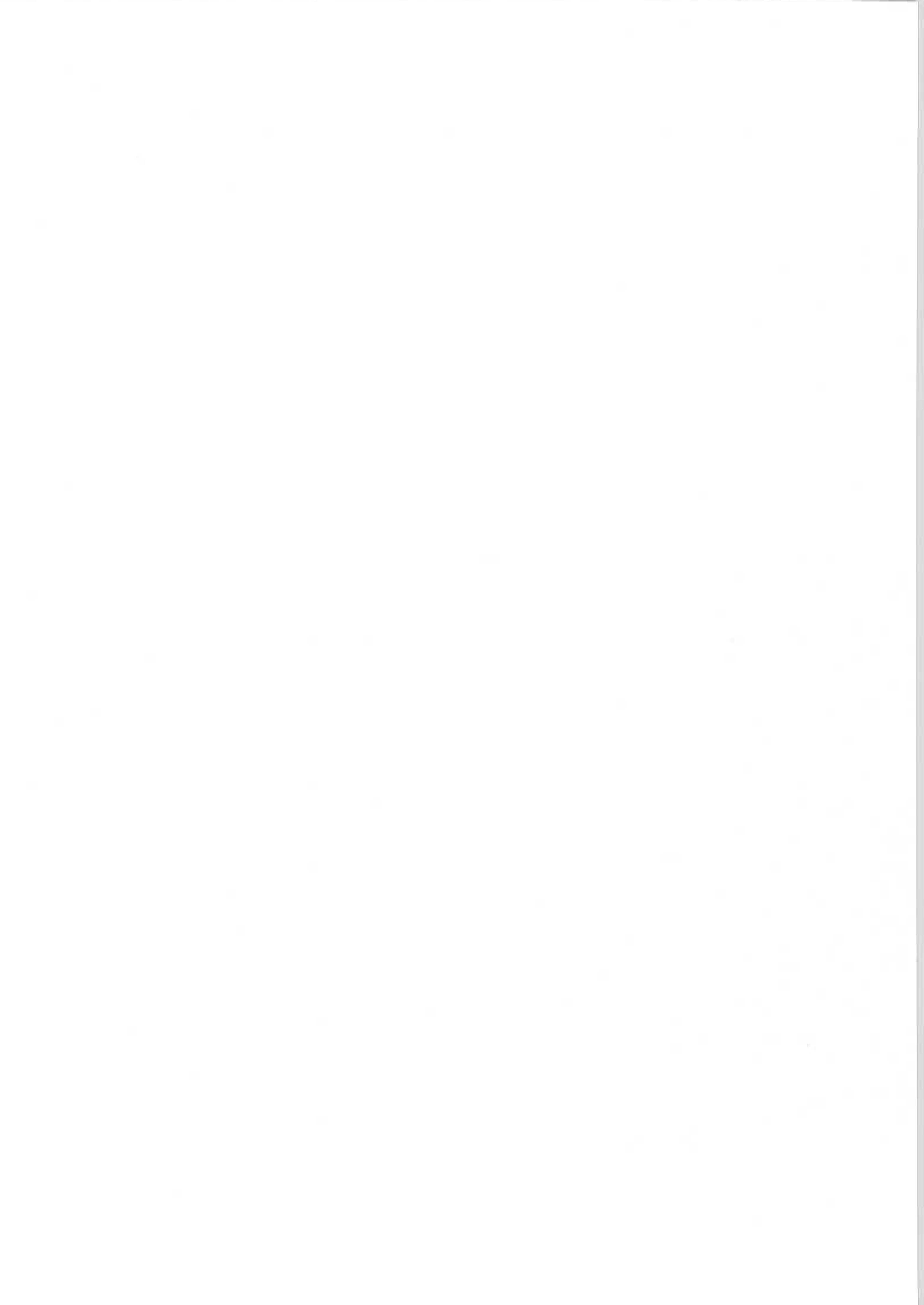
Appendix 5

Written Submissions of Evidence



TROJANS BREAST CANCER SUPPORT GROUP

23 Hunters Lane
Leavesden
Watford, Herts
WD25 7BA

16th April 2003

Heather Smith
Committee Administrator Law and Administration
London Borough of Harrow
Civic Centre
Harrow Middx,
HA1 2UH

Dear Ms Smith

Re the future of Mount Vernon Hospital as per Beds and Herts Plan

I am writing on behalf of the Trojans Breast Cancer Support Group.
This Group meets monthly at Mount Vernon Hospital and supports Patients and their Partners who mainly live within a 20 mile radius and includes Harrow, Watford and Pinner and Hemel Hempstead.

As Patients we have all been privileged to receive treatment at this World renowned Cancer centre and are therefore concerned about any reduction in Services for ourselves or future Patients.

We know that this is an old and rambling site but feel there is much scope to build a new Centre of Excellence. This would continue to serve the local population for many years to come and could become a National Centre for the treatment of Cancer.

Yours sincerely

Virginia Barber

Virginia Barber
Vice-chair Trojans Breast Cancer Support Group

Peddie, K,Select Comm Support

From: NHS Scutiny Email Account
To: Peddie, K,Select Comm Support
Subject: FW: F.A.O. Katherine Peddie; Hatch End Association Responses to NHS Consultation
Date: 20 August 2003 15:57PM

From: Paul Samet
To: NHS Scutiny Email Account
Cc: heather.smith@harrow.gov.uk
Subject: F.A.O. Katherine Peddie; Hatch End Association Responses to NHS Consultation
Date: 20 August 2003 10:53PM

<<File Attachment: CANCER_R.RTF>>

Dear Ms Peddie,

I am sending, as an attachment, the responses prepared by the Hatch End Association to the consultation documents regarding the Future of Cancer Services at Mount Vernon Hospital. Our responses are in the form of two letters to the chairmen of B&HSHA and NWLSHA. For convenience I have put them together in a single attachment. I have removed the 'headed paper' indication, as that takes rather a lot of space with an intricate graphic but all the text is included.

Heather Smith, of LBH Chief Executive's Department, is sending you the brief papers we submitted to the borough's Scrutiny Committee.

Do not hesitate to contact me if you need to but I shall be away from home for 2 weeks starting on 27 August. The e-mail address is on this note and the telephone number is 020 8428 0314.

I wish your committee well in its deliberations.

Paul Samet

Resposes to the Consultation on the Future of Cancer Services

The following two letters were sent in mid-August by the Association to the strategic health authorities concerned.

i) To Bedfordshire & Hertfordshire SHA

19 August 2003

To Mr Ian White, OBE,
Chairman,
Bedfordshire & Hertfordshire Strategic Health Authority,

Dear Mr White,

I am writing on behalf of the Hatch End Association, which has a membership of some 1900 households, so roughly 4000 local residents. This response has been approved at the August meeting of our executive committee.

Being in the northern part of Harrow we are clearly interested in some of the proposals of your consultation paper, 'Investing In Your Health', particularly those aspects that appear to affect some of the medical services available to us. Much of the document is concerned with local services in Bedfordshire and Hertfordshire: we make no comments on those. The two aspects that we wish to comment on are

i) Cancer Services at Mount Vernon Hospital;
ii) The effect of 'Option1' or 'Option 2' on facilities at Watford.

So we only answer questions 4 and 5 of your document. As well as our answers to these questions I give our reasons for answering in the way we do.

Question 4
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?

Our answer is **NO**.

We have no objection to the establishment of a cancer centre in the Bedfordshire-Hertfordshire area. In our view, however, that should not be done by the removal of the service from Mount Vernon Hospital.

Question 5
This question asks for preference between Option1 and Option 2, which affect the location of services such as obstetrics and major A & E, depending on the location of a new cancer Centre.

Our answer is **OPTION 2**.

Our reason for this choice is that it maintains services at Watford that are used by local residents. If Watford services were to be reduced in a major way there would

have to be considerable reorganisation in services based on Northwick Park Hospital, as the alternatives in Hertfordshire would be largely inaccessible.

I trust you find these comments helpful.

For your information I enclose a copy of our reply to North West London Strategic Health Authority.

Yours sincerely

PAS

ii) To North West London SHA

19 August 2003

Ms Jane Kelly,
Chairman,
North West London Strategic Health Authority,

Dear Ms Kelly,

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

I am writing in response to the invitation in your recent consultation document. This letter is on behalf of the Hatch End Association, which has a membership of some 1900 households, so roughly 4000 residents, in this district of north Harrow, and has been approved by our executive committee at its August meeting.

Following the publication of 'Investing in your Health' in March by the Bedfordshire and Hertfordshire Strategic Health Authority, with its proposals of moving services from Mount Vernon, we were pleased to hear the statements by Mr Steve Peacock, at the public meeting held in Hatch End on 30th April, that there would be a separate review of cancer services, with the aim of providing radiotherapy and some chemotherapy facilities at Mount Vernon. This was seen as a more helpful and constructive attitude towards the needs of patients in North West London. We have found the consultation document, issued in mid-June, of great interest but also somewhat frustrating, in particular in its lack of detail. Being asked to give answers to its questions seems like having to sign a 'blank cheque'.. I accept that this might appear to be a negative attitude: the Bedfordshire & Hertfordshire document had quite specific proposals, so at least we knew where we stood – mostly, against those that affect local patients.

We understand the NHS differences between a '***cancer centre***' and a '***cancer unit***'.. In these terms, we have to accept that Mount Vernon is not a cancer centre at present and there is little expectation of it becoming one in the future, as there is no likelihood of the surgical support, that the Calman-Hine report recommends, being provided. On the other hand, the oncology service at Mount Vernon has worked in a highly satisfactory manner for several years, with surgical support from Northwick Park, Hillingdon, Watford hospitals, as well as many others. If one were to set up a

cancer unit from scratch, to give local services, this would presumably be a modest affair. Mount Vernon, however, has over 40 years experience, it is the largest unit of its kind south of Birmingham, with many in-patient cancer beds and it has many other services on site, such as the Gray Institute, the Paul Strickland Scanner Centre, the Lynda Jackson Centre and Michael Sobell House for general patient support. There does not seem to have been any suggestion of utilising all these supporting facilities – is this perhaps because they are not NHS funded and just 'happen' to be on the site? Bedfordshire and Hertfordshire have indicated they would welcome these, without giving any indication of any financial help for them to move. Your document uses phrases such as '*we want*', '*we hope*', '*this may be*' but these do not seem to offer enough incentive to the support services to make decisions regarding their future.

We have been told, at consultation meetings, and many other meetings with the local NHS bodies, that putting medical support service on the Mount Vernon site to make it into a full cancer centre would 'destabilise' other local hospitals. Many of the supporting services, such as surgery and A & E used to be on the site, until they were removed some years ago, but that is history that cannot be easily undone. There has been no local request for it to become a cancer centre in the NHS sense. We would suggest that it would make good sense to utilise what there is currently at Mount Vernon, probably with some improvements to reflect changes in the way services are provided. Mount Vernon would then become what could be termed a '***Cancer Unit*** +', rather more than a simple unit but less than a centre, within the local cancer networks. Your own document (near the bottom of page 5) uses the term '*non-surgical oncology centre*' and we are happy to adopt that term. The level and quality of work done are more important than nomenclature.

There is one other general point that we do not understand. We are frequently told that the aim of the NHS is to provide services locally, wherever possible. That is how we understand the NHS document 'Keeping the NHS Local – A New Direction of Travel' (issued in February 2003). Indeed, Mr Peacock has told us that your Health Authority was a major contributor to the formulation of the policy outlined in that document. We understand, of course, that there will always be some complicated (and rare) cases that cannot be handled locally, where the nearest hospital with the requisite expertise is not local. But with a disease like cancer, where the expectation is that probably 1 person in 3 will suffer from it at some time, it would seem that the majority of patients ought to be able to expect to have treatment not very far from their homes. Yet what we currently have from Bedfordshire & Hertfordshire and from your own Authority discusses services in their geographical areas, rather than in terms of where people live. I mention this because the majority of current Mount Vernon patients live within about 15 miles of it, some in North West London, some in Berkshire, some in Buckinghamshire and some in Hertfordshire. There seems to be no coherent planning. Is it really impossible to have major services that cut across the boundaries of health authorities?

Finally, we support the general statement on this matter produced by the London Borough of Harrow's Health and Social Care Scrutiny Sub-Committee.

I now turn to the questions you have asked us in the consultation document. (I have copied your questions, with answers in *italics*.)

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

Q2 If you accept this proposition, do you accept that Mount Vernon's future is not dependent on it being a specialist cancer centre? *Yes. It is not technically a cancer centre at the moment but already does more than a cancer unit. This service should not be reduced.*

Q3 If you believe that Mount Vernon needs to change in another direction, please give brief details *There are already plans to move one of the Northwood general practices to the site, which we welcome. Services are to be moved from Hillingdon Hospital as it is redeveloped. Some of these changes would also give support for cancer patients.*

Q4 Do you support the general proposition of the development of Mount Vernon as a local provider of cancer services, as outlined above? *Yes, with reservations. We believe that much more is possible than what is indicated in the document.*

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. We note, however, that on page 12 (some) chemotherapy is also intended to remain at MVH. But why are there any doubts about the ability to provide a high quality and safe service? It is done currently.*

Q6 Are there any other issues linked to the development of local services at Mount Vernon of which you wish us to be aware? *In addition to the local cancer services provision , the acreage of the site leaves space for other local non-surgical provision such as a rehabilitation centre following surgery etc for chronic illnesses plus a Physiotherapy centre. We note also the location on the site of Bishopswood Hospital, which could lead to a useful future partnership between the NHS and the private sector to support local services We would also suggest staff exchanges between MVH and the London Cancer Centre (at Hammersmith?), with links between the Gray Institute and a teaching hospital. The establishment of an ACAD unit capable of dealing with minor (local anaesthetic) surgery would relieve pressure on Hillingdon and give additional support to local GPs.*

The future of the Plastic Surgery unit is of concern in connection with the future of the cancer services. There is a long-term commitment that this should be moved to Northwick Park but progress on this has been painfully slow. Leaving it at MVH – but in improved accommodation, for what is currently there is a disgrace and possibly not even safe – helps the Cancer Unit by providing surgical and anaesthetic support. However, the original reason for the requirement of moving the Plastic Surgery away from MVH was the lack of a Paediatric unit: there is still none and we know of no plans to have one.

Currently, assessment and diagnosis is done in cooperation with local hospitals. For this to continue it is necessary for there to be appropriate local pathology support, for rapid analysis of test results. This has to be on site.

Please do not hesitate to contact me if you so desire.

For your information I enclose a copy of our reply to Bedfordshire & Hertfordshire SHA.

Yours sincerely
PAS

Comments by Hatch End Association

for LBH Health & Social Care Scrutiny Committee

on 'Proposals for Mount Vernon Hospital Cancer Service'

1. **Introduction** These comments refer mainly to the consultation document published on 19 June by the North West London Strategic Health Authority (NWLSHA), regarding the future of the cancer service at Mount Vernon Hospital (MVH).

2. We welcome the document as an improvement on what has come before, in particular the proposals by the Bedfordshire & Hertfordshire SHA (BHSA), 'Investing in your Health', discussed at the meeting in April. However, there is a general lack of detail of the extent of the services that will be provided and we wish to see rather more than is provided at the moment. Too much of the document is expressed in general terms, indicating aspirations and hopes – which are welcome – but these do not give much indication of we can expect to see in service.

3. **The New NWLSHA Document** It seems to us that a good place to start our discussion is the third paragraph of the **'Conclusions'**, on page 16: *'We do not underestimate the difficulty in bringing about the proposed changes. They are not about continuing with the services that are there now but on a smaller scale; they are about redesigning cancer services to meet the needs of patients with a chronic illness, by effective relations between a cancer unit and primary care, supported by partnership working with the proposed cancer services'*. We agree entirely with these sentiments.

4. Our problem is that there is such a lack of detail that one does not know what is actually being proposed. The BHSA document had mentioned the possibility of continuing with some ambulatory radiotherapy, the new document (on page 12) adds that there would be some chemotherapy as well. For most of the services there are statements like 'we want', 'we hope', 'this may be' – it is not clear just how much of a service is intended. We are not against change and realise that full implementation of both BHSA and NWLSHA proposals will take several years, until about 2010 or so. There will certainly be changes in methods of cancer treatment in the intervening years. A good place to start might be a statement of how much of the present services will remain and what changes are intended. What proportion of the north-west London population will be expected to receive cancer treatment at MVH? (It is worth noting that for some Hertfordshire patients in the vicinity of MVH that might still be the treatment centre of choice, rather than Hatfield or Hemel Hempstead, a point that is reinforced by the maps on 8 and 10.) If treatment is to be provided at Hammersmith or somewhere in Hertfordshire, how is access to be provided and at what cost? The research carried out by the Gray Cancer Institute depends on having enough patients within easy access (minutes, at times, because radio-isotopes with very short half-life times are involved) – without an appropriate patient population the 'hope' expressed (on page 14) that the Institute would remain might not be realistic. Similarly, the Paul Strickland Scanner Centre offers facilities far in advance of what are generally available – just 'hoping' that these will continue is hardly enough.

5. Another matter where there is little detail is the size and constitution of the local population. Harrow has a very large ethnic population, currently estimated to be about 41% of the borough. It is known that the incidence of some illnesses, such as coronary heart disease and diabetes, varies between different racial groups. Has any thought been given to any similar variations in the incidence of cancer, even of different forms of cancer, that might have effects on the provision that has to be made? There is no mention of such considerations in the NWLSHA document.

6. **Cancer Centre or Cancer Unit?** The NWLSHA document discusses the services that a full Cancer Centre can be expected to provide, with assessment, surgery, follow-up treatment, much of it provided by a district general hospital, whereas the Cancer Unit would have a more limited range of services, working in conjunction with a centre. This may be a good way of setting up services in the first place but this is not where we are with MVH. There has not been cancer surgery on any large scale there for some years, that is done very satisfactorily in local hospitals such as Northwick Park and Hillingdon, where the staff work in close conjunction with the MVH oncologists. It would seem better to build on these relationships rather than reduce treatment abilities greatly.

7. It is actually quite difficult to find evidence of improved survival rates in hospitals implementing much of Calman-Hine (there does not seem to be any hospital that currently implements *all* of Calman-Hine) – or that survival rates in a non-surgical oncology centre like MVH are worse. The lack of such evidence is a matter of concern if decisions are being taken to support the 'National Cancer Plan' without appropriate clinical data. Calman-Hine was intended to be advisory, not prescriptive.

8. So, it should be possible to regard the future MVH Cancer Service as being a 'Cancer Unit+', to coin a phrase, offering more than a 'simple' unit is expected to do. Our understanding of the NWLSHA document is that this is also their view and we support them.

9. **The Long Term Review** There is one matter with regard to the 'Long Term Review' that we wish to mention. The statistical information, which was claimed to give support to the implementation of Calman-Hine proposals (as part of the case for moving much of MVH to a site in Hertfordshire, with its implications that MVH was unable to meet the Calman-Hine specifications) was questioned last autumn, by Professor Mervyn Stone, an expert on medical statistics. His views have now been supported by two eminent statisticians, Professor Sir David Cox and Dr David Spiegelhalter, that the data as given does not support the case for improved survival rates in specialist cancer centres. This is serious, as it undermines the case presented by BHSA. We accept that there may be a good *political* argument for a cancer centre in Hertfordshire but no proper *clinical* case has been made for this.

Paul Samet
Chairman,
Hatch End Association
2 July 2003

Comments by Hatch End Association on

'Investing in Your Health'

(BHSHA Consultation Document)

1. **Introduction** These comments refer to the ways in which the Bedfordshire and Hertfordshire proposals affect residents in North West London, in particular in Hatch End. Insofar as much of the BHSHA document is concerned with the reorganisation of acute services in Bedfordshire and Hertfordshire, we have no problems with much of the document, although even here there are some matters of detail. For us the principal issue is, naturally, the future of the Mount Vernon Cancer Centre. We discuss this and the implications for the future.

That we are even being asked to consider Bedfordshire and Hertfordshire proposals for a service located in Middlesex is an accident of history. Several years ago, principally for financial reasons Mount Vernon and Watford hospitals were joined into a single trust, then expanded to include other hospitals, and run by South West Hertfordshire Trust. Various services, such as A & E, were removed and other parts run down. Currently, some of the medical services on the site are under the jurisdiction of BHSHA although the site itself is owned and managed by Hillingdon Hospital. There is considerable wonder in our area that the future of what is regarded as a local service is being decided by an authority in another county, largely on the basis of acute services that are of little concern to local residents.

2. **The Mount Vernon Cancer Centre** We now turn to considering the Cancer Centre. This is a well-known and highly regarded service. The adjoining Gray Research Institute, the Scanner Centre, the Lynda Jackson Macmillan Centre and others all contribute to the overall service that patients receive. The Long Term Review Panel's report has never been placed before the public for consultation, contrary to usual practice when major changes in service delivery are being proposed. Hiding it as an appendix to the main consultation document, with only a few paragraphs in the main text, blandly suggesting that the SHA accepts the recommendation, is disingenuous. Especially so as the Panel's statistical basis for its conclusions have been challenged as unsound, a criticism that has been brushed aside or ignored by BHSHA. In the absence of a consideration of this objection one has to conclude that the proposed move is a political and administrative decision, not based on patient service.

In our view, the recent NHS consultation paper, 'Keeping the NHS Local' (February 2003) is highly relevant. The aim, we are told, is that the development of options should be *with* people not *for* them. In section 2.1.8 we have the revealing statement that 'open discussion with patients and the public, and with staff, needs to begin right at the outset – before minds have been made about how services could or should change'. Nothing of this kind has happened in this consultation process. The general thrust of this document is that the planning of services should aim to make them local, as far as that is possible. We have been told this does not refer to specialised services but nowhere does the paper say so. For conditions that are rare

and where nationally there are only a few thousand cases per year there is little possibility in having specialists available all over the country. But cancer services, which affect large numbers of the population – one estimate is that a quarter of the population will need these at some time in their lives – are not such rarities and must surely be kept largely 'local'. Yes, of course, there will be occasions when a particular case has to be referred a 'national specialists' but this is not the norm.

3. **Other matters** ***Maternity*** at Watford is used for some deliveries in the north of Harrow, so a move to elsewhere would also have an impact on local residents, possibly a rearrangement by the local PCTs and hospitals. We would therefore support Option 2, as this keeps a larger maternity service at Watford.

Plastic Surgery and Burns are currently at Mount Vernon, although the Expert Advisory Group (and the subsequent Evaluation Panel) set up to examine these services in 1999, following a proposal that they should be moved to Chelsea and Westminster, concluded that these units should be moved to Northwick Park. The proposal to move to them was made on the grounds that there was no paediatric service on the Mount Vernon site. It was fiercely opposed by the local community and the staff. We note with dismay that the consultation document introduces a long-term plan to move these units from MVH to Hertfordshire (section 9.1.21), although there is no actual question for the public to answer on this. It has the appearance of trying to undermine official policy without saying so. That the units have not moved in the intervening four years is, as far as we have been informed of the matter, due to financial bickering between various NHS bodies. The original reason, the lack of paediatrics which might have sound medical reasons, seems to have been forgotten in the financial squabbles.

4. **An Alternative Proposal** The Calman-Hine report (1995) envisaged centres serving populations upward of 1 million. Very well, Mount Vernon has a catchment of 2 million, with a little over half of these in Bedfordshire and Hertfordshire. The BHSHA proposals are for a centre covering 1½ million patients – the population of the two counties – with the remaining ½ million to be serviced elsewhere. Where exactly? Hammersmith has been suggested but that is hardly local for us either. It is planned that some radiotherapy would remain at Mount Vernon and there has been a very recent suggestion that some chemotherapy could be placed at Hillingdon. What is the point of moving the chemotherapy from Mount Vernon? It seems to us that it would be sensible to have ***two centres***, one in Hertfordshire, at Hatfield or Hemel Hempstead, with the other at Mount Vernon, each equipped to deal with 1 million patients. The latter would serve mostly North West London but also the area around Watford and Rickmansworth, as well as some of Buckinghamshire. For the Watford and Rickmansworth areas Mount Vernon is far more local than either Hemel Hempstead or Hatfield. The size is within the Calman-Hine suggested minimum catchment area.

The administrative argument has been put forward that this would require major surgical and medical support at MVH, which would unbalance other local hospitals but no information has been put forward to support this objection. Currently, surgical work is performed at Northwick Park and Hillingdon, among local hospitals, with close consultancy from the oncologists based at MVH. Why is this not possible? It

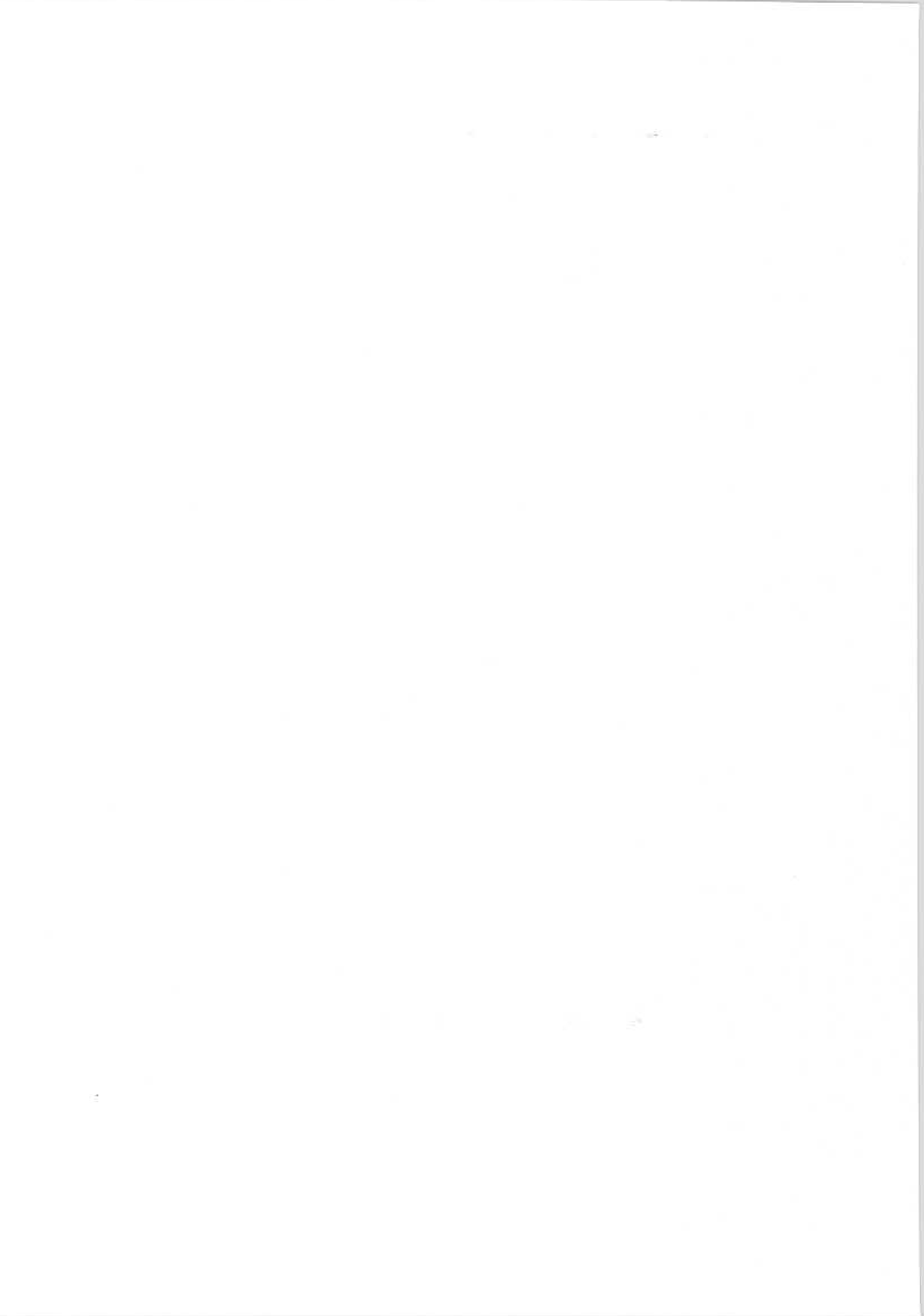
puts the convenience of patients above that of administrators, which we do not regard as a bad thing.

There is actually one interesting advantage of our proposal. It allows a comparison of the Calman-Hine argument that preferably all parts of the cancer service should be on one site with the current 'Mount Vernon' style, with surgery in a local hospital and follow-up treatment on a nearby site. As we have already noted, the statistical information in the Long Term Review Report has been challenged as being flawed and inadequate.

5. **A Long Term Fear** Suppose that the BHSHA proposals are implemented largely as proposed. What then becomes of the cancer surgery currently carried out at Northwick Park? (We cannot speak about details of Hillingdon but know that cancer surgery is certainly done there.) If the Calman-Hine doctrine of surgery and support being on the same site it would seem that the cancer surgery section at Northwick Park, and presumably that at Hillingdon, would be transferred to somewhere else. The effect would be a far worse, definitely not local, service for residents of North West London. This seems to be the logical, if unintentional, conclusion of the actions started by BHSHA.

6. **Conclusion** We are concerned that services in North West London will be worsened simply for reasons of what is to happen to acute services in Bedfordshire and Hertfordshire, which are of little concern to us. The function of a SHA should surely be to improve services, not to make them worse.

Paul Samet
Chairman,
Hatch End Association
17 April 2003



THE COMMUNITY VOICE

The voice of the local community using NHS hospitals and health services in North West London and South West Hertfordshire

PROPOSALS TO MAKE RADICAL CHANGES TO CANCER SERVICES AT MOUNT VERNON HOSPITAL

SELECT COMMITTEE
01 SEP 2003
SUPPORT

THE COMMUNITY RESPONSE

BACKGROUND

1. Bedfordshire/Hertfordshire Strategic Health Authority issued a Paper (March 2003) consulting on future arrangements for health services in its six main hospitals. This was legitimate and procedurally correct. But in the Paper they included a decision to close the Cancer Centre at Mount Vernon, (run by them but in the London area), and build a new one at Hemel or Hatfield.

   This decision was challenged, legally, by "The Community Voice" as being in breach of judicial review rules on three counts – "illegality" – "irrationality" – "procedural impropriety". This point was conceded by Beds/Herts lawyers and an additional 3 months consultation including the future of the existing cancer service was agreed.

2. North West London Strategic Health Authority and local Primary Care Trusts had intended not to consult the public themselves but to leave it to Beds/Herts Health Authority.

   The different legal position has forced it to mount a three month public consultation, ending September 11th, with all relevant stake holders. But it's unpreparedness for consultation and the three month limit has meant that it has had insufficient time to analyse, plan, issue proposals, cost or consider alternatives.

   The N.W. London Consultative Paper is therefore vague in its proposals, expressing uncertainty on the future of the complex of cancer services currently at Mount Vernon, or of the medical and support staff.

   It also does not provide any information at all on the future of the many charitable cancer support units, e.g. the Scanner Centre, the Gray Cancer Institute, the Restoration of Appearance and Function Trust, OR other such as the Lynda Jackson Scanner Centre, Chart Lodge, Michal Sobell House and the Marie Curie Research Wing. All these are essential components of the teamwork built up over many years.

CONCLUSIONS

1. The Bedfordshire/Hertfordshire Proposal

   We agree in principle that Bedfordshire or Hertfordshire are entitled to build a new Cancer Centre for their residents in their locality, at a site agreed by consultation. But our many discussions over years with senior medical people, other staff, patients, the public and our financial advisers, all inform us that to close the existing Cancer Complex at Mount Vernon and try to move it would be a medical and financial disaster.

2. The North West London Proposal

   The community can only respond constructively to a public consultation if presented with factual service proposals. In the case of Mount Vernon we cannot agree or disagree until we are given definite statements on the following issues: How much radiotherapy? How many cancer beds? How many doctors, nurses? How much chemotherapy? Where will chemotherapy be? What happens to the H.D.U.? What about the cancer (Thoracic) operations at Harefield? Etc. etc.

   In addition, as the public subscribe huge amounts of its money to Mount Vernon services each hear, e.g. the R.A.F.T. charity collects £1 million from donations every year, what guarantees are there that unplanned action by N.H.S. bodies will not destroy these vital services?

   In view of this totally unsatisfactory rushed consultation the community is demanding that the closing date for this consultation is deferred for 6 months until the stakeholders (staff and public) are presented with carefully planned and firm proposals for Mount Vernon approved by the Department of Health.

   Unless this reasonable request is granted the Community has no option but to consider litigation and to make a fresh approach to the Secretary of State for his support for consultation which conforms to the requirements of the Health and Social Care Act 2001.

3. A list of the forty affiliated organisations supporting this paper and covering Hillingdon, Harrow, Pinner, Hatch End and S.W. Herts is attached.

Mike Turner

Mike Turner
CHAIRMAN

2 River Close
Ruislip
Middlesex
HA4 7UY

THE COMMUNITY VOICE

The voice of the local community using NHS hospitals and health services in North West London and South West Hertfordshire

MEMBERSHIP APRIL 2003

Barnhill, Charville & Yeading Ward Labour Party
Business & Professional Women, Watford
Carpenders Park Residents Association
Cassiobury Residents Association
Civil Service Pensioners Alliance
Eastbury Residents Association
Eastcote Residents Association
Fourways Women's Club
Harefield Community Association
Harefield Tenants & Residents Association
Harrow Pensioners Forum
Hatch End Association
Hillingdon Pensioners
Ickenham Residents Association
Jewish Association of Cultural Societies
League of Jewish Women
Mount Vernon Comforts Fund
Northwood Grange Evening Townswomen's Guild
Northwood Hills Evangelical Church
Northwood Hills Residents Association
Northwood / Pinner Council Conservative Group
Northwood Residents Association
Oak Farm Residents Association
The Pinner Association
Pinner Labour Women's Group
Re-Beat Club Harefield
Restoration of Appearance & Function Trust
Rickmansworth Residents Association
Ruislip Afternoon Townswomen's Guild
Ruislip Evening Townswomens' Guild
Ruislip Residents Association
Ruislip / Northwood Labour Party
Ruislip / Northwood Liberal Democrats
South Harrow & Roxeth Residents Association
South Ruislip Residents Association
Three Rivers Labour Party
Watford Liberal Democrats
Wheelchair Users Association

+

Individual Members

ARGUMENTS IN SUPPORT OF RETAINING AND DEVELOPING THE EXISTING COMPLEX OF CANCER SERVICES ON THE MOUNT VERNON SITE

1. It has an international reputation for the academic research in the Gray Cancer Institute and the clinical research in the Marie Curie Wing.

   The synergy of clinical and academic research work is one of its greatest strengths.

2. The cancer complex has sixty five designated cancer beds (full every day), and apart from the 16 consultants, the support team includes 70 nurses – including nurse practitioners and clinical nurse specialists as well as junior medical staff and therapy radiographers. This unit is necessary to support radiotherapy and chemotheràpy patients.

3. Alongside the cancer complex is the Paul Strickland Scanner Centre, the best equipped in Britain (not NHS funded), which has already scanned 200,000 patients, and provides the means towards the early diagnosis of serious diseases such as cancer and heart disease, through the provision of the very latest and most accurate scanners. It relies on contributions from the public 18 miles around Mount Vernon to support the multi- million pound work at the centre. It has recently built a new £1M building to house a cycloton to aid in treatment and research.

4. The Restoration of Appearance and Function Trust (R.A.F.T.), a charity. It has its own building on the Mount Vernon site and carries out first class research into skin cancer, wound healing and tissue engineering and works closely with the Plastics/Burns Unit at Mount Vernon. Businesses, Trade Unions and the public donate around a £1M each year to support its activities.

5. Both the Calman/Hine Report and the House of Commons Select Committee on Health state Cancer Research should be alongside Cancer Treatment. They are at Mount Vernon.

6. The Lynda Jackson MacMillan Centre gives expert medical and psychological help to patients and relatives.

   The Prime Minister visited it in 2002 and commented on its excellence and it was given an NHS award.

7. Michael Sobell House (a Hospice) has an excellent record and support from a wide area around the Mount Vernon site.

8. Chart Lodge, a Hostel with 10 rooms for overnight stay for patients or relatives, is a unique unit built from funds from the community.

9. Harefield Hospital (1 mile from Mount Vernon) has recently opened two new modern operating theatres (cost £1.5M) and cancer patients from Mount Vernon who need Thoracic (Lung) operations go there.

10. The Mount Vernon Cancer Centre has a two bed high dependency facility, with a resuscitation team consisting of an Anaesthetist. An O.D.A. (Operating Department Assistant, the Day Hospital Staff Grade), and nursing staff provided by the relevant ward/department. Advanced Life Support training has been given to the nursing staff on site.

    In the case of a paediatric crash this would involve a paediatric nurse rather than a non-paediatric nurse, and a Plastic Surgeon rather than the medical grade staff.

11. Watford General Hospital is only 4½ miles from Mount Vernon. There is already considerable collaboration between the two hospitals on Pathology, Accident and Emergency, Maternity, etc. This link although cross border could be strengthened.

12. Mike Richards, National Cancer Director who advises the Government on cancer policy, said recently at a Public Meeting in Uxbridge "If I was building a Cancer Centre from scratch, I would want on it all the facilities they have at Mount Vernon".

13. The cancer services at Mount Vernon have been there for 40 years, working successfully, safely, and with huge financial and active support from patients, the staff and the public.

Why destroy it now?

Mike Turner.

Mike Turner
August 2003

2 River Close
Ruislip
Middlesex
HA4 7UY

Peddie, K,Select Comm Support

From:	NHS Scutiny Email Account
To:	Peddie, K,Select Comm Support
Subject:	FW: Mount Vernon Hospital: The future of Services for Cancer Patients
Date:	20 August 2003 09:23PM

From: Roger Sale
To: NHS Scutiny Email Account
Subject: Mount Vernon Hospital: The future of Services for Cancer Patients
Date: 19 August 2003 15:43PM

<<File Attachment: JOINT_NH.DOC>> <<File Attachment: HTMLPAGE.HTM>>

Dear Mr Hamilton

I attach a letter outlining the impact of the recommendations of the consultation papers on our particular service.

Paul Strickland Scanner Centre is a unique organisation. We purchase 'state of the art' cross sectional imaging systems from money donated by the public, currently having a capital replacement value of over £3.5m. We then operate the scanners, providing the service primarily to the Cancer Treatment Centre at Mount Vernon Hospital on a 'not for profit' basis and without passing on either capital replacement or maintenance costs. Our price per unit of service is significantly lower than either Private Sector or NHS providers locally.

Roger Sale
Director
Paul Strickland Scanner Centre
Mount Vernon Hospital
Northwood
Middlesex. HA6 2RN.
Tel: 01923 844353
Fax: 01923 844600

www.paulstrickland-scannercentre.org.uk

paul strickland
scanner centre
www.paulstrickland-scannercentre.org.uk
Mount Vernon Hospital
Northwood, Middlesex HA6 2RN
Tel: 01923 844353 Fax: 01923 844600
e-mail: rsale@pssc.freeserve.co.uk

19th August 2003

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

Dear Mr Hamilton

Mount Vernon Hospital: The future of Services for Cancer Patients.

- Part of the international reputation of the Mount Vernon Cancer Centre is the advanced diagnostic imaging facilities it uses in diagnosing and staging cancer.
- The National Health Service could/would not afford to invest in providing the level of imaging required.
- Paul Strickland Scanner Centre raised the funds to build an imaging centre and provide a CT and a MRI scanner 16 years ago using funds donated by the public.
- The Centre still provides service to the NHS, using donated funds to replace the capital equipment, and providing scans on a 'not for profit' basis at purely operating cost, i.e. excluding capital charges, capital replacement programmes etc.
- The Centre currently provides:
    1. A 32 slice per second Computerised Tomography (CT) scanner – the first of its type in the UK.
    2. Two 1.5 tesla Magnetic Resonance Imaging (MRI) scanners – both state of the art and equal in specification to new machines now ordered by the NHS elsewhere.
    3. A Positron Emission Tomography (PET) scanner – one of only five available to the NHS in England, and the only one provided by public donation and run on a 'not for profit' basis for the NHS. We plan to replace this with a 'state of the art' PET/CT scanner in early 2004.
    4. The only purpose built Cyclotron/Radiopharmacy facility in the UK, provided from a generous anonymous gift, supported by public donation, to provide the radioactive tracer for the PET scanner. The cyclotron is owned and operated as a joint venture between Paul Strickland Scanner Centre and PETNet Pharmaceuticals Inc, the largest PET radiopharmaceutical manufacturer in America.

A Company with Limited Liability registered in England No. 2033936. Charity No. 298867.
VAT registration number 773 6779 71

- The Eastern Region Cancer review recommends that the NHS should provide the equivalent of the Paul Strickland Scanner Centre, but only suggests using a single 16 slice CT, one MRI scanner and no PET facility, thus wasting the generosity of the local population. Current International Society of Haematology guidance is that no patient with lymphoma should be treated without access to PET.
- The scanners provided by Paul Strickland Scanner Centre operate to near full capacity scanning patients suspected of or under treatment for cancer, and provides scans within a maximum of 5 days of receipt of a referral. NHS units with a single CT and MRI provide services for the whole acute service and have waiting times measured in months. To attempt to absorb the cancer workload into the standard NHS facility could only delay scanning, and therefore, treatment.
- The Paul Strickland Scanners provide imaging to support the extensive research led by the Marie Curie Research Unit and the Gray Cancer Institute. Many of the tracers used for PET research have a radioactive half-life of two minutes. It is therefore impossible to undertake this sort of research without a PET scanner and the associated Cyclotron facility on the same site. The SHA document does not enable the cyclotron or PET scanner to relocate to e new Cancer Centre site.
- The Board of the Paul Strickland Scanner Centre have offered to relocate the Charity to a new hospital site if that unit provides better care for cancer patients than is presently available, and to continue providing a 'state of the art' service on a non-profit making basis. The Consultation document appears to reject this offer. Without an active Cancer Treatment Centre at Mount Vernon, the workload for the Scanner Centre falls below the 'critical mass' and the Scanner Centre will close.

I will expand any point if requested either at the meeting or in writing before or after the meeting.

Yours sincerely

Roger Sale FIBMS

Director

Kirk House
97-109 High Street
Yiewsley
West Drayton
Middlesex
UB7 7HJ

Tel: 01895 452000
Fax: 01895 452108
website: www.hillingdon.nhs.uk

19th August 2003

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

Dear Mr Hamilton

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

I am writing to you to enclose a couple of documents to be considered at the Joint NHS Scrutiny Committee meeting on the 9th September at Hillingdon Civic Centre.

Firstly, I am enclosing a copy of the supporting statement that Elaine House, Executive Director of Commissioning & Performance Management, submitted to the Overview and Scrutiny Committee in Hillingdon on the 31st July. This outlines the background and context for the proposals that have been laid out and how they will affect Hillingdon PCT.

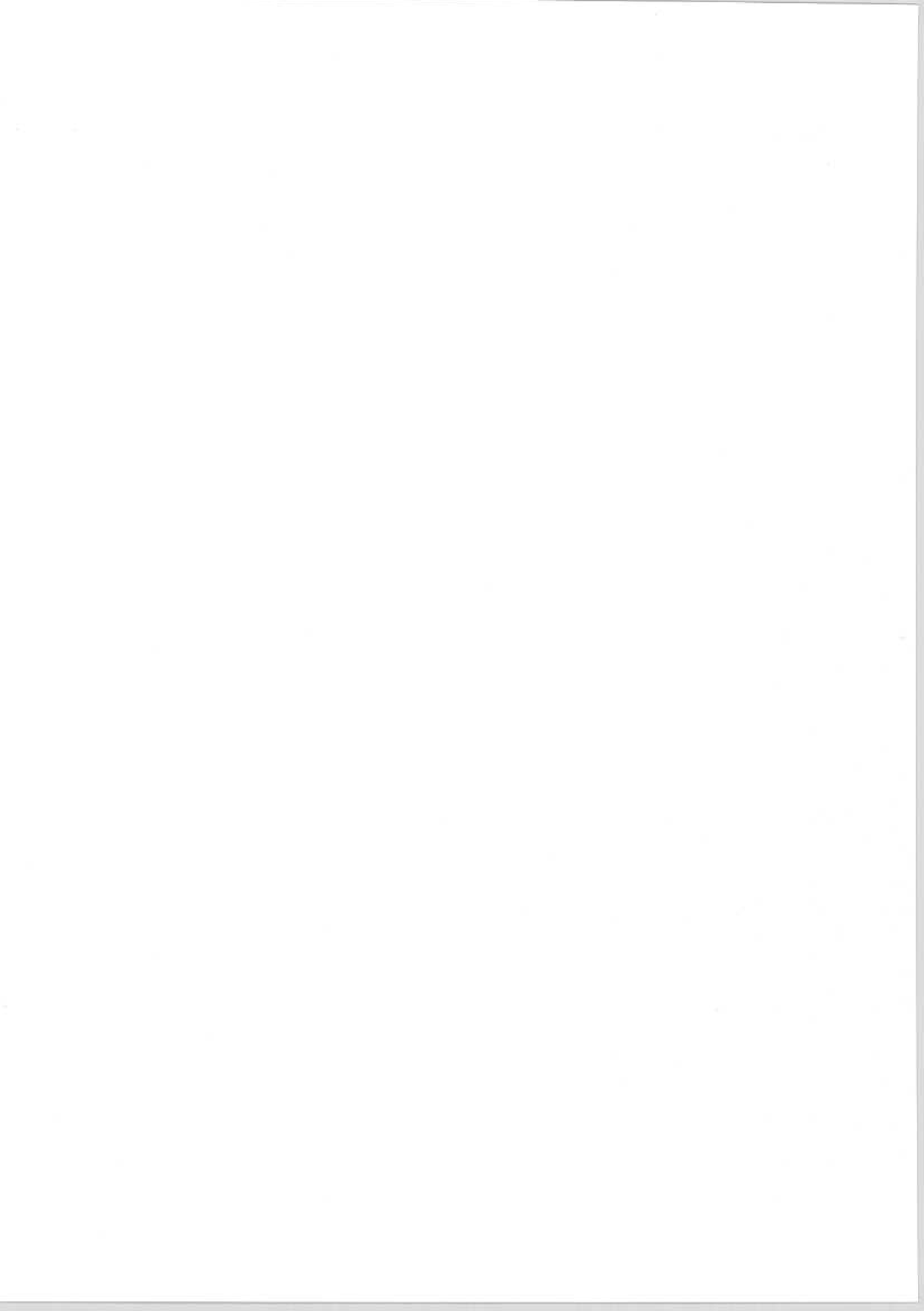
The second document is my response to the minutes of the meeting of 31st July, addressed to Cllr Catherine Dann, clarifying a couple of points around local primary care services and Calman-Hine which I felt did not accurately reflect either the services that we provide in Hillingdon, or the basis of the national Cancer Plan and the long-term review of cancer. I would appreciate it if these comments were taken into account at the meeting on the 9th.

For your information, Elaine House will be attending the meeting on the 9th of September and will be able to answer any queries you may have regarding Hillingdon PCT, if this is appropriate.

Yours sincerely

pp **Graeme Betts**
Chief Executive

CC: Sarah Pond – Chair, Hillingdon PCT
Elaine House – Executive Director of Commissioning & Performance Management



Health & Social Care Overview & Scrutiny Committee
Thursday 31 July 2003

Consultation on Cancer Services at Mount Vernon Hospital

SUPPORTING STATEMENT OF
ELAINE HOUSE, DIRECTOR OF COMMISSIONING, HILLINGDON PCT

1. Background

1.1.1 In March 2003, Bedfordshire & Hertfordshire Strategic Health Authority launched it's public consultation "Investing in your Health". The document proposed options for the future configuration of health services within the two counties, including the proposal to develop a new cancer centre.

1.1.2 At present the cancer centre for the counties is at Mount Vernon Hospital and it is part of the Mount Vernon Cancer Network. Other members of this network are Bedford Hospital, Luton & Dunstable Hospital, Queen Elisabeth II Hospital, Lister Hospital, Watford Hospital and Hemel Hempstead Hospital.

1.1.3 The proposals from Bedfordshire & Hertfordshire are to establish a new cancer centre at either a new hospital development in Hatfield or at Hemel Hempstead.

1.1.4 The proposed new centre would provide all the expected services of a cancer centre, ie cancer surgery, the treatment of paediatric cancers, treatment of rare and complex cancers, and the centre would be supported by a full range of 24 hour surgical and medical specialties on site.

N.B. Mount Vernon does not provide cancer surgery, the treatment of paediatric cancers or intensive care, and has limited surgical and medical specialties on site.

1.2.1 The proposals from Bedfordshire & Hertfordshire were seen to have an impact on the current patient flows to Mount Vernon from other areas, predominantly NW London, Thames Valley and NC London, as well as an impact on the current services and the site.

1.2.2 The three PCTs most affected in NW London, Brent, Harrow and Hillingdon, together with the NW London Strategic Health Authority have therefore issued their own public consultation document "Mount Vernon Hospital : The Future of Services for Cancer Patients".

1.2.3 The Bedfordshire & Hertfordshire consultation ends on 1 September 2003. The NW London consultation ends on 12 September 2003. All three PCT Boards will meet in September to consider the outcome of their consultation. The PCTs views will be considered by the NW London Strategic Health Authority at it's own Board meeting at the end of September. During October, Bedfordshire & Hertfordshire Strategic Health Authority Board will meet to consider the outcome of the NW London consultation and it's own consultation "Investing in Your Health".

2. Current Cancer Services at Mount Vernon

2.1.1 Mount Vernon cancer services are run by West Hertfordshire Hospital Trust. The Trust manages Watford, St Albans and Hemel Hempstead Hospitals.

2.1.2 The services provided on the Mount Vernon site are ambulatory and in-patient radiotherapy and ambulatory and in-patient chemotherapy.

2.2.1 The number of patients treated by radiotherapy in the year 2002/03 was 2639. Approximately10% of the patients treated were Hillingdon patients, ie 279. Very few patients receiving only radiotherapy treatment required in-patient care.

2.2.2 Well over 90% of all radiotherapy treatment is delivered by linear accelerators. Mount Vernon currently has 7 linear accelerators. There will be 9 operational linear accelerators on site by 2005 with an additional 2 machines being added to the current compliment. 2 of the existing linear accelerators are also being upgraded within this timescale.

2.3.1 The number of patients treated by chemotherapy in the year 2002/03 was 1445. Approximately 14% of the patients treated were Hillingdon patients ie 245.

2.3.2 The majority of patients receive their treatment as outpatients or daycases. The daycase chemotherapy suite has 12 chairs and one bed and deals with 60-70 patients on an average day.

2.3.3 Mount Vernon has 65 in-patient beds for patients who cannot be treated as outpatients or day cases for chemotherapy (approximately 10% of patients)

3. North West London Proposals

3.1.1 If the Bedfordshire & Hertfordshire proposal to develop a new cancer centre is agreed this will result in approximately half the current patient activity undertaken by the Mount Vernon cancer services moving to the new centre (in approximately 8-10 years).

3.1.2 It is proposed by NW London that in the intervening years the Mount Vernon cancer service strengthens its links with the NW London Cancer Network to gradually become a fully integrated member of that network.

3.1.3 The accredited Cancer Centre for NW London is the Hammersmith Hospital, where rare and complex cancers are treated.

3.1.4 Cancer services for Hillingdon residents are currently provided at Hillingdon Hospital, Mount Vernon Hospital, Great Ormond Street, Northwick Park, The Royal Marsden, The Royal Free and University College Hospitals (including the Middlesex). Cancer treatment at these hospitals will continue in the future as some local hospitals are accredited units eg common cancer surgery for breast and urological cancers at Hillingdon Hospital, head and neck cancers and

colorectal cancer services at Northwick Park.

3.2.1. The NW London PCTs together with the NW London StHA and the NW London Cancer Network, are currently developing cancer plans in line with the emerging cancer strategy for NW London, to define what cancer services will be provided at Mount Vernon in the future.

3.2.2. Our expectation is that both Hillingdon Hospital and Mount Vernon will provide outpatient chemotherapy. Within Hillingdon Hospital's Strategic Outline Case the hospital has stated that it will develop a chemotherapy suite for daycase chemotherapy. In light of the consultation and the views of local people, the hospital is considering the provision of this suite at Mount Vernon in future, rather than Hillingdon Hospital.

3.2.3. The chemotherapy suite would benefit from the proposed continued ambulatory radiotherapy that we believe could be retained at Mount Vernon. An independent study will be made to test the viability of ambulatory radiotherapy on the site.

3.2.4. Hillingdon Hospital will also investigate the provision of some in-patient beds for patient who become unwell during radiology or chemotherapy treatment. Where the beds will be sited ie at Hillingdon Hospital or Mount Vernon, will depend on clinical support services and 24 hour coverage on these sites in the future.

3.2.5. Hillingdon Hospital will also be investigating whether surgery for common cancers could be provided at Mount Vernon when their new Diagnostic and Treatment Centre is functional and more elective surgery is provided on the site.

4. Linkages with other Health Services

4.1.1. The importance of the role of clinical networks cannot be overemphasised. The networks develop clinical links and plan for patients to be treated by the most appropriate clinical teams that transcend organisational and geographical boundaries. Clinical networks also strategically plan for future services, plan to meet service accreditation, develop the required workforce, share best practice and spread expertise and learning, consolidate expertise by sub-specialty and plan for the introduction of new medical and scientific advances.

4.1.2. The West London Cancer Network is currently developing its strategic framework that will be used to shape its strategy for the provision of cancer services in the future.

4.1.3. The Mount Vernon Cancer Network, which as already stated is the network that serves Bedfordshire & Hertfordshire hospitals, has already completed its strategic planning, hence the identified need for its own cancer centre closer to its population centre.

4.2.1 The integration and sharing of clinical and non-clinical support services that serve a site are particularly critical when planning the delivery of any operational service. These range from hotel services through to pathology services, from

anaesthetic support to surgical intervention. It is therefore important that cancer services on the Mount Vernon site are planned to maximise the benefits of local acute services support, and integration where appropriate. The other non-clinical services on the site will also be a large contributing factor to the level of cancer services that can be provided in future.

4.2.2 The PCT and Hillingdon Hospital have published plans for the development of the site in "Mount Vernon Hospital – Help us to Shape its Future". This document commits to the development of a Diagnostic and Treatment Centre to undertake more elective surgery on the site (already approved in the Hospital's Strategic Outline Case by the NW London StHA). The PCT will also be developing a new 60+ bedded unit for care of the elderly and intermediate care services and providing more direct access diagnostics for GPs.

4.3.1 The Mount Vernon cancer service is laudable due to the holistic care provided on the site. The Patients' Hostel, Michael Sobell House, the Paul Strickland Scanner Centre and the Lynda Jackson Macmillan Centre all provide services of immense value for local people being treated for and living with cancer. The PCTs and NW London StHA hope that these services will stay at Mount Vernon in the future to continue to serve the patients treated there from the surrounding local communities.

5. Conclusion

5.5.1 It is virtually impossible for health experts or indeed scientists to predict with certainty what cancer services will look like in 10 years time. This is in the main due to the fast progression of medical and scientific advances that will be made during that timescale, and future services will be developed by the increasing influence of clinical networks that will see more treatment for common cancers at local hospitals for part, in not all, of patients care. Telemedicine and advancing information technology will also influence the configuration of services within networks.

5.5.2 The NW London PCTs and NW London StHA have demonstrated through their consultation document that there is a real commitment to keeping local cancer services on the Mount Vernon site to continue to serve local people.

5.5.3 The detailed plans of what services will be provided in future will be developed and informed by the Hillingdon Cancer Strategy Board, the NW London Cancer Network and the Study for Ambulatory Radiotherapy, together with national guidance and medical and scientific advances, and, most importantly, when the outcome of the consultation in known.

5.5.4 Whatever decisions are taken about the preservation and development of local cancer services, they will continue to take account of the need to provide continuous improvement and be flexible enough to develop in line with current and future practice and local patient needs.

Elaine House

28 July 2003

Hillingdon NHS
Primary Care Trust

Direct Line: 01895 452001
E-mail: graeme.betts@hillingdon.nhs.uk

Kirk House
97-109 High Street
Yiewsley
West Drayton
Middlesex
UB7 7HJ

Tel: 01895 452000
Fax: 01895 452108
website: www.hillingdon.nhs.uk

Our Ref.: GB/PC/105

13th August 2003

Cllr Catherine Dann
Chairman, Overview & Scrutiny Committee
London Borough of Hillindon

Dear Catherine

Re: Overview and Scrutiny Special Meeting – 31st July 2003

Thank you for sending me the minutes of the above meeting. I would like to outline my concern about a couple of the points in them.

In point 3 of the minutes it states that *'primary care services in Hillingdon, in terms of infrastructure and human resources, are 1-2 decades behind other parts of the country, and it was important that this issue be addressed'.*

There is no evidence offered to support this assertion and I feel that such a bald statement really needs support before it is disseminated widely. Very many people work very hard in primary care in Hillingdon and they would be justifiably upset to see such a sweeping generalisation which has no factual evidence to support it.

Further, I reject this assertion completely for rather than being 1 – 2 decades behind other parts of the country, primary care services in Hillingdon compare favourably with those across the country. I have set out below some evidence to support my view.

In terms of infrastructure, the majority of primary care premises in the borough are of a high standard. Although some premises are of lower quality this is being addressed; there have been three major premises developments in the last two years, with a further one commencing next month. Yiewsley Health Centre will be redeveloped next year, and there are plans through the LIFT scheme to continuously update primary care premises. This is an enviable record in North West London, let alone the rest of the country.

Also, Hillingdon was the first borough in the country to have 100% of all GP practices computerised and linked. Most practices use their computers effectively which brings huge benefits to patients in terms of continuity of care, prescribing and evidence based practice. Also, the PCT has supported practices with resources for data entry clerks, to facilitate this process.

With reference to human resources, the NHS has limited resources when it comes to recruitment and retention. However, Hillingdon PCT has invested significant resources in GP staff and community services, such as community nursing (£1 million pounds for community nursing alone in 2000). Further, the PCT has supported practices by contributing to an increase in nursing and GP resources across Hillingdon, as well as providing HR advice to all practices. This is not to say that there aren't areas of difficulty for recruitment, especially in Hayes, but even here, the PCT has invested in a number of exciting pilot projects to attract and retain qualified professional staff.

In terms of primary care as a whole, Hillingdon PCT performed well in primary care in the recent star ratings that were published nationally, with a high percentage of patients being able to access GP and healthcare professional services within the target times of 24 and 48 hours. The PCT performed well with generic prescribing, which is in large part due to its innovative work with GPs and community pharmacists.

The second point I have concerns about is that the minutes seem to imply in answer to question 6 that Calman Hine is out of date and therefore not relevant to the cancer services that are provided today. This point was put to Professor Mike Richards, the National Cancer Director and author of the national Cancer Plan who spoke at one of the consultation meetings. He said that the work done in 1995 by Calman-Hine was an important starting point for the Mount Vernon consultation process and improving cancer services;

"What Calman-Hine said was that we need to ensure all parts of the country receive a uniformly high and safe level of service, as close as possible to where the patient lives. This should be regardless of where the service is based – in primary care, community settings, secondary or tertiary centres". He went on to say *"We are also looking at the number of cancer patients going through the system in order to give the service a critical mass, at present we are developing guidance and further policy to improve the shape of the service. So, for example, for breast cancer you might need a different set of local services as there are a large number of patients, while cancer of the oesophagus requires more complex surgery and hospital treatment. It is a question of balancing population and service".* He also reiterated the findings of Calman-Hine which indicated that cancer centres have much better outcomes due to the high number of cases it sees for the rarer cancers. This is the model that cancer services are following in the UK and there has been much more recent evidence to prove this theory which is readily available.

It is also important to bear in mind that, in terms of the long-term review of cancer for Mount Vernon, other, more recent research findings were taken into consideration, and these supported the model of care outlined in the National Cancer Plan.

I hope that you will take these points into account when taking your final decision with regards to the consultation. I would be grateful if you would circulate this letter to those that received the original minutes, as I feel that the statement on primary care services is demoralising for staff ands damaging to the reputation of primary care and Hillingdon PCT.

Yours sincerely

Graeme Betts
Chief Executive

65 Belmont Road, Uxbridge, Middlesex UB8 1QT
Tel: 01895 257858 Fax: 01895 813300
e-mail: staff@hill-chc.fsnet.co.uk

Chairman:
Mrs M Ditchburn

Chief Officer:
Mr B Hardy-King

20th August 2003

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

Dear Mr Hamilton,

Re: Public consultation on the proposals of two Strategic Health Authorities

a) **Bedfordshire & Hertfordshire SHA: "Investing in Your Health"**
b) **NW London SHA "Mt. Vernon Hospital: The Future of Services for Cancer Patients"**

In writing to the Joint Overview & Scrutiny Committee, Hillingdon CHC is conscious that at the present time CHCs and OSCs share similar and overlapping duties with respect to the communities that they serve. We shall of course be responding ourselves to the two above public consultations. We also wish to offer every possible assistance to the Joint OSC in its difficult task of representing the views of the 2,000,000 people residing in the catchment area of the Mount Vernon Cancer Centre. With a population of this size conflicting views are inevitable, but it would be undemocratic to suppress the views of any section. We therefore urge that the OSC reflects faithfully the variation of views across the large geographic area that it represents.

Or interest in the two consultations focuses on two issues. Firstly, residents in our area use services at Watford Hospital and reduction of services at that hospital would impact directly on these patients, as well as adding unacceptable demands on Hillingdon Hospital and Northwick Park Hospital. We therefore totally reject Option 1 in the Beds. & Herts. consultation document, which proposes developing Hemel Hempstead Hospital as the major acute hospital in Herts.

Secondly, Mount Vernon Cancer Centre is geographically in Hillingdon, in North West London. The future of the Mount Vernon Cancer Centre is a major concern of local people and we have therefore been fully involved in this issue since our inception as a CHC.

We were represented on the Long Term Review of the Mount Vernon Cancer Network and Centre, which reported in 2002, now usually referred to as the Rosie Varley Review, and we rejected its final recommendation that the Cancer Centre should be moved to Hertfordshire.

Together with Harrow CHC, we referred our concerns about the Bedfordshire & Hertfordshire SHA's 2003 public consultation to the Secretary of State for Health. This led to the intervention of the North West London SHA later in the year, with its proposal to replace the Mount Vernon Cancer Centre with a Cancer Unit - which was an improvement on previous proposals.

We have taken a very active role in both these public consultations, which have caused great public concern, with packed meetings, angry public responses and universal rejection of all proposals to move the Mount Vernon Cancer Centre or to replace it with a Cancer Unit.

Against this background we draw your attention to several documents which we hope will assist your Committee in its assessment of evidence and its representation of the views of the public:

1. "The Future of the Mount Vernon Cancer Centre - Hillingdon Community Health Council's response to proposals of Bedfordshire & Hertfordshire SHA and North West London SHA 2003" - ***this report records the intense local rejection of the proposal to move the Cancer Centre away from its site at Mount Vernon Hospital, together with rejection of the proposal to replace the Cancer Centre with a Cancer Unit at Mount Vernon.***

2. "Hillingdon CHC's Minority Report rejecting the recommendations of the Final Report of the Long Term Review of the Mount Vernon Cancer Network and Centre" - ***we rejected the recommendation of the Rosie Varley Report that the Cancer Centre be moved from Mount Vernon Hospital.***

3. A map showing distribution of the Mount Vernon Cancer Centre's patients, distributed to Rosie Varley Review members - ***this clearly indicates the dense population which surrounds Mount Vernon, across three SHAs - Beds & Herts. SHA, (formerly Eastern Region); North West London SHA, (formerly London Region); Thames Valley SHA (formerly South East Region).***

4. a) A covering letter from Hillingdon CHC with Professor Mervyn Stone's critical assessment of Report 3, the only clinical evidence provided with the Rosie Varley Report, and b) A letter from Professor Sir David Cox and Professor David Spiegelhalter commenting on Report 3 and Professor Stone's appraisal - ***these academic criticisms strip the recommendations of the Rosie Varley Report of clinical validity.***

5. Hillingdon CHC's Mount Vernon Cancer Centre Patient Survey, 2001 - ***a survey set up during the Rosie Varley Review, to investigate patients' views - 90% of the total sample of 472 patients and carers wanted the Cancer Centre to stay at Mount Vernon - and this view was held across all areas of residence by those showing a preference, ranging from 66% of 77 people from north Herts., 93% of 143 people from south Herts., to 98% of 184 people from London.***

6. Hillingdon CHC's Mount Vernon Cancer Centre Public Opinion Survey, 2003 - ***a survey of 1108 people undertaken during the 2003 public consultations on the future of the Cancer Centre, (48% from Hillingdon, 23% from Harrow, 21% from Hertfordshire), of whom 96% wanted the Cancer Centre to stay at Mount Vernon, in preference to Hemel Hempstead or Hatfield, and 95% did not regard residual cancer services at Mount Vernon as a satisfactory replacement for the Cancer Centre.***

We hope the above documents will prove helpful to the Joint Overview and Scrutiny Committee.

We appreciate that your Committee is in no way responsible for the terms of reference under which it must operate, but we ask you to record our concern about the following factors:

a) The short time scale under which you are obliged to work, without warning, particularly in view of seasonal holidays.

b) Our concern at the loss of local democratic representation, since local OSCs are debarred from making independent submissions within the consultation process.

c) Our concern for the future, after abolition of CHCs, when there will be no provision for expression of local concerns within NHS consultations covering a large geographic area - which we consider a deplorable suppression of local views.

Despite these concerns we wish you well in your deliberations. Please let us know if we can help in any way, which we would be pleased to do.

Yours sincerely,

Maggie Ditchburn
Chairman

Bob Hardy-King
CHC Locum Chief Officer

THE FUTURE OF THE MOUNT VERNON CANCER CENTRE

Hillingdon Community Health Council's

response to proposals of

Bedfordshire & Hertfordshire SHA

and

North West London SHA

2003

Compiled by: Joan Davis

THE FUTURE OF THE MOUNT VERNON CANCER CENTRE

Hillingdon Community Health Council's Response to proposals of Bedfordshire & Hertfordshire SHA and North West London SHA, 2003

Page CONTENTS

2 Preface

3 Introduction

4 A Rejection of the recommendations of the Long Term Review of the Mount Vernon Cancer Network and Centre – the Rosie Varley Report

5 B Case for an overview of the Cancer Centre's current catchment area and the continuing needs of that population

6 C Case for three cancer centres in Bedfordshire, Hertfordshire and North West London

7 D Case for reviewing Government policy on cancer centres and updating the Calman-Hine Report, on which Government policy is based

8 E Concerns about current statistical evidence to support proposals

8 F Other factors relevant to rejection of current proposals to move the Cancer Centre

9 G Case for Mount Vernon cancer services to be the responsibility of North West London SHA

10 H Plastic Surgery

10 I Response to Beds. & Herts. SHA: "Have your say on these important decisions", listed on page 102 of "Investing in Your Health"

11 J Answers to specific questions in the text of the NWL SHA's consultation document

12 K Conclusions

Appendix 1 Hillingdon CHC's minority report, dissenting from the recommendations of the Rosie Varley Report

Appendix 2 Patient Distribution Map

Appendix 3 Report by Professor Mervyn Stone: "A critical appraisal of Supplementary Report 3 of the Mount Vernon Long Term Review"

Appendix 4 Letter from Professor Sir David Cox and Professor David Spiegelhalter

Appendix 5 Summary of the Hillingdon Community Health Council's "Mount Vernon Cancer Centre Patient Survey – November 2001" (Copies of the full survey report are available on request)

Appendix 6 Hillingdon Community Health Council's "Mount Vernon Cancer Centre Public Opinion Survey 2003"

Preface

Background information

1. In April 1994, the Mount Vernon Hospital in Northwood, Middlesex, and the Watford General Hospital in Hertfordshire were merged to become the Mount Vernon and Watford NHS Trust.

2. In 1998 there was public consultation on the proposal that the Mount Vernon Plastic Surgery and Burns Centre be moved to Chelsea & Westminster Hospital but, after unprecedented public opposition, it was eventually decided that it should move instead to Northwick Park Hospital. This move has not yet been implemented and no firm plans for implementation are yet in place. In the meantime the buildings housing Plastic Surgery & Burns have become progressively more dilapidated and now cause major concern. (August 2003).

3. In April 1999 the site at Mount Vernon and all its assets passed to Hillingdon Hospital NHS Trust, together with responsibility for both acute and primary health services on the site. These services thus became the responsibility of London Region NHS, later North West London Strategic Health Authority

4. At the same time, responsibility for tertiary services in the Mount Vernon Cancer Centre and the Mount Vernon Plastic Surgery and Burns Centre passed to what was then Eastern Region NHS, later Bedfordshire & Hertfordshire Strategic Health Authority, with local control exercised by Watford Hospital, later South West Hertfordshire NHS Trust.

5. In 2001, Eastern Region set up the Long Term Review of the Mount Vernon Cancer Network and Centre, which issued its Final Report in May 2002, recommending that the Mount Vernon Cancer Centre be moved to a new or redeveloped major hospital in Hertfordshire. This Review and Report are generally referred to by quoting the name of the Chairman, Rosie Varley.

6. In March 2003, Bedfordshire & Hertfordshire Strategic Health Authority issued a public consultation document "Investing in Your Health" proposing changes to its acute health services including two options for provision of a major hospital in Hertfordshire, either by development of the Hemel Hempstead Hospital or by building a new hospital at a site in Hatfield. It proposed that the Mount Vernon Cancer Centre be moved to this major Hertfordshire hospital, whichever site was ultimately selected. The Rosie Varley Report and its supplementary documents became part of the consultation documents, including Report 3, which contained the clinical evidence under-pinning the Rosie Varley recommendations.

7. Following referral of the Beds. & Herts. SHA's consultation to the Secretary of State for Health by East Berkshire CHC, Harrow CHC and Hillingdon CHC, North West London Strategic Health Authority came forward with new proposals in June 2003. Its public consultation document "Mount Vernon Hospital: the future of services for cancer patients", proposes that NW London SHA provides a Cancer Unit at Mount Vernon to replace the Cancer Centre, offering better cancer services than were previously envisaged for that site.

8. Both the above public consultations end in September 2003. This report is Hillingdon Community Health Council's response to their proposals.

Introduction

1. In 2003, as outlined in the preface to this document, both Bedfordshire & Hertfordshire SHA and North West London SHA are consulting the public on their separate proposals relating to the future of cancer services at Mount Vernon Hospital.

2. Their proposals inter-relate and contain a great deal of common ground. It therefore appears useful for us to respond by first considering those factors which are relevant to both consultations, followed by consideration of the particular questions posed within the two consultation documents.

3. Throughout both consultations there has been very great public interest and concern in the London Borough of Hillingdon.

4. A very angry public consultation meeting was held in Ruislip in March 2003 about Beds. & Herts. SHA's proposals in "Investing in Your Health". This was the only public meeting in Hillingdon about these proposals and the hall was filled to capacity. There was universal rejection of the proposal to move the Mount Vernon Cancer Centre to another site.

5. Three subsequent meetings in Hillingdon, called by Hillingdon PCT to outline its provision of secondary health services at Mount Vernon, were entirely dominated by the issue of the future of the Cancer Centre. At each of these meetings there was universal praise for the Cancer Centre and total rejection of proposals to move it elsewhere.

6. Following the publication of North West London SHA's consultation document, three public meetings were held in Hillingdon, all very well attended and all totally rejecting the proposal to replace the Mount Vernon Cancer Centre with a Cancer Unit; not a single voice supported the platform party at any of the meetings.

7. The views expressed at these meetings of course influence our response to the consultation documents and form a basis for our comments. We therefore start by totally rejecting the assumption that the Mount Vernon Cancer Centre must be moved. We also reject the conclusions and recommendations of the Report of the Long Term Review of the Mount Vernon Cancer Network and Centre, Chaired by Rosie Varley, which is cited in the Bed. & Herts. SHA's consultation document at 9.1.14 as evidence to support its proposal to move the Cancer Centre.

8. This response considers a number of relevant factors under separate headings, as indicated in the list of contents on page 1.

A. Rejection of the recommendations of the Rosie Varley Report

1. We were represented on the Rosie Varley Review and, together with the Gray Cancer Institute, dissented from its recommendations.

2. Our minority report was presented to the Chairman, who refused to publish it with the Report, on the grounds that the recommendations were arrived at by consensus and that therefore minority reports could not be accepted for publication – a ruling that appeared to be designed to suppress dissent, which of course we strongly resented. We attach a copy now for reference, as Appendix 1.

3. All the points raised in that minority report remain valid and should be taken into account as representing our current views although, to avoid duplication, we do not repeat them all now.

4. The only clinical evidence provided to underpin the Rosie Varley Report was assembled hurriedly in the days immediately preceding the final meeting of the Review Group. There was no time to seek independent assessment of the evidence before that meeting. It was therefore published, as Report 3, without being challenged. It remains part of the Rosie Varley Report and is thus one of the papers supplementing "Investing in Your Health".

5. Subsequent to publication, we submitted Report 3 to the scrutiny of Professor Mervyn Stone, for his statistical appraisal. Professor Stone is emeritus professor of statistics in the Department of Statistical Science of University College London. He has worked since 1955 in the theory of probability and statistics and its application to a wide range of subjects, including clinical trials and medical research. He is highly critical of Report 3 and his conclusions seriously undermine the recommendations of the Long Term Review. He states that Report 3 is both misleading and deceptive. His summary conclusions are:

   "The case is made that Report 3 misinterprets and misrepresents the research studies on which it relies.

   The report should therefore be rejected as evidence on which to base decisions about the future of the Mount Vernon Cancer Centre"

6. Professor Stone's report was widely circulated by Hillingdon CHC, together with a covering letter. These are attached as Appendix 3.

7. Professor Stone invited peer review of his appraisal and we appreciate that at our request Bed. & Herts. SHA subsequently submitted his appraisal, together with Report 3, to Professor Sir David Cox of Oxford University and Professor David Spiegelhalter of the Medical Research Council, Cambridge. Their response, attached as Appendix 4, complemented Professor Stone's concerns and in their conclusions they commented:

   "Perhaps the most important criticism that can be made is to ask whether the review has followed Calman-Hine too inflexibly and not allowed for 'local factors'."

8. It is pertinent to note that, since Report 3 was the only clinical evidence produced in support of the Rosie Varley recommendations, the above academic appraisals strip those recommendations of both clinical credibility and validity.

B. Case for an overview of the Cancer Centre's current catchment area and the continuing needs of that population

1. The Mount Vernon Cancer Centre sits at the centre of a dense population, spanning the boundaries of three strategic health authorities - Beds. and Herts., North West London and Thames Valley - which it is well placed to serve and which it serves very well. This is illustrated in the patient distribution map attached as Appendix 2.

2. There is some inconsistency between the various sets of published population figures in the two consultation documents and the Rosie Varley Report. We therefore refer to the data in the most recent document, published by NW London SHA.

3. A little under half of Mount Vernon Cancer Centre's NHS radiotherapy patients, 47%, reside in the area of the Beds. & Herts. SHA, with 36% from London (NW and North Central SHAs) and 17% from Thames Valley SHA. For chemotherapy the London SHAs contribute 47% of patients with 38% from Beds. and Herts. and 17% from Thames Valley. Clearly the catchment cuts across SHA boundaries.

4. The Cancer Centre is much loved by its patients, whichever SHA area they happen to live in. They simply want the Cancer Centre to continue serving them – see the Hillingdon Community Health Council's two recent surveys, attached as Appendix 5 and Appendix 6:

    a) Mount Vernon Cancer Centre Patient Survey, 2001, which surveyed 472 patients and their carers, from across the full catchment area, in which 90% favoured developing the Cancer Centre on the Mount Vernon site

    b) Mount Vernon Cancer Centre, Public Opinion Survey 2003, with over 1100 responses, 48% from Hillingdon, 23% from Harrow, 21% from Hertfordshire (mainly South West Herts.) of which 96% chose Mount Vernon as their preferred site for the Cancer Centre.

4. Mount Vernon Cancer Centre is located on the boundary of three SHAs, as already noted. No SHA views population needs broadly, across SHA boundaries and it is customary for all SHAs to support each other in their decisions – loyalty to the NHS prevents public criticism of peers. This acts against the interests of the population centred around Mount Vernon.

5. For the majority of its patients, Mount Vernon is a local hospital, easily accessible and convenient, since it is surrounded by major roads – the M40, M25, and M1 - and with good links to London via the London Underground to Northwood, with adequate local bus services to surrounding towns.

6. Since the catchment population for a cancer centre always exceeds a million people, those who live at the margins inevitably have substantial journeys. People coming from the extremities of Hertfordshire and Bedfordshire have undoubted travel problems at present, but they are a small percentage of the total and their needs should not obscure the fact that Mount Vernon is highly convenient for most of its patients, including the dense population resident in South West Hertfordshire. It may be argued that the needs of the majority should not be pushed aside in order to meet the needs of relatively few.

7. However, it is the view of this CHC that the needs of the total population of Mount Vernon patients would be better met if there were three cancer centres in the area covered by the Beds. & Herts. SHA and the NW London SHA, which is considered further in the next section of this response.

8. We urge that no decision should be taken to move the Mount Vernon Cancer Centre without first subjecting its services to an overview spanning the three SHA boundaries, so that the needs and wishes of its current population, as a whole, are properly taken into account.

****

C. Case for three cancer centres in Bedfordshire, Hertfordshire and North West London

1. At the public consultation meeting in Hillingdon the National Cancer Director, Professor Mike Richards, said "One million is the lowest possible level I would recommend anyone to consider for a cancer centre; 1.3 or 1.4 million people is a level that is more viable".

2. Although a little below optimum for three cancer centres, the combined population of Bedfordshire and Hertfordshire (1.6 million is quoted at 3.27 in Bed. & Herts. SHA's document) and North West London (1.7 million is quoted on page 5 of NW London SHA's document) is within guidelines for three cancer centres and we believe that this option should be fully explored before any decision about the Mount Vernon Cancer Centre is taken.

3. The fact the Mount Vernon Cancer Centre is already serving the populations of South Buckinghamshire, East Berkshire, and some patients from North Central London SHA, swells the catchment population. The Rosie Varley Report, on page 24, estimates the potential patient population from those areas wishing to use Mount Vernon in 2008 as approaching 0.7 million, bringing the relevant total to roughly 4 million, which would clearly justify three cancer centres.

4. At the meeting in Hillingdon, Professor Richards pointed out that the survival rate of patients diagnosed with cancer is rising and that patients are living longer with cancer. This means that patients require cancer services for more years of their lives, swelling the number of patients at any one time.

5. The demographic changes of an ageing population make it likely that the demand for cancer services will continue to grow, since cancer affects older people disproportionately.

6. Growth in the number of patients would inevitably put additional strains on the existing system of two cancer centres, already serving a combined population above optimum.

7. In addition, the capacity of a third cancer centre in the area would greatly aid flexibility to meet the many uncertainties of rapid change in cancer treatment, expected in the years ahead.

8. The above factors combine to strengthen the numerical case for retaining the services of the Mount Vernon Cancer Centre, alongside the development of a new cancer centre in Hertfordshire.

9. Also, the provisions of three cancer centres in the combined area – at Hammersmith, Mount Vernon and Hatfield - would provide more people with relatively local tertiary cancer services, in accordance with Government policy to provide more services closer to home.

10. The population of Hillingdon, Harrow and South West Hertfordshire clearly wishes to retain the Mount Vernon Cancer Centre (see Appendix 5 and Appendix 6) and a cancer centre in Hatfield would undoubtedly be convenient for more residents of NW London.

11. Three cancer centres rather than two would benefit many very sick patients, particularly those at the edge of the combined area, by reducing their travelling time and its consequent stress. Patients' visitors would also benefit.

12. We urge that no decision should be taken to move the Mount Vernon Cancer Centre without full consideration of the case for providing three cancer centres in the area.

****

D. Case for reviewing Government policy on cancer centres and updating the Calman-Hine Report, on which Government policy is based.

1. The Calman-Hine Review was set up as a result of wide concern about the UK's cancer survival statistics, relative to other advanced countries, in the late 1980s and early 1990s. Its Report was published in 1995.

2. There have been rapid advances since then in cancer treatments, new technology, information and communication technology and scientific discovery, making the Report's recommendations obsolescent.

3. In particular, the recommendation that all cancer centre services should be on one site needs to be reviewed to take account of tele-medicine and conferencing facilities that were not available a decade ago when the Calman-Hine Review was reaching its conclusions.

4. The Calman-Hine Report acknowledges that " ... it is impracticable to devise a single blueprint for a cancer centre" and "...decisions will have to be taken in the light of local circumstances and take account of the views of patients and their carers."

5. Close observance of national policy and Calman-Hine guidelines is a fundamental problem when considering options for the future of the Mount Vernon Cancer Centre. In our view there is a serious risk that the result could be destruction of much that is good at Mount Vernon and the creation of a new facility in Hertfordshire which is totally out of date by the time it is built.

6. A thorough reconsideration of policy is urgently needed.

E. Concerns about current statistical evidence to support proposals

1. We have already referred, in Section B, to our concerns about statistical evidence emanating from the Rosie Varley Report.

2. We have called constantly for evidence to justify the claim that major change is needed at the Mount Vernon Cancer Centre - such as statistics to show that Mount Vernon's survival rates are poor in comparison with other cancer centres, or statistics showing that moving a cancer centre to co-site its facilities has led to improvement in patient survival rates - either of which would justify change. No such evidence has ever been produced. In the absence of such evidence, it is our view that Mount Vernon's unique strengths should not be put at risk by making it a guinea pig to test the purely theoretical advantages of moving it.

3. In our search for statistical data we became aware of problems concerning cancer registries, whose historical shortcomings are not widely known amongst the public. The current lack of adequate data on which sound decisions can be taken is a cause for very great concern – but this is no excuse for taking decisions based on low quality evidence. We hope that effective initiatives to address these issues are already being introduced and that wherever possible long-term decisions will be delayed until sound data is available.

****

F. Other factors relevant to rejection of current proposals to move the Cancer Centre.

1. The Mount Vernon Cancer Centre is able to offer only minor surgical facilities. No major cancer surgery takes place on site. It does not have the resources of a District General Hospital or A&E. It currently relies on the Plastic Surgery and Burns Centre for anaesthetics. However there are plans to improve road access to Watford Hospital, four miles away, and for Hillingdon Hospital to increase secondary surgical facilities on the Mount Vernon site, both of which will enhance existing support provision for the Cancer Centre.

2. The Mount Vernon Cancer Centre's many strengths are a powerful factor in calls for its retention - its unique complex of long established clinical teams, unparalleled ethos of patient care, beacon facilities for non-clinical patient support in the Lynda Jackson Macmillan Centre, pioneer patient hotel facilities in Chart Lodge, excellent hospice facilities in Michael Sobell House, the best equipped scanner centre in the country in the Paul Strickland Scanner Centre, plus an on site cyclotron, and the internationally renowned research emanating from co-operation between the Marie Curie Wing of the Cancer Centre and the Gray Cancer Institute's academic research. Many of these facilities have been provided by charitable donation, at no expense to the NHS, and remain dependent on these outside resources.

3. These strengths could not survive if the Cancer Centre were moved off its present site – most staff are clear that they have local commitments and would not transfer to Hemel Hempstead or Hatfield, similarly the volunteers at the Lynda Jackson centre would not transfer, the Paul Strickland Scanner Centre relies on local charity for its funding and could not survive transfer and above all the Gray Cancer Institute is clear that any move would destroy its current internationally acclaimed translational research and that for academic reasons it will not move into Hertfordshire. Adverse impact on research is of particular concern, since this is the only long-term hope for beating the scourge of cancer.

4. In implementing Government policy, for which they are employed, NHS administrators focus on the fact that Mount Vernon Cancer Centre cannot comply fully with national policy, which leads them to the conclusion that it must be moved. Their brief does not allow them to recognise the value of alternative strategies that actually meet the spirit of Calman-Hine, in essence although not in detail.

5. At Mount Vernon, in the absence of on site facilities, there has been specific effort to integrate services provided by specialists operating from different hospitals, with common clinics, patient conferences and dual decisions. This implements the spirit of Calman-Hine although services are delivered from different sites. Patients are often bemused at the suggestion that more needs to be done, since they know that their surgeon and oncologist have liaised to good effect over decisions relevant to their care.

6. The need for emergency support services is another area where Mount Vernon has set up sound procedures to provide safe patient care. The rare need to transfer a patient to Watford Hospital for care not available at Mount Vernon is subject to arrangements providing direct access to the relevant service. When asked to provide evidence of deaths or disadvantage to patients because they were treated at Mount Vernon, both clinicians and NHS administrators have been unable to cite any cases.

7. In an imperfect world it is impossible to provide for every possible risk in any cancer centre and it should be noted that no cancer centre in UK fully complies with either Calman-Hine or the extended list of desirable features listed in the Rosie Varley Report, which appears in the NW London SHA's consultation document as its Appendix Two.

8. In making decisions about the Cancer Centre, the paramount factor should be the advantage for the majority of patients, rather than focusing on either adherence to details of national policy or the statistically remote risks for a very small number of patients. Thus in considering options there should be a balancing of losses and gains, with emphasis always on the maximum good for the majority of patients.

****

G Case for Mount Vernon cancer services to be the responsibility of NW London SHA

1. Mount Vernon Cancer Centre is geographically and historically in London. It is on a site owned by Hillingdon Hospital, which provides secondary services for the population of Hillingdon, within the boundary of North West London SHA.

2. The fact that the Mount Vernon Cancer Centre is currently in the control of Bedfordshire and Hertfordshire SHA is a relatively recent accident of history, as noted in the preface to this response.

3. We urge that responsibility for the cancer services on the Mount Vernon site reverts to North West London SHA's control at the earliest possible date.

H. Plastic Surgery

1. We were concerned that "Investing in your health" item 9.1.21 suggests moving the plastics services from Mount Vernon Hospital to a major acute hospital in Hertfordshire. However the reply received from Stephen Ladyman MP on behalf of the Department of Health, in response to our referral to the Secretary of State, assures us that: …

   The reference in "Investing in Your Health" to moving plastic surgery provision to Hertfordshire is perhaps a little misleading ….the document is referring to the need for separate specialist services for the Bedfordshire and Hertfordshire area. "Investing in Your Health" does not over-ride the outcome of previous consultation within the North West London SHA which proposed moving the regional plastic surgery centre to Northwick Park. The expectation is that North West London SHA will go ahead with this as planned.

2. We assume that this statement is endorsed by both Beds. and Herts. and NW London SHAs.

****

I. Response to "Have your say on these important decisions", listed on page 102 of the Beds. & Herts. SHA's consultation document

1. The first three questions are relevant for the people of Hillingdon only indirectly and we therefore think it inappropriate for us to respond. We restrict our comments to those issues which impact on existing services used by Hillingdon residents.

2. **Question Four** Our response is clearly "No", since people in Hillingdon strongly object to the proposal that the Cancer Centre be moved off the Mount Vernon site.

3. **Question Five** Our response is clearly "Option Two", but our comments fall into two categories which we will deal with separately.

   a) Option One - Proposal to develop Hemel Hempstead Hospital.

   - Hillingdon residents use a number of services at Watford Hospital and there is therefore a strong objection to any reduction in service at that hospital. Option One proposes unacceptable changes in the following departments at Watford Hospital:
     Accident and Emergency, Surgery, Medicine, Paediatrics, Obstetrics and Neonatal
   - Reduction in services at Watford Hospital would result in additional pressures on both Hillingdon and Northwick Park Hospitals, which would have adverse effects on services available at those hospitals for Hillingdon residents.
   - Historically, local people were given an undertaking during public consultation prior to closure of the Mount Vernon Hospital A&E Department that loss of those services would be compensated for by a strengthening of services at Watford and other local hospitals. Financial allocation was made specifically for that purpose. It would be a breach of faith to downgrade the provision of emergency services at Watford Hospital.

b) Option Two - proposal to build a major new hospital and cancer centre at Hatfield

- The people of Hillingdon are sympathetic to the wish of Beds. & Herts. SHA to have a major new hospital and cancer centre in its domain and, providing that this does not take services from the Mount Vernon Cancer Centre, the proposal has our full support.

****

J. Responses to particular questions posed in the NW London consultation document

Q1 *Do you accept that Mount Vernon needs to change*

- We do not accept the proposition that Mount Vernon needs to change to a significant degree, but we accept that Mount Vernon Cancer Centre needs to progress in the light of medical advances.

- Earlier sections of this response indicate why the evidence submitted in the document fails to convince us that major change is needed.

- Appendix 1 is uncontentious – we readily accept that volume of workload and improved patient outcomes are inter-related, but Mount Vernon already qualifies as having sufficient workload.

- Appendix 2 specifications for cancer centre services was set out as an ideal scenario during the Rosie Varley Review, but it was recognised that no cancer centre in the country actually achieves it! It is useful as a wish list, but it is not appropriate to reject Mount Vernon because it does not have these services.

- In view of the long time-scale for a new cancer centre to be built in Hertfordshire and the rapid advances to be expected in cancer treatment, information technology and cancer registry data, we believe there would be much merit in the inherent flexibility of retaining Mount Vernon's current services, to provide the potential to adjust services later if that proves beneficial. If as is thought likely, the need for surgery in cancer treatment is reduced, a Non-Surgical Oncology Centre would become increasingly valuable.

Q2 *... do you accept that MV's future does not depend on it being a specialist cancer centre*

- The plans for developing Mount Vernon's acute and community services are widely welcomed – some of these developments would also provide useful support for cancer services on the site.

- If the Cancer Centre were moved a Cancer Unit would be accepted, reluctantly, as the best alternative.

Q3 *If ... Mount Vernon needs to change in another direction, ...give brief details*

- Adequate financial resources must be available for new services and to improve buildings, many seriously neglected for decades, which is already promised.

- We would have no objection to the Cancer Centre being renamed a "Non-surgical Oncology Centre" providing it retains its current role, services and research.

Q4 *Do you support Mount Vernon becoming a local cancer services provider, as outlined?*

- Very reluctantly, as fall-back option

Q5 *Do you support development of an ambulatory radiotherapy service at Mount Vernon?*

- Very reluctantly, as fall-back option

Q6 *Are there any other linked issues you wish to raise?* No

****

K. Conclusion

1. This Community Health Council strongly objects to the proposal to move the Mount Vernon Cancer Centre off its present site.

2. It calls for responsibility for cancer services on the Mount Vernon site to revert to North West London SHA at the earliest opportunity.

3. It recognises, reluctantly, that if the Cancer Centre were moved off the Mount Vernon site, then its replacement by a Cancer Unit would be the best option available.

4. It prefers Option Two of the Beds & Herts. SHA's options, providing that this refers only to the provision of acute health services and excludes moving the Mount Vernon Cancer Centre or its services to Hatfield.

5. It urges that before final decisions are taken, fresh consideration be given to the needs of the large and dense population surrounding Mount Vernon which would be seriously disadvantaged by the proposals in the consultation document, and that such review totally disregard both Strategic Health Authority boundaries and county boundaries.

6. It strongly advocates that further consideration be given to the possible provision of three cancer centres - at Hammersmith, Hatfield and Mount Vernon - to meet the needs of the total population identified on page 6, in section C.

7. It urges that before final decisions are taken the Government reconsiders its cancer centre guidelines, to reflect the many new opportunities provided by recent advances in cancer treatment and information technology, developed subsequent to the Calman-Hine Review.

8. It deplores the lack of statistical evidence to underpin the proposals currently under consideration and it urges that statistical recording of data be strengthened, to provide a more useful and robust resource on which future decisions can be based.

9. It urges that the views of patients and the public be a major factor in final decisions about the future of the Mount Vernon Cancer Centre. These views are clearly indicated in the two surveys carried out by Hillingdon CHC as its contribution to the consultation process:
   a) "Mount Vernon Cancer Centre Patient Survey – November 2001"
   b) "Mount Vernon Cancer Centre Public Opinion Survey – August 2003"

   both of which show the strong opposition of local people to the proposals under consultation.

August 2003

Signed

Maggie Ditchburn
Chair

Signed

Bob Hardy-King
CHC Locum Chief Officer

Appendix 1

27th May 2002

Hillingdon Community Health Council's Minority Report rejecting the recommendations contained in the Final Report of the Long Term Review of the Mount Vernon Cancer Network and Centre

Hillingdon Community Health Council was represented today at the final meeting of the Long Term Review of the Mount Vernon Cancer Network and Centre but was unable to endorse the Review's final recommendations. It therefore issues this minority report to explain why it dissented from the majority view, noting a number of fundamental flaws and concerns, which are detailed below.

1. Framework of the Review

a. The Review was set up primarily to consider options for residents of Hertfordshire and Bedfordshire. This is a different population from the population currently served by the Mount Vernon Network and Cancer Centre. The current patients from Hertfordshire and Bedfordshire comprise just over half the Cancer Centre's total patients, with roughly 30% of patients coming from the London Region and the rest from South East Region and elsewhere.

b. Hillingdon CHC holds the view that the Review should have been undertaken for the benefit of all existing patients, not for a different population. The Review Group has attempted to be sensitive to the needs of those in Hillingdon and elsewhere from outside its core population, but we do not think that its final recommendations reflect the needs or wishes of the present patients of the Mount Vernon Cancer Centre, particularly those resident in Hillingdon, whom this CHC represents.

c. Hillingdon Primary Care Trust and the North West London Strategic Health Authority are responsible for providing health services for Hillingdon people. Both were members of the Review Group and they concurred with the Review's recommendations. They rejected alternative options to support the Mount Vernon Cancer Centre on its present site, because they feared that adding substantial acute services at Mount Vernon could destabilise local hospitals. Hillingdon CHC fully shares their concern that services at Hillingdon and Watford hospitals should be safeguarded. However it is our view that serious consideration should have been given to other options that were summarily rejected because they did not conform to the constraints that the Review adopted as guidelines.

2. Constraints of the Review

a. The Review has been constrained by two factors that have limited its options. It has adhered strictly to the guidelines of the Calman-Hine Report, which is current government policy, and it has rejected all options that deviate from the model of an ideal cancer centre, which was developed at an early stage of the review process.

b. The Calman-Hine Report itself is far less rigid, recognising that its guidelines should be modified by local factors. The Report states "it is impracticable to devise a satisfactory single blueprint for a Cancer Centre" and "decisions will have to be taken in the light of local circumstances and take account of the views of patients and their carers". We also consider it pertinent that Calman-Hine reported in 1995 and that there are now advances in both cancer treatment and information technology that were not available when the Report was published. Further changes between now and the implementation of the Review's recommendations, which lie many years ahead, make it very likely that present guidelines will be obsolete before delivery.

c. The model for an ideal cancer centre was initially developed to guide the Review's discussion on options. However this model was subsequently used as an absolute requirement, not as a guide.

d. The combination of these constraints led to summary rejection of innovative ideas. This is particularly a matter for concern since in our view greater effort should have been made to support the Cancer Centre on its present site to avoid the adverse effects of moving it elsewhere. Solutions requiring modification of guidelines should have been explored vigorously, particularly the possibility of greater collaboration between the Cancer Centre and Watford General Hospital without complete implementation of either the ideal model or Calman-Hine guidelines.

3 Lack of statistical and research evidence to underpin the Review's basic assumptions

a. No statistical evidence was produced for the Review concerning the survival rates of Mount Vernon Cancer Centre's current patients. Poor survival rates would give weight to proposals for change, but we would argue that if survival rates are currently good then the case for change is substantially weakened.

b. Similarly, no independent evidence is available to show that the introduction of Calman-Hine recommendations actually influences patients' survival rates. There has been an improvement in cancer patients' survival rates in recent years, but specific causes for this welcome advance have not been isolated. Medical authorities are confident that Calman-Hine will eventually impact on survival chances, but the current lack of statistics of any kind from the UK or abroad is unsatisfactory. We had expected comparisons with successful cancer centres across the world to guide the Review's deliberations, but no comparisons were available.

c. No Cancer Centre in the UK currently complies fully with the Calman-Hine criteria. The Review's recommendations to transform the Mount Vernon Cancer Centre into a fully compliant model will, if implemented, make this Cancer Centre a trial case to test the guidelines. However this Cancer Centre is already highly successful, in terms of international research reputation, patient opinion and rich resources on its present site. The world famous translational research based on co-operation between the Cancer Centre and the Gray Cancer Institute will be lost if the Cancer Centre moves site, and the move will also break the Cancer Centre's links with the Lynda Jackson Macmillan Centre, Michael Sobel House, Chart Lodge and possibly the Paul Strickland Scanner Centre, all of which are heralded nationally as first class institutions. We believe that these enviable strengths should not be put at risk without firm statistical evidence to justify moving the Cancer Centre off its present site.

4 The views of Mount Vernon Cancer Centre patients and their escorts

a. As a contribution to the review process, Hillingdon CHC undertook a survey of patients and their escorts in Mount Vernon Cancer Centre in order to provide evidence of their views.

b. 90% of the 472 patients and carers answering the survey preferred development on the Mount Vernon site rather than any other option – the percentage of Londoners choosing this option was 98% and in Hillingdon the support was 100%. These results are significant because the sample comprised people with personal awareness of the services actually provided by the Cancer Centre. The survey confirmed that over 80% of patients were willing to travel an hour or more to obtain a highly regarded service.

c. Patients repeatedly note the dedication of the Mount Vernon staff to patient care. This staff ethos has been built up over many years and there are great fears that this would be unlikely to survive transplantation to another site, since staff would be lost in the move and staff teams destroyed.

d. The results of this survey are a compelling influence on Hillingdon CHC in its rejection of the Review's recommendation to move the Cancer Centre away from Mount Vernon. The views of patients and their carers should be a central consideration in all such recommendations.

4 Retention of Mount Vernon as a possible ambulatory centre

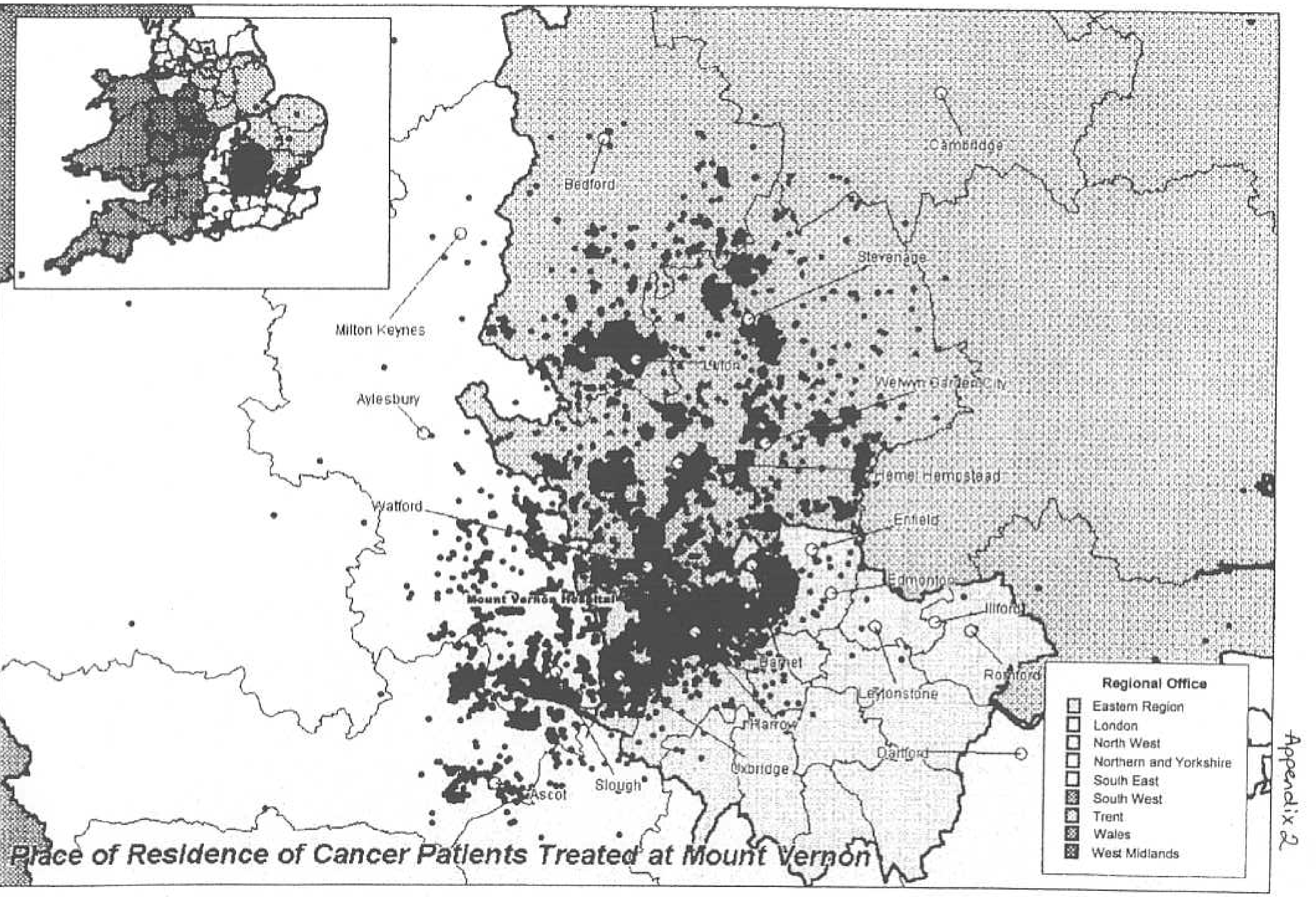
a. We recognise that, if the Cancer Centre is moved elsewhere, the retention of limited radiotherapy services on site would benefit some local people.

b. Serious consideration should be given to the enhancement of the ambulatory centre proposals in the Review's Final Report, by the inclusion of more extensive services

To reiterate, we are unable to endorse the Review's findings and we accordingly issue this minority report. However we welcome the Report's acknowledgement that the Mount Vernon Cancer Centre is desperately in need of remedial action to address its immediate needs, after years of neglect, and we hope that implementation of support proposals will be swiftly confirmed.

Joan Davis, Vice Chairman

Appendix 2



Place of Residence of Cancer Patients Treated at Mount Vernon

65 Belmont Road, Uxbridge, Middlesex UB8 1QT
Tel: 01895 257858 Fax: 01895 813300
e-mail: staff@hill-chc.fsnet.co.uk

Chairman:

Chief Officer:

29 August, 2002

Dear Mount Vernon Cancer Centre Stakeholder,

"Report 3, Mount Vernon Long Term Review, Evidence in Support of the Clinical Model",

The above report, which was published as a supplementary paper in support of the final recommendations of the Long Term Review of the Mount Vernon Cancer Network and Centre, raised various statistical issues. In response to our request for help with these statistics, Professor Mervyn Stone has kindly sent us his appraisal of the report.

Professor Stone is highly critical of Report 3 and his conclusions seriously undermine the recommendations of the Long Term Review. He states that Report 3 is both misleading and deceptive. His detailed analysis is erudite and academic, but his summary conclusions are simple:

- "The case is made that Report 3 misinterprets and misrepresents the research studies on which it relies.
- The report should therefore be rejected as evidence on which to base decisions about the future of the Mount Vernon Cancer Centre".

We believe these charges are so serious that Professor Stone's analysis should be made available to all those concerned with the future of the Mount Vernon Cancer Centre. We are therefore circulating this paper widely, guided by the distribution list of the Review's Final Report. A full distribution list is available on request.

Professor Stone is emeritus professor of statistics in the Department of Statistical Science of University College London. He has worked since 1955 in the theory of probability and statistics and its application to a wide range of subjects, including clinical trials and medical research.

In his criticism of Report, 3 Professor Stone invites referral of his assessment to the highest statistical authorities in the UK. His views cannot lightly be ignored.

Yours sincerely,

Maggie Ditchburn

Maggie Ditchburn
Chairman

Enclosed
A critical appraisal of "Supplementary Report 3'of the Mount Vernon Long Term Review Evidence in Support of the Clinical Model" - by Professor Mervyn Stone

A critical appraisal of "Supplementary Report 3 of the Mount Vernon Long Term Review: Evidence in Support of the Clinical Model"

Summary.

The case is made that Report 3 misinterprets and misrepresents the research studies on which it relies. The report should therefore be rejected as evidence on which to base decisions about the future of the Mount Vernon Cancer Centre.

1. Introduction.

Para. 3.9 of Report 3 comes to the conclusion that:

"The *evidence is strong* [my emphasis] that high quality care (adhering to best practice) normally found in hospitals with an oncology centre improves survival."

The Report draws its "evidence" for this conclusion from three sources:

(i) the 1996 Lancet paper of Selby et al (Sea) entitled "Benefits from specialised cancer care";

(ii) the 2000 British Journal of Cancer paper of Stockton & Davies (S&D) entitled "Multiple cancer site comparison of adjusted survival by hospital of treatment: an East Anglian study";

(iii) an extension of the S&D study to deal with the data for a further 3 years.

Ignoring the bit of the Report's conclusion that is tautologically indisputable, the rest has a ring of commonsense: it must be the case that oncology centres generally have better knowledge and wider experience in the treatment of cancers than less specialised hospitals. However, the Report's conclusion is paradoxically also:

(i) misleading when it is associated, as Report 3 does associate it, with the claim in the Report's para.3.2 that specialised centres were *"never detrimental"* (a claim that misinterprets Sea and that remains unproven);

(ii) deceptive and misleading when it purports (as it clearly does) to be a valid inference from the East Anglian data studied by S&D or from the later analysis of the data for 1998-2000.

Even without the deceptive element in (ii), there would be a strong case for the rejection of Report 3 and its replacement by something that gave a faithful account of what Sea really says. With the element of deception, however, the case for rejecting the report is unanswerable. This charge is not made lightly since it reflects on the competence of those who prepared and offered the report as a contribution to the debate about the future of the Mount Vernon Network. The following paragraphs will explain and justify the basis of the charge in the non-technical language that participants in the Review might expect—even if it takes more space to do that.

2. What Selby et al (Sea) really say and how Report 3 is misleading about it.

2.1 Sea firmly supports the claim that specialisation in larger hospitals helps with survival —but with the implicit caveat of *"other things being equal"*. If, for example, a large "green field" hospital were unable to manage its cleaners properly then its specialist surgery might look bad (or if, as in the Bristol Hearts affair, its specialist surgeons lacked the necessary experience!). The qualification is easily overlooked.

2.2. The paper adopts the scientifically necessary "meta-analytic" approach in which each study is given the weight of a single this-or-that-way contribution to the question at issue. It summarises the findings of a wide range of studies (in which the individual biases could go this way or that) and judges that the evidence as a whole goes in the direction assumed by Calman-Hine. The review is scientifically acceptable because this judgement is presented in a reserved way with the "other

things being equal" caveat clearly in mind. In other words, the evidence goes in favour of specialised centres "on the balance of probabilities" rather than as "beyond reasonable doubt".

2.3. By contrast, Report 3 is misleading when it interprets Sea as saying that "All the evidence indicated that *specialised cancer centres* [my italics] either improved survival or made no difference, but were never detrimental." In its conclusions, Sea explicitly refers to a 1994 review paper (Stiller,C.A., Br.J.Cancer, **70**, 352) with the comment that "Stiller has noted that no *study* [my italics] has ever shown a disadvantage from management in a specialised centre for any cancer." I have used the italics here to emphasise the salient point that Report 3's phrase "never detrimental" has to be applied not to individual centres but, rather awkwardly, to the summary findings of studies in which the information from centres has been pooled or averaged. Within any study, particular specialised centres might be doing badly even though the study on the whole speaks in favour of such centres.

2.4. Judging whether an individual study speaks in favour of specialised centres can be a delicate business. One of the studies mentioned in Sea's Lancet review is the 1991 population study on lung cancer by Greenberg et al entitled "Cancer staging may have different meanings in academic and community hospitals" (J.Clin.Epidemiology, 44, 505). This study compared the two university hospital centres with the unspecified number of "community centres" that in combination serve the population of two states of the USA.
The central message of the paper was that, for a majority of the 1658 patients (the 82% that had non-small-cell tumours), there was nothing more than very weak evidence in favour of cancer centres when staging bias was removed by using "performance" or "functional status" to assess the condition of patients instead of their stage "Survival differences between patients diagnosed in university and community hospitals were exaggerated when stage was included in the analysis, because the biased stage data obscured the generally worse condition of community hospital patients at the time of diagnosis." In the corrected analysis, the data still showed a slight tilt in favour of centres, which was enough to justify Sea counting the study as one more item on the scales in favour of specialised centres and to account for the "may" in their only comment on the study—that it showed "university and cancer centres in the USA may achieve better long-term outcomes". However it might have been more informative to have described this study as *inconclusive* rather than favouring either centres or community hospitals—and hence not as one to be classed as "detrimental" to community hospitals. Perhaps Sea (and Report 3) should have asked how many of the studies considered were inconclusive for the question at issue, rather than being merely "non-detrimental" to specialised centres.

3. How Report 3 is deceptive about what the Stockton & Davies (S&D) paper should have told us.

3.1. S&D's study was "a preliminary investigation into which hospitals would benefit from investment and development, and which should have services restricted, with respect to the implementation of the Calman-Hine strategy of specialised cancer care." The hospitals were the three with radiotherapy and oncology departments (Group 1: specialised) and the six without (Group 2: non-specialised). The patients in the final analysis were the 14,527 with one of six common cancers diagnosed in 1989-1993 and satisfying some minimal inclusion criteria including follow-up for 5 years.

3.2. For each of the six cancer sites and for patients aged under and over 75 separately, the survival records of the patients in Groups 1 and 2 were compared under an assumption of the sort that is needed to apply Cox's proportional hazards regression model. This is that a randomly selected patient in Group 2 has x times the probability of death of a randomly selected patient in Group 1, when the (necessarily conceptual) comparison is made the same number of days from diagnosis (whatever that number) and when the two patients are of the same sex, are in the same 10-year-age-band, and have the same standardized stage at diagnosis. The unspecified numerical x in this comparison is the *hazard ratio*. If x were 1.2 (as the central estimate appears to be for the breast cancer cases under 75 in S&D's Figure 1), that would mean, according to the model, that a woman at one of the non-specialised hospitals has a 20% higher probability of death at any time (up to 5

years) than a woman, in the same age band and at the same stage, at one of the specialised hospitals.

3.3. Statistical regression technique allows x to depend explicitly on age-band, stage, and (where relevant) sex, and in so doing makes an adjustment for different 'case mixes' that would otherwise potentially bias the survival comparison. Although there is some choice in the formulation of this adjustment, the widespread use of the proportional hazards model indicates that its application is considered helpful in reducing the likely bias of any unadjusted comparison.

3.4. S&D gave 95% confidence intervals for the hazard ratio x for the $12 = 6\times2$ comparisons of Groups 1 and 2. For these comparisons, the data were analysed without consideration of which of the hospitals in their group patients were in. Such pooling is usually ill-advised since it neglects to take account of differences between hospitals within the same group. S&D acknowledge that there were wide differences of this sort (as is usually found to be the case). They justify the pooling on the grounds that "when the results are pooled, these variations must lose their impact". They could have been more precise about the two conditions under which their confidence intervals are scientifically acceptable:

Condition 1: *The particular assumption* (in my para.3.2) *that underlies S&D's comparison of Groups 1 & 2 would hold true for the comparison of any pair of the nine hospitals.* With this condition, S&D's hazard ratio x (from the group comparison) is the ratio of weighted combinations of the individual hospital probabilities of death with weights given by the proportions of patients in the hospitals within each group. This would be a sensible parameter of interest for what S&D call 'local purposes'.

Condition 2: *Interest is confined to the East Anglian population served by the nine particular hospitals in the S&D study.*

3.5. If, however, the question of interest was more general than local, namely, how far the S&D findings (that clearly do favour specialized hospitals) can be generalized to some larger populations of specialized and non-specialized hospitals, in the sense considered by Calman-Hine, then the S&D confidence intervals are manifestly defective. They take no account of the unanalysed variation between hospitals within each of the two groups. The size of this variation would determine the maximal confidence that could be given to any support for the Calman-Hine principle from the comparison of the three specialised hospitals in group 1 with the six general hospitals in group 2. The fact that S&D concede that the data show "wide variation" in the performance of individual hospitals does suggest that the strength of that support may be little more than a tilt in the balance of the sort referred to in my para.2.4. In short, the significance levels (asterisks and P-values) in S&D's Figure 1 cannot be taken as relevant to the question of generalised inference.

3.6. The S&D paper appears to be thoroughly confused on this question. It suggests that the quality of the Eastern Region Cancer Registry data overcomes any previous tentativeness about the evidence for Calman-Hine. It is even dismissive of Sea when it observes that "it is inevitable that evidence from many different studies is not consistent in definitions of specialization and case mix, and that the information available on variables is likely to affect apparent outcome", before claiming that its own study "using routinely collected cancer registration data, has uniform definitions and *it is clear which tumours are more successfully treated in specialized hospitals* [my emphasis], taking into account stage as the indicator of case mix." S&D's final paragraph, however, does contain a seed of doubt: "The health authorities who have received this information are naturally hesitant to take dramatic action based on this information alone, but nevertheless it does lend more support to the view that the strategy proposed in the Calman-Hine report is likely to be beneficial."

3.7. A benign view can be taken of the S&D paper if we stick with its final paragraph—and ignore its attempt to represent its findings in favour of Calman-Hine as strong, much stronger than the alleged weaker pretensions of Sea. It would be difficult to take the same view of Report 3, whose *raison d'etre* is clearly revealed in its conclusion already quoted i.e. to represent the findings of its further application of the S&D methodology as strong, generalisable evidence in favour of Calman-Hine

—which it cannot be.

3.8. Report 3 is remarkable not only for the *non sequitur* character of its conclusion, but even as a contribution to the "local purposes" of S&D:

(a) Its Table 1 presents the good news that the survival statistics of East Anglian patients diagnosed in 1998-2000 were better than those for 1989-93 —without looking at the data for patients diagnosed in 1994-97 and without splitting the data into the two groups in question.

(b) Its Table 2 shows that for the new patients there are now no significant "local purpose" differences between Group 1 and Group 2 to match those presented by S&D as evidence in favour of specialised centres. (Report 3 does not comment on the contradiction between this and its "evidence is strong" conclusion).

4. In short, Report 3 appears to be little more than superficial hype deployed in support of a thesis whose complexity requires a much more delicately shaded analysis, taking account if possible of a range of influential factors.

5. I hope that any reader so far will have been persuaded by the explanations and arguments given here. For those who may have residual doubts as to whether this critique of Report 3 can be trusted and who would like their doubts to be resolved, I can offer only one suggestion—an appeal to wider or greater authority! The S&D paper makes a mis-spelt acknowledgement to Dr David Spiegelhalter of the MRC Biostatistics Unit, Cambridge, who was the statistical advisor to the Bristol Hearts inquiry: I cannot believe that he would support any claim that the S&D findings (without analysis of an individual hospital factor) give *strong* support to the Calman-Hine principle. An even higher authority would be Professor Sir David Cox of Nuffield College, Oxford, (the originator of the statistical technique used in S&D and in Report 3)—who has indicated that he would be willing to comment on the issue to those concerned (presumably the Bedfordshire & Hertfordshire Strategic Health Authority).

Mervyn Stone, Department of Statistical Science, UCL.

David Spiegelhalter PhD CStat
Senior Scientist

Appendix 4

Biostatistics Unit

Ms J Fenelon
NHS Eastern Regional Office
Capital Park
Fulbourn
Cambridge
CB1 5XB

April 29, 2003

Dear Ms Fenelon,

Report of the Long Term Reviews of Mount Vernon Cancer Centre

Thank you very much for your letter of 7th February, and we are very sorry for the delay in replying.

Comments on Supplementary Report 3

- We first consider a somewhat technical, but important, statistical issue. Both Stockton and Davies (2000) and Table 2 of the Supplementary Report 3 compare survival in hospitals with and without specialist cancer centres. In both cases the comparisons appear to be based on pooling all patients in each group, in effect comparing (using an estimated hazard ratio) all those in a composite 'specialist hospital' with a composite 'non-specialist' hospital. The resulting intervals of possible error for the hazard ratio therefore appear to ignore an important component of variation: the inevitable variability in outcome between individual specialist, and between individual non-specialist, hospitals. Stockton and Davies acknowledged that this variability was substantial. The quoted intervals for the statistical error are therefore too narrow (by an unknown amount) and therefore tend to overstate the evidence for the differences between centres found in Stockton and Davies (2000).
- Supplementary Report 3 does not make much use of Stockton and Davies (2000), and instead states in Table 2 that "Recent data indicate there are now no significant survival differences between centres and DGHs (under 75 only)". This conclusion is further somewhat spuriously strengthened by the intervals being too narrow.
- Supplementary Report 3 concludes that "The evidence is strong that high-quality care (adhering to best practice) normally found in hospitals with an oncology centre improves

MRC Biostatistics Unit
Institute of Public Health
University Forvie Site
Robinson Way
Cambridge CB2 2SR
U.K.

Tel: +44 (0)1223 330373
Fax: +44 (0)1223 330388
E-mail: david.spiegelhalter@mrc-bsu.cam.ac.uk

survival". It appears at first that this contradicts the evidence presented in Table 2. However, we note the use of 'normally', which does not rule out these standards being applied in non-specialist hospitals. In order for there not to be a contradiction between the conclusion of the Supplementary Report, and the evidence presented in Table 2, one should presumably conclude that care has improved, but this high-quality care is not necessarily limited to specialist hospitals.

Comments on the Final Report

- The Final Report does not appear to have made much use of Supplementary Report 3, nor made explicit claims that proposed changes would improve survival. Our previous conclusion, that Supplementary Report 3 does not in itself provide strong evidence for future survival benefits in specialist centres, therefore appears of limited relevance when it comes to examining the basis for the strategic decision being proposed.
- The Final Report has instead relied strongly on Calman-Hine and guidance documents. The basis for Calman-Hine and subsequent guidance goes way beyond the evidence provided in Supplementary Report 3, and a detailed critique would require an extensive research exercise using modern data sources. This is beyond our remit.

Conclusions

Supplementary Report 3 does not, in itself, provide good evidence for future improved survival in specialist centres, but this issue does not appear to be a crucial feature in the Final Report. Questioning the whole basis for Calman-Hine and subsequent guidance is a major undertaking, particularly as those recommendations have received widespread professional support.

Perhaps the most important criticism that can be made is to ask whether the review has followed Calman-Hine too inflexibly and not allowed for 'local factors'.

We apologise again for the delay and hope our comments may still be useful.

Yours sincerely,

Dr David Spiegelhalter Professor Sir David Cox

MOUNT VERNON CANCER CENTRE
PATIENT SURVEY

Summary

1. The survey took place over 14 days in November 2001 in the Mount Vernon Cancer Centre. Participants were contacted in the waiting room of the Chemotherapy Suite, the Lynda Jackson Macmillan Centre and the Paul Strickland Scanner Centre.

2. 472 responses were received. 76% of the participants were patients, 24% were members of the public escorting patients.

3. Participants represented a variety of areas: 17% from Eastern Region (North), 32% from Eastern Region (South), 41% from London Region, 10% from South Eastern Region and 1% from other regions. (See p.6 for the differentiation of Eastern Region into North and South areas.)

4. 20% of respondents were new patients (having visited the Cancer Centre once or twice), 55% were established patients. 25% were escorting patients.

5. The majority of patients (74%) had the choice of Mount Vernon made for them by their doctor.

6. The majority of patients (77%) rated the Cancer Centre service as "excellent" and a further 20% rated it as "good".

7. The Paul Strickland Scanner Centre, the Lynda Jackson Macmillan Centre, the Marie Curie clinical research, academic research at the Gray Laboratory and Chart Lodge hostel were very highly valued by those patients who were aware of them.

8. A high proportion of patients in London Region and Eastern Region (South) have short journeys to Mount Vernon. A very high proportion (82%) in all regions accept one hour as a reasonable journey time.

9. 90% of respondents expressed a strong preference for developing the Cancer Centre at Mount Vernon and this preference applied to respondents from all regions. 84% of respondents thought it very important that surgery and oncology should be together on one site.

10. 46% of respondents thought it was very important that the Cancer Centre should be in a big hospital with many support services.

11. The majority of respondents (67%) thought it was very important to have academic research on the Cancer Centre site.

12. 63% of respondents are not prepared to accept the loss of local services to improve Cancer Centre services.

13. 48% of London region respondents chose transfer to a South Hertfordshire hospital as their first choice if Mount Vernon Cancer Centre closed, with 47% preferring a London hospital. A significant number gave London as their least favoured option.

55 Belmont Road, Uxbridge, Middlesex UB8 1QT
Tel: 01895 257858 Fax: 01895 813300
[illegible]

Chairman: Mrs M Ditchburn

Chief Officer: Ms P Miller

Jennifer Fenelon
Eastern Regional Office
Capital Park
Fulbourn
Cambridge, CB1 5XB

6 December 2001

Dear Ms Fenelon,

Response to the Preliminary Report of the Long Term Review of Mount Vernon Cancer Network and Centre

Thank you for your letter of 30th November 2001. With regard to our previous submission of 29th November 2001, we have now finished the Cancer Centre patient survey and have pleasure in enclosing the final report for the January meeting of the Review Group.

The final report is based on the views of 472 respondents, an increase of some 30% over the previous sample. The previous findings were endorsed by the larger sample, with figures deviating usually only by 1%, or at most 2%. Summarising the main findings:

- 90% of respondents preferred the development of the Mount Vernon Cancer Centre rather than build a new hospital on a greenfield site or developing a district general hospital.

- 98% of respondents from North West London want their cancer treatment to stay at Mount Vernon. However, if the Cancer Centre was to close, 48% would prefer to be transferred to South Hertfordshire and 47% to a London hospital.

- 82% of respondents regarded an hour as an acceptable journey time to travel for treatment, with 31% prepared to travel even longer.

We trust that the views of patients will be influential in the Review Group's deliberations, in accordance with current Government policy.

Yours sincerely,

P. Miller

Patricia Miller
Chief Officer

Appendix 6

Future plans for the
MOUNT VERNON CANCER CENTRE

A public opinion survey about the proposals issued for public consultation in 2003

Published by Hillingdon Community Health Council
August 2003

Mount Vernon Cancer Centre:

Public Opinion Survey, 2003

CONTENTS

Page

1. Summary
2. Responses table
3. Home areas of survey respondents
4. Postcodes of survey respondents
5. Question 1. Who should the Cancer Centre serve?
6. Question 2. Which SHA should decide the future of the Cancer Centre?
7. Question 3. Should Mount Vernon Cancer Centre and Herts. acute services be joined into one consultation?
8. Question 4. Do you accept that the Mount Vernon Cancer Centre should be moved off its present site?
9. Question 5. Please indicate any additional information you would find helpful.
   a. Statistics comparing Mount Vernon with other cancer centres
   b. Evidence that moving other cancer centres has improved patients' survival rates
   c. Other information requested
10. Question 6. Should Mount Vernon be a site option in the consultation?
11. Question 7. If there were three options for the Cancer Centre, which would you choose?
12. Question 8. Would a satellite radiotherapy unit at Mount Vernon be satisfactory?
13. Question 9. Should there be an anonymous staff survey, to find out how many would be willing to move?
14. Question 10. Should research be a major factor in deciding the Cancer Centre's future?
15. Question 11. Where should the Plastic Surgery Centre be sited?
16. Copy of the survey form

Hillingdon Community Health Council thanks all those who participated in this survey by distributing the forms, answering the questions, or assisting in other ways. Without the help received, this survey could not have taken place.

MOUNT VERNON CANCER CENTRE
PUBLIC OPINION SURVEY

Published by Hillingdon Community Health Council August 2003

Summary

1. The survey took place between April and July 2003. It was distributed at public meetings, churches, doctors' surgeries, Mount Vernon Hospital and a supermarket, and also by CHCs, community associations, Community Voice, and residents' associations.

2. Hillingdon CHC did not have the resources to control the sample to make it statistically representative, but outcomes are highly indicative of the views of the public in the densely populated area surrounding the Mount Vernon Cancer Centre, where the majority of survey respondents reside.

3. The total number of survey respondents was 1108. 48% came from Hillingdon, 23% from Harrow, 21% from Hertfordshire; 2% did not indicate their home area, except in some cases by postcode (which cannot be used to identify the above areas, because postcodes cross county boundaries). The 234 Hertfordshire residents came mainly from South West Hertfordshire, from postcode areas WD19 (93 responses) and WD3 (41 responses). Hillingdon CHC did not have the resources to extend the survey further north or east.

4. The body of this report analyses the responses according to home area of the respondents but a full analysis of responses by postcodes is available on request. In this summary, percentages refer to the whole sample of 1108 responses.

5. There was a very high degree of agreement amongst participants on the following issues:
   - 91% wanted the Cancer Centre to continue to serve its present population (5% did not respond)
   - 79% wanted the Cancer Centre's future to be decided by all surrounding SHAs, not just Beds & Herts SHA (6% did not respond)
   - 93% did NOT agree that the Mount Vernon Cancer Centre should move (3% did not respond)
   - 95% thought Mount Vernon should have been included in the consultation as a site option for the Cancer Centre (2% did not respond)
   - 96% wanted the Cancer Centre to stay at Mount Vernon, in preference to Hemel Hempstead or Hatfield (1% did not respond)
   - 95% did NOT regard residual cancer services at Mount Vernon as a satisfactory replacement for the Cancer Centre (1% did not respond)
   - 90% wanted an anonymous staff survey before decisions are made (3% did not respond)
   - 92% wanted research to be a major factor in deciding the Cancer Centre's future (2% did not respond)
   - 9% wrote notes that they wanted the Plastic Surgery Centre to stay at Mount Vernon – although this was NOT offered as an option!
   - 80% wanted statistics comparing Mount Vernon's results with other cancer centres

6. A number of responses volunteered appreciation for the work of the Cancer Centre and its staff.

Responses to all survey questions are reported and analysed in the main text, including those which became irrelevant during the consultation

Mount Vernon Cancer Centre: Public Opinion Survey 2003

SUMMARY OF RESPONSES TO HILLINGDON CHC QUESTIONNAIRE

Question No.	Question	Response	Response	Response
1	Who should the Cancer Centre serve ?	Its current population 91%	A smaller population, mainly from Hertfordshire 4%	
2	Which SHA should decide the future of the Cancer Centre ?	Beds. & Herts SHA 16%	All the surrounding SHAs e.g. Beds & Herts, NW London etc 79%	
3	Should Mount Vernon Cancer Centre and Hertfordshire acute services be joined into one consultation ?	A joint consultation is best 26%	There should betwo separate consultations 68%	
4	Do you accept that the Mount Vernon Cancer Centre should be moved off its present site ?	I agree that the Cancer Centre should move 4%	I do not accept that it should move 93%	
5	Please indicate any additional information you would find helpful.	Statistics comparing Mount Vernon's results with other cancer centres 60%	Evidence that moving other cancer centres has improved their patients survival rates. 44%	
6	Should Mount Vernon be a site option in the consultation ?	Yes 96%	No 2%	
7	If there were three options for the cancer centre, which would you choose ?	Leave it at M ount Vernon 96 %	Move it to Hemel Hempstead 1 %	Hatfield 2%
8	Would a satellite radiotherapy unit at Mount Vernon be satisfactory ?	Yes 4%	No 94%	
9	Should there be an anonymous staff survey, to find out how many staff would be willing to move ?	Yes 90%	No 7%	
10	Should research be a major factor in deciding the Cancer Centre's future?	Yes 92%	No 6%	
11	Where should the Plastic Surgery Centre be sited ?	Move it to Northwick Park 65%	Move it to Hertfordshire 13%	

HOME AREAS OF SURVEY RESPONDENTS

Bedfordshire & Hertfordshire SHA includes:
Bedfordshire
Hertfordshire
North West London SHA includes:
Brent
Harrow
Hillingdon
Thames Valley SHA includes:
Berkshire
Buckinghamshire

Home Area	Strategic Health Authority
Bedfordshire	Bedfordshire & Hertfordshire SHA
Berkshire	Thames Valley SHA
Brent	North West London SHA
Buckinghamshire	Thames Valley SHA
Harrow	North West London SHA
Hertfordshire	Bedfordshire & Hertfordshire SHA
Hillingdon	North West London SHA

Table showing actual survey numbers, by home areas

	Beds	Berks	Brent	Bucks	Harrow	Herts	Hillingdon	(blank)	Grand Total
Total	5	9	1	41	256	234	537	25	1108

Table showing survey home areas as % within the whole sample

	Beds	Berks	Brent	Bucks	Harrow	Herts	Hillingdon	(blank)	Grand Total
Total	0%	1%	0%	4%	23%	21%	48%	2%	100%

Comment

1. The survey was distributed at public consultation meetings, churches, doctors' surgeries, Mount Vernon Hospital, and a supermarket, and also by CHC's, community associations, Community Voice and residents' associations, in the period from April 2003 to July 2003.

2. Hillingdon CHC did not have the resources to make the sample statistically representative, so the results must be considered as merely indicative.

3. The survey sample comes mainly from areas close to Mount Vernon - limited resources prevented distribution of the survey over a wider area.

4. Analysis of the data can be by home areas or by postcdes on request; a separate sheet indicates the distribution of respondents by postcodes.

Summary of findings

1. The Majority of respondents came from Hillingdon (48%), Harrow (23%), or Hertfordshire (21%). 2% did not indicate their home area.

2. Totals by home area are different from totals by postcode because some respondents omitted to supply complete data. Of the 25 responses not showing home area, 8 also did not show postcode. Of those showing home area, 116 did not show postcode.

3. Some home areas had few respondents; all respondents will be included in totals , but detailed analysis and comments will generally be restricted to the three largest groups - Hillingdon , Harrow and Hertfordshire (which is mainly resident in South West Hertfordshire) .

Mount Vernon Cancer Centre: Public Opinion Survey, 2003

POSTCODES OF SURVEY RESPONDENTS

Area	Group															Group total	Area total
Beds & N. Herts		LU2	LU5	MK4	MK45	SG5	SG6	SG12									
		2	1	1	2	2	1	1								Total 10	Total 10
Mid & S. Herts	AL	AL1	AL2	AL3	AL4	AL5	AL9										
		1	1	1	2	3	2									Total 10	
	N	N12															
		1														Total 1	
	WD	WD	WD1	WD2	WD3	WD4	WD5	WD6	WD7	WD13	WD17	WD18	WD19	WD23	WD24		
		1	4	2	41	1	2	1	1	1	10	6	93	5	2	Total 170	
	HP	HP1	HP2	HP3	HP4												
		4	2	2	1											Total 9	Total 190
NW London	EN	EN4	EN5	EN6	EN11												
		1	9	4	1											Total 15	
	HA	HA1	HA2	HA3	HA4	HA5	HA6	HA7	HA8								
		7	41	19	207	210	65	8	4							Total 561	
	N & W	N20	NW4	W3	W7												
		1	1	1	1											Total 4	
	UB	UB3	UB4	UB5	UB6	UB7	UB8	UB9	UB10								
		11	64	7	1	12	27	19	32							Total 173	Total 753
Thames Valley	RG	RG2	RG5	RG7	RG9	RG42	RG45										
		1	1	1	1	1	1									Total 6	Total 6
	HP	HP5	HP6	HP7	HP9	HP13	HP14	HP16									
		5	3	7	2	1	2	1								Total 21	
	SL	SL2	SL3	SL4	SL6	SL9											
		1	1	1	1	12										Total 16	Total 37
Other SHA's and blank responses		SN10	SW1	TW3	TW4	Blank											
		2	1	1	1	107										Total 112	Total 112
																	Total 1108

Note: Postcodes do not co-incide with either county or SHA areas, so the above groupings of postcodes are merely indicative. Many survey forms did not show both home area and postcode - 8 forms showed neither. Therefore totals arrived at by postcode are not the same as totals arrived at by home area.

Mount Vernon Cancer Centre: Public Opinion Survey, 2003

Responses to Question 1. Who should the Cancer Centre serve?

Options: 1. Its current patient population 2. A smaller population, mainly from Hertfordshire

Table showing actual survey numbers, according to home areas

SHA	Area	Current population	Herts. population	(blank)	Grand Total
Beds. & Herts.	Hertfordshire	207	23	4	234
	Bedfordshire	5			5
North West London	Brent	1			1
	Harrow	234	4	18	256
	Hillingdon	493	14	30	537
Thames Valley	Berkshire	8	1		9
	Buckinghamshire	41			41
Not shown	(blank)	22		3	25
Grand Total		1011	42	55	1108

Table showing survey responses as % within each home area.

SHA	Area	Current population	Herts. population	(blank)	Grand Total
Beds. & Herts.	Hertfordshire	88%	10%	2%	100%
	Bedfordshire	100%	0%	0%	100%
North West London	Brent	100%	0%	0%	100%
	Harrow	91%	2%	7%	100%
	Hillingdon	92%	3%	6%	100%
Thames Valley	Berkshire	89%	11%	0%	100%
	Buckinghamshire	100%	0%	0%	100%
Not shown	(blank)	88%	0%	12%	100%
Grand Total		91%	4%	5%	100%

Comment:

This question was included because the consultation document issued by Beds. & Herts. SHA focused on the needs of its own population, rather than the needs of the current population served by the Mount Vernon Cancer Centre, which spans three Strategic Health Authorities .

Summary of findings

1. 91% of survey respondents wanted the Mount Vernon Cancer Centre to serve its current population rather than a smaller population, mainly from Hertfordshire. This view was closely consistent across all home areas.

2. 4% of all respondents wanted the needs of the Hertfordshire population to be the main consideration. However 10% of those from Hertfordshire held this view, which included 15% of the 93 respondents from postcode area WD19 - other postcodes had either too few respondents or too few responses in this category to allow useful conclusions.

3. 5% of responses were blank which could imply ambivalence, or uncertainty in understanding the question.

Mount Vernon Cancer Centre: Public Opinion Survey, 2003

Responses to Question 2. Which SHA should decide the future of the Cancer Centre?

Options: 1. Beds. & Herts SHA 2. All the surrounding SHAs

Table showing actual survey numbers, according to home areas

SHA	Area	Beds. & Herts SHA	All the surrounding SHAs	(blank)	Grand Total
Beds. & Herts.	Hertfordshire	105	122	7	234
	Bedfordshire	2	2	1	5
North West London	Brent		1		1
	Harrow	18	229	9	256
	Hillingdon	25	470	42	537
Thames Valley	Berkshire	4	5		9
	Buckinghamshire	10	31		41
Not shown	(blank)	3	17	5	25
Grand Total		167	877	64	1108

Table showing survey responses as % within each home area.

SHA	Area	Beds. & Herts SHA?	All the surrounding SHAs?	(blank)	Grand Total
Beds. & Herts.	Hertfordshire	45%	52%	3%	100%
	Bedfordshire	40%	40%	20%	100%
North West London	Brent		100%		100%
	Harrow	7%	89%	4%	100%
	Hillingdon	5%	88%	8%	100%
Thames Valley	Berkshire	44%	56%	0%	100%
	Buckinghamshire	24%	76%	0%	100%
Not shown	(blank)	12%	68%	20%	100%
Grand Total		15%	79%	6%	100%

Comment:
Beds. & Herts. SHA 's consultation proposals focused on its own population, which led to calls from the public in North West London for decisions about the future of the Mount Vernon Cancer Centre to be shared by all SHA's using its services.

Summary of findings:
North West London respondents were strongly in favour of all surrounding SHAs deciding the future of the Mount Vernon Cancer Centre, but only half of the Hertfordshire respondents preferred this option. Numbers of responses within individual postcodes were too small to identify geographic differences within Hertfordshire.

Mount Vernon Cancer Centre: Public Opinion Survey, 2003

Responses to Question 3. **Should Mount Vernon Cancer Centre and Herts. acute health services be joined into one consultation?**

Options 1. A joint consultation is best 2. There should be two separate consultations

Table showing actual survey numbers, according to home areas

SHA	Area	One consultation	Two consultations	(blank)	Grand Total
Beds. & Herts.	Hertfordshire	98	123	13	234
	Bedfordshire	2	3		5
North West London	Brent	1			1
	Harrow	54	188	14	256
	Hillingdon	111	392	34	537
Thames Valley	Berkshire	7	2		9
	Buckinghamshire	6	33	2	41
Not shown	(blank)	10	12	3	25
Grand Total		289	753	66	1108

Table showing survey responses as % within each home area.

SHA	Area	One consultation	Two consultations	(blank)	Grand Total
Beds. & Herts.	Hertfordshire	42%	53%	6%	100%
	Bedfordshire	40%	60%	0%	100%
North West London	Brent	100%	0%	0%	100%
	Harrow	21%	73%	5%	100%
	Hillingdon	21%	73%	6%	100%
Thames Valley	Berkshire	78%	22%	0%	100%
	Buckinghamshire	15%	80%	5%	100%
Not shown	(blank)	40%	48%	12%	100%
Grand Total		26%	68%	6%	100%

Comment:

1. Beds. & Herts. SHA consulted the public on its proposals for changes to acute health services in Herts, including the development of a new or expanded hospital at Hemel Hempstead or Hatfield. It was proposed that, whichever site became the major hospital, the Mount Vernon Cancer Centre should be moved there.

2. At public meetings in North West London, people objected to the future of the Cancer Centre, an inter-regional issue, being merged in one consultation with the relatively local issue of Hertfordshire's acute health services.

3. After this issue was referred to the Secretary of State by two Community Health Councils, North West London SHA consulted the public on its own proposals for cancer services at Mount Vernon, with the two consultations running in parallel.

Summary of findings

This question became redundant during the course of the survey, but responses are shown for interest. Interpreting the question caused difficulty for some respondents, particularly in the latter stages of the survey when the question had been overtaken by events, which may explain the range of responses.

Mount Vernon Cancer Centre: Public Opinion Survey, 2003

Responses to Question 4. **Do you accept that the MV Cancer Centre should be moved off its present site?**

Options 1. Yes - I agree that the Cancer Centre should move 2. No - I do not accept that it should move

Table showing actual survey numbers, according to home areas

SHA	Area	Yes	No	(blank)	Grand Total
Beds. & Herts.	Hertfordshire	34	194	6	234
	Bedfordshire	1	3		4
North West London	Brent		1	1	2
	Harrow	8	243	5	256
	Hillingdon	8	514	15	537
Thames Valley	Berkshire	1	8		9
	Buckinghamshire	1	40		41
Not shown	(blank)	3	18	4	25
Grand Total		56	1021	31	1108

Table showing survey responses as % within each home area.

SHA	Area	Yes	No	(blank)	Grand Total
Beds. & Herts.	Hertfordshire	15%	83%	3%	100%
	Bedfordshire	20%	60%	20%	100%
North West London	Brent	0%	100%	0%	100%
	Harrow	3%	95%	2%	100%
	Hillingdon	1%	96%	3%	100%
Thames Valley	Berkshire	11%	89%	0%	100%
	Buckinghamshire	2%	98%	0%	100%
Not shown	(blank)	12%	72%	16%	100%
Grand Total		5%	92%	3%	100%

Comment:
The Bed. & Herts. SHA consultation assumed that the Cancer Centre should move - keeping it at Mount Vernon was not a consultation option.

Summary of findings

1. 93% of all respondents did not want the Mount Vernon Cancer Centre to be moved, with the percentage higher in both Harrow (95%) and Hillingdon (96%).
2. Clearly Hertfordshire residents concurred in rejecting the proposal to move the Cancer Centre, but the percentage was lower, at 83%.
3. Examination of responses by postcodes showed that numbers were too small to identify significant geographic differences .

Responses to Question 5. **Please indicate any additional information you would find helpful**

In the first two sections of Question 5, participants had the option of ticking boxes, or leaving them blank

a) Statistics comparing Mount Vernon's results with other cancer centres
Table showing % of respondents requesting this data

Harrow	61%
Herts	62%
Hillingdon	61%
All participants	60%

b) Evidence that moving other cancer centres has improved patients survival rates
Table showing % of respondents requesting this data

Harrow	44%
Herts	48%
Hillingdon	42%
All participants	44%

c) Other information requested A wide range of questions and comments were noted; they were counted within topic areas.

Topics (generalised)	No.	Questions (generalised)	No.	Comments (generalised)
Survey validity	3	Views of users and families? (2)	4	Survey questions biased (2)
Consultation process	4	Various	4	All sceptical that the public is able to influence outcome
Cancer centre guidelines	20	Various concerning evidence	16	Change guidelines / meet guidelines
Preserve what is good	3	Evidence that moving the CC would improve services?	4	Various
SHA boundary issues	2	How would others cope without MV?	1	MV Cancer Centre should be under London control
Population factors	10	Various	7	More housing; population ageing; MV central for patients
New cancer centre + Mt.Vernon	0		13	Keep MV and build another in Herts.
Staffing issues	9	Views of staff?	5	Fear loss of staff (3); Service quality depends on staff (2)
Cost factors	17	Value of land?(4) What about equipment from charity?(5)	10	Various
Research factors	2	Effect on Gray? Effect of loss on Cancer Centre?	3	Concern about loss of research
Radiotherapy	0		2	Concern about long wait for treatment
Travel factors	30+	Distance? Extra public transport? More ambulances?	26	Concern about travel distance, public transport, cost
Praise for the Cancer Centre			40+	Notes of praise for the Cancer Centre were appended

Summary of findings

1. 60% of respondents wanted statistics comparing Mount Vernon with other cancer centres - a similar response from all areas
2. 44% of respondents wanted evidence that moving other cancer centres has improved patients' survival rates - a similar response from all areas.
3. Travel issues were the most common concerns - from roughly 3% of the whole sample.
4. Praise for the current service and staff was conspicuous. The form did not invite comments, but many respondents noted their appreciation in margins etc.

A more detailed list of questions and comments can be made available on request

Mount Vernon Cancer Centre: Public Opinion Survey, 2003

Responses to Question 6. **In this consultation, Mount Vernon is not one of the site options. Should it be included?**

Options: 1. Yes 2. No

Table showing actual survey numbers, according to home areas

SHA	Area	Yes	No	(blank)	Grand Total
Beds. & Herts.	Hertfordshire	217	11	6	234
	Bedfordshire	5			5
North West London	Brent	1			1
	Harrow	251	2	3	256
	Hillingdon	519	6	12	537
Thames Valley	Berkshire	8	1		9
	Buckinghamshire	40		1	41
Not shown	(blank)	17	5	3	25
Grand Total		1058	25	25	1108

Table showing survey responses as % within each home area.

SHA	Area	Yes	No	(blank)	Grand Total
Beds. & Herts.	Hertfordshire	93%	5%	3%	100%
	Bedfordshire	100%	0%	0%	100%
North West London	Brent	100%	0%	0%	100%
	Harrow	98%	1%	1%	100%
	Hillingdon	97%	1%	2%	100%
Thames Valley	Berkshire	89%	11%	0%	100%
	Buckinghamshire	98%	0%	2%	100%
Not shown	(blank)	68%	20%	12%	100%
Grand Total		95%	2%	2%	100%

Comment:

Mount Vernon was not offered as a site option for the Cancer Centre in either of the consultations, but the North West London consultation proposed that a Cancer Unit be developed on the same site, to replace the Cancer Centre.

Summary of findings

Very notable consistency in the responses, with 95% of the total sample indicating the view that Mount Vernon should have been offered as a site option.

Mount Vernon Cancer Centre: Public Opinion Survey, 2003

Responses to Question 7. **If there were three options for the Cancer Centre, which would you choose?**

Options:

1. Leave it at Mount Vernon
2. Move it to Hemel Hempstead
3. Move it to Hatfield

Table showing actual survey numbers, according to home areas

SHA	Area	Mount Vernon	Hemel Hempstead	Hatfield	(blank)	Grand Total
Beds. & Herts.	Hertfordshire	207	8	15	4	234
	Bedfordshire	4		1		5
North West London	Brent	1				1
	Harrow	253	2	1		256
	Hillingdon	533			4	537
Thames Valley	Berkshire	8	1			9
	Buckinghamshire	40			1	41
Not shown	(blank)	19	1	2	3	25
Grand Total		1065	12	19	12	1108

Table showing survey responses as % within each home area.

SHA	Area	Mount Vernon	Hemel Hempstead	Hatfield	(blank)	Grand Total
Beds. & Herts.	Hertfordshire	88%	3%	6%	2%	100%
	Bedfordshire	80%	0%	20%	0%	100%
North West London	Brent	100%	0%	0%	0%	100%
	Harrow	99%	1%	0%	0%	100%
	Hillingdon	99%	0%	0%	1%	100%
Thames Valley	Berkshire	89%	11%	0%	0%	100%
	Buckinghamshire	98%	0%	0%	2%	100%
Not shown	(blank)	76%	4%	8%	12%	100%
Grand Total		96%	1%	2%	1%	100%

Comment:
Mount Vernon was not offered as a site option for the Cancer Centre in either of the public consultation documents.

Summary of findings
96% of the sample wanted Mount Vernon Cancer Centre to remain on its current site; this overwhelming support was endorsed by respondents from all home areas.

Responses to Question 8. Would a satellite radiotherapy unit at Mount Vernon be satisfactory?

Options: 1. Yes - satisfactory 2. No - unsatisfactory

Table showing actual survey numbers, according to home areas

SHA	Area	Yes	No	(blank)	Grand Total
Beds. & Herts.	Hertfordshire	22	206	6	234
	Bedfordshire	1	4		5
North West London	Brent		1		1
	Harrow	5	251		256
	Hillingdon	15	515	7	537
Thames Valley	Berkshire	1	8		9
	Buckinghamshire		41		41
Not shown	(blank)	2	21	2	25
Grand Total		46	1047	15	1108

Table showing survey responses as % within each home area.

SHA	Area	Yes	No	(blank)	Grand Total
Beds. & Herts.	Hertfordshire	9%	88%	3%	100%
	Bedfordshire	20%	80%	0%	100%
North West London	Brent	0%	100%	0%	100%
	Harrow	2%	98%	0%	100%
	Hillingdon	3%	96%	1%	100%
Thames Valley	Berkshire	11%	89%	0%	100%
	Buckinghamshire	0%	100%	0%	100%
Not shown	(blank)	20%	80%	0%	100%
Grand Total		4%	94%	1%	100%

Comment:

1. The Beds. & Herts SHA proposal was to leave a satellite radiotherapy unit on the Mount Vernon site, led by radiotherapists, under direction and remote control from the Cancer Centre at either Hemel Hempstead or Hatfield. At the start of this survey, that was the only option offered.

2. Subsequently, North West London SHA proposed developing a Cancer Unit on the site, subject to proposed viability studies - this offered the possibility of a wider range of services including possibly some chemotherapy.

3. In view of the above, respondents completing the form at different points in the survey had different options on offer. This makes the outcome of this question of limited value, but data is shown for interest.

Summary of findings

Despite the above limitations, there was clearly no enthusiasm for reduction of services on the Mount Vernon site, with 94% considering that unsatisfactory.

Responses to Question 9. Should there be an anonymous staff survey, to find out how many staff would be willing to move?

Options: 1. Yes 2. No

Table showing actual survey numbers, according to home areas

SHA	Area	Yes	No	(blank)	Grand Total
Beds. & Herts.	Hertfordshire	211	20	3	234
	Bedfordshire	5			5
North West London	Brent	1			1
	Harrow	230	21	5	256
	Hillingdon	487	32	18	537
Thames Valley	Berkshire	8	1		9
	Buckinghamshire	38	2	1	41
Not shown	(blank)	22	2	1	25
Grand Total		1002	78	28	1108

Table showing survey responses as % within each home area.

SHA	Area	Yes	No	(blank)	Grand Total
Beds. & Herts.	Hertfordshire	90%	9%	1%	100%
	Bedfordshire	100%	0%	0%	100%
North West London	Brent	100%	0%	0%	100%
	Harrow	90%	8%	2%	100%
	Hillingdon	91%	6%	3%	100%
Thames Valley	Berkshire	89%	11%	0%	100%
	Buckinghamshire	93%	5%	2%	100%
Not shown	(blank)	88%	8%	4%	100%
Grand Total		90%	7%	3%	100%

Comment:

1. In public meetings there was often reference to the reluctance of staff to move away from Mount Vernon, but this was not backed by any published evidence.

2. Public concern focused on the value of retaining established clinical teams and the difficulty of finding alternative staff.

Summary of findings

90% of respondents wanted an anonymous survey to explore the views of the Mount Vernon Cancer Centre staff ; this was echoed across all home areas.

Responses to Question 10. Should research be a major factor in deciding the Cancer Centre's future?

Options: 1. Yes 2. No

Table showing actual survey numbers, according to home areas

SHA	Area	Yes	No	(blank)	Grand Total
Beds. & Herts.	Hertfordshire	209	23	2	234
	Bedfordshire	4		1	5
North West London	Brent	1			1
	Harrow	241	11	4	256
	Hillingdon	494	29	14	537
Thames Valley	Berkshire	8	1		9
	Buckinghamshire	40	1		41
Not shown	(blank)	21	2	2	25
Grand Total		1018	67	23	1108

Table showing survey responses as % within each home area.

SHA	Area	Yes	No	(blank)	Grand Total
Beds. & Herts.	Hertfordshire	89%	10%	1%	100%
	Bedfordshire	80%	0%	20%	100%
North West London	Brent	100%	0%	0%	100%
	Harrow	94%	4%	2%	100%
	Hillingdon	92%	5%	3%	100%
Thames Valley	Berkshire	89%	11%	0%	100%
	Buckinghamshire	98%	2%	0%	100%
Not shown	(blank)	84%	8%	8%	100%
Grand Total		92%	6%	2%	100%

Comment:
In public meetings, representatives of the Gray Cancer Institute stated that it would not be willing to move to Hertfordshire and that its research would be damaged if the Cancer Centre moved off the Mount Vernon site.

Summary of findings
92% of respondents considered that research should be a major factor in deciding the Cancer Centre's future, which was echoed across all home areas.

Mount Vernon Cancer Centre: Public Opinion Survey, 2003

Responses to Question 11. **Where should the Plastic Surgery Centre be sited?**

Options: 1. Move it to Northwick Park 2. Move it to Hertfordshire 3. *(Mt. Vernon was NOT an option - but some replies wrote it in, which was recorded)*

Table showing actual survey numbers, according to home areas

SHA	Area	Northwick Park	Hertfordshire	*Mount Vernon*	(blank)	Grand Total
Beds. & Herts.	Hertfordshire	84	99	18	33	234
	Bedfordshire	1	2		2	5
North West London	Brent	1				1
	Harrow	196	12	21	27	256
	Hillingdon	401	15	62	59	537
Thames Valley	Berkshire	4	2		3	9
	Buckinghamshire	23	5		13	41
Not shown	(blank)	13	6	1	5	25
Grand Total		723	141	102	142	1108

Table showing survey responses as % within each home area.

SHA	Area	Northwick Park	Hertfordshire	*Mount Vernon*	(blank)	Grand Total
Beds. & Herts.	Hertfordshire	36%	42%	8%	14%	100%
	Bedfordshire	20%	40%	0%	40%	100%
North West London	Brent	100%	0%	0%	0%	100%
	Harrow	77%	5%	8%	11%	100%
	Hillingdon	75%	3%	12%	11%	100%
Thames Valley	Berkshire	44%	22%	0%	33%	100%
	Buckinghamshire	56%	12%	0%	32%	100%
Not shown	(blank)	52%	24%	4%	20%	100%
Grand Total		65%	13%	9%	13%	100%

Comment:

1. Previous public consultation on the future of the Mount Vernon Plastic Surgery Centre, some years ago, resulted in a decision that it be moved to Northwick Park Hospital, but no date was set for implementation.

2. The Plastic Surgery Centre has always worked closely with the Cancer Centre, with which it is co-sited at Mount Vernon; both are the responsibility of Beds. & Herts. SHA. That SHA's proposal to move the Cancer Centre included a brief reference to its intention to move the Plastic Surgery Centre with the Cancer Centre.

3. Hillingdon CHC and Harrow CHC jointly referred the Bed. & Herts. SHA's consultation to the Secretary of State, noting the SHA's proposal to move the Plastic Surgery Centre to Hertfordshire. In the Department of Health's reply, it was confirmed that the Plastic Surgery Centre will not move to Hertfordshire, the decision to move it to Northwick Park still stands and Beds. & Herts. SHA will in due course provide entirely new plastic surgery services at its major hospital in Hertfordshire.

4. This question was therefore relevant at the start of the survey period, but became irrelevant later. Respondents at different dates were therefore informed by differing factors and the outcome of the question is therefore of limited value, but the results are included for interest.

5. This question did not offer Mount Vernon as a site option for the Plastic Surgery Centre, as its future had already been agreed after public consultation. However, it became apparent, early in the survey period, that a number of respondents were writing notes on the form urging retention at Mount Vernon, so this fact was recorded.

Summary of findings

1. There was a clear difference in responses from the North West London area and those received from Hertfordshire - Northwick Park was preferred by 75% from Hillingdon and 77% from Harrow but only 36% from Hertfordshire, in comparison with 42% from that County who preferred a move to their area.

2. The most remarkable outcome is that 9% of respondents felt sufficiently strongly that the Plastic Surgery Centre should remain at Mount Vernon that they scored out the two options offered by the question and wrote a note favouring Mount Vernon instead.

Hillingdon Community Health Council Survey

Have your say on the future of the Mount Vernon Cancer Centre!

Bedfordshire & Hertfordshire Strategic Health Authority is consulting with the public on moving Mount Vernon Cancer Centre, in about ten years time, to an expanded hospital in Hemel Hempstead or to a new hospital in Hatfield. This follows a recommendation by the Long Term Review of the Mount Vernon Cancer Centre and Network that the Cancer Centre should be moved off the Mount Vernon site.

To have your say on these proposals, tick boxes below to show your views.

1. Knowing that just over half its current patients live in Hertfordshire, who should the Cancer Centre serve?
   Its current patient population? ☐ A smaller population, mainly from Hertfordshire? ☐
2. Which Strategic Health Authorities should make decisions about the future of the Cancer Centre?
   Beds. & Herts. SHA? ☐ All the surrounding SHAs e.g.Beds.& Herts, NW London etc ☐
3. Should Mount Vernon Cancer Centre and Herts. acute health services be joined into one consultation?
   A joint consultation is best ☐ There should be two separate consultations ☐
4. Knowing that the Cancer Centre cannot meet Government guidelines if it stays at Mount Vernon, do you accept that it should be moved off its present site?
   I agree that the Cancer Centre should move ☐ I do not accept that it should move ☐
5. Please indicate any additional information you would find helpful, or which might influence your views:
   Statistics comparing Mount Vernon's results with other cancer centres ☐
   Evidence that moving other cancer centres has improved their patients' survival rates ☐
   Other information ....

In this consultation, Mount Vernon is not one of the site options. Should it be included?
Yes ☐ No ☐

If there were three options for the Cancer Centre, which would you choose?
Leave it at Mount Vernon ☐ Move it to Hemel Hempstead ☐ Move it to Hatfield ☐

If the Cancer Centre moves away, Mount Vernon will still provide some radiotherapy - but no cancer doctors, nurses, or beds. Other Cancer Centre services will be at Hemel / Hatfield, or Hammersmith in London. Simple chemotherapy may be available at local hospitals e.g. Hillingdon. Is this satisfactory?
Yes ☐ No ☐

Some Cancer Centre staff say they would not move from Mount Vernon to Hemel Hempstead or Hatfield. This would break up staff teams and replacements could be hard to find. Should there be an anonymous staff survey, before decisions are made, to find out how many staff would be willing to move?
Yes ☐ No ☐

The Gray Cancer Institute has said it will not go to Hertfordshire and that its current research will end if the Cancer Centre is moved. Should research be a major factor in deciding the Cancer Centre's future?
Yes ☐ No ☐

Five years ago, after public consultation, it was agreed that Mount Vernon Plastic Surgery would move to Northwick Park Hospital, but this consultation paper proposes moving it to Herts. What is your view ?
Move it to Northwick Park ☐ Move it to Hertfordshire ☐

se tick where you live: Harrow ☐ Hillingdon ☐ Berks. ☐ Bucks. ☐ Herts. ☐ Postcode ☐

Please return, by 1st Aug 2003, to: Hillingdon Community Health Council, FREEPOST, (SCE6842), Uxbridge, UB8 1BR

South Harrow and Roxeth Residents' Association

Chairman : Mr J.Daymond, 3 Roxeth Grove, South Harrow 020 8864 1317
Secretary : Mr A. Hooper, 66 Wood End Avenue, South Harrow, HA2 8NT 020 8248 0616

20/8/2003

Professor Sir Ron De Witt
Chief Executive
North West London SHA
Victory House
170 Tottenham Court Road
London W1T 7HA

Dear Sir Ron,

I am writing on behalf of the Members of South Harrow and Roxeth Residents' Association and other residents in the South Harrow area. As indicated in my letter of 28/5/2003, we have a Membership of nearly 1,000 households in the South Harrow area.

Over the last few months many Members have taken part in the consultation process to consider the North West London Strategic Health Authority Paper -" Mount Vernon Hospital : The Future of Services for Cancer Patients".

Please find the enclosed formal response to the above Paper and hope that you will take it into consideration at your SHA Board meeting on September 23rd. I would formally like to thank members of your Board who have attended many meetings over the last few months in Hillingdon and Harrow. I appreciate it has been quite difficult at times.

I am copying several other people/ organisations who have been involved in the consultation and I would be willing to answer any questions which might arise from any recipient.

Yours sincerely,

Neville Hughes

Neville Hughes, President

cc Mr. Gareth Thomas, M.P., House of Commons, London SW1A 0AA
Mr. Tony McNulty, MP.,House of Commons, London SW1A 0AA
Bill Hamilton, F.A.O. Katherine Peddie, Room 359, County Hall, Bedford, Beds MK42 9AP
Heather Smith, Committee Administrator, L. B. Harrow Health & Social Care Committee
Sue McLellen, Harrow PCT., Grace House, Harrovian Business Village, Bessborough Road, Harrow.
Mr. Owen Cock, Vice Chairman, Harrow CHC, 2 Junction Road, Harrow

South Harrow and Roxeth Residents' Association

President: Mr N.Hughes, 8 Balmoral Road, South Harrow HA2 8TD (020 8422 5357)
Chairman: Mr J.Daymond, 3 Roxeth Grove, South Harrow HA2 8JG (020 8864 1317)
Secretary: Mr T. Hooper, 66 Wood End Avenue, South Harrow (020 8248 0616)

The following is the formal response on behalf of the Members of South Harrow and Roxeth Residents' Association to the North West London Strategic Health Authority Paper entitled :-

" MOUNT VERNON HOSPITAL : THE FUTURE of SERVICES for CANCER PATIENTS"

As President of South Harrow and Roxeth Residents' Association, (SHARRA), I have been requested to send to all the appropriate people/organisations the following response to the above Paper. These comments have been formulated following the attendance of local residents at public consultation meetings and also at two public SHARRA meetings when the issues were discussed in depth. In the opinion of the SHARRA Committee they represent the views of the vaste majority of Residents living in the South Harrow area.

As indicated above, these comments relate directly to the North West London Strategic Health Authority (NWLSHA), Paper. However, very careful consideration has also been given to the earlier Paper, "Investing in Your Health", submitted by the Bedfordshire and Hertfordshire Strategic Health Authority, (BHSHA).. Our views on that Paper were submitted in written evidence to the London Borough of Harrow Health and Social Care Scrutiny Sub-Committee and we are not making any further formal response. However, some aspects of the BHSHA Paper have received much debate in our area and the following response also includes references and comments on the BHSHA where it is relevant to Mount Vernon.

Before responding to the specific questions contained in the NWLSHA Paper, we believe it is extremely important to raise several issues which have given much concern and some of which may require wider debate.

1. Consultation Process.

The original BHSHA consultation Paper quite rightly set out to analyse the needs of their residents and make proposals which were appropriate to them. However, health needs and services can not and should not be determined by "political" boundaries. There is no disagreement that BHSHA may well need a Cancer Centre within their area but there was a clear disregard for patients in all the surrounding areas and the Paper gave a totally biased and unbalanced view of future options.

The Paper submitted by NWLSHA was very welcome but it only came about because of intervention by CHC's and the massive public response. We find it truly unbelievable that senior Management at NWLSHA could not have anticipated such a response. Over many years, we have seen much evidence of the difficulties which arise when multi Health areas are involved with change and there appears to be a major reluctance for

one area to disagree with another lead area. We appreciate also that much of the preparation and internal debate on the Mount Vernon future took place at a time of restructuring within the Regional Health services. This makes it even more important that the needs of all residents should be considered in a balanced way and the general response of professional staff and the public anticipated on key issues.

Our Members have been very critical of the apparent lack of publicity and location of public consultation meetings. This is not an easy problem to solve but it does require further detailed consideration before any future consultations.There appears to be too much dependence upon a single advertisement in the local Press which statistics will show is read by a low percentage of the population. The unfortunate timing of the Harrow public meetings is to be regretted but we appreciate the difficulties brought about by the compressed timescale. The first meeting was only a very short time after the start and the second is in a very poor location a few days before the end. The latter makes it impossible for an organisation like ours to respond to any debate or new issues raised.

We are extremely concerned about the confusion and lack of confidence in the whole consultation process arising from the demise of CHC's. Their key role has been demonstrated in this consultation. The role of the Scrutiny Committees of the London Boroughs is crucial at a time when Health Authorities have been revised and major decisions are being made which will have a profound impact on future health services. The London Borough of Harrow has made every effort to consult widely but many Members lack the background experience which was available in the CHC and which will take time to assimilate. We are extremely concerned about the Department of Health Directive of 17th July 2003. It is clearly impossible for a "one joint overview and scrutiny committee" representing all the authorities affected by Mount Vernon Cancer services to come to any agreed position. To insist that this Directive should apply to this consultation which is well advanced is clearly a nonsence and the basic concept should be reviewed. We strongly deplore the waste of time by many Council Members and Officers and are extremely concerned that Mount Vernon Cancer services are effectively a "guinea pig" for a new political organisation.

NWLSHA Paper - General Comments.

We welcomed the decision by NWLSHA to produce an alternative set of proposals for Mount Vernon Cancer services but strongly deplore their acceptance of the original timescale as determined by BHSLA. We fully appreciate the pressures on BHSLA to get approval for improvement to their acute services but once it is accepted that the BHSLA Paper"Investing in your Health" is unacceptable for Hillingdon and Harrow residents,(and other areas), it was essential to make totally independent proposals which reflected the needs and aspirations of London Borough residents. This clearly was not practicable within the timescale accepted by NWLSHA and the result is a Paper lacking in definitive proposals. It is full of "hopes" and "expectations" and residents and organisations like ours are being asked to comment on nebulous proposals. It is unrealistic to expect residents to approve initial proposals with statements at public meetings that this is only a first stage

of consultation and a series of "progress " documents will be produced in due course.

We welcomed the statement by NWLSHA that they would take over full responsibility for the specialist services at Mount Vernon and hence end the split management situation on that site. This has never been logical and has always been a recipe for problems. It is therefore of extreme concern that, as the consultation has progressed, it has become increasingly clear that the NWLSHA assumption of management responsibility could be long delayed and may not occur until all the restucturing has taken place. This is not acceptable and should be reconsidered - if necessary at Ministerial level.

We totally reject the assumption by NWLSHA that the Varley Report and the associated Appendix 2 Interpretation of Calman-Hine should be the basis for their proposals. NWLSHA appear to have accepted without reservation the BHSLA basis for their proposals. This must be challenged. It was clear from the BHSLA Paper that their interpretation was selective in order to justify their required outcomes. In particular, we wish to note that the Varley Report was never subjected to public consultation and many aspects have been challenged by eminent Statisticians. During the public consultation process, there has been no satisfactory response by NWLSHA, (or BHSLA), to this challenge. It should also be very clearly noted that Calman-Hine did not provide a prescriptive specification for future Cancer Centres. The unfortunate acceptance by NWLSHA of Appendix 2 pre-empts the outcome of the consultation. There is absolutely no statistical evidence to demonstrate that the Mount Vernon "non-surgical oncology centre" has poorer survival rates than any Cancer Centre which has more of the Appendix 2 services. (No UK hospital meets Appendix 2!!). At every consultation meeting, senior NHS Managers have been challenged to provide statistical evidence to demonstrate that Mount Vernon has an inferior record. There is no such evidence.

We recognise the tremendous value of the total "Cancer Community" at Mount Vernon. The NWLSHA Paper gives very little confidence that key activities such as the Gray Research Institute and Paul Strickland Scanner Centre would continue at their current level of expertise. The lack of definitive proposals and total lack of clarity on future beds availability must lead to uncertainty in all the non-NHS activities.

There is a total lack of any analysis of future staff needs, potential problems with staff retention or recruitment,etc. It is accepted that the very preliminary nature of the Paper makes this difficult but we believe at this stage, it should be stated that the current staff operating across the whole Cancer Community at Mount Vernon Cancer Centre is the result of decades of development and breaking up these teams will have profound implications. Many of our Members have also expressed concern that if BHSHA retain the management of the Mount Vernon Cancer Centre, the retention and deployment of key staff will be outside NWLSHA control.

Our comments and observations on the NWLSHA questions are as follows :-

Question 1 Do you accept that Mount Vernon needs to change ?
We recognise the need to evolve as medical procedures develop and also the impact of the anticipated decisions by BHSHA. The former, however, we believe will strengthen the role of what is essentially a "non-surgical oncology centre". The current procedure where major surgery is carried out at other local DGH's can continue. The NWLSHA also has a strategic responsibility for the probable increase in elected surgery which potentially would provide additional support services. We do not see the need or justification for massive reduction in the services currently provided. The statistics summarising the location of patients attending the Cancer Centre at Mount Vernon do not support the BHSHA conclusions. They show that at least least 50% come from outside the BHSHA area and a very significant number reside in the South West Herts area which is nearer to Mount Vernon than other BHSHS preferred locations. There is also inadeqate weighting given to the anticipated increase in demand due to an ageing population and higher survival rates. We do not believe that a case has been made for only two cancer centres in the area covered by both consultation Papers.

We do see the need for more fundamental changes involving the Plastic surgery unit and Harefield hospital, (see later)..

Question 2 - Mount Vernon future is not dependent on it being a specialist Cancer Centre ?
Following the answer to Q1, we clearly do not accept a major reduction in the Cancer Centre. We appreciate that senior NHS Mangers - probably not located at the hospital- could essentially close the Cancer Centre and replace it with other services. However, they would have to take full responsibility for the subsequent closure of the Research activities, massive increases in travelling for patients, a break up of world famous teams and services and a loss of confidence in the NHS management by at least a million residents.

Question4. A local provider of Cancer Services ?.
We see Mount Vernon as a local provider of cancer services but NOT as defined by NWLSHA. The proposals would result in a significant increase in travelling for patients to Inner London. Many of these would be seriously ill and require regular attendance. The NWLSHA Paper gives no recognition of the Department of Health guidelines, "Keeping the NHS Local - A new Direction of Travel".

Question 5. Development of Ambulatory Radiotherapy Centre ?
We support the retention and development of both radiotherapy and chemotherapy. We have noted with interest that the BHSHA Paper stated without any qualification that in their proposals - quote, " it is planned that an ambulatory radiotherapy unit will be retained on the Mount Vernon site". (Page 83, para 9.1.17.). NWLSHA are setting up a special study to see if this is viable and it will not report until early 2004. This clearly is confusing to the layman. The most important issue ,we believe, is a clear decision on the retention of the majority of the 65 beds currenlty available.

Other Comments

1. Stategic Planning

Over the last decade or so, we have seen major changes at Mount Vernon with no clear indication of any long term strategic thinking at all. My organisation has corresponded with successive Health Ministers over the need to have a major long term appraisal of the three world famous centres - Harefield Heart services , Mount Vernon Cancer and Mount Vernon Plastic Surgery and Burns. On every occasion, decisions have been made based on the proposals of one individual Health Authority with no totally independent review. It has frequently been clear that the management and operation of such advanced centres of excellence do not fit comfortably in the general local health regimes.

We wish to state very strongly that this is the final opportunity for a totally independent review to be undertaken. The major problems associated with the Harefield move to Paddington have resulted in a major delay and no irrevocable decisions have been made. We accept that the Burns unit may be more appropriately located at a Regional centre. However, the delay in moving the Plastic Surgery unit - which has close associations with the Cancer Centre - could be part of an advanced medical Centre incorporating all three centres of excellence.

It must also be strongly emphasised that the residents of Outer London Boroughs - in particular Hillingdon and Harrow in this context - are extremely concerned about the continuous pressure by some Health Authorities and by Medical Colleges to move key services to Inner London. The potential exists with these three centres of excellence which are very close together to redress the balance. Residents are increasingly concerned about the additional problems for patients and families.

2. The future of Watford Hospital

At a late stage in this consultation, a senior member of West Herts Hospitals NHS Trust introduced into the debate the suggestion that potential developments in and around the hospital could lead to the possible location of a Cancer Centre at Watford. It is not clear whether this is a formal proposal or even whether it is supported by BHSHA. It clearly has significant implications for Mount Vernon. It is also relevant to note that the driving force behind this suggestion is the lack of support in South West Herts to have a Cancer Centre elsewhere in Herts. or Beds. which would not be as convenient as Mount Vernon.

Summary.

1.SHARRA does not support any significant reduction in Cancer services at Mount Vernon. It must be a priority of all NHS Managers to ensure that a local service is continued for diagnosis and both radiotherapy and chemotherapy and an appropriate number of beds must be retained to meet these needs.

2. The NWLSHA had inadequate time to prepare a realistic Paper for such an important service. It is far too vague and indefinite and we strongly recommend that no decisions are made for at least 6 months until more rigorous proposals can be considered. BHSHA would also have difficulties but the need for two only centres has not been proven and future demands have been given inadequate consideration.

3. The inadequate timescale for NWLSHA has probably contributed to their use of the Varley Report and the associated specific interpretation of Calman-Hine. This is fundamental to the whole consultation and NWLSHA's refusal to reconsider it during the consultation process undermines any confidence in the whole process.

4. We believe that inadequate consideration has been given to the other major cancer services on the Mount Vernon site - in particular there is a lack of confidence in the future of the Gray Research Institute and Paul Strickland centre.

5. We welcome the indication that NWLSHA will take over responsibility for managing the whole Mount Vernon site. We are extremely concerned about the lack of clarity about the timing and do not believe it should be delayed for years. Allied to this, we are extremely concerned about the lack of any indication of future staffing. There is a major danger of highly skilled teams being disbanded and a very serious possibility of many leaving the NHS or the UK.

6. The lack of progress with proposed developments at Harefield and the Plastic surgery unit, gives a final opportunity to make an independent review of the potential for integrating the three centres of excellence in the London Borough of Hillingdon . It gives an opportunity for one of the most advanced medical research and treatment centres in the world.

Neville Hughes

Neville Hughes, President

19.8.20036

8 Balmoral Road
South Harrow
Middx.
HA2 8TD
(020) 8422 5357

21/8/2003

Katherine Peddy
Room 359
County Hall
Bedford, Beds. MK42 9AP

Dear Ms. Peddy,

Further to my covering letter of 20/8/2003, I think it may not have had details of my address - will you please replace it with the enclosed.

I sincerely apologise for any inconvenience.

Thank you,

Neville Hughes

Neville Hughes
(President, South Harrow and Roxeth Residents' Association).

South Harrow and Roxeth Residents' Association

President: Mr N.Hughes, 8 Balmoral Road, South Harrow HA2 8TD (020 8422 5357)
Chairman: Mr J.Daymond, 3 Roxeth Grove, South Harrow HA2 8JG (020 8864 1317)
Secretary: Mr T. Hooper, 66 Wood End Avenue, South Harrow (020 8248 0616)

20/8/2003

Professor Sir Ron De Witt
Chief Executive
North West London SHA
Victory House
170 Tottenham Court Road
London W1T 7HA

Dear Sir Ron,

I am writing on behalf of the Members of South Harrow and Roxeth Residents' Association and other residents in the South Harrow area. As indicated in my letter of 28/5/2003, we have a Membership of nearly 1,000 households in the South Harrow area.

Over the last few months many Members have taken part in the consultation process to consider the North West London Strategic Health Authority Paper -" Mount Vernon Hospital : The Future of Services for Cancer Patients".

Please find the enclosed formal response to the above Paper and hope that you will take it into consideration at your SHA Board meeting on September 23rd. I would formally like to thank members of your Board who have attended many meetings over the last few months in Hillingdon and Harrow. I appreciate it has been quite difficult at times.

I am copying several other people/ organisations who have been involved in the consultation and I would be willing to answer any questions which might arise from any recipient.

Yours sincerely,

Neville Hughes

Neville Hughes, President

cc Mr. Gareth Thomas, M.P., House of Commons, London SW1A 0AA
Mr. Tony McNulty, MP.,House of Commons, London SW1A 0AA
Bill Hamilton, F.A.O. Katherine Peddie, Room 359, County Hall, Bedford, Beds MK42 9AP
Heather Smith, Committee Administrator, L. B. Harrow Health & Social Care Committee
Sue McLellen, Harrow PCT., Grace House, Harrovian Business Village, Bessborough Road, Harrow.
Mr. Owen Cock, Vice Chairman, Harrow CHC, 2 Junction Road, Harrow

Peddie, K,Select Comm Support

From: NHS Scutiny Email Account
To: Peddie, K,Select Comm Support
Subject: FW: Mt Vernon Consultation - Att. Katherine Peddie   Further!!
Date: 26 August 2003 08:57PM

From: tpgash
To: NHS Scutiny Email Account
Subject: Mt Vernon Consultation - Att. Katherine Peddie   Further!!
Date: 23 August 2003 16:05PM

<<File Attachment: HALPIN2.JPG>> <<File Attachment: PROF_STO.DOC>> <<File Attachment: HTMLPAGE.HTM>>

Sorry, I really thought that my email 21/8/03 was more than enough, then today the bundle of papers from Hillingdon CHC arrived today. [Sadly App. 4 was incomplete in my bundle so I don't know where that was going].
It was virtually inevitable that there would be a NOOMBY (not out of my backyard) protest, but I hoped we could avoid going over old ground and every negative thing you can think of.
1. On the matter of statistics, I enclose copies of my earlier attempt to address and the shamingly taut response from Jane Halpin.
2. Hillingdon try to bring in too many arguments - cancer centre approach is not justified - model of cancer centre is not valid - Mt Vernon is fine as base for cancer centre - etc.
3. One always has to be wary of surveys of self-selecting responders and classically Hillingdon have exposed the weakness in the response to question 4, which apparently says "it doesn't matter if it is substandard, just don't move it".
4. There is much about the research and "facts" underpinning IiYH that is doubtful, I would like to know if there is later DoH information on cancer centres, but not wait around vaguely until new technology changes the requirements.
5. Is it possible to get a professional description of exactly what SHA and those behind the plan mean by "ambulatory" and give us a clear idea of the volumes of radiotherapy time/appointments at the centre and at Mt Vernon site after restructure?
Sincerely and apologetically
Trevor Gash

Sincerely and apologetically

Bedfordshire and Hertfordshire NHS
Strategic Health Authority

☎ (Direct) 01727 792923
e-mail: jane.halpin@bedsandherts-ha.nhs.uk
Fax: 01727 792902

Tonman House
63-77 Victoria Street
St. Albans
Hertfordshire
AL1 3ER

Tel: 01727 812929
Fax: 01727 792800
website: www.bedsandherts-ha.nhs.uk

h:\userdata\janeh\jane\word\filing\cancer\networks\mv\gash letter 12 nov 02.doc
12th November 2002

Mr Trevor Gash
5 Farrs Lane
East Hyde
Beds
LU2 9PY

Dear Mr Gash

Mount Vernon Cancer Network & Centre Long Term Review Supplementary Report 3

Thank you for your letter of the 3rd October. My apologies for the delay in responding.

I think the key points that you raised were:

- The letter circulated from Hillingdon CHC (containing Professor Stone's statistical comments on Report 3) risked moving things backwards rather than forwards.
- The highly academic approach to statistical detail, whilst presumably valid, does not actually refute the main conclusion of the report (demonstrating that the impact of cancer centres is either to improve patient outcomes or to leave them unchanged but it was never detrimental).
- Whether there should be some form of stakeholder forum for addressing such issues to continue the broad consensus, which has developed throughout the revue, rather than individual people or organisations objecting to specific points without looking at the totality of what is recommended.

I think that these are valid and important points, and I am grateful to you for raising them. I have copied our Head of public involvement into this response, so that she is aware of your helpful comments.

Yours sincerely

Dr Jane Halpin
Acting Medical Director

cc Mrs Lynda Dent

Chair: Ian White CBE
Chief Executive: Jane Herbert

5 Farrs Lane
East Hyde
Beds.
LU2 9PY

3 October, 2002

Ms J Herbert
Chief Executive
Bedfordshire & Hertfordshire
Strategic Health Authority
Tonman House
63-77 Victoria Street
St Albans
Herts AL1 3ER

Dear Ms Herbert,

Mount Vernon Cancer Network & Centre Long Term Review Supplementary Report 3

I have been pondering the submission by Hillingdon CHC for a time. Whilst lacking any formal qualifications to address the issues raised, I am concerned to see that consideration of proposals should develop on a constructive basis.

As I understand it, the findings of the Expert Advisory Committee, 1995 (Calman-Hine Report) were to the effect that cancer treatment and outcome varied from unit to unit within the UK and that generally outcome was worse than that seen in other parts of Western Europe.

Since the Plan derived from the Report seeks to establish methods and structures for the collation of reliable data, statistical **certainty** does not seem to have been the basis of the Committees assessment, but rather the balance of probabilities based on an accumulation of evidence pointing the same way.

The problem of certainty in relation to health data, in my view, is similar to the problems related to weather forecasting. We know how to measure elements, we understand vast numbers of cause /effect relationships, but the sheer volume of possible interactions makes it impossible, with the current level of knowledge and computing power, to improve on probability.

In his paragraph 2.1, Professor Stone affirms that Selby et al (Sea) "firmly supports the claim that specialisation in larger hospitals helps with survival – but with the **implicit** caveat of *'other things being equal'*" [my highlighting]. Whilst he says that the qualification is easily overlooked, he does not indicate any issue that has been specifically ignored by Report 3 or suggest an element that should be factored into any assessment.

Prof. Stone attacks Report 3 for its deception rather than its imprecision, but whilst taking a gentle side-swipe at tautology offers no explanation of his distinction between "deceptive" and "misleading".

Prof. Stone ventures into the area of the possible impact of different assessment standards in staging when seeking to persuade that "a slight tilt in favour" should have been treated as "inconclusive" by Sea. Now despite his summary presenting the case that Report 3 misrepresents Sea, the claim in his paragraph 2.4 is actually of wrong classification by Sea.

He pursues academic rigour in asking whether studies should more correctly have been considered "inconclusive" rather than "non-detrimental" by Sea, but fails to explain the practical importance of such reclassification.

Presumably he is somehow satisfied that impacts of culture (professional and social), diagnosis quality, staging standards and survival monitoring are adequately addressed. He does not help us here. Has other peer review commented on any or some of these aspects of Sea?

His criticism of Report 3 in his paragraph 2.3 also seems to be directed more correctly at Sea when he quotes "Stiller has noted that no study has ever shown **a disadvantage** from management in **a specialised centre** for any cancer" [my highlighting].

From Report 3 he quotes "that **specialised cancer centres** either improved survival or made no difference, but were never detrimental" [my highlighting]. The latter seems more in keeping with his comment regarding the pooling or averaging of information within **studies** [my highlighting].

Whilst Prof. Stone is eminently qualified to challenge the statistical validity, and/or the application, of the figures in Tables 1 – 4, having highlighted the apparent non-sequitor character of the Report 3 Conclusion, he does not attempt to rationalise its components or reflect on the actual part Tables 1 – 4 are intended to take in the Conclusion.

The elements appear to be:

1) a. Evidence is strong that care adhering to best practice improves survival

   b. Best practice is normally found in hospitals with an oncology centre

2) Improvements *(in outcome ?)* seen are **presumably** the results of successful efforts to improve *(care ?)* performance

3) We **know** that

   a. pressure to adopt best practice has resulted in more microscopical confirmation and better staging

   b. peer review has stressed the need for multidisciplinary working

   c. the evidence (within the Report) indicates that consultants are referring more cases to cancer centres

I have some concerns with the construction of this Conclusion.
It is difficult for me to identify any direct link between the Tables and the Conclusion other than 3) c.
There is an apparent conflict between 1) a. and 2.
What part does the criteria of follow-up for 5 years play in the Stockton & Davies assessment of survival and how does the 1998 – 2000 review allow for this?
It is not necessarily the case that better care leads to better recovery/survival. The impact could be confined to such things as improving patient comfort, reducing timescales of actual treatment or establishing a "buffer" against outside adverse elements.

However, there is a shift implied by the notes accompanying Tables 1 – 4 and declared in Conclusion 3, which is that the issue is not whether treatment is at a cancer centre, but whether or not treatment is undertaken within a well managed network that includes a cancer centre. On that basis we are to see, Table 4 indicating a higher percentage of cases diagnosed and treated at Stage 1, Table 3 showing a greater percentage of cases treated in cancer centres, Table 2 depicting more consistent performance at different units and Table 1 reflecting that locally better survival was achieved overall.

There is an implication that the units within the group studied, in the past decade have employed a strategy of integration, but this is not spelt out.

If the inference is correct, then I am not clear as to the significance placed by Prof. Stone on the absence of data for 1994-97, which if it was a transitional period could easily produce erratic results. However, as I remarked at the outset, I do not have medical or statistical qualifications so even the method and significance of 95% confidence intervals is really beyond me. It would, nonetheless, be useful to know if the data in Tables 1 – 4 could be generalised for the simpler evaluation implied by the elements of the Conclusion.

Thus I return to my opening theme. The May 2002 Report of the Long Term Review to which Report 3 is supplementary places us currently in a period of "active debate" ahead of "formal consultation". I am not aware of the procedural arrangements that cover the present phase.

I do recall that some of us attending Stakeholder Conferences felt that some statements, opinions and conclusions drew on data not fully presented, so I am sympathetic to the testing of assertions within the Review. What concerns me, and this was also raised in the Conferences, is that the various parties should not return to the trenches and start lobbing grenades. We need to move on constructively.

If Prof. Stone is aware of data that, rather than simply being unreliable, repudiates the conclusions of Report 3 to the extent of demonstrating that the assessment of the impact of cancer centres is either inconclusive or detrimental, then perhaps he can present it and those concerned can look in the first case to other areas of evidence or in the latter to re-evaluating the Review.

Is there, or should there be some form of stakeholder forum for addressing such issues ahead of formal consultation to enable the largest consensus ahead of that consultation?

I do not have the resources to circulate all stakeholders and accordingly approach you as present custodian of the Review to consider and take forward as you see fit.

Yours sincerely

Trevor Gash
(A representative of South Beds CHC at Stakeholder Conferences)

Peddie, K,Select Comm Support

From: NHS Scutiny Email Account
To: Peddie, K,Select Comm Support
Subject: FW: Mt Vernon Consultation - Att. Katherine Peddie
Date: 22 August 2003 09:21PM

From: tpgash
To: NHS Scutiny Email Account
Subject: Mt Vernon Consultation - Att. Katherine Peddie
Date: 21 August 2003 16:13PM

<<File Attachment: HTMLPAGE.HTM>>

Hi,
You will know that Beds CHC members came in late to this latest review and I've only just received the notes preparatory to the September meetings, so please excuse if these hasty jottings mistake the terms of the undated communication from Bill Hamilton.

1. It is not clear what impact rejection of the proposals by North West London populace would have for the scheme. Some NHS professionals have indicated that it could still go ahead, but this seems to run contrary to the catchment requirements, which are given as a basis for achieving "excellence".
2. If the proposal is accepted by North London, but mainly through public inertia, and patients in that area subsequently demand to be treated in London, how will that affect efficiency/excellence etc.?
3. To what extent does the apparent poor health, safety and financial state of Hertfordshire hospitals potentially undermine the projected benefits of a Cancer Network?
4. How can Hospitals qualifying for Foundation status justify joining a Network with those of significantly lower star-rating and a] expect patients to believe they are best served,
   b] take full advantage of their status ?

Regards
Trevor Gash

Peddie, K,Select Comm Support

From: NHS Scutiny Email Account
To: Peddie, K,Select Comm Support
Subject: FW: Consultation on Mount Vernon Hospital: The future of Services for Cancer Patients
Date: 22 August 2003 12:25PM

From: Yvonne.Lembke@nwlh.nhs.uk
To: NHS Scutiny Email Account
Cc: Mike.Thompson@nwlh.nhs.uk
Subject: Consultation on Mount Vernon Hospital: The future of Services for Cancer Patients
Date: 22 August 2003 10:56PM

<<File Attachment: MTVERNON.DOC>> <<File Attachment: BEDSHERT.DOC>>

For the attention of Bill Hamilton via Katherine Peddie:

In response to your letter addressed to Mike Thompson, dated 7 August 2003 regarding the above, please find attached final drafts, which are subject to ratification by our Trust Board on 27 August.

For your information, Mike Thompson is on annual leave until Tuesday 26 August.

Yvonne Lembke
PA to Mark Devlin, Deputy Chief Executive
Tel: 020 8869 2997
Fax: 020 8869 2014
email: yvonne.lembke@nwlh.nhs.uk

The North West London Hospitals
NHS Trust

27 August 2003

Northwick Park Hospital
Watford Road
Harrow
Middlesex
HA1 3UJ

Tel: 020 8864 3232
Fax: 020 8869 2009
DDI: 020 8869

Jane Buckingham
North West London Strategic Health Authority
FREEPOST NAT 4348
London W1T 7BR

Dear Jane

Response to NW London StHA Consultation - Future of Mt Vernon Cancer Services

We welcome the additional consultation being undertaken on cancer services at Mt Vernon by the StHA and that it ties in with the timescale for the Bedfordshire & Hertfordshire consultation.

We have set out our response as per the questions posed in the consultation document. The response was ratified by the Trust Board at its meeting on 27 Aug.

Q1 - Do you accept the proposition that Mt Vernon needs to change

Yes. As set out in the document and in line with Calman-Hine, NHS Cancer Plan and the recommendations of the Long Term Review. Mt Vernon is not recognised as a cancer centre (but as non-surgical oncology centre) and we do not believe this is sustainable. To re-establish a full range of medical, surgical and support services is not a viable option and would be detrimental to those other local trusts that have subsequently developed these services.

Q2 - If you accept this, do you accept that Mt Vernon's future is not dependent on it being a specialist cancer centre.

Yes. As per the vision set out in the document *Mt Vernon help us to shape its future*. In providing Cancer care (including possibly ambulatory radiotherapy, please see comments in Q5), elective and non-elective services, intermediate care and enhanced primary care it will become a viable provider of services to its local population and beyond.

Q3 - If you believe Mt Vernon needs to change in another direction please give brief details

As above.

Q4 - Do You support the general proposition of the development of Mt Vernon as a local provider of cancer services

Yes. As per the document as a unit providing for example - Outpatients, Chemotherapy, Palliative Care, Patient and Carers support, and possibly radiotherapy.

Q5 - Do you support the proposition of the development of ambulatory radiotherapy, provided all quality and safety requirements are met.

We support the proposed viability study for provision of ambulatory radiotherapy with the recommendation that clear timeframes are set on this. Given current capacity constraints at the Hammersmith Hospital the Mt Vernon service could potentially support west London residents in the short and medium term. If, though, it was found in future that this was no longer viable an alternative location for this service could be at Northwick Park Hospital.

Q6 - Are there any other issues linked to the development of local services at Mt Vernon you want to be made aware.

The changes set out are clearly a long-term plan. We believe that key to the developments is a consistent service to west London residents that reflects patient journeys to appropriate local and specialist centres irrespective of traditional organisational boundaries.
During that time the NHS and cancer care will change so that it is important that plans, whilst put in place, are also able to adapt with the changing environment. This may mean more patients treated at local centres who previously would have to travel to specialist centres.

We would welcome the opportunity to discuss the above further. I hope you find the comments set out constructive.

Yours sincerely

John Pope
Chief Executive

Cc Director, NW London Cancer Network
Director, Mount Vernon Cancer Network
Sue McLellan, Chief Executive, Harrow PCT
Lise Llewellyn, Chief Executive, Brent PCT
Chair, Harrow Health Scrutiny Committee
Chair, Brent Health Scrutiny Committee
Katherine Peddie, Bedfordshire Joint Scrutiny Committee
Chairs, Brent & Harrow CHCs
Steve Peacock, Director of Planning, NW London StHA

30 July 2003 **DRAFT**

Consultation Response
Bedfordshire & Hertfordshire Strategic Health Authority
Charter House
FREEPOST 145
Parkway WGC
Hertfordshire AL8 6BR

Dear Sir / Madam

Investing in your health - Consultation

Please find below the formal response from North West London Hospitals to the above consultation document. We have set out our response in two parts, one to the proposed reconfiguration of acute services in Bedfordshire and Hertfordshire and the other to the proposed changes specifically to Mount Vernon Hospital.

Acute Service Reconfiguration

Clearly Option Two would mean little change to services provided by North West London Hospitals. However Option One would mean that the status of Watford Hospital changes in a number of key areas. If this option was pursued then this trust would clearly see an increase in the numbers of patients seen / referred for the following.

A&E / Trauma - This Trust is already one of the largest providers of emergency care in London and beyond. Any additional activity would impact on its capacity to deliver these services.

Maternity - The impact of the changes resulting from Brent & Harrow's consultation on maternity services are still being worked through. As part of this we have concentrated Obstetric services at Northwick Park Hospital with a midwife led unit at Central Middlesex Hospital. If Watford were to function as a Birthing Centre then a number of mothers living south of Watford may choose to be managed at Northwick Park. This would clearly affect our capacity to deliver maternity services.

At this moment in time therefore the Trust would formally object to Option One. For this position to change we would as a minimum need prior agreement both on re-mapping of patient and financial flows and identification of additional capacity. Even agreement on the former is not sufficient in itself given the physical constraints on capacity.

Mount Vernon Hospital

The Trust supports, in principle, the proposed changes set out. We believe that the case for change at Mt Vernon is well established. The issues raised by the Long Term Review, in line with the principles of Calman Hine and NHS Cancer Plan, mean that it cannot continue as a non surgical oncology centre. We believe that the number of patients travelling to another centre, as well as the Hammersmith Hospital will be minimised and in time reduce. To re-establish a full range of medical, surgical and support services is not a viable option and would undermine those other local trusts who have subsequently developed these services.

We do believe that Mt Vernon has potentially a strong future as set out in *Mt Vernon; help us to shape its future*. In providing Cancer care, elective and non-elective services, intermediate care and enhanced primary care it will become a viable provider of services to its local population and beyond.

We support the proposed viability study for provision of ambulatory radiotherapy with the recommendation that clear timeframes are set on this. Current capacity constraints at the Hammersmith Hospital mean that this could potentially support the service to west London residents in the short and medium term. In time it could be possible to establish ambulatory radiotherapy at Northwick Park Hospital, where it may be more appropriate given its full range of acute DGH services and existing significant range of cancer services.

We do not have a strong preference for the location of the new centre in Hertfordshire though we understand that Watford may now be an option. If this was the case it could mean less travelling for those patients accessing the centre from the Mt Vernon catchment area.

The future of the Gray Laboratory could be unclear depending on the outcome of the consultation. We believe that any new centre would benefit from academic links with Imperial College and the Hammersmith Hospitals as the main centres within North West London given the patient flows across both networks.

Finally we would add that, in terms of acute services and cancer, the changes set out clearly are over a long term. During that time the NHS and cancer care will change so that it is important that plans, whilst put in place, are also able to adapt with the changing environment.

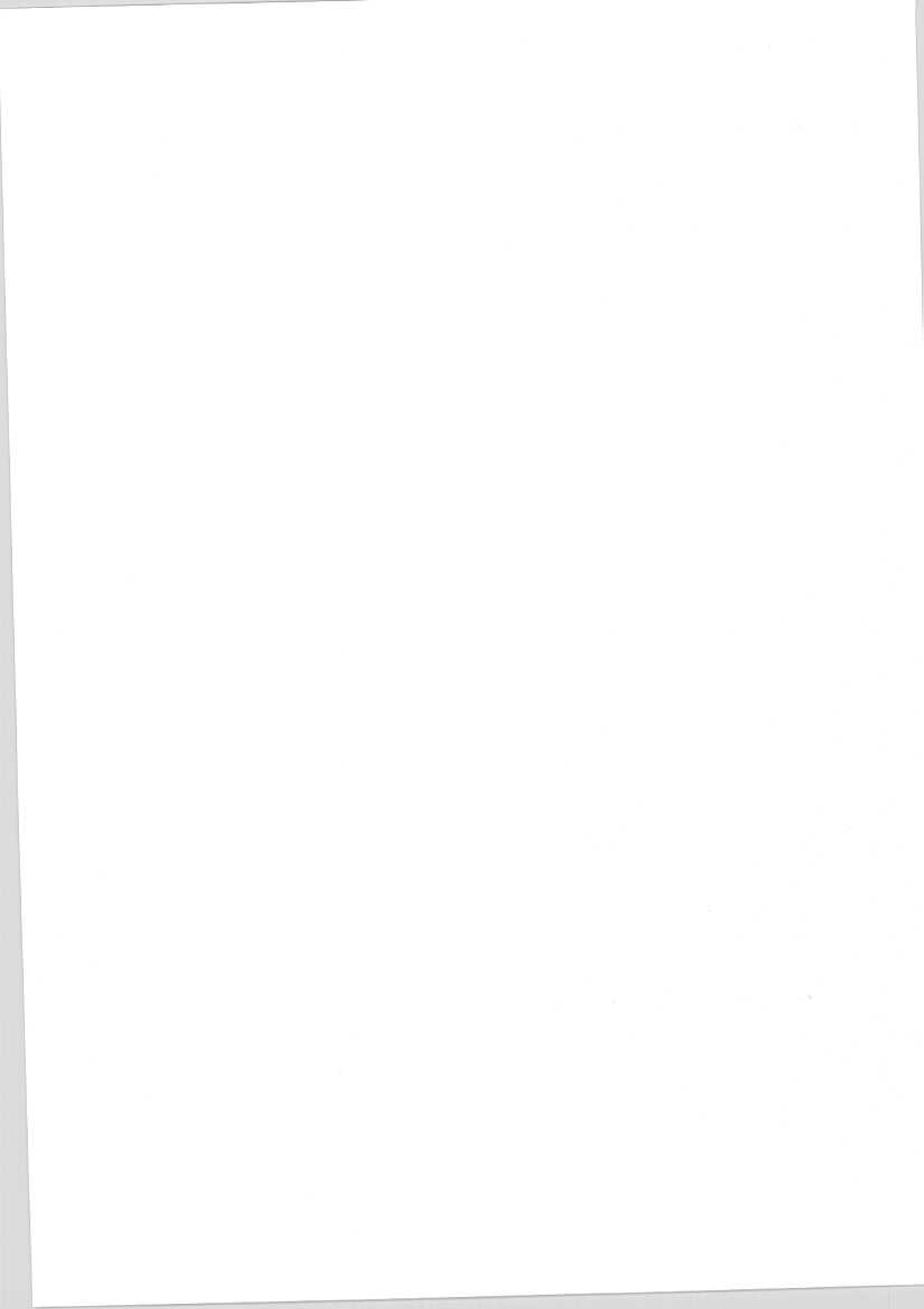
You will no doubt be aware that North West London Strategic Health Authority consulting around Mt Vernon Cancer services in parallel with this process and we will be feeding these views into this as well.

We would welcome the opportunity to discuss the above further. I hope you find the comments set out constructive.

Yours sincerely

John Pope
Chief Executive

Cc Director, NW London Cancer Network
Director, Mount Vernon Cancer Network
Sue McLellan, Chief Executive, Harrow PCT
Lise Llewelly, Chief Executive, Brent PCT
Chair, Harrow Health Scrutiny Committee
Chairs, Brent & Harrow CHCs
Steve Peacock, Director of Planning, NW London StHA



PO Box 100
Mount Vernon Hospital
Northwood
Middx HA6 2JR UK
T: 01923 828611
F: 01923 835210
e-mail: <surname>@gci.ac.uk
web: www.gci.ac.uk/

Joint Executives
Barry D Michael BSc MSc PhD
Peter Wardman PhD DSc CChem FRSC
Head of Administration
Jane Evers BSc PhD
Founded in 1957
by LH Gray FRS 1905 - 1965

Bill Hamilton
Assistant Chief Executive (Scrutiny)
F.A.O. Katherine Peddie
Room 539, County Hall
Caudwell Street
Bedford, Beds MK42 9AP

27 August 2003

Dear Mr Hamilton

Consultation on Mount Vernon Hospital: the future of services for cancer patients

I apologise for the delay in responding to your invitation. I attach a two-page summary of the views of the Gray Cancer Institute on the proposals of Hertfordshire & Bedfordshire Strategic Health Authority (prepared in April 2003), and note briefly below further comments on the document issued in June 2003 by North West London SHA with Brent, Harrow and Hillingdon PCTs.

By way of background, the Gray Cancer Institute is an independent research charity employing about 90 staff in its own buildings in the grounds of Mount Vernon Hospital. It has close links with clinical staff at Mount Vernon Hospital with decades of experience of collaborative research projects (the first laboratory buildings opened in 1957). It raises around £5M pa from granting agencies to fund its research, employs its own staff and maintains its own buildings.

The proposals under discussion clearly threaten cancer research on the Mount Vernon site, and were completely inadequate in their consideration of the future research environment in the several scenarios presented. Indeed, government has already acknowledged that even the flagship Calman-Hine strategy neglected this area.

We do not consider the public consultation process initiated by Bedfordshire & Hertfordshire SHA to have been properly conducted: the dilution and merging of the issues gave too little consideration of cancer services and almost none of research. Its presentation was manipulative, and the conduct and composition of the review chaired by Mrs Varley left much to be desired. We have summarised our criticisms in the paper dated 17 April 2003 that is attached.

However, we welcomed the later consultation by North West London SHA and its partners. It injected a new focus on cancer services that went some way to counteract the broad brush of the earlier consultation. Particularly noteworthy was the personal effort by Mr Steve Peacock, Executive Director of Strategy and Planning, who in our view brought a fresh, consultative and concerned approach to the issues. He visited the Institute and sought our opinions on the future developments in radiotherapy treatment. We also welcomed the effort locally by Hillingdon and Harrow PCTs and Councils in their public debates and scrutiny committees. These activities contrasted with the failure of the Varley Review to even note discussions that were contraindicative of its preconceived agenda.

Gray Laboratory Cancer Research Trust
Registered in England
Registered Offices above
Charity No. 1044176
Company No. 3020745
Not for profit/Limited by guarantee

Supported by

In spite of this late surge in activity concerning the future of cancer services, it is inevitable that with the timetable imposed, the hastily-commissioned second consultation had to be based on the preferences presented by Bedfordshire & Hertfordshire SHA: there was not time to re-examine all the issues and make up for the deficiencies in the *Investing in Your Health* paper. The North West London consultation must therefore attract some of the same basic criticisms that the earlier review warranted. It now seems to be a *fait accompli* that a new cancer hospital will be planned for a new site near Hatfield, and that all else must be fitted around this premise.

Throughout these reviews, the nonsensical imposition of (probably) medieval county boundaries to define administrative regions without regard to where patients actually live shines through. Even the most casual observer would wonder why there was a review lasting many months by Bedfordshire & Hertfordshire only to require a hasty review, weeks only in preparation, by the NW London Authority to paste over the cracks – or gaping holes – left by the earlier review. The design of the cover of the Bedfordshire & Hertfordshire review (a representation of people within the two county boundaries with absolutely nothing outside) underlined the mentality. The absence of public consultation in Buckinghamshire and Berkshire, where many stakeholders live, was another illustration of fundamental deficiencies in the review process.

In summary, the neglect of research as a factor in delivering improved treatment was a gross deficiency in the Varley review. The emergency crew sent out by North West London SHA and the local PCTs to douse the flames set alight by Bedfordshire & Hertfordshire SHA was a fair attempt at damage limitation, but suffered from the mistakes already made. We welcome the work of the Joint NHS Scrutinity Committee in safeguarding the interests of future cancer patients in this area.

Yours sincerely

P. Wardman

Professor P Wardman DSc PhD CChem FRSC
Joint Executive

Views of the Gray Cancer Institute[1] on the consultation paper *Investing in your health*[2] and the Long Term Review of Mount Vernon Cancer Network & Centre[3]

- The merging of the two reports into one consultation is not for reasons of convenience or rationale, but to divert and dilute discussion of the options for the cancer centre.
- The presentation in the consultation paper and feedback form of only two options for the Cancer Centre, rather than the eight considered by the Mount Vernon Review, is an outrageous manipulation of the consultation process.
- If the Cancer Centre moves from Mount Vernon, the link between the research laboratories and the clinic will be lost. No credible proposals for rebuilding research on a new site are provided.
- Both reviews gave an unacceptably low priority to research, and the costs of research were ignored in financial analyses.
- The Mount Vernon review was flawed by bias in its conduct and content; the Paul Strickland Scanner Centre and other key stakeholders were not represented on the review.
- The Mount Vernon review team made much of population density and travel times, but failed to ask the public first what it considered was a reasonable travel time for treatment.
- A much-reduced, 'ambulatory' radiotherapy facility at Mount Vernon would provide inferior treatment compared to the specialist centre: the reviews ignored changes to treatment technology that will be in place in the next decade. Better treatment is worth the extra travel time.
- Neither reviews addressed organisational structures and assumed that the status quo should continue, in spite of common sense pointing to the urgent need for change.

---

1. **Merging of consultations.** While some issues are obviously linked, the two consultations *must* be separate. The acute services review deals with issues almost exclusively the concern of residents of Bedfordshire and Hertfordshire (as emphasised even by the artwork on the cover); the Mount Vernon report addresses matters affecting a much wider and quite different, inter-Regional population.
2. **Presentation of only two options.** This is deceitful and akin to entering a voting booth and finding that the eight candidates in an election have been reduced to two by council officials, the two they have decided are the front-runners – without public consultation.
3. **Breaking the links between treatment and research.** The Gray Cancer Institute is an independent charity. It owns its own buildings, finances its own staff (about 80) and funds the vast majority of research outside the NHS: it adds value to NHS research funds ten-fold. It does not have the resources to relocate its laboratories even if strategically desirable (any move, if funds *were* available, would probably be closer to academic centres in London). None of the alternative locations for the Cancer Centre offer advantages for research in the form of a strong academic research presence. The President of the Royal College of Radiologists wrote: 'The Faculty of Clinical Oncology of The Royal College of Radiologists ... has relied heavily on the research leadership provided by the Gray Laboratory and the Mount Vernon Cancer Centre. We would therefore regard it as a major loss to the whole speciality and our standing in the world of radiation oncology if the Cancer Centre is separated from the Gray Laboratory'.
4. **Low priority for research.** Although 'the Gray Institute tail wagging the Cancer Centre dog' is inappropriate, today's research is tomorrow's improved treatment. The Review relied on the Calman-Hine report (1995) on the organisation and delivery of cancer care services. However, government considers that research was given insufficient emphasis in that report: the House of Commons Select Committee on Science and Technology indicated that: 'research based on cancer networks should be given more emphasis than was evident in the Calman-Hine report'.[4] 'The Government entirely agrees

---

[1] PO Box 100, Mount Vernon Hospital, Northwood, Middx HA6 2JR. Tel. 01923 828611. http://www.gci.ac.uk.
[2] Bedfordshire and Hertfordshire Strategic Health Authority, March 2003.
[3] Review commissioned by NHS Executive Eastern Regional Office, published May 2002.
[4] House of Commons Science and Technology Committee. Sixth Report. *Cancer Research – A Fresh Look*. Published 25 July 2000, London, The Stationery Office, Volume I (332-I), Volume II(HC 332-II).

with this point.'[5] The Select Committee called for: 'approximately twelve large centres of cancer research excellence ... closely linked with basic and translational cancer research laboratories'. Concurring, the US National Cancer Institute records: 'the one common denominator of all successful NCI cancer centers is excellence in research. Successful cancer centers have scientifically strong research bases'. Mount Vernon is an obvious location for such a centre. It simply does not make sense to start from scratch in a site in an academic wilderness, and throw away over 50 years of clinic/laboratory collaboration at Mount Vernon. The consultation paper mentions the possibility of a medical school, with no supporting information to lend credibility. Government funds university research after competitive assessment. However, the 2001 Research Assessment Exercise does not include any entries from the University of Hertfordshire in appropriate departments: they did not have research even to *bid* for funds. The University of Luton scored the lowest ranking in Biological Sciences, not attracting any funding in 2002.

5. **The costs of research were ignored.** In contrast to these reviews, the 1998 Public Consultation Document issued by Hillingdon Health Authority concerning Mount Vernon, considering the implications of a possible relocation to a new site, correctly noted: 'this option has a number of substantial disadvantages... To this [the capital cost] must be added the costs of moving ... the Paul Strickland Centre and the Gray Laboratory. Relocation would inevitably disrupt ... the research programmes'.[6] About £15 M would be needed to relocate the Gray Institute. The Mount Vernon Review (§5.49) should be amended to increase the total capital cost of the 'green field' option from £100 M to £115 M, i.e. *more* than the Mount Vernon refurbishment figure of £111 M. How the estimates deal with the loss of the Paul Strickland Scanner Centre is not evident. The cost table for the 60-year operational period can be similarly challenged. The typical GCI non-NHS research income is £4.5 M pa (rather more than the additional revenue costs of £2 – 4 M pa for Mount Vernon mentioned in §5.56). Hence to maintain the current volume of research we can, presumably, conservatively add recurrent research costs for all except the two Mount Vernon options of 64 years × £4.5 M, i.e. about £290 M.

6. **Conduct of the Mount Vernon review.** Key stakeholders such as the Paul Strickland Scanner Centre were not represented, in spite of that charity providing to the NHS diagnostic and imaging services of international excellence and essential to improving cancer treatment, which will be either lost or replaced by a much inferior facility if the report's recommendation is implemented. The review Chair, writing to Members of Parliament on 13 February 2001, noted 'Mount Vernon is currently low on the list of options', an unusual indication of Chair bias 15 months before the review team met to assess the options.

7. **Treatment options and travel times.** The review analysed travel times to suggest that Mount Vernon was ill-placed to serve the population, without asking the public how far it would travel to receive the best treatment. Thankfully, common sense was injected by the Hillingdon Community Health Council; the results of their survey provided an entirely different, and much more realistic, emphasis on geographical placement. The proposed much-reduced radiotherapy facility at Mount Vernon would provide inferior treatment compared to a specialist centre. It would not have the latest technology or the best consultants. The review did not seek expert advice on the future of radiotherapy a decade hence (its sole independent clinical advisor was not qualified in that speciality). We believe that the public would travel a little further to receive the best treatment.

8. **Organisational structures.** The present status of Mount Vernon is bizarre. It is located outside the region of the Bedfordshire & Hertfordshire Strategic Health Authority, with the site landlord also outside that region, but with the clinical services largely managed via a historically recent affiliation first with Watford and later also with Hemel Hempstead. We believe that Mount Vernon should have independent Trust status with its own chief executive and be landlord of the site. An early decision by the Secretary of State to implement such a proposal as the focus of a comprehensive cancer centre with the Royal Marsden Hospital as the model would halt the damaging planning blight that is already affecting the Mount Vernon site, make best use of the capital investment that is required immediately at this site, and enable improved treatment to be delivered to the citizens of the widest possible area at the earliest date.

Prof P Wardman, on behalf of the Management Group, 17 April 2003 (e-mail: wardman@gci.ac.uk)

---

[5] *Government Response to the Sixth Report of the House of Commons Science and Technology Committee: Session 1999/2000. Cancer Research – A Fresh Look.* Department of Health. Published as Cm 4928, November 2000.

[6] *A Contract with Local People. A Public Consultation Document.* Hillingdon Health Authority in partnership with Harrow & Hillingdon Healthcare NHS Trust; The Hillingdon Hospital NHS Trust; and the Mount Vernon & Watford Hospitals NHS Trust, 1998.

Grace House
Harrovian Business Village
Bessborough Road
Harrow
Middlesex, HA1 3EX

Telephone: 020 8422 6644 (Switchboard)
Facsimile: 020 8426 8646

Joint Scrutiny Committee
Room 359
County Hall
Cauldwell Street
Bedford
Bedfordshire
MK42 9AP

22nd August 2003

Dear Bill,

Re: Harrow PCT evidence to Joint Scrutiny Committee

Please find enclosed the evidence from Harrow Primary Care Trust for:

1) Bedfordshire and Hertfordshire Strategic Health Authority Consultation – Investing In Your Health
2) North West London Strategic Health Authority Consultation – Mount Vernon Hospital: The Future of Services for Cancer Patients.

I hope that you find the enclosed evidence useful and await further correspondence regarding the response of the Joint Scrutiny Committee. Should you have any queries in the meantime, please do not hesitate to contact me.

Yours sincerely,

pp Natalie Grazin

SUE McLELLEN
Chief Executive

Primary Care Trust

Grace House
Harrovian Business Village
Bessborough Road
Harrow
Middlesex, HA1 3EX

Telephone: 020 8422 6644 (Switchboard)
Facsimile: 020 8426 8646

Joint Scrutiny Committee
Room 359
County Hall
Cauldwell Street
Bedford
Bedfordshire
MK42 9AP

22nd August 2003

Dear Sir/Madam

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

Please see below the evidence from Harrow Primary Care Trust to the North West London Strategic Health Authority Consultation, Mount Vernon Hospital: The Future of Services for Cancer Patients.

The evidence from Harrow Primary Care Trust takes into account considerations from a clinical perspective, as well as views expressed by Harrow residents during public consultation, and other meetings that were held between April to August 2003. Whilst cancer services at Mount Vernon Hospital have been a predominant focus of the meetings, some of the consultations held during this period were also arranged to discuss the Bedfordshire and Hertfordshire Strategic Health Authority Consultation, Investing In Your Health.

Harrow Primary Care Trust hosted these meeting on:

- Thursday 24th August 2003 at Harrow Leisure Centre (Public meeting)
- Wednesday 30th April 2003 at Harrow Arts Centre (Public meeting)
- Thursday 15th May 2003 at Pinner Village Hall (Public meeting)
- Thursday 17th July 2003 at Hatchend High School (Public meeting)

A further public consultation meeting, organised by Harrow Primary Care Trust, is scheduled for:

- Monday 8th September 2003 at Harrow Leisure Centre.

The views expressed at this meeting will also be taken into account in before a formal response regarding the consultation is made. Harrow Primary Care Trust would like to state that its Trust Board has yet to finalise its response to the consultation and therefore some amendments to the evidence below may be made.

1) Background evidence:

In March 2003, Bedfordshire and Hertfordshire Strategic Health Authority launched the consultation, 'Investing in your Health'. Any decision and subsequent changes arising from this consultation would impact on health service provisions to Harrow residents.

Public consultation meetings were therefore organised to inform local residents of this impact, and to listen to views raised by the public, to ensure that Harrow Primary Care Trust was able to respond to the consultation in a way that addressed the needs of its population and stakeholders. From the consultation meetings that were held, it became apparent that there were very strong local views regarding the proposed relocation of Cancer Services from Mount Vernon to a new Cancer Centre based at either Hemel Hemsptead or Hatfield. These views, coupled with the effect that the perceived loss of a highly respected cancer service would have on Harrow residents, led Harrow Primary Care Trust to become influential in instigating the current consultation, Mount Vernon Hospital: The Future of Service for Cancer Patients. This stance highlights Harrow Primary Care Trust's commitment to involving and incorporating the views of its population and stakeholders into the change and development of local health services.

It should also be acknowledged that Harrow Primary Care Trust has remained fully engaged with its local Health & Social Care Overview Scrutiny Committee throughout the consultation period. The Primary Care Trust has presented evidence to this committee on two occasions. .

The evidence that follows relates to each question that is outlined in the consultation document and a summary of evidence is also provided.

Harrow Primary Care Trust would like to stress that this consultation is only the start of a lengthy change process for the cancer services provided at Mount Vernon Hospital. The Primary Care Trust is fully committed to working with its local population and stakeholders over the next few years, to ensure that any developments that take place will have maximum benefit for all.

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

Harrow Primary Care Trust supports the fact that the populations of Bedfordshire and Hertfordshire require their own Cancer Centre and that the location of this Cancer Centre needs to be fully accessible for the residents of both these counties. Harrow Primary Care Trust also accepts that this development will mean changes for the Cancer Services that are currently provided from Mount Vernon. However, developments to turn Mount Vernon into a full Cancer Centre, as defined by Calman-Hine and the NHS Cancer Plan are not seen to be a viable solution to the current situation. This is due mainly to the following:

- The populations across Bedfordshire and Hertfordshire and North West London do not support the need for 3 Cancer Centres.
- Harrow Primary Care Trust is a member of the West London Cancer Network, and therefore the local Cancer Centre for Harrow residents is based at the Hammersmith Hospital.

- Significant enhancements would need to take place at Mount Vernon Hospital to support the development of a full Cancer Centre (e.g. surgery, medical services, support services and emergency back up). This is not a viable or sustainable option and would compromise developments that have taken place within other local trusts that currently provide these services.
- Information provided from the Thames Cancer Registry, (*Cancer in South East England 2000, Thames Cancer Registry, Kings College London)*, indicates that most cancer care for Brent and Harrow residents is carried out within the West London Cancer Network: 74% of diagnosis, 84% of surgery, 64% of chemotherapy, 18% of radiotherapy. The majority of Radiotherapy (67% for Brent and Harrow) is however provided from Mount Vernon. This highlights that the reduction or change of radiotherapy services at Mount Vernon will have a substantial impact on Harrow residents.
- Changes in cancer treatments over the coming years could result in less people needing to attend a Specialist Cancer Centre for their treatment. A third Cancer Centre would therefore not support these changes in patient care.

Based on this evidence, Harrow Primary Care Trust would therefore support the proposition that Mount Vernon needs to change in a direction that is suitable for its local population.

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

As defined by Calman-Hine and the NHS Cancer Plan, Mount Vernon Cancer Centre is not considered to be a Cancer Centre, but rather a non-surgical oncology centre. In relation to the evidence presented above and the fact that Mount Vernon does not fully comply with national guidance on what constitutes a full Cancer Centre, it would seem fair to argue that the future of Mount Vernon is not dependent on it being a specialist Cancer Centre.

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

Harrow Primary Care Trust is aware of the business case being developed by Hillingdon Hospitals NHS Trust and the resulting developments this will denote for the Mount Vernon site. In short, these include the development of a Diagnostic and Treatment Centre, provision of older people's services, intermediate care services, and enhanced primary care services.

Harrow Primary Care Trust would therefore support the development of these services on the Mount Vernon site as it is anticipated that this would provide significant benefit for Harrow residents.

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

Harrow Primary Care Trust would fully support the development of Mount Vernon as a local provider of cancer services as outlined in the consultation document. Namely: a unit providing outpatient services; chemotherapy; palliative care; patient and carer support; and radiotherapy. From the evidence presented in question 2 (above), and that provided by West Hertfordshire Hospitals NHS Trust in the consultation document, it is clear that Harrow residents make considerable use of the radiotherapy services at Mount Vernon.

67% of patients across Brent and Harrow attend Mount Vernon for radiotherapy, 18% also attend for chemotherapy, (*Cancer in South East England 2000, Thames Cancer Registry, Kings College London)*. This equates to 279 Radiotherapy treatments and 205 chemotherapy treatments in 2002-03 for Harrow residents *(Mount Vernon Hospital: The Future of Services for Cancer Patients, North West London Strategic Health Authority, 2003)*. Harrow Primary Care Trust believes Mount Vernon provides radiotherapy and chemotherapy services for a significant proportion of Harrow cancer patients, and that this is a solid base for future development, provided clinical safety measures can be met.

Mount Vernon's setting also means that it is a local and accessible service. Concerns have been raised over the accessibility of the Hammersmith Hospital and also of the new Cancer Centre in Hertfordshire. It is therefore important that those patients who can access the services that are proposed for the Mount Vernon site continue to do so. Harrow Primary Care Trust would also recommend that the accessibility of the two cancer centres, for those patients who are not able to continue to access Mount Vernon in the future, be fully investigated and transport arrangements be provided to meet the needs of these patients and their carers.

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

Harrow Primary Care Trust supports the need for a viability study to investigate the provision of Ambulatory Radiotherapy on the Mount Vernon site. The development of such a service would need to be clinically safe for patients before Harrow Primary Care Trust would consider fully agreeing to such a development.

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

The changes that are set out in the consultation document for the future of Mount Vernon are a long-term plan, with anticipated implementation being for 2010. Harrow Primary Care Trust recognises and supports the need for investment in maintaining Mount Vernon's current resources, and in the future development of the site. West Hertfordshire Hospitals NHS Trust has developed a Full Business Case for the replacement and maintenance of Linear Accelerators on the Mount Vernon site. Harrow Primary Care Trust has fully supported this investment and signed up to this development, which will mean a significant investment of almost £1 million by Harrow Primary Care Trust over the next three years.

Harrow Primary Care Trust also recognises that cancer treatments are often provided in more than one location. Over the next few years it is essential that further work is undertaken involving local residents and stakeholders, to map care pathways for patients and ensure that investment for cancer care is provided in the appropriate places.

In order for cancer services to be developed appropriately on the Mount Vernon site, it is essential that the impact of any developments are assessed against the provision of services elsewhere. For example, the need for Harrow residents to attend Hammersmith Hospitals for treatment in the future needs to be addressed. Harrow Primary Care Trust therefore welcomes the opportunity to work with its population and stakeholders in North West London and Bedfordshire and Hertfordshire, to ensure that services at Mount Vernon become fully integrated into the West London Cancer Network. The Primary Care Trust is also committed to working with these groups to implement Clinical Outcomes Guidance for

each tumour group, as and when these are produced. The role that Mount Vernon will play in this implementation will also need to be fully assessed.

Harrow Primary Care Trust also recognises that cancer treatments will develop over the next few years, which could result in more patients being treated away from Specialist Cancer Centres. Any developments at Mount Vernon would need to be flexible to meet the needs of possible changes in patient care and Harrow Primary Care Trust would support this position.

8) Conclusion.

On balance, Harrow Primary Care Trust would endorse the proposed changes as set out in the consultation document, Mount Vernon Hospital: The Future of Services for Cancer Patients. The need for change is well established as set out in the evidence presented above. There is a requirement for Mount Vernon to become fully compliant with the aims of Calman-Hine and the NHS Cancer Plan. In accordance with this, it is essential that changes at Mount Vernon take place.

Harrow Primary Care Trust supports the need for a viability study to investigate the provision of Ambulatory Radiotherapy on the Mount Vernon site. The development of such a service would need to be clinically safe for patients before Harrow Primary Care Trust would consider fully agreeing to such a development.

Harrow Primary Care Trust would recommend that the developments set out in the consultation document should result in the provision of a range of cancer services for local residents, and would support investment in this direction.

Harrow Primary Care Trust acknowledges that this is the start of the change process for Mount Vernon and is fully committed to working collaboratively with all stakeholders over the coming years, to ensure that the development of cancer services will have maximum benefit for all. The Primary Care Trust would also like to stress its commitment to working with staff and services at Mount Vernon Hospital during this period and pending any changes that occur.

I hope that you find the above evidence helpful and await further correspondence regarding the response of the Joint Scrutiny Committee.

Yours sincerely,

pp Natalie Grazia

SUE McLELLEN
Chief Executive

Primary Care Trust

Grace House
Harrovian Business Village
Bessborough Road
Harrow
Middlesex, HA1 3EX

Telephone: 020 8422 6644 (Switchboard)
Facsimile: 020 8426 8646

Joint Scrutiny Committee
Room 359
County Hall
Cauldwell Street
Bedford
Bedfordshire
MK42 9AP

22nd August 2003

Dear Sir/Madam

Re: Investing In Your Health

Please see below the evidence from Harrow Primary Care Trust to the Bedfordshire and Hertfordshire Strategic Health Authority Consultation, Investing In Your Health. Our evidence focuses solely on the proposed reconfiguration of acute services in Bedfordshire and Hertfordshire. Our evidence to the proposed changes at Mount Vernon Hospital and Mount Vernon Cancer Centre have been made separately in relation to the consultation, Mount Vernon Hospital: The Future of Services for Cancer Patients.

This evidence from Harrow Primary Care Trust has been informed by, and takes into account, considerations from both a clinical point of view as well as views that have been expressed by Harrow residents during public consultation meetings that were held in April and May 2003.

Harrow Primary Care Trust would support Option 2 as set out in the consultation document. Our reasoning behind this decision is as follows:

1) A&E:
The document states that A&E departments will continue at all sites. However, the detail of this is that A&E departments at the four "non-major" sites would be staffed by Nurse Practioners, GPs, other primary care staff and "semi-clinical" staff.

Harrow has a fairly large emergency workload flowing towards Watford General Hospital, as demonstrated within the emergency inpatient figures received from West Hertfordshire

Hospitals NHS Trust. This would suggest that we are making fairly significant use of the A&E Department at Watford General Hospital. Unfortunately we are not provided with activity data for our use of A&E services at West Hertfordshire Hospitals NHS Trust, so are unable to quantify this.

It is anticipated that a downgrading of Watford A&E, as set out in Option 1, may shift the flow of patients from Watford back to North West London Hospitals NHS Trust. This Trust is already one of the largest providers of emergency care in London and surrounding areas and the redirection of activity from Watford would have a significant impact on the ability of services at North West London Hospitals NHS Trust to cope with this additional capacity. In addition, given that Northwick Park Hospital is actually in Brent and that it is at the very east of Harrow, it is essential that Watford General Hospital retains a full A&E department in order to maintain access for Harrow residents who live in the west of the Borough.

2) Emergency Inpatient Activity:
From activity information received from West Hertfordshire Hospitals NHS Trust, the major areas of activity for Harrow Primary Care Trust, with the exception of Plastic Surgery and Obstetrics (see below), suggest a general elderly emergency admission profile i.e. activity in general medicine (97 cases), orthopaedics (69 cases) and care of the elderly (68 cases). These people will currently be going through the A&E department, and they may therefore not end up at Watford at all. Option 2 in the consultation document does, however, suggest that emergency admissions will still be possible at Watford. Should this service not be available, this would be a fairly heavy caseload to accommodate within the existing North West London Hospitals NHS Trust Services.

3) Obstetrics:
This is now a very significant area of activity at Watford, with 180 deliveries contracted for 2002-03 but a current year-end actual total of 291. Under Option 1, the proposal is that Watford would no longer be a full obstetric unit, but would be a birthing centre, offering midwife only care. This change could result in a number of mothers living south of Watford choosing to have their pregnancy managed at North West London Hospitals NHS Trust.

North West London Hospitals NHS Trust is still working through the impact of the changes resulting from Brent and Harrow's consultation on maternity services. This has resulted in all obstetric services being concentrated on the Northwick Park Hospital site, with a midwife led unit on the Central Middlesex site.

Option 1 would have a significant impact on the capacity of obstetrics services at North West London Hospitals NHS Trust, which they would at present be unable to cope with. Harrow Primary Care Trust, therefore strongly supports the plans for obstetrics as laid out in Option 2.

Option 1 would also present very significant risks for Harrow Primary Care Trust, in that there would be very limited choice of access to a comprehensive maternity service within easy travel distance for Harrow women. North Central London Strategic Health Authority is currently conducting a consultation, "Healthy Start, Healthy Futures". This focuses on improving health services for children, young people, pregnant women and babies. This consultation could result in the transfer of a full obstetric service on to one site, which could possibly mean the transfer of services from Barnet General Hospital to Chase Farm Hospital. Watford General Hospital and Barnet General Hospital are the two second biggest providers of maternity care for Harrow women after North West London Hospitals

NHS Trust, and the loss of both services would have a very significant impact on the service that is available locally to women, which Harrow Primary Care Trust would not be in a position to accept. Harrow Primary Care Trust therefore strongly supports the plans for obstetrics as laid out in Option 2.

4) Emergency Paediatric Activity
Harrow has a small flow of emergency paediatric activity to Watford. Option 2 would mean retaining inpatient beds at Watford General Hospital and establishing ambulatory paediatric services alongside A&E departments to provide observation and testing for children who need investigation or treatment. Harrow Primary Care Trust is satisfied that the models under either option would meet the need for emergency paediatric services.

5) Planned Surgery:
There is little inpatient elective surgery being undertaken at Watford for Harrow residents: in 2002, there were just 45 orthopaedic FCEs, 22 general surgery FCEs and 23 gynaecology FCEs. Activity for elective day cases is also fairly small: 26 orthopaedic FCEs, 16 general surgery FCEs and 12 gynaecology FCEs.

With the introduction of the London Patient Choice Programme, we have already begun to see a shift in the number of patients attending Watford for planned surgery. The next few months will see the development of further Diagnostic & Treatment Centre (DTC) capacity within North West London and the extension of London Patient Choice Programme to the full range of specialties and to a lower waiting time threshold. In this context, Harrow Primary Care Trust anticipates a continuation of the shift away from planned surgery activity for Harrow from West Hertfordshire Hospitals NHS Trust.

On balance, therefore Harrow Primary Care Trust has no preference with regards to planned surgery and would not oppose the development of a DTC at Hemel Hempstead, as laid out in Option 2. The retention of access to emergency services at Watford General Hospital is a greater priority for Harrow Primary Care Trust.

6) Conclusion:
On balance, Harrow Primary Care Trust would support Option 2 as the preferred option for reasons outlined in relation to A&E, emergency medicine services and maternity services.

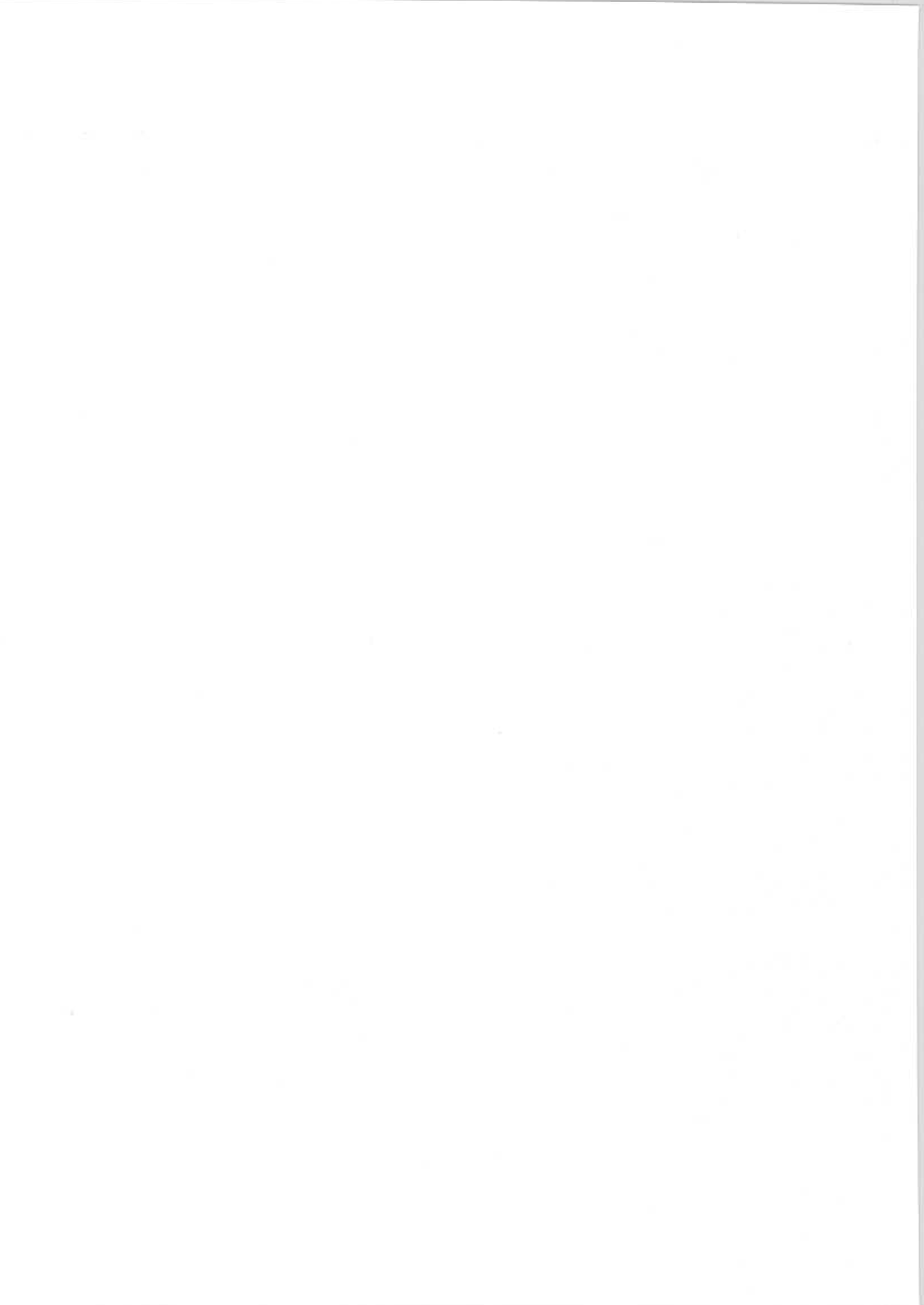
The proposals with regards to elective surgery and emergency paediatric services are acceptable to Harrow Primary Care Trust under both options. However, these represent a very small proportion of Harrow activity at West Hertfordshire Hospitals NHS Trust and therefore the strong preference of Harrow Primary Care Trust would be for Option 2.

I hope that you find the above evidence helpful and await further correspondence regarding the response of the Joint Scrutiny Committee.

Yours sincerely,

pp Natalie Grazin

SUE McLELLEN
Chief Executive



FROM: Professor Roy Sanders
Director of Research

raft

Restoring Lives

THROUGH RECONSTRUCTIVE PLASTIC SURGERY RESEARCH

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

Leopold Muller Building
Mount Vernon Hospital
Northwood
Middlesex HA6 2RN
Tel: (01923) 835815
(01923) 844017
Fax: (01923) 844031
Internet: http://www.raft.ac.uk
Email: charity@raft.ac.uk

21 August 2003

Chief Patron
HRH The Duchess of Kent GCVO

Patrons
Mr John Apthorp OBE
The Lady Ashcroft
Sir Robin Chichester-Clark
Lady Kirby Laing MB BS DMRD
The Lady Lamont
The Earl & Countess of Leicester
The Rt Hon Lord Merlyn-Rees
Mrs Moyra Pim Armstrong
Mr David Suchet
The Rt Hon Lord Tebbit CH
The Rt Hon Lord Wakeham DL

Council of Management
Mr David C T Pollock (Chairman)
Mr Marcus Agius
Ms Lisa Arnold
Mr John Craig CBE
Mrs Hermione Crosfield OBE
Mr E Michael Garston LLB
The Hon Tony Grimston
Mr Alan Henderson
The Earl Howe
Mr Sam Laidlaw
Lady Oliver
Mr Tony Sacker
The Rt Hon Sir Murray Stuart-Smith
Mr Edward Whitley

Director of Research
Professor Roy Sanders
BSc MB BS FRCS

Director (Admin & Appeals)
Mrs Hilary Bailey MInstF

Dear Mr Hamilton,

I am asked to respond on behalf of the RAFT Institute of Research & Plastic Surgery to the consultation document on the future of services for cancer patients. I find it extraordinary that the consultation period coincides with the principal period of vacation, that your letter is dated 6 August, was received on 11 August and that a response is required by 22 August. There seems to be variance with the letter from the North West London NHS Strategic Health Authority which is dated 19 June and stipulates a period of consultation until 12 September.

It was necessary for us to obtain the consultation paper from the Cancer Centre since it has never been sent to us. Even Mr Cussons, the Clinical Director for the plastic surgery services, states to me that he has never seen it. Perhaps you would care to consider these comments and whether this constitutes a satisfactory response.

It is, within the timescale, only possible to give cursory attention to the consultation document as I am sure you will understand and I will constrain my remarks to aspects of the proposals which affect research in plastic surgery.

The repeated reviews which have been undertaken in relation to the Cancer Centre, and indeed to plastic surgery, have seriously destabilised the clinical service and our ability to raise and retain funds to support research especially since the outcome of each review has been to achieve absolutely nothing except to propose yet another interim solution or a further review.

FROM: Professor Roy Sanders
Director of Research

The joint clinical and research view from plastic surgery has been that the disruption of what has been one of the most profitable, inventive and leading collaborations in the field of cancer surgery between the various surgical elements at Mount Vernon the Cancer Centre and the Gray Laboratory is a tragic loss to the standard of care of present and future cancer patients in the world. The correct solution is to reconsolidate the service either on this or another site at the earliest moment.

The transfer of oral and maxillofacial surgery to the Central Middlesex Hospital has left head and neck surgery without any plastic surgical support. It is not true, as on page 6 of the consultation document, to say that it has moved to Northwick Park. It is therefore also untrue to say that link services have been retained on the Mount Vernon site. It would be optimal if head and neck surgery were reconsolidated here until moved to an appropriate centre so that our research into this important element of cancer treatment can receive the same investigation and development as we are presently committing to the management of skin cancer.

From the research point of view, since much of our work is related to cancer, it would be desirable that Bedfordshire and Hertfordshire's plans to develop a new integrated cancer centre at Hatfield or Hemel Hempstead should come to fruition and, as contracted by the North West Thames Regional Health Authority, that the establishment of RAFT and the whole research unit should be resited with the centre.

One of the great tragedies of the excellence of the dissipation of Mount Vernon has been the loss of confidence by Cancer Research UK in its ability to sustain the Gray Laboratory in its present setting since it is the juxtaposition of patients with science which has enabled the major advances the Gray Laboratory, the Cancer and Plastic Surgery Centre have achieved and, through it and the Cancer Centre, the major advances which RAFT has been able to achieve.

The presence of an ambulatory centre for the treatment of cancer patients at Mount Vernon as a replacement for a major oncology centre will greatly impair the ability of the RAFT Institute to produce cutting edge research in the field of cancer. However, if it is inevitable, it will be infinitely desirable that, at the earliest moment, a decision be made, which crosses regional boundaries, to enable the co-location of a major cancer centre with the associated services of anaesthesia, reconstructive surgery in its various forms, <u>and</u> research.

I fear these comments will pass unregarded but felt I should, even at this short notice, produce some response.

Yours sincerely,

Copy to: Mr Paul Cussons

To: The London Borough of Harrow Health & Social Care Scrutiny Sub-Committee

From: The Pinner Association. 30.06.03

Response to the North West London Strategic Health Authority Consultation Document "Mount Vernon Hospital: The Future of Services for Cancer Patients"

As our previous submission (22.4.03) to the Committee was based upon the Beds. & Herts. Strategic Health Authority's (BHSHA) document "Investing in Your Future", we thought it appropriate to await actual publication of North West London Strategic Health Authority's (NWLSHA) proposals on Mount Vernon– now available under the title in our heading – before responding to your invitation to make further comment.
Our response to the NWLSHA document should therefore be read in conjunction with our earlier submission.

We welcome the NWLSHA document in three ways:

1) as recognition of the strength of public feeling against the Herts. & Beds. proposals to transfer the MV Cancer Centre to Herts;
2) as an earnest of the NWLSHA's intention to take Mount Vernon Hospital back into London management; and
3) as a further assurance that this important local hospital has a long term future.

However, though generally well constructed and well written, it gives cause for concern in a number of respects, not least for its absence of detail, understandable in the light of the short time scale available for its preparation, but none the less raising many more questions than it invites us at various places in the document to answer. To illustrate this, we make general comments in the form of answers to the questions posed and follow these within some more specific points.

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

Yes, in order to rescue it from the long-term decline to which years of no investment and constant erosion of services have condemned it.

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

Yes, but it is equally the case that a unique cancer community does not need to be destroyed in order to provide the improvements which will ensure MV's future.

Q3. If you believe that MV needs to change in another direction, give brief details

It is not a question of changing in another direction. As the document concedes, MV is not a fully-fledged "Cancer centre" within the accepted NHS definition, but a "non-surgical oncology centre". There seems to us no reason why that status cannot be retained, given the general agreement, accepted by NWLSHA, on the future increases that can be expected in the incidence of cancers, to the benefit of local patients and of the continuity of vital research.

.... continued ....

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

Q5. Do you support the development of an ambulatory radiotherapy service at MV provided all quality and safety requirements are met?

These questions are taken together since the key to the nature of services to be provided is the word "ambulatory". Senior oncologists at Mount Vernon are in no doubt that a purely ambulatory service (ie without the 65 beds currently dedicated to cancer patients, all of them full virtually all the time) would drastically reduce the scope of treatment that could be offered, both in qualitative terms and in terms of the range of cancers that could be treated. The effect of this would be to downgrade patient service and choice and seriously to undermine the scale of research, both clinical and more exploratory.

Rather than answer **Q6.,** we would make these additional comments:

1. Although the document is concerned primarily with cancer services, it does make reference to the other proposed developments on the MV site which, as was stated in our previous submission, we warmly welcome. However, there is no mention of the plastic surgery unit, which the Herts./Beds. plans imply they might also wish to transfer.

2. Much is made throughout of the findings of the Long Term Review of Cancer Services as the basis for moving the Mount Vernon Cancer Centre. This review has never been the subject of public scrutiny or discussion and a significant minority of the members of the Review body disagreed with its findings, though the final document was published without qualification.

   Moreover, a distinguished retired academic, Professor Mervyn Stone (a Hillingdon resident), has criticised the statistical analyses used to back these findings as seriously flawed. His views have subsequently been endorsed by Professor Sir David Cox and Dr. David Spiegelhalter, eminent statisticians at Oxford and Cambridge respectively. They conclude:

   > "Perhaps the most important criticism that can be made ...... is to ask whether the Review has followed Calman-Hine too inflexibly and not allowed sufficiently for local factors."

3. There is no indication of the timing of any of the proposals with regard to London-run cancer services. The implication of this, supported by the tenor of much of the document, is that NWLSHA will allow the BHSHA plans for moving the Cancer Centre to Herts. to proceed, before assuming control. Surely, to break up a first-class team only to have to try and find, shortly afterwards, new staff and equipment in an attempt to replace it with another, albeit perhaps lesser, unit in the same location would be needlessly inefficient and likely to result in a waste of scarce resources.

In short, there are many questions to be answered before we should feel able to endorse these proposals.

For and on behalf of The Pinner Association

James Kincaid
Chairman, Health Sub-Committee

The Pinner Association

FOUNDED IN 1932
REGISTERED CHARITY 1971. No 262349
ONE OF THE LARGEST AMENITY
SOCIETIES IN THE COUNTRY

To: The London Borough of Harrow Health & Social Care Scrutiny Sub-Committee

From: The Pinner Association. 22.04.03

Response to the Beds. & Herts. Strategic Health Authority Consultation Document "Investing in your Health"

Let me say at the outset that we applaud the Authority's attempt to apply a degree of strategic thinking to the reorganisation and development of the acute hospital services within their area of responsibility.
The comments which follow relate to those aspects of their proposals which impinge upon the level and quality of health care currently enjoyed by residents of the Borough of Harrow and which might be likely to affect the future levels of this care.
Our concern therefore focuses particularly on the proposals to remove plastic surgery and the majority of cancer services from the Mount Vernon site.

1. The transfer of cancer services is postulated as an integral part of both options offered, but has never been the subject of any public consultation, despite the importance of these services to patients from at least four Strategic Health Authority areas. The document under review gives no opportunity to opt for the Cancer Centre remaining where it is, but in any case we believe that an issue of this importance to a large inter-regional population should not be decided in the interests merely of the residents of Hertfordshire and Bedfordshire.

2. An extended period of public consultation some three years ago resulted in the decision that plastic surgery should transfer from Mount Vernon to Northwick Park Hospital, yet both options in the Beds./Herts.document assume that this service will also move to Herts., again with the only choice offered being whether to move it to Hemel Hempstead or to Hatfield.

3. In the light of the above points it is somewhat ironic that the document consistently refers to the recent DoH paper "Keeping the NHS. Local" - which lays maximum emphasis on the need to consult the public at every stage on intended major changes in health services including even before the planning stage.

4. The Cancer Centre is very highly regarded within its current catchment area and little or no hard evidence is available that moving it, with all the disruption and huge cost that will entail, will result in a better service, surely the critical test of any major change.

Continued ....

PUBLISHERS OF
The Villager

5. Over many years a variety of research and support organisations, several with national and even international reputations, have developed around the cancer Centre on its present site. The nature and funding (largely charitable) of these institutions is such that they are unlikely and/or unable to follow the Centre in any move.
   The Gray Research Institute, the Marie Curie Research Wing, the Paul Strickland Scanner Centre, as well as the Lynda Jackson Macmillan Centre and other support facilities, together with the Cancer Unit, form a Cancer Community unique in the UK which would be destroyed by the arbitrary removal of the Cancer Centre to Hemel Hempstead/Hatfield.

In summary, the future of the Mount Vernon Cancer Centre is too important to be decided within the narrow confines of what is best for Bedfordshire and Hertfordshire, with whose desire for more centrally based acute services including cancer care we have every sympathy. The Mount Vernon Cancer Community is a national asset which should be preserved and if possible developed as part of the government's commitment to improving the overall standard of cancer care in the UK.

Finally, a few words on the North West London SHA document "Mount Vernon Hospital- Help us Shape its Future".
We fully accept and welcome the proposals for development of the Mount Vernon site with all the proposed community health and non-acute services most of which have little connection or overlap with the Beds./Herts. proposals for the removal of acute services and as such might have been implemented at any time. However they are additionally welcome for the assurance they provide as to Mount Vernon's future, which might otherwise have seemed precarious in the light of the Beds./Herts. plans.
Where we do take issue is with the somewhat complacent assumptions about the readiness with which the half-million or so north-west London residents who hitherto came within the Mount Vernon Cancer catchment are to be absorbed into other existing cancer institutions. We would wish for evidence of considerably more detailed planning in this regard.

For and on behalf of The Pinner Association

James Kincaid
Chairman, Health Sub-Committee

Ref: lg/cvw/letters

Bedfordshire Heartlands

Primary Care Trust

Health Improvement and Partnership Directorate
2 Doolittle Mill
Froghall Road
Ampthill
Bedfordshire
MK45 2NX

Tel: 01525 636803 [6803]
Fax: 01525 636800 [6800]
E-mail: leigh.garraway@bedsheartlandspct.nhs.uk

22nd August 2003

Professor Sir Ron De Witt
Chief Executive
North West London Strategic Health Authority
Victory House
170 Tottenham Court Road
London
W1T 7HA

SELECT COMMITTEE
29 AUG 2003
SUPPORT

Dear Professor De Witt

Mount Vernon – The Future of Services for Cancer Patients

Thank you for providing an opportunity to comment on the proposals for the future of Mount Vernon Hospital, which are set out in your recent consultation document.

Mount Vernon is the principal tertiary centre for the South Bedfordshire area of the PCT and many oncology specialists at Mount Vernon outreach to the Luton & Dunstable Hospital, which is the Cancer Unit for Luton and South Bedfordshire. The future services of Mount Vernon are extremely important to the PCT and PCT Managers are active within the Mount Vernon Cancer Network.

The Board of the PCT received a paper on the 24th July [enclosed] that summarised the main proposals in the consultation document. The Board supported the –

- need for Mount Vernon to change in line with the proposed cancer centre developments at the Hammersmith Hospital and in Hertfordshire, i.e. at Hemel Hempstead or new hospital at Hatfield;

- proposal that Mount Vernon's long-term future is likely to be a combination of ambulatory non-surgical oncology centre to a smaller catchment area than at present and local community diagnostic and treatment Centre in support of primary care;

- continuing provision of ambulatory radiotherapy at Mount Vernon as long as appropriate quality standards can be achieved.

I do hope this response addresses the key questions set out in the consultation document. The PCT would be pleased to receive the overall outcome of the consultation process in due course.

Yours sincerely

Leigh Garraway
Director of Health Improvement and Partnership

cc John Swain – CE
Robin Younger – Chairman
Dr Steve Feast – PEC Chair
Bill Hamilton – Assistant CE [Scrutiny], BCC

BEDFORDSHIRE HEARTLANDS PRIMARY CARE TRUST

BOARD MEETING

THURSDAY 24TH JULY 2003

CONSULTATION DOCUMENT – THE FUTURE OF SERVICES FOR CANCER PATIENTS – MOUNT VERNON HOSPITAL

1. INTRODUCTION

The StHA Strategy *Investing in your Health* for the future organisation of hospital services in Bedfordshire & Hertfordshire makes proposals for the creation of a new cancer centre for South Bedfordshire and Hertfordshire. It is proposed that this centre is co-located with either Hemel Hempstead Hospital or a new hospital at Hatfield. Such a centre would provide the full range of specialist diagnostic, surgical and oncology services.

The creation of such a facility together with the development of the Hammersmith Hospital as a similar centre for North West London brings the future of Mount Vernon Hospital into sharp focus.

The NW London StHA has set out proposals for the future of Mount Vernon Hospital in tandem with *Investing in your Health* and views are sought from all organisations that use Mount Vernon as a tertiary centre. Residents of Heartlands who live in the Dunstable and Houghton Regis locality use Mount Vernon as a principal cancer centre for tertiary referrals from the Luton & Dunstable Hospital.

2. NATIONAL ORGANISATION MODEL FOR CANCER SERVICES

The National Model for Cancer Services described in the National Cancer Plan recommends the organisation of cancer services on three levels.

Primary Care	Prevention, early identification of cancer and palliative care.
Cancer Units	Located in local District General Hospitals with multi-disciplinary teams able to treat common cancers, such as colorectal and breast cancer.
Cancer Centres	Situated in larger hospitals [probably teaching hospitals] supporting a population of 1-2 million with adequate resources to treat the less common cancers, e.g. head & neck, urological and gynae cancers. Such services to include surgery, complex chemotherapy and radiotherapy.

Mount Vernon supports a wide catchment area ranging across Bedfordshire and Hertfordshire, North West London, North Central London and Thames Valley StHAs.

Mount Vernon is not currently recognised as a cancer centre but as a non-surgical oncology centre [chemotherapy and radiotherapy]. This is because Mount Vernon closed as a general hospital some years ago and cannot provide comprehensive surgery for either common or rare cancers.

It is not considered viable to re-establish Mount Vernon as a cancer centre as this would involve having to move surgical services from neighbouring hospitals, such as Hillingdon, Northwick Park [Harrow] or Watford.

3. PROPOSALS FOR THE FUTURE OF MOUNT VERNON

The proposals for Mount Vernon are –

⇒ the development of Mount Vernon Hospital as a local facility within the West London Cancer Network

⇒ that the unit be used to provide ambulatory non-surgical oncology to a smaller, local catchment area, including the provision of

- outpatient services
- complex chemotherapy not available at DGH Cancer Units
- palliative care from the Michael Sobell NHS Hospice
- patient & carer support from the Lynda Jackson Centre
- radiotherapy in support of cancer centres
- scanning from the Paul Strickland Centre
- overnight stays [where necessary] at Chart Lodge Patient Hotel
- research at the Gray Institute

⇒ Mount Vernon will be able to "scale down" its overall capacity to support a smaller catchment area as the new cancer centres for Bedfordshire and Hertfordshire and the other StHAs detailed above are established. This will take some time.

⇒ In addition to the above cancer services Mount Vernon develops as a "local hospital" similar to the Community Diagnostic and Treatment Centres proposed in *Investing in your Health*. Such a facility would provide

- elective intermediate day surgery
- community diagnostics
- intermediate medical care
- care of the elderly services
- enhanced primary care services

4. TIMESCALES

The development of a new cancer centre for Bedfordshire & Hertfordshire either on a new hospital site or Hemel Hempstead will take a number of years to bring into place. If it is a new hospital site at Hatfield, it is estimated that it will take approximately 10 years to commission. Mount Vernon will therefore be the

principal provider of complex chemotherapy and radiotherapy to Bedfordshire & Hertfordshire for some years. It will be important to continue to invest in the Hospital to meet cancer plan waiting times.

In the immediate future the Bedfordshire & Hertfordshire Cancer Network is taking forward recommendations to centralise complex cancer surgery services by identifying DGHs within the StHA area to provide cancer centre surgical and oncology services for most of the StHA catchment area [Bedford and Mid Beds residents will continue to link with Addenbrooke's Cancer Centre].

In this development programme, it is proposed that the Luton & Dunstable Hospital will provide Head & Neck cancer services; Watford will provide Gynae with Lister and Hemel Hempstead providing Upper GI and Urological services.

During this interim arrangement Mount Vernon will continue to provide complex chemotherapy and radiotherapy services to the Bedfordshire & Hertfordshire Network.

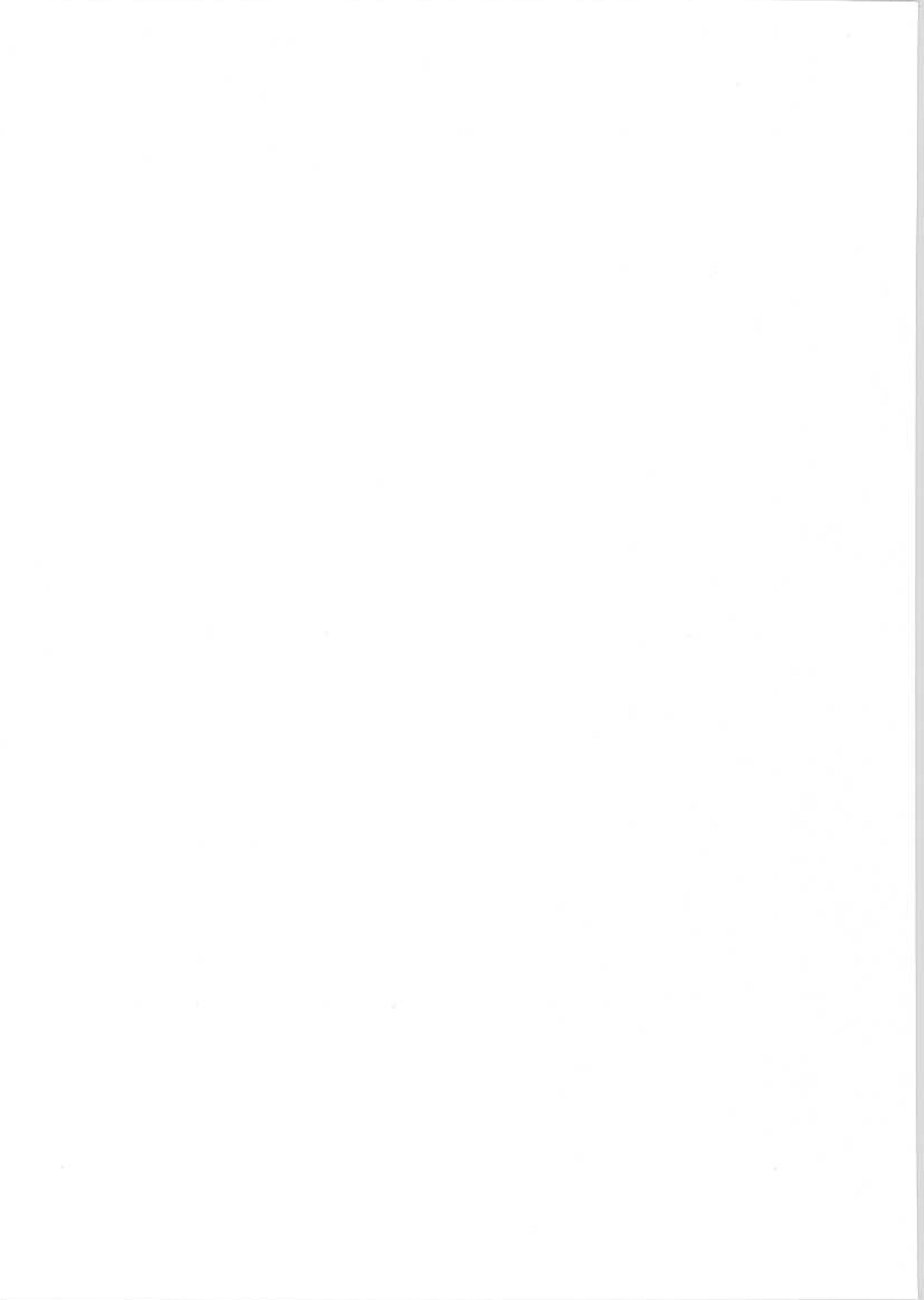
5. RECOMMENDATIONS

Members of the Board are asked to support the general recommendations set out in the consultation document and summarised in this paper.

Leigh Garraway
Director of Health Improvement & Partnership

Dr Rysz Bietzk
PCT Clinical Cancer Lead

16th July 2003



Bedfordshire and Hertfordshire **NHS**
Ambulance and Paramedic Service
NHS Trust

Ambulance Headquarters
Hammond Road
Bedford
MK41 0RG

Tel: 01234 408999
Fax: 01234 270480
Email: info@bhamb.nhs.uk
Website: www.bhamb.nhs.uk

1st September 2003
AW/mr

Mr Bill Hamilton
Assistant Chief Executive (Scrutiny)
FAO Katherine Peddie
Room 359
County Hall
Cauldwell Street
Bedford
MK42 9AP

Dear Bill

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

Thank you for your letter of 8th August 2003 regarding the Joint NHS Scrutiny Committee which is due to meet on the 9th September at Hillingdon Civic Centre to consider the consultation on the Mount Vernon Hospital and the future of Services for Cancer Patients.

You indicated that you are interested in any comments we might have on this consultation and I am writing with a few points that you may wish to take into consideration. The Ambulance Trust is responsible for transporting many patients from Bedfordshire and Hertfordshire for treatment at Mount Vernon Hospital. The patients we take are often very unwell and the quality of the current Patient Transport Service (PTS) falls below the expectations of many of those patients. Journeys are long and often uncomfortable in ageing PTS vehicles and the staff struggle to meet appointment/treatment times and to offer a return journey without an extended wait. From the patients point of view their journey to Mount Vernon is part of their overall care. Long and uncomfortable journeys do not add positively to their overall experience and outcome of their treatment/care. We know these issues are very real as we have been involved in the Cancer Care Group and transport is a significant concern.

Agreeing a sustainable way forward for cancer services and acute services in Bedfordshire and Hertfordshire is regarded as a priority by the Ambulance Trust. We would agree with the main reasons for change in the June 2003 Consultation Paper on Mount Vernon Hospital and support the retention and development of ambulatory cancer services for patients at Mount Vernon. We would however

Chief Executive - Anne Walker
Chair - Maria Ball

like more local services for patients in Bedfordshire and Hertfordshire so that the transport that we are responsible for providing can be more appropriate for their needs.

This Trust regards the agreement of a long term plan which would establish a sensible and sustainable pattern of acute and specialist service provision in Hertfordshire and Bedfordshire as a priority. The Trust would wish to see a new cancer centre as part of that provision.

I hope these comments are helpful. I am sorry for the delay in forwarding them to you which was due to annual leave.

Yours sincerely

Anne Walker.

Anne Walker
Chief Executive

cc: BHAPS Board

Peddie, K,Select Comm Support

From: NHS Scutiny Email Account
To: Peddie, K,Select Comm Support
Subject: FW: Mount Vernon
Date: 20 August 2003 09:23PM

From: Stan Dische
To: NHS Scutiny Email Account; Jane Evers; Nicola Ward; Peter Wardman
Subject: Mount Vernon
Date: 19 August 2003 16:57PM

Gray Cancer Institute
Chairman Professor Stanley Dische

Mr. Bill Hamilton
Assistant Chief Executive
Bedford County Council

FAO Katherine Peddle

Dear Mr. Hamilton

Your letter which was dated 6 Aug. 2003 concerning the future of services for cancer patients at Mount Vernon hospital and the invitation to present a submission by 22 August has just reached me. I do not think it is appropriate or indeed possible for me to prepare a detailed submission at that this time. As you know over the recent years we have communicated a great deal of material to the many different review committees and inquiries which have been set up to deal with the subject. Professor Peter Wardman has been responsible for a number of communications from the Gray Cancer Institute.

All the review bodies have recognized that the Mount Vernon Cancer Centre together with the Grey Cancer Institute have established an international reputation for cancer care and cancer research. Together they form one of the most important places in the field of cancer within the country. Unfortunately the continuation of this work appears to have been given no priority by these reviews.

We are presently negotiating with a leading university for the GCI to be incorporated within it and this may require a removal of elements to a university campus. We hope to come to decisions within a matter of months. Continuation of work on the Mount Vernon site is part of the negotiation and we would think it important to continue our successful cooperation with the staff of the Cancer Centre. It remains extremely important to the advance of knowledge concerned with radio and tumour biology that this work continues.

If your files do not contain information previously submitted or if any new information is required then please contact my secretary at the GCI, Nicola Ward, or our administrator Dr. Jane Evers.

Yours Sincerely

Stanley Dische

Stanley Dische
e-mail address dische@mtvern.co.uk
home address Apartment 11
36 Jamestown Road
Camden Lock
London NW1 7BY
telephone/fax (0)207 482 2603

Primary Care Trust

Working with our partners for a healthier Brent

SELECT COMMITTEE
0 9 SEP 2003
SUPPORT

Commissioning and Modernisation
Wembley Centre for Health & Care
116 Chaplin Road
Wembley
Middlesex
HA0 4UZ

Tel: 020 8795 6680
Fax: 020 8795 6679

Email: jill.shattock@brentpct.nhs.uk

Mr W Hamilton
Assistant Chief Executive (Scrutiny)
FAO Katherine Peddie
Room 359
County Hall
Cauldwell Street
Bedford
Beds
MK42 9AP

Ref: JS/SA/92

5th September 2003

Dear Mr Hamilton

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

Please find enclosed copies of evidence provided to the local Overview and Scrutiny Committee, with regards to the above.

The enclosed consists of a covering letter to Mary Farrell and the papers that were considered by the PCT Board in July. The final response, to take into account any views not yet received will be considered by the Board on 25th September.

If you should require any further information, please do not hesitate to contact me.

With regards

Yours sincerely

Jill Shattock
Head of Performance and Service Development

Cc: Simon White, Brent Council
Stephen Jones

Brent NHS
Primary Care Trust

Working with our partners for a healthier Brent

Commissioning and Modernisation
Wembley Centre for Health & Care
116 Chaplin Road
Wembley
Middlesex
HA0 4UZ

Tel: 020 8795 6680
Fax: 020 8795 6679

Email: jill.shattock@brentpct.nhs.uk

Councillor Mary Farrell
Chair, Health Overview Panel
Brent Town Hall
Forty Lane
Wembley
HA9 9HD

1st August 2003

Dear Mary

Re: Mount Vernon Reconfiguration

I am writing to set out the PCT's views on the above, as proposed, in parts, by Bedfordshire and Hertfordshire Strategic Health Authority and North West London Strategic Health Authority.

I enclose a copy of a paper that was presented to the PCT Board on 17th July which will explain the somewhat complicated history to this exercise. The paper and draft responses were agreed in principle, by the Board, subject to receiving Brent public's views over the next month and at an open meeting to be held on 8th September, which I will be attending.

In summary, the population of Brent likely to be affected is to the north of the borough. The planned changes to Mount Vernon will not change the services that the small numbers of Brent patients' access on that site.

The wider acute Trust changes across Bedfordshire and Hertfordshire would have significant implications if services to Watford General Hospital (part of West Hertfordshire NHS Trust) were changed, namely A&E and maternity. It is the PCT's view that these proposals would not be acceptable due to the potential consequences for our local acute Trust, North West London Hospitals.

Please let me know if there is any further information you would like.

With best wishes

Yours sincerely

Copy

Jean Gaffin OBE
Chair

Enc.

Cc: Simon White, Policy & Regeneration Unit, Brent Town Hall.
Stephen Jones, Director of Joint Working, Brent PCT.

A. Bedfordshire & Hertfordshire Strategic Health Authority - Investing in Your Health.

B. North West London Strategic Health Authority – Mount Vernon Hospital, Help us to Shape its Future.

C. Mount Vernon Hospital: The Future of Services for Cancer Patients.

1. Earlier in the year, Bedfordshire and Hertfordshire Strategic Health Authority launched a consultation paper, entitled *"Investing in Your Health" (A)*, which sets out proposed changes for the hospitals and services across the two counties. These proposals may not affect Brent residents directly but it does include West Hertfordshire Hospitals NHS Trust, which in turn covers both Watford and Mount Vernon hospital sites. North West London Strategic Health Authority, in conjunction with Hillingdon, Harrow and Brent PCTs, have also produced a shorter document outlining just the Mount Vernon proposals in more detail (B). Immediate local reactions to the Mount Vernon document (B), necessitated a further detailed examination of the options for Mount Vernon specifically relating to cancer services and so "Mount Vernon Hospital: The Future of Services for Cancer Patients" (C), was produced and the consultation period extended to 12th September 2003.

2. Investing in Your Health sets out two options for the re-profiling of acute hospital care in Hertfordshire and Bedfordshire. These can be summarised as follows:

   i. Option one envisages retaining the six existing major hospitals including the substantial redevelopment of Hemel Hempstead Hospital and the Lister Hospital in Stevenage. Both would provide the full profile of acute hospital services as well as specialised ones. Under this option Watford and QE II Hospital in Welwyn Garden City would concentrate mainly on elective care. The Mount Vernon Cancer Centre would be transferred to Hemel Hempstead and appropriate services developed around it to meet 21st century requirements.

   ii. Option two envisages a new hospital development on a new site at Hatfield (replacing the QE II Hospital at Welwyn Garden City). Watford Hospital would provide the full range of hospital services as well as specialised ones. The Lister Hospital and Hemel Hempstead would concentrate mainly on elective care. Under this option the Mount Vernon Cancer Centre would be developed on the new hospital site at Hatfield.

3. Both options assume that ambulatory radiotherapy and some chemotherapy will remain on the Mount Vernon site. The change will be where patients require to be inpatients during their treatment, in which case it would be necessary to travel to the new Mount Vernon Cancer Centre site or to the West London Cancer Centre at the Hammersmith Hospital.

4. The future of the Mount Vernon Cancer Centre has already been subject to a long term review; in which it was concluded that the two ways in which the service could be configured to met the recommendations of the Cancer Plan, were either by becoming part of a comprehensive district general hospital or by becoming a stand alone cancer hospital.

It is acknowledged that the development needed for Mount Vernon to achieve the appropriate accreditation as a stand alone centre is not sustainable.

5. The site resides in NWL Strategic Health Authority area and is owned by Hillingdon Hospital, the relocating of the specialist services provides an opportunity for Harrow and Hillingdon PCTs to develop services on the site. The proposal includes retaining "ambulatory" cancer care as part of both the Hertfordshire and West London Cancer networks; i.e. outpatient clinics from the centres at Hammersmith and Hertfordshire, diagnostics (existing – Paul Strickland centre), chemotherapy, radiotherapy, palliative care (existing hospice – Michael Sobell House) and patient and carer support (existing - Lynda Jackson Centre).

6. Based on 02/03 figures, 170 Brent patients attended the Mount Vernon site, 52 for chemotherapy and 118 for radiotherapy, this would not change under these proposals.

7. All consultation documents have been widely circulated to GP practices in the North Brent area and a summary was provided to GP practices across the rest of Brent. To date no comments from either GPs or members of the public have been received by the PCT.

DRAFT

Bedfordshire & Hertfordshire
Strategic Health Authority
Tonman House
63-77 Victoria Street
St Albans
Herts Al1 3ER

18th July 2003

Dear Sirs

Re: Investing in Your Health

I am writing to provide a formal response from Brent PCT to the proposals set out in the above document, as considered by the PCT Board yesterday. I appreciate formal consultation doesn't end until September but the timing of our Board meetings have necessitated early consideration.

As part of the proposed changes affect the services to be provided on the Watford Hospital site, which could have substantial ramifications on our local NHS Trust, the PCT feels that option two which leaves Watford Hospital unchanged would be the most preferable.

If you should require any more detail please do not hesitate to contact me.

With regards

Yours faithfully

Jean Gaffin OBE
Chairman

Draft

Professor Sir Ron De Witt
Chief Executive
North West London Strategic Health Authority
Victory House
170 Tottenham Court Road
London W1T 7HA

18th July 2003

Dear Ron

Re: Mount Vernon: The Future of Services for Cancer Patients

I am writing to provide a formal response from Brent PCT to the questions posed in the above document, as considered by the PCT Board yesterday and shown in the attached.

I appreciate formal consultation doesn't end until September but the timing of our Board meetings have necessitated early consideration.

With regards

Yours sincerely

Dr Lise Llewellyn
Chief Executive

Questions:

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

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

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

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

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.

Q6 Are there any other issues linked to the development of local services at Mount Vernon of which you wish us to be aware?
No.

BRENT
COMMUNITY HEALTH COUNCIL

22 Willesden High Road, London, NW10 2QD

Tel: 020 8451 4697
Fax: 020 8451 4533

1ST September 2003

TO WHOM IT MAY CONCERN

BRENT COMMUNITY HEALTH COUNCIL'S RESPONSE

**Re: A CONSULTATION PAPER
MOUNT VERNON HOSPITAL – THE FUTURE OF SERVICES FOR CANCER PATIENTS**

Brent Community Health Council's response is in the form of comments and conclusions, and cover the points raised in the questionnaire.

It is hoped that all interested parties in the decision making process concerning Mount Vernon will carefully consider their policies in order to avoid further mistakes.

At present Mount Vernon serves a population of over two million people including residents of Harrow, Hillingdon, Brent (NWLSHA), Barnet (NCLSHA), Buckinghamshire and parts of Berkshire (Thames Valley SHA). Of course, it also serves patients from Beds and Herts including West Herts just across the County borders where patients would probably find it more convenient to attend Mount Vernon than the proposed centres at either Hemel Hempstead or Hatfield. An overwhelming number of the currently served population of Harrow and Hillingdon but also from other parts including Hertfordshire are in favour of retaining the Cancer Centre at Mount Vernon. A petition to save Mount Vernon has over 60,000 signatures. Despite the poor infrastructure, Mount Vernon receives popular acclaim. This is indeed endorsed in a paper by Helen Mellor. (Strategic Projects Director) of NWLSHA in June 2003 and notes also that Hillingdon and Harrow CHC had serious reservations about the Beds and Herts consultation document and in a joint letter to the Secretary of State for Health have expressed their concern.

It has been generally agreed, for one purpose or another, that Mount Vernon will need a great deal of re-building. This will obviously incur considerable costs. If the re-building planning included the creation of an extended Cancer Centre, then in relative terms, such extra costs would be diminished, specifically if we take into account the immense costs of moving the existing viable equipment including the new Paul

Strickland scanners. It would also strengthen the case to retain at Mount Vernon the complementary prestigious Burns and Plastic Centre. The important Grays Research Institute, which is unlikely to move, could stay at Mount Vernon, as well as The Linda Jackson MacMillan Centre and Michael Sobell House. It will also please the many clinicians who are unhappy about the prospects of moving.

Conclusion

1. Brent Community Health Council objects to the proposal to move the Mount Vernon Cancer Centre off its present site.

2. It calls for responsibility for cancer services on the Mount Vernon site to revert to North West London SHA at the earliest opportunity.

3. It recognises, reluctantly, that if the Cancer Centre were moved off the Mount Vernon site, then its replacement by a Cancer Unit would be the best option available.

4. It prefers Option Two of the Beds and Herts SHA's options, providing that this refers only to the provision of acute health services and excludes moving the Mount Vernon Cancer Centre or its services to Hatfield.

5. It urges that before final decisions are taken the Government reconsiders its cancer centre guidelines, to reflect the many new opportunities provided by recent advances in cancer treatment and information technology, developed subsequent to the Calman-Hine Review.

6. Given the principles set out in the document Shifting The Balance of Power,

   We urge that the views of patients and the public be a major factor in final decisions about the future of the Mount Vernon Cancer Centre. These views are clearly indicated in the two surveys carried out by Hillingdon CHC as its contribution to the consultation process;

   a) "Mount Vernon Cancer Centre Patient Survey – November 2001"

   b) "Mount Vernon Cancer Centre Public Opinion Survey – August 2003"

   both of which show the strong opposition of local people to the proposals under consultation.

Signed: ______________________

Mansukh Raichura

Chair, Brent Community Health Council

95 Belmont Road, Uxbridge, Middlesex UB8 1QT
Tel. 01895 257858 Fax: 01895 813300

Chairman:
Mrs. M Ditchburn

Chief Officer:
Mr. B Hardy-King

September 2003

Cllr. David Horne, Chairman,
Joint Mount Vernon Scrutiny Committee,
County Hall, Calderwell Street,
Bedford MK42 9AP

Dear Cllr. Horne,

Email "Trevor Gash, NHS Scrutiny Email Account" to "Peddie K, Select Comm Support"

Hillingdon CHC was shocked to read this e-mail, copied to members of the Joint Scrutiny Committee. We refute this scurrilous document and write to you in response.

Throughout the Mount Vernon consultations, we have stated publicly that our objective is to achieve the best possible cancer services for patients. We have also stated that we will give full support to the proposal to move the Cancer Centre if convincing evidence is produced that:

a) Mount Vernon has poor patient survival rates
b) Moving all services onto one site has improved patient outcomes in other cancer centres.

Such evidence would justify the proposals, but Report 3 of the Rosie Varley Review is the only statistical evidence provided and that has been discredited in academic appraisal. We conclude therefore that there is no statistical evidence to justify the destruction of the excellent services currently provided at Mount Vernon.

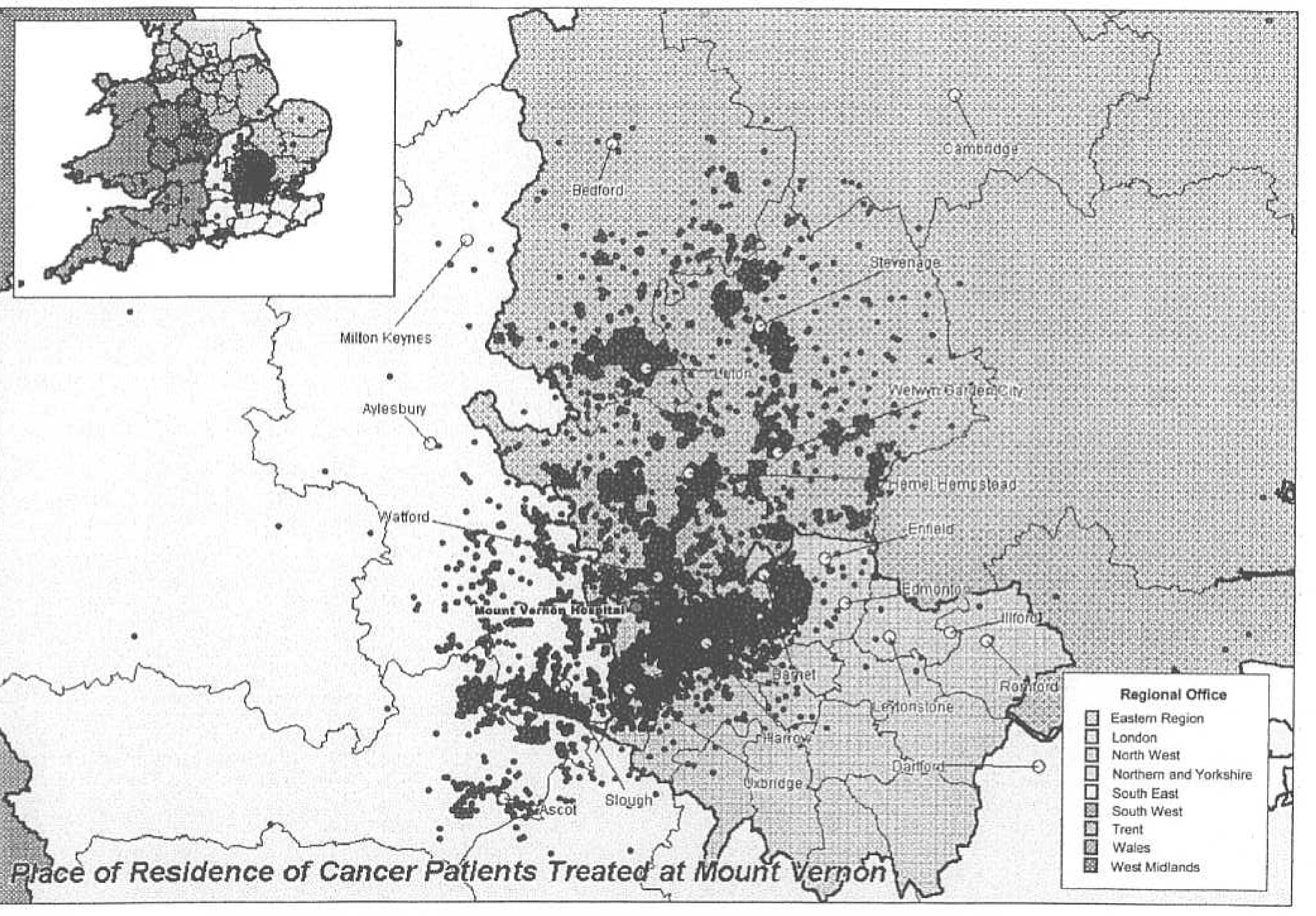
Furthermore, public consultation has had two significant outcomes. Firstly, the conspicuous lack of clinical evidence to justify the proposals and lack of support from clinical staff of the Mount Vernon Cancer Centre. If they supported the proposals, clinicians would surely have been anxious to persuade the public to share their views. Their absence from public meetings can only be interpreted as at least ambivalence, if not outright rejection of the proposals. This has undoubtedly contributed to the second outcome of the consultation - the universal rejection of the proposals by the public in the area surrounding the Cancer Centre.

We attach a map, provided for the Rosie Varley Review, already circulated to members of the Joint Scrutiny Committee, which has not photocopied well in black and white. This justifies our contention that, if the Mount Vernon Cancer Centre is moved, the majority of its patients will be disadvantaged – which is hardly a NOOMBY response as suggested by Trevor Gash!

We ask for your reassurance that the contemptuous attitude of this e-mail is not shared by members of the Joint Scrutiny Committee.

Yours sincerely,

Joan Davis, Vice Chairman


Place of Residence of Cancer Patients Treated at Mount Vernon
Regional Office
Eastern Region
London
North West
Northern and Yorkshire
South East
South West
Trent
Wales
West Midlands
Cambridge
Bedford
Stevenage
Milton Keynes
Luton
Welwyn Garden City
Aylesbury
Hemel Hempstead
Watford
Enfield
Edmonton
Mount Vernon Hospital
Ilford
Romford
Barnet
Leytonstone
Harrow
Dartford
Uxbridge
Slough
Ascot