MINUTES OF A MEETING OF THE JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE LOOKING AT NHS ENGLAND PROPOSALS FOR A SINGLE CENTRE FOR COMPLEX UROLOGICAL CANCER SURGERY IN ESSEX HELD ON TUESDAY 6TH SEPTEMBER 2016 AT 3PM AT COUNTY HALL, CHELMSFORD.

PRESENT:

Essex County Councillor Ann Naylor (Chairman)
Braintree District Councillor Jo Beavis
Southend Councillor Helen Boyd
Thurrock Councillor Tony Fish
Southend Councillor Cheryl Nevin
Essex County Councillor Andy Wood

The following officers were present to support the throughout the meeting:

Fiona Abbott – Lead Health Scrutiny Officer, Southend Borough Council.

Graham Hughes – Scrutiny Officer, Essex County Council.

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1. **Membership, attendance and apologies for absence**

Both Southend and Thurrock Councils had changed their nominations for the Joint Committee since the last formal meeting. The following was noted:

(i) Southend Councillor Helen Boyd had replaced Councillor Lawrence Davies. Councillor Cheryl Nevin continued as their other nomination;
(ii) Thurrock Councillor Tony Fish replaced Councillor Leslie Gamester.

Essex County Council representation remained unchanged.

2. **Declarations of interest**

Councillor Nevin declared that she had previous employment at both Basildon and Southend Hospitals.. No other declarations were made.

3. **Minutes**

The draft minutes of the meeting held on 9 March were approved as a true record.

4. NHS England Project Update

The following joined the meeting:

NHS England – Midlands and East:

Ruth Ashmore, Assistant Director of Specialised Commissioning.
Pam Evans, Service Specialist, Specialised Commissioning.
Jessamy Kinghorn, Head of Communications and Engagement, Specialised Services.

Colchester Hospital:

Rachel Webb, Director of Operations.
John Corr, Consultant Urologist FRCS, Cancer Lead.

Southend Hospital

Sue Hardy Chief Executive.
Sampi Mehta, Lead Clinician.

The Committee considered a report UCJHOSC02/16 from NHS England (NHSE) which included a specific report for the Joint Committee and an appendix with activity plan, and the Report of the External Review Panel visit 14th June 2016. During subsequent discussion the following was raised/highlighted and/or noted:

Timetable:

(i) The recommendation from the Independent Review Panel would be considered by NHSE's Regional Executive with a view to a final decision being made in the coming weeks;
(ii) NHSE planned to take mitigating actions to minimise any disproportionate impact on certain patients and to maintain patient choice;
(iii) The Senior Oversight Group would meet on the 16th September to discuss membership of the Implementation Team;
(iv) An Equality Impact Assessment would be completed by NHSE;

Clarification on the proposed service

(v) Most pre and post-operative services would continue to be provided at a patient's local hospital;

(vi) The project had not been driven by financial considerations. The main reason for change had been to improve the quality of services and improve patient outcomes. For treatments that were required only by a small number of patients locally each year it meant specialist centres so that clinicians and care staff can maintain their expertise;

(vii) There would still be patient choice with other specialist centres in the region also being an option for Essex patients;

(viii) Colchester Hospital was now in a Sustainability and Transformation plan 'footprint' with Suffolk. However, the hospital will remain part of Essex for this urological cancer surgery modality of care;

(ix) Urological cancer specialists in Essex were at more than just the two hospital locations (Colchester and Southend) who contested providing the surgical centre and it was possible that there could be some further collaboration with the other hospitals in Essex in the future in providing some limited surgery;

Engagement

(x) NHSE had been provided with patient contacts from the Clinical Nurse Specialists and spoke to 23 patients either face to face or on the telephone. The majority of the patients had suffered from prostate cancer but all three cancers had been represented from amongst the 23. Most responses had been parochial favouring their local hospital for the surgery although the overriding issue most valued was to get the surgery done as fast as possible. The draft report would be submitted to the Senior Oversight Group first before being shared with the JHOSC;

Communication

(xi) Members remained concerned about the adequacy and clarity of communications about the project to patients and the public and sought assurances from NHS England representatives that this would be addressed in future communications on this project. A clear narrative would be needed from NHS England to make the rationale for the change very clear to the public;

(xii) Some members highlighted the merits of a specific leaflet communication to all households;

(xiii) Members felt that NHS England needed to further develop its external partnership working with greater stakeholder engagement, particularly with patients;

(xiv) It was acknowledged that the previous formal cancer networks had brought some benefit to communications and information exchange.

Despite these not now being in place there was still a strong informal network with the Clinical Nurse Specialists at each hospital a good example of local collaborative working;

Sustainability and accessibility

(xv) There was still member concern about travel implications on some future prospective patients due to the geography of Essex with Tendring residents facing a particularly challenging trip to Southend;
(xvi) Initial contact with hard-to reach groups can be difficult although Clinical Nurse Specialists will thereafter fully support those groups going forward;
(xvii) NHS England acknowledged that any significant changes to the population in Essex may give rise to re-evaluation of the service but that, at the moment, it was the best model to improve patient outcomes;
(xviii) There could be displacement of services both ways with some other services from Southend that may need to move in future;
(xix) Further thought would be given to potential impact on clinical staff of the change particularly around travel, their places of work and future recruitment;
(xx) As mitigation for some increased travelling time for the actual complex surgery, there was an onus on the provider to demonstrate the accessibility of other supporting services such as outpatients and minimise the need for travel. There was the suggestion that the current Joint Oncology Care Clinic at Broomfield could be expanded and that this could be mirrored at other hospitals;
(xxi) Clinicians considered that further investment was necessary. Robotic surgery would need to be part of the future service and currently robotic surgery was only available at Broomfield Hospital.

AGREED:

(I) The Joint Committee would discuss its final conclusions after the close of the meeting and publish a report later in the month;
(II) A further update from NHS England was requested at year-end on the engagement exercise undertaken and issues arising ahead of the launch of the new service in 2017.

The meeting was closed at 4.20pm.

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Chairman