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South East London Joint Health Overview and Scrutiny Committee
Agenda

Thursday, 6 July 2023
6.00 pm,
Civic Suite
Lewisham Town Hall
London SE6 4RU

For more information contact: Nidhi Patil (nidhi.patil@lewisham.gov.uk)

This meeting is an open meeting and all items on the agenda may be audio recorded and/or filmed.

Part 1

South East London Joint Health Overview and Scrutiny Committee
Members

Members of the committee, listed below, are summoned to attend the meeting to be held on Thursday, 6 July 2023.

Jeremy Chambers, Monitoring Officer, Lewisham Council
Wednesday, 28 June 2023

Members	
Councillor Suzanne Abachor	London Borough of Southwark
Councillor Felicity Bainbridge	London Borough of Bromley
Councillor Christine Banton	London Borough of Lambeth
Councillor Chris Best	London Borough of Lewisham
Councillor Mark Brock	London Borough of Bromley
Councillor Clare Burke-McDonald	Royal Borough of Greenwich
Councillor Liam Jarnecki	London Borough of Lambeth
Councillor Maria Linforth-Hall	London Borough of Southwark
Councillor Lisa-Jane Moore	London Borough of Bexley
Councillor Rachel Taggart-Ryan	Royal Borough of Greenwich
Councillor Christopher Taylor	London Borough of Bexley
Councillor Carol Webley-Brown	London Borough of Lewisham

Our Healthier South East London Joint Health Overview & Scrutiny Committee

MINUTES of the Our Healthier South East London Joint Health Overview & Scrutiny Committee held online on 8 April 2021 at 6.30 pm.

PRESENT:

Councillor Judi Ellis (Chairman)
Councillor Mark James (Vice-Chairman) and Councillor Marianna Masters (Vice-Chairman)
Councillor Gareth Allatt
Councillor Richard Diment
Councillor Alan Downing
Councillor Nanda Manley-Browne
Councillor John Muldoon
Councillor David Noakes
Councillor Victoria Olisa

NHS PARTNERS: Jessica Arnold
Andrew Bland
Michael Boyce
Sara Cottingham
Neil Kennet-Brown
Martin Wilkinson

53 APOLOGIES

Apologies for lateness were received from Cllr John Muldoon. Councillor Liz Johnstone-Franklin sent apologies that she was unable to join the meeting due to technical issues.

54 DISCLOSURE OF INTERESTS AND DISPENSATIONS

There were no declarations of interest or dispensations.

55 MINUTES

Agreed that the minutes of the meeting held on 2nd September 2020 be confirmed as a correct record.

56 QUESTIONS

The Joint Committee did not have formal provision for public questions, but the chairman was aware of two questions which had arisen. One question concerned the need to keep local people at the heart of decision-making. As part of this the

Committee had requested to be kept informed of dates and timetables for the borough-based boards.

The other issue was about the proposals for an American health insurance company to take over a number of GP practices across the boroughs of Greenwich, Lewisham and Southwark. Andrew Bland confirmed that there were no changes to services, the issue had been considered at Southwark's health scrutiny committee, and there was a statement on the CCG website which could be appended to the minutes. Some members of the Joint Committee considered that there were implications across the region for how primary care networks operated, and that there was a need to raise such matters. In response, Mr Bland explained that all that was happening was that an existing contract holder was being taken over by another organisation.

57 INTEGRATED CARE SYSTEMS - NEXT STEPS

Andrew Bland provided an update based on the presentation that had been circulated with the agenda on the OHSEL Integrated Care System. He stated that the CCG had written to NHS England to say that the timing of the national engagement, at Christmas/New Year 2020/21, was not ideal. A White Paper covering proposals for England had been published on 11 February 2021 – "Integration and innovation: working together to improve health and social care for all." An integrated care system had been in place in South East London since June 2019, but the current proposals would provide a legislative basis from 1st April 2022, at which point the CCG would cease to exist. The four principles underlying the changes were –

(i) improving population health and healthcare;
(ii) tackling unequal outcomes and access;
(iii) enhancing productivity and value for money;
(iv) helping the NHS to support broader social and economic development.

Much of the proposals reinforced how South East London worked already. In particular, decisions would continue to be taken as close to communities as possible, with more commissioning brough together at local level, collaboration with providers would be supported and there would be deeper collaboration with partners including local government. The White Paper covered a range of issues beyond integration.

The new ICS NHS body would have a chairman and chief executive responsible for day to day running of services, with an ICS Health and Care Partnership bringing together a wide range of partners to address health, public health and social care needs, including leading Members from each of the six boroughs. NHS providers would not see any change to their sovereignty, but would have new statutory duties to focus on the needs of local populations.

Responding to questions and concerns from members, Mr Bland stated that NHS England had also launched a consultation on competition, and there was likely to be further discussion around this. Provider trusts would be required to be part of integrated care systems and to work within peer provider collaborative arrangements. Provider trusts would be included withing the ICS Health and Care Partnership. The CCG merger had anticipated the new arrangements and enshrined joint commissioning across South East London. There was intended to be a provider framework, but it had not been issued yet.

There were no firm changes to Public Health, but there was an encouragement towards more collaborative working. Borough based boards had been operating over the past year, but the pandemic had meant that many of the spending decisions had been taken centrally. Bringing commissioners and providers together to make local decisions in public would improve accountability.

There had been a commitment to providing granular information at borough level, but Mr Bland explained the pandemic had limited this. However, the queues for services were not formulated by borough, so patients wanting to know how long they would have to wait need to know the aggregate figures across the region for each provider. Planning services should be carried out around populations rather than around institutions.

Asked whether the South East London Stakeholder Reference Group could be re-instated, Mr Bland commented that something similar could possibly be developed. The ICS proposals did not have any prescriptive proposals on engagement and consultation.

The proposals were likely to change, so the Joint Committee needed to continue to monitor what was proposed and how it would be applied in South East London.

58 COVID- WAVE 2 IMPACT AND RESTORATION - ACUTE SERVICES

The Joint Committee received a presentation from Sarah Cottingham on the restoration of acute services, following the second wave of covid-19. The second wave had peaked at the end of January 2021, with 324 of 421 critical care beds devoted to covid, then plateaued until demand reduced from mid/late February. Acute hospitals across the region had worked collaboratively, supported by the rest of the system, and had provided aid to other regions in Kent and London. The spike in demand for mental health services seen after the first wave of covid was repeated following the second wave.

As Covid demand had reduced, elective care had been ramped up, managed on the basis of clinical prioritisation. Significant progress had been made in reducing the average “clearance rate” (length of wait for clinically urgent patients) to 3.2 weeks, below the ideal rate of 4 weeks. This had involved using independent sector providers alongside NHS SE London capacity. There had also been a focus

on wider elective restoration plans - the spring recovery plan aimed to return to 90% of pre-pandemic capacity across diagnostic, outpatient and day-patient/inpatient services by the beginning of July. There were expected to be approximately 15,000 people waiting for more than 52 weeks as at the end of March 2021 - an increase from 8,700 at the end of November 2020. The shape of the waiting list meant that it was likely to get worse post July 2021, before it improved. There were no quick fixes, and a lengthy period of backlog reduction would be needed. A focus on staff wellbeing and support would be needed during this transition back to business as normal and the need for staff to take leave was taken into account in the recovery plans.

In response to questions, it was reported that demand for urgent cancer services had remained high during the second wave. A&E services had seen higher attendances than during the first wave, although St Thomas's had benefitted from the lower levels of commuters and tourists in central London. Discussions had continued with local authorities on discharge issues, but the cooperation of services across the wider NHS was particularly crucial, with some treatments allocated to suitable private sector providers where this was safe and effective. Theatres were now back up to 90% + availability.

59 COVID-19 VACCINATION PROGRAMME

The Joint Committee received a presentation from Jessica Arnold, Director of Flu and Covid Vaccinations for South East London, on progress with the vaccination programme. The vaccination programme was being delivered through nine hospitals (four of which would return to business as usual after completing second doses), twenty five primary care sites (including churches, mosques and the Greenwich vaccine bus), twenty community pharmacies and three mass vaccination centres (at Charlton FC, Bromley Civic Centre and one in development in Bexley.)

As of the previous day, 825,000 vaccinations had been delivered across South East London, working through the priority cohorts. Roughly 200,000 people in priority groups 1-9 were not vaccinated. Most vaccinations being delivered now were second doses. There was data to confirm that take up rates were lower in African and Caribbean populations and in more deprived areas. Maximising understanding of the available data was key to tackling vaccine hesitancy, and a dashboard of key statistics was circulated to stakeholders weekly. There was extensive engagement with community champions, faith leaders and the voluntary sector and a range of social media and events at regional, borough and local levels. A "Spring Forward" plan was being developed for delivery during April to maximise coverage of cohorts 1-9, particularly focussing on NHS Trust staff, social care staff, care home staff and cohort 6 (people with underlying health conditions and their carers.) There were a range of locally-driven initiatives, including more pop-up clinics, more vaccinations in the home, enhanced clinical time funded to invest in effective call, and recall, expansion of the single point of coordination to

include telephone access, enhanced and targeted communications to cohort specific groups, coupling health checks for people with learning disabilities and serious mental illness with a vaccination offer and greater outreach through employers to staff, including asking care home employers to fund travel time and expenses.

A Member was concerned that there was pressure on care home staff from employers to get vaccinated - she considered that it was important to work with staff and trade unions to encourage vaccination. Ms Arnold confirmed that, when visiting care homes to vaccinate residents, every opportunity was taken to discuss vaccination with staff. Another concern was nursery staff, who were often asked to test in their own time.

Members discussed how health inequalities were reflected in the vaccination figures, with more deprived areas and communities showing lower percentages of vaccination. Figures for Lambeth were behind Bromley and Bexley, but it was noted that there were pockets of difficulty such as in the north of Bexley. There were no figures specifically on vaccination levels amongst domiciliary care staff, but the NHS was working closely with local authorities to ensure that agencies were targeted with communications about encouraging their staff to come forward. As younger cohorts became eligible for vaccination it would be important to ensure that the messaging remained relevant and nuanced. Ms Arnold was not able to comment on the issue of at what level herd immunity could be achieved.

60 THE IMPACT OF COVID-19 ON MENTAL HEALTH

The Joint Committee received a presentation on the impact of Covid-19 on mental health from Martin Wilkinson. During the first wave of covid, some adult services had been restricted and had been forced to adapt to the challenging new conditions, particularly utilising digital technology; however, during the second wave services had remained fully operational. Staff sickness levels and the need to adapt to social distancing and other infection control measures were particular challenges. There had initially been a reduction of activity, but since the easing of restrictions there had been spikes in activity, particularly with people previously unknown to mental health services. The recovery priorities included ensuring that both local providers had sufficient capacity in the right services and providing improved access to talking therapy. Increased investment of £35m was planned for the next three years.

Referrals and caseloads for CAMHS services had remained high during the pandemic, and there had been an increase of approximately 30% in demand for services comparing 2019/20 with 2020/21. Reducing waiting times was a high priority, and they were looking to build on initiatives to support families and communities, investing in the Kooth Platform for children and young people and the Qwell Platform, a sister platform for online self-help and counselling for adults over 25 years. Two urgent Mental Health Prevention Summits had been held,

resulting in the launch of the South London Listens campaign and a proposed community-led summit in June 2021.

A Member commented on under-representation of black people, and highlighted Lambeth's work to reduce disparity of outcomes. It was intended that the work in Lambeth would be rolled out to other boroughs.

A Member commented that alcohol usage appeared to be going up during the pandemic and asked whether there was any focus on drug and alcohol dependency, as this would lead to increased mental health problems in the future. Dual diagnosis was certainly an area of priority, but there were no new issues at regional level as a result of the pandemic.

The priorities for the additional £35m funding for community mental health were being delivered through delivery plans at borough level, and new posts were being created.

Referring to the graphs at Appendix 2, a Member asked for an update since November 2020. It was confirmed demand had changed - the trend of fewer people already known to mental health services and more people previously unknown to mental health presenting had continued. There was a focus on identifying people earlier and working with primary care to prevent them going into crisis.

(Councillor Richard Diment declared an interest during this item as a Governor of Oxleas NHS Foundation Trust.)

61 PATHOLOGY SERVICES UPDATE

The Joint Committee received a report from Neil Kennet-Brown, Place-Based Director (Greenwich) and SRO for Pathology Programme on progress since the last update to the meeting on 7th July 2019. The new service, a partnership with Synlab, would be commencing from May 2021. The Lewisham and Greenwich NHS Trust had decided in late 2018 not to be part of the South East London Pathology Network, and they had developed a network with Barts Health NHS Trust and Homerton University NHS Trust. However, GP direct services for Bexley, Greenwich and Lewisham would move across in October 2021.

Members from Greenwich and Lewisham were aware of concerns of staff and that patients and GPs would see no real changes. about the effect of the changes, including issues around loss of local knowledge and close clinical links with GPs, travel times to the centralised laboratory. Mr Kennet-Brown confirmed that the establishment of a Pathology Network was a statutory requirement; he assured Members that partners were working closely together and patients and GPs would see no real changes, staff would be protected by TUPE and the knowledge and skills would still be retained within the NHS.

62 DATE OF NEXT MEETING/WORKPLAN

An agenda setting meeting would be set up within the next few weeks involving the Chairman, Vice-Chairmen and Andrew Bland. It was agreed that all members of the joint committee would be invited to attend.

The Chairman, on behalf of the Joint Committee, concluded the meeting by thanking all NHS staff for their service – both for their normal work and their efforts to combat Covid-19.

South-East London (SEL) Joint Health Overview and Scrutiny Committee (JHOSC)

Declarations of Interest

Date: 6 July 2023

Contributor: Jeremy Chambers (Director of Law and Corporate Governance), Lewisham Council

Outline and recommendations

Members are asked to declare any personal interest they have in any item on the agenda.

1. Summary

1.1. Members must declare any personal interest they have in any item on the agenda. There are three types of personal interest referred to in the Council's Member Code of Conduct:

(1) Disclosable pecuniary interests

(2) Other registerable interests

(3) Non-registerable interests.

1.2. Further information on these is provided in the body of this report.

2. Recommendations

2.1. Members are asked to declare any personal interest they have in any item on the agenda.

3. Disclosable pecuniary interests

3.1. These are defined by regulation as:

(a) Employment, trade, profession or vocation of a relevant person* for profit or gain

(b) Sponsorship –payment or provision of any other financial benefit (other than by the Council) within the 12 months prior to giving notice for inclusion in the register in respect of expenses incurred by you in carrying out duties as a member or towards your election expenses (including payment or financial benefit from a Trade Union).

(c) Undischarged contracts between a relevant person* (or a firm in which they are a partner or a body corporate in which they are a director, or in the securities of which they have a beneficial interest) and the Council for goods, services or works.

(d) Beneficial interests in land in the borough.

(e) Licence to occupy land in the borough for one month or more.

(f) Corporate tenancies – any tenancy, where to the member's knowledge, the Council is landlord and the tenant is a firm in which the relevant person* is a partner, a body corporate in which they are a director, or in the securities of

which they have a beneficial interest.

(g) Beneficial interest in securities of a body where:

(a) that body to the member's knowledge has a place of business or land in the borough; and

(b) either:

(i) the total nominal value of the securities exceeds £25,000 or 1/100 of the total issued share capital of that body; or

(ii) if the share capital of that body is of more than one class, the total nominal value of the shares of any one class in which the relevant person* has a beneficial interest exceeds 1/100 of the total issued share capital of that class.

*A relevant person is the member, their spouse or civil partner, or a person with whom they live as spouse or civil partner.

4. Other registerable interests

4.1. The Lewisham Member Code of Conduct requires members also to register the following interests:

(a) Membership or position of control or management in a body to which you were appointed or nominated by the Council

(b) Any body exercising functions of a public nature or directed to charitable purposes, or whose principal purposes include the influence of public opinion or policy, including any political party

(c) Any person from whom you have received a gift or hospitality with an estimated value of at least £25.

5. Non registerable interests

5.1. Occasions may arise when a matter under consideration would or would be likely to affect the wellbeing of a member, their family, friend or close associate more than it would affect the wellbeing of those in the local area generally, but which is not required to be registered in the Register of Members' Interests (for example a matter concerning the closure of a school at which a Member's child attends).

6. Declaration and impact of interest on members' participation

6.1. Where a member has any registerable interest in a matter and they are present at a meeting at which that matter is to be discussed, they must declare the nature of the interest at the earliest opportunity and in any event before the matter is considered. The declaration will be recorded in the minutes of the meeting. If the matter is a disclosable pecuniary interest the member must take not part in consideration of the matter and withdraw from the room before it is considered. They must not seek improperly to influence the decision in any way. **Failure to declare such an interest which has not already been entered in the Register of Members' Interests, or participation where such an interest exists, is liable to prosecution and on conviction carries a fine of up to £5000**

6.2. Where a member has a registerable interest which falls short of a disclosable pecuniary interest they must still declare the nature of the interest to the meeting at the earliest opportunity and in any event before the matter is considered, but they may stay in the room, participate in consideration of the matter and vote on it unless paragraph 6.3 below applies.

6.3. Where a member has a registerable interest which falls short of a disclosable pecuniary interest, the member must consider whether a reasonable member of the public in possession of the facts would think that their interest is so significant

that it would be likely to impair the member's judgement of the public interest. If so, the member must withdraw and take no part in consideration of the matter nor seek to influence the outcome improperly.

6.4. If a non-registerable interest arises which affects the wellbeing of a member, their, family, friend or close associate more than it would affect those in the local area generally, then the provisions relating to the declarations of interest and withdrawal apply as if it were a registerable interest.

6.5. Decisions relating to declarations of interests are for the member's personal judgement, though in cases of doubt they may wish to seek the advice of the Monitoring Officer.

7. Sensitive information

7.1. There are special provisions relating to sensitive interests. These are interests the disclosure of which would be likely to expose the member to risk of violence or intimidation where the Monitoring Officer has agreed that such interest need not be registered. Members with such an interest are referred to the Code and advised to seek advice from the Monitoring Officer in advance.

8. Exempt categories

8.1. There are exemptions to these provisions allowing members to participate in decisions notwithstanding interests that would otherwise prevent them doing so. These include:-

(a) Housing – holding a tenancy or lease with the Council unless the matter relates to your particular tenancy or lease; (subject to arrears exception)

(b) School meals, school transport and travelling expenses; if you are a parent or guardian of a child in full time education, or a school governor unless the matter relates particularly to the school your child attends or of which you are a governor

(c) Statutory sick pay; if you are in receipt

(d) Allowances, payment or indemnity for members

(e) Ceremonial honours for members

(f) Setting Council Tax or precept (subject to arrears exception).

9. Report author and contact

9.1. Jeremy Chambers, Director of Law and Corporate Governance, Lewisham Council

Jeremy.Chambers@lewisham.gov.uk , 0208 31 47648

South-East London (SEL) Joint Health Overview and Scrutiny Committee (JHOSC)

Report title- SEL JHOSC: Revised Terms of Reference

Date: 6 July 2023

Outline and recommendations

This report asks the members of the South-East London Joint Health Overview and Scrutiny Committee (JHOSC) to discuss and agree the revised Terms of Reference (ToR) for the Committee.

The Committee is asked to:

- Discuss and agree the revised Terms of Reference (ToR) for the JHOSC.

1. Summary

1.1. The Health and Care Act 2022 put the ICS on a statutory footing from 1 July 2022, making them responsible for planning and funding health and care services in the area they cover.

1.2. Following that, the ToR for the JHOSC have been revised to allow the committee to look at discretionary cross-borough strategic health matters, as well as mandatory cross-borough substantial reconfiguration proposals.

1.3. This report asks members to discuss and agree the revised ToR for JHOSC.

2. Recommendations

2.1. The Committee is asked to:

- Discuss and agree the revised Terms of Reference (ToR) for the JHOSC.

3. Background

3.1. After the Health and Care Act 2022 put the Integrated Care Systems on a statutory footing, the ICS took on the NHS planning functions previously held by former clinical commissioning groups and services are now being planned and designated at a South-East London level. The revised ToR have been drafted to reflect these NHS contextual changes.

3.2. There are two key types of Joint Health Overview and Scrutiny Committees- discretionary and mandatory.

3.3. The ToR retain the ability for the Committee to meet to consider and respond to proposals for substantial reconfigurations that affect the entire ICS area. In this case the JHOSC acts as a mandatory committee.

3.4. The ToR also allow for greater scrutiny of wider, system level issues that relate to the planning, provision and operations of health services across the ICS. In this case the JHOSC acts as a discretionary committee.

4. Chair and Vice-Chair of the JHOSC

4.1. The Committee will appoint a Chair and Vice-Chair at its first meeting of the municipal year and the ToR set-out that the Chair & Vice-Chair should be members of different participating autorities.

4.2. The ToR also recommend that the Chair and Vice-Chair be re-appointed at the first meeting of every new municipal year.

5. Formal and Informal JHOSC meetings

5.1. It is suggested that the JHOSC should hold two formal meetings in a municipal year with capacity for more should substantial reconfiguration proposals arise. Apart from these formal meetings, the JHOSC may also hold informal meetings to set work programme items and consider information briefings from the NHS or other partners.

5.2. The formal meetings of the JHOSC will be hosted amongst the participating authorities on a rotational basis. The ToR state that the administrative and research support for these meetings will be provided by the scrutiny teams of the 6 boroughs working together.

6. Financial implications

6.1. There are no direct financial implications arising from this report.

7. Legal implications

7.1. There are no direct legal implications arising from this report. Individual local authorities may have specific constitutional practices to follow in relation to the revised terms of reference.

8. Equalities implications

8.1. The Equality Act 2010 brought together all previous equality legislation in England, Scotland and Wales. The Act included a new public sector equality duty, replacing the separate duties relating to race, disability and gender equality. The duty came into force on 6 April 2011. It covers the following nine protected characteristics: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation.

8.2. There are no direct equalities implications arising from this report.

9. Climate change and environmental implications

9.1. There are no direct climate change or environmental implications arising from the implementation of the recommendations in this report.

10. Crime and disorder implications

10.1. There are no direct crime and disorder implications arising from the implementation of the recommendations in this report.

11. Health and wellbeing implications

11.1. There are no direct health and wellbeing implications arising from the implementation of the recommendations in this report.

12. Appendices

12.1. Appendix A- SEL JHOSC Terms of Reference July 2023

13. Report author and contact

If you have any questions about this report please contact the Scrutiny manager (Lewisham Council): Nidhi Patil, 020 8314 7620, Nidhi.Patil@lewisham.gov.uk

South East London Joint Health Overview and Scrutiny Committee

South East London Integrated Care System

The South East London Integrated Care System (ICS), brings together local health and care organisations and local councils to design care and improve population health and healthcare, tackle unequal outcomes and access, enhance productivity and value and help the NHS to support broader social and economic development through shared leadership and collective action.

The Health and Care Act 2022 put the ICS on a statutory footing from 1 July 2022, making them responsible for planning and funding health and care services in the area they cover.

The ICS is a partnership of local health and care providers and local authorities responsible for collaboratively planning and commissioning health and care services for the South East London region, which covers the London Boroughs of Bexley, Bromley, Greenwich, Lambeth, Lewisham and Southwark.

The SEL ICS includes the South East London Integrated Care Board, which takes on the NHS planning functions previously held by clinical commissioning groups, and an Integrated Care Partnership, which brings together the NHS and local authorities as well as health and care providers and partners as equal partners to focus more widely on health, public health and social care and is responsible for developing an integrated care strategy, setting out how the wider health needs of the local population will be met.

TERMS OF REFERENCE

The Joint Health Overview and Scrutiny Committee is constituted in accordance with the Local Authority Public Health, Health & Wellbeing Boards and Health Scrutiny Regulations 2013 (the “Regulations”) and Department of Health Guidance to review and scrutinise any matter, including, when required, substantial reconfiguration proposals, relating to the planning, provision and operation of health services covering more than one Council area from within the South East London Integrated Care System. The ICS is a partnership of local health and care providers and local authorities responsible for collaboratively planning and commissioning health and care services for the South East London region, which covers the London Boroughs of Bexley, Bromley, Greenwich, Lambeth, Lewisham and Southwark.

The Joint Committee’s terms of reference are:

1. To carry out overview and scrutiny in relation to planning, provision and operation of health services that cross local authority boundaries in the SEL ICS footprint area. This does not prevent the appointing local authorities from separately scrutinising local health issues. However, there are likely to be

occasions on which this committee is the best way of considering how the needs of a local population, which happens to cross council boundaries, are being met.

2. To convene as, and to undertake all the functions of, a statutory Joint Health Overview and Scrutiny Committee (JHOSC) when required, in accordance with the Regulations and Department of Health Guidance.
   This includes, but is not limited to the following:

(a) To consider and respond to proposals from the SEL Integrated Care System (ICS) for the substantial reconfiguration of Health Services in South East London.

(b) To scrutinise any consultation process that relate to more than one borough conducted by the SEL ICB, but not to replicate any consultation process.

This does not include the power to make any decision to make a referral to the Secretary of State in relation to the proposals from the SEL ICS for Bexley, Bromley, Greenwich, Lambeth, Lewisham and Southwark. However, any individual borough may make a specific delegation to the JHOSC in relation to their own power to make such a referral on their behalf.[1]

Membership

Membership of the Committee will be two named Members from each of the following local authorities:

London Borough of Bexley;
London Borough of Bromley;
Royal Borough of Greenwich;
London Borough of Lambeth;
London Borough of Lewisham;
London Borough of Southwark.

Members must not be an Executive Member.

[1] This remains the current position with regards to powers to make a referral to the Secretary of State until changes to the reconfiguration process that were introduced through the Health and Care Act 2022 are implemented and new statutory guidance around this is published.

PROCEDURES

Chair and Vice-Chair

1. The Committee will appoint a Chair and Vice-Chair at its first meeting, and at the first meeting of every new municipal year. The Chair and Vice-Chair should be members of different participating authorities.

Substitutions

2. Substitutes may attend Committee meetings in lieu of nominated members. Continuity of attendance throughout a review is strongly encouraged however.

3. It will be the responsibility of individual committee members and their local authorities to arrange substitutions and to ensure that the lead authority is informed of any changes prior to the meeting.

4. Where a substitute is attending the meeting, it will be the responsibility of the nominated member to brief them in advance of the meeting

Quorum

5. The quorum of the meeting of the Joint Committee will be 4 members, each of whom should be from a different participating authority.

6. The meeting should start at the time stated on the agenda, but it is acceptable to wait up to 15 minutes for quorum to be achieved. If after 15 minutes there is still not a quorum present, the meeting shall terminate.

Voting

7. It is hoped that the Committee will be able to reach their decisions by consensus. However, in the event that a vote is required each member present will have one vote. In the event of there being an equality of votes, the Chair of the meeting will have the casting vote.

8. On completion of a scrutiny review by the Joint Committee, it shall produce a single final report, reflecting the views of all the local authorities involved.

Meetings

9. Meetings of the Joint Committee will normally be held in public and will take place at venues within South East London. The normal access to information provisions applying to meetings of the Overview and Scrutiny committees will apply. However, there may be occasions on which the Joint Committee may need to make visits outside of the formal Committee meeting setting.

10. Meetings shall last for up to two hours from the time the meeting is due to commence. The Joint Committee may resolve, by a simple majority, before

the expiry of 2 hours from the start of the meeting to continue the meeting for a maximum further period of up to 30 minutes.

Local Overview and Scrutiny Committees

11. The Joint Committee will encourage its Members to inform their local overview and scrutiny committees of the work of the Joint Committee and any proposals contained within the SEL Integrated Care System.

12. The Joint Committee will invite its Members to represent to the Joint Committee the views of their local overview and scrutiny committees on the work of the SEL ICS and the Joint Committee's work.

Communication

13. The Joint Committee will establish clear lines of communication between the NHS, participating local authorities and itself. All formal correspondence between the Committee, local authorities and the NHS on this matter will normally be administered by officers from the same borough as the Chair.

Representations

14. The Joint Committee will identify and invite witnesses to address the committee and may wish to undertake consultation with a range of stakeholders.

Support

15. Administrative and research support will be provided by the scrutiny teams of the 6 boroughs working together.

Assumptions

16. The Joint Committee will be based on the following assumptions: -

    (a) That the Joint Health Scrutiny Committee is constituted to carry out overview and scrutiny in relation to planning, provision and operation of health services that cross local authority boundaries in the SEL ICS footprint area and to respond to the work of the Integrated Care System this includes, when required, to respond to any proposals it puts forward and any consultation it may carry out, as well as comment on the public and patient involvement activity in which the NHS has engaged in relation to this matter.

    (b) That the SEL ICS will permit the Joint Committee access to the outcome of any public consultation phase prior to the formulation and submission of the Joint Committee's response to such public consultations.

(c) Efforts will be made to avoid duplication. The individual health overview and scrutiny committees of individual authorities shall endeavour not to replicate any work undertaken by the SEL ICS JHOSC.

Reconfiguration of Children's Cancer Principal Treatment Centre serving south London, Kent and Medway, most of Surrey, East Sussex, Brighton and Hove

Presentation to the South East London Joint Health Overview and Scrutiny Committee

6 July 2023

Today we would like to

- Tell you more about plans for the service reconfiguration of the Principal Treatment Centre (PTC)
- Share an overview of our work to date including our plans for the forthcoming consultation
- Seek feedback on our plans and on how we work together going forward

Structure of our presentation

Agenda
1. Background and case for change
2. Options development and evaluation
3. Where are we now
4. Equality and Health Inequality Impact Assessment
5. Consultation plan and document, including stakeholder engagement
Appendix – supporting slides

1. Background and case for change

Caring for children with cancer

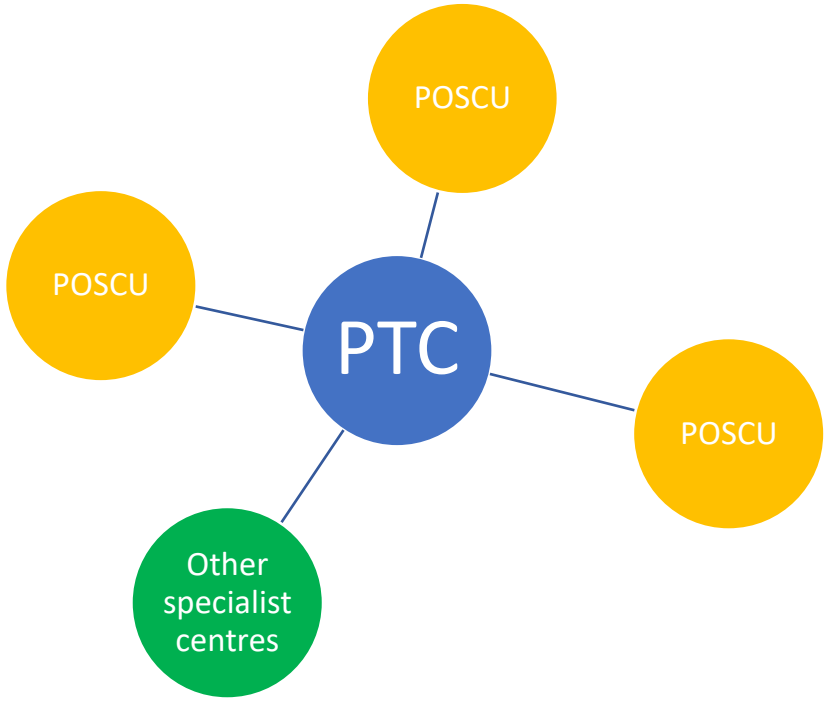
Principal Treatment Centres

Children with cancer in England receive some of the best care in the world, at the forefront of cutting-edge treatments and technology.

Their care is coordinated and led by Principal Treatment Centres, which provide diagnosis, treatment plans, and highly specialised care for children aged 15 and under with cancer.

Principal Treatment Centres are responsible for making sure each child gets the specific expert care they need for their particular cancer, and for coordinating treatment by different hospitals, if needed. Treatments for cancer in children can be complex and intensive and are often delivered as part of a clinical trial. Children can become acutely ill during treatment, requiring a high level of medical support.

There are 13 Principal Treatment Centres across England.



Shared care

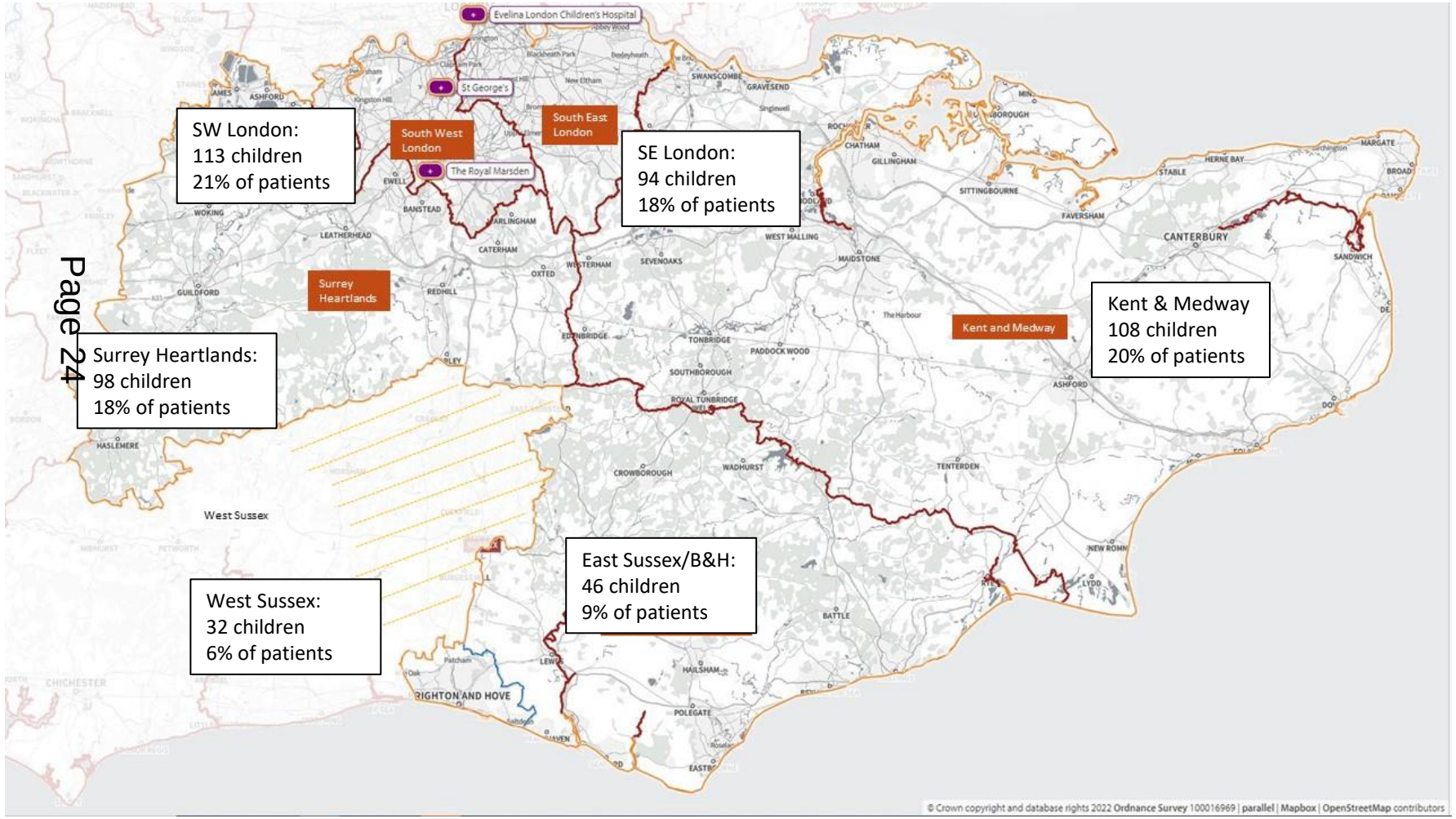
Principal Treatment Centres work in partnership with Paediatric Oncology Shared Care Units (POSCUs) at specified hospitals across their catchment areas, allowing care to be delivered closer to children's homes.

Many children with cancer also receive care in their homes. This can be from staff or 'outreach' services from the Principal Treatment Centre, POSCU or staff from children's community nursing teams.

Principal Treatment Centres also coordinate children's care with cancer services that are provided at other specialist centres (if not provided by the Principal Treatment Centre), and with national services to ensure children receive the right care at the right time and in the right place.

The Principal Treatment Centre catchment area

The catchment area of the Joint Principal Treatment Centre (The Royal Marsden and St George's)
(including number of children treated as inpatients at The Royal Marsden and St George's in 2019/20)



The Principal Treatment Centre (PTC) provides cancer care for children aged one to 15 who live in the area which covers south London, Kent, Medway, East Sussex, Brighton and Hove, and the majority of Surrey. It is acknowledged that children can access a PTC who live outside of a defined catchment area, and not all children resident within a defined PTC catchment area, diagnosed with cancer, choose to attend that particular PTC for their treatment

Childhood cancer in South East London

Children newly diagnosed with cancer

While a diagnosis of cancer clearly has a huge impact on people's lives, it is relatively rare among children.

The rate of diagnosing new cancers among children in both South West London and Surrey is around **135 cases per million per year**. This means that around **1 child in every 7,400** are diagnosed with cancer each year.

On average, each year there are:

- 42 children diagnosed with cancer from South East London

Children receiving cancer treatment

In total, the PTC treats around 1,400 children per year. Of these, in 2019/20:

- 252 children (18%) came from South East London

Nearly all children are seen as an outpatient (99%); 23% also had an inpatient stay.

Due to data quality for patient postcodes, we are not able to show the actual split of all these patients between boroughs. However, below we indicate the likely distribution of patients, based on population size.

Borough	Approximate number of new cancer **diagnosed** per year
Lambeth	c.7
Lewisham	c.9
Southwark	c.8
Bexley	c.8
Brent	c.10
Bromley	c.10
Greenwich	c.9

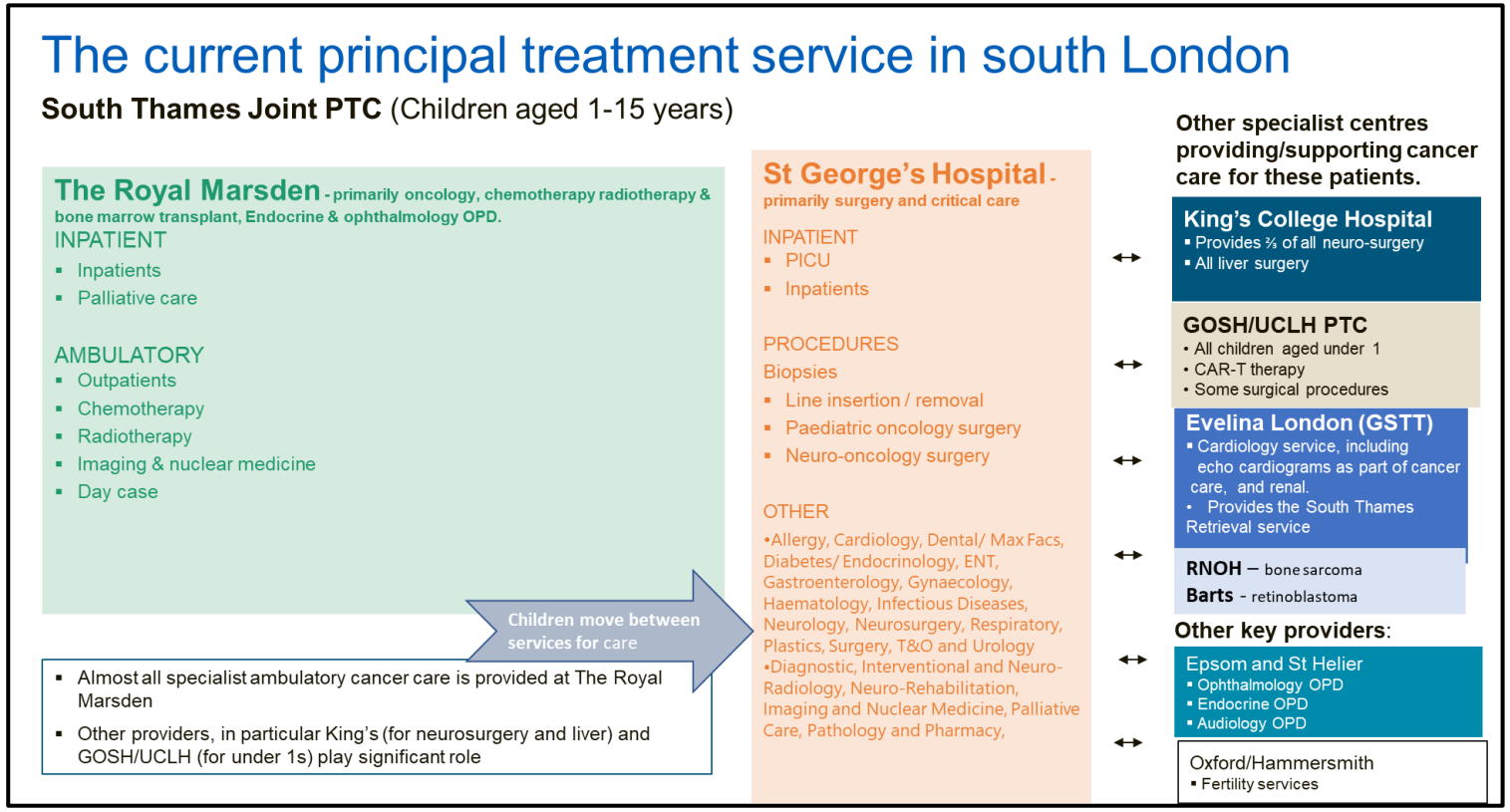
Borough	Approximate number of patients **treated** per year
Lambeth	c.45
Lewisham	c.50
Southwark	c.45
Bexley	c.45
Brent	c.55
Bromley	c.60
Greenwich	c.50

Please note that the tables contain modelled numbers and do not relate to real patient diagnoses or treatment.

Sources: NDRS new cancer registrations 2015-2019
ONS mid-year population estimates 2021
PTC programme "data lake" 2019/20 data

The current Principal Treatment Centre

- The Royal Marsden provides the majority of inpatient and outpatient care for children with cancer in the Principal Treatment Centre catchment area. Care is provided at its Sutton site.
- If children require surgery, critical care and some other specialist children's services they are treated at St George's Hospital in Tooting.
- The Royal Marsden works closely with the Institute of Cancer Research, which is based on its Sutton site, on world leading research into children's cancer care.



Some children also travel to other London hospitals for care, this is because of the expertise these hospitals have in specialist areas. This will continue in the future too.

Case for change

Being on the **same site as a children's intensive care unit and cancer surgery** is now a national requirement for all Principal Treatment Centres in England, as set out in the national specification for Principal Treatment Centres published in November 2021.

Locating the future Principal Treatment Centre on the **same site as children's intensive care** will mean:

- ✓ no more hospital transfers for children who need intensive care: very sick children will not need to be transferred eight miles from Sutton to Tooting to receive intensive care. This happens safely but can be very stressful for children, parents, and the staff involved
- ✓ no more hospital transfers for children who the clinical team thinks may need admission to an intensive care unit: pre-emptive transfers to safely manage the inbuilt geographical risk will not be needed
- ✓ fewer admissions to intensive care: some can be avoided if intensive care doctors are able to visit the child on the ward and keep a close eye on progress.

Placing the future Principal Treatment Centre on the **same site as children's cancer surgery** will:

- ✓ improve patient experience as patients can get more of their care in a familiar place rather than having to find their way around different sites.

Other **benefits** of relocating specialist services for children with cancer include:

- ✓ the ability to provide a service that, in line with the other 12 Principal Treatment Centres in England, is equipped to give complex new treatments which require children's intensive care services to be on-site (such as CAR-T which uses a child's own treated immune cells to treat their cancer)
- ✓ the potential to further develop multidisciplinary team working and research.

Transferring critically unwell patients is associated with a risk of physiological deterioration and adverse events(1) and the emotional and psychological stress for parents should not be underestimated(2). Although specialist transport services have been shown to enhance safety and quality(3), the 2008 "Safe and Sustainable" framework, produced by clinicians and endorsed by the relevant Medical Royal Colleges, states that paediatric oncology and paediatric intensive care have "absolute dependency, requiring co-location". It is this clinical advice, backed up by subsequent expert reviews(4) that underpins the national service specification requirement.

See Appendix 1 for references

2. Options development and evaluation

Summary of options appraisal process

We have already run an option appraisal process – consisting of four elements:

Longlist to shortlist	In line with NHS formal reconfiguration guidance, a short list of options was developed from a long list of all potential options by applying **first fixed points** (things that cannot be changed) and then **hurdle criteria** (to determine viability).	Following this stage, **two options remained**: the trusts running St George's and Evelina London Children's hospitals. Both were asked to complete a formal proposal document outlining how they would deliver the service using set criteria.
Evaluation Criteria	Evaluation criteria were developed over 2020/2022, reflecting the requirements of the service specification and incorporating research, patient and carer experience, capacity and resilience.	This resulted in four domains for evaluation: clinical, research, enabling requirements, and patient and carer experience. Measurable sub-criteria were developed for each domain, drawing on expertise from clinicians, parents, and managers from in London and outside London.
Weighting the evaluation criteria	Four expert panels comprised of patient and carer representatives, charities, researchers from outside London, clinicians (medical and nursing) from in and outside London, managers, and experts in various specific fields (e.g. emergency preparedness, human resources) were established to weight and score the criteria within each domain.	In September 2022, the Programme Board finalised the high-level weighting given to each of the domains. Between October and November 2022, the identified panels for each domain undertook a virtual, two-stage exercise to establish the sub-weights for the criteria within their domain.
Scoring the proposals	In November 2022 both Trusts submitted their proposals, aligned with the domains and sub-criteria. During December 2022, the topic-specific expert panels scored the submissions against each of the sub-criteria for their specific domain.	Final scores were calculated for each option using the pre-agreed weighting.

Final weightings

Programme Board members set the domain weights and expert panels weighted the sub-criteria.

Clinical domain

36%

- Interdependencies 35%
- Treatment transfers 27.5%
- Network effectiveness and system benefits 19.5%
- Transition 18%

Patient and carer experience domain

26%

- Quality of facilities 25%
- Patient navigation 23%
- Family support 21%
- Engagement and collaboration 16%
- Service accessibility 15%

Enabling domain

19%

- Capacity 30.5%
- Resilience 25%
- Organisational support for staff 23.5%
- Impact on staff 21%

Research domain

19%

- Performance and capability 39%
- People 32%
- Place 29%

There are two strong proposals for the relocated PTC

- Although the services which the **current Principal Treatment Centre** in south London provides are safe and high quality, they do not; and cannot comply with the national service specification. As a world-leading cancer hospital, not a children's hospital, The Royal Marsden does not have a children's intensive care unit or children's cancer surgery on-site. Children's intensive care units are always at hospitals that provide many other specialist children's services. In the context of the change in the service specification, the Royal Marsden is contributing actively to the review process to ensure the very best outcome is achieved for children.

- We are fortunate to have two strong options for relocating the Principal Treatment Centre which we will be consulting on:
  - Evelina London Children's Hospital, which is run by Guy's and St Thomas' NHS Foundation Trust and is based on the St Thomas' site in Lambeth
  - St George's Hospital, which is run by St George's University Hospitals NHS Foundation Trust (part of St George's, Epsom and St Helier Group) and is based in Tooting.

- In combination with the new specification for Paediatric Oncology Shared Care Units (POSCUs) this will enable NHS England London to implement the national vision for children's cancer services, driving continued improvement across the network with enhanced levels of care closer to where children live.

Our vision is that the future centre will lead coordinated children's cancer care of the highest standard across the catchment area. We are ambitious about what we can deliver for our patients by providing care in a specially designed environment that also supports the delivery of new treatments as they become available; continuation of ground-breaking research; and access to clinical trials. We know these things are very important to children with cancer, their families, and the staff who deliver the current service.

Things to note:

In setting its clinical model, the Programme Board overseeing this reconfiguration made a number of key decisions including:

- No matter which option is chosen, children will need travel to other London hospitals for the care listed below. This is because of the expertise these hospitals have in these specialist areas – these services are not going to move as part of the reconfiguration
  - Royal London Hospital (RLH), Whitechapel – eye cancer
  - Royal National Orthopaedic Hospital (RNOH), Stanmore - bone cancer
  - Great Ormond Street Hospital for Children (GOSH), Bloomsbury – care of babies aged 0 to 12 months with cancer of any type
  - King's College Hospital (KCH), Denmark Hill – liver cancer
  - St George's Hospital, Tooting and King's College Hospital, Denmark Hill – neurosurgery for cancer of the brain and central nervous system. See table below
  - University College London Hospitals' Grafton Way building (UCL), near Euston - proton beam radiotherapy at one of only two proton beam machines in England.

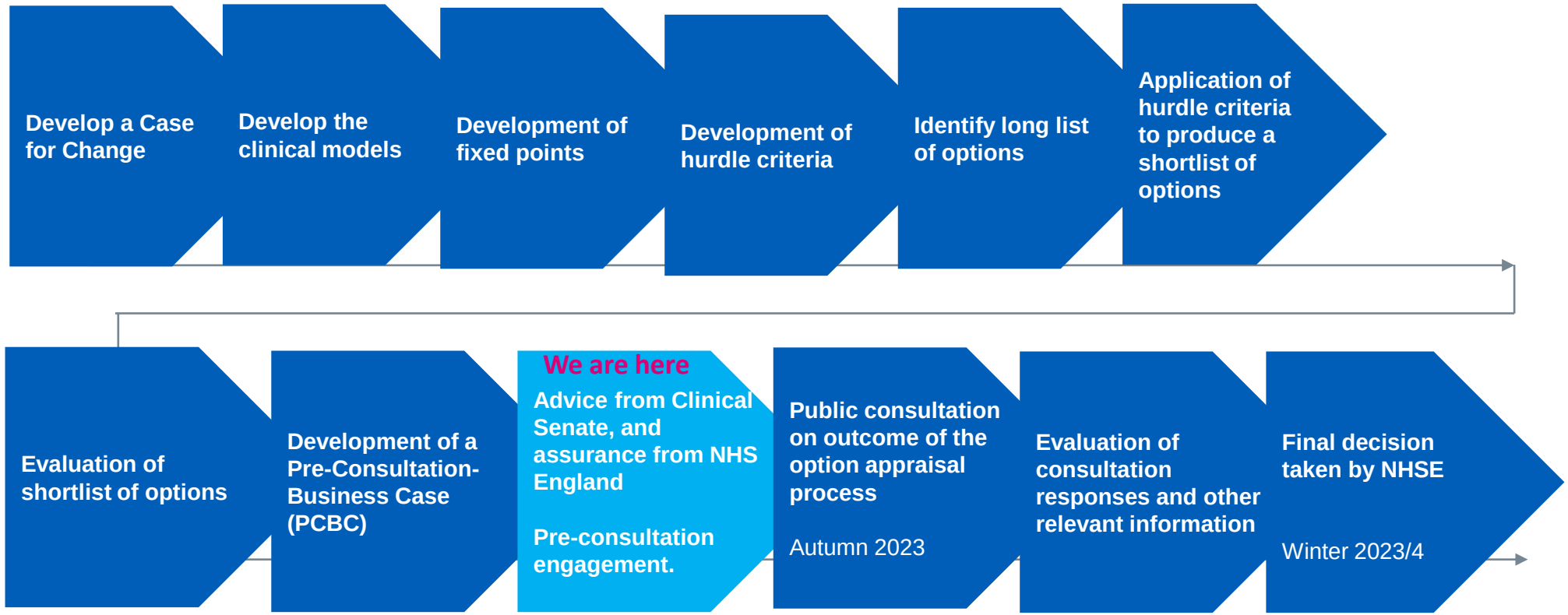
- **Access** - the Principal Treatment Centre must be accessible for all service users in terms of journey time and should therefore be based within Greater London.
- **Timeliness -** once a decision has been made, the new service must 'go live' within a 2.5 year implementation timeline
- **Affordability** - so long as both options remain affordable, the cost will not influence the decision. Instead, the decision will focus how to create the best possible service for children with cancer.

Outcome of scoring

- The Evelina London Children's Hospital option received a higher overall score than the St George's option, scoring higher in three of the four key areas.
- Based on the evidence provided by the evaluation, Evelina London is NHS England London's preferred option at this stage in the process.
- Both options scored highly and are viable options for the location of the future centre. We are very much keeping an open mind.
- NHS England London will only make their final decision on the location of the future centre after hearing the views that come forward during the public consultation and taking account of all other relevant factors.

3. Where are we now

Where we've been and where we are now



A formal reconfiguration process is required when moving a significant service from one site to another to ensure all stakeholders have the opportunity to review and comment on the case for change, clinical model and proposals.

Consultation with SE London JHOSC will continue in forthcoming months; including during the decision-making phase.

4. Equality and Health Inequality Impact Assessment

Equality and Health Inequality Impact Assessment: Process

Purpose of the EHIA

To support meeting legal duties including the Public Sector Equality Duty (Equality Act 2010) and the Health and Social Care Act (*to have regard to the need to reduce inequalities between persons in access to, and outcomes from healthcare services*)

What changes are we assessing the impact of?

A change in location of the current PTC and the implications of this change on patient travel arrangements including travel time, complexity of journey (including parking arrangements) and cost.

Additional considerations:

- the prospect of the service change process itself
- the prospect of a new environment and aspects of onsite accessibility
- other potential benefits

The EHIA takes a non-comparative, population-based approach.

Which population groups were considered in terms of experiencing differential impacts?

Those with a protected characteristic as specified in the Equality Act 2010, or who typically face health inequalities, including those living in deprived areas or families on low incomes (EHIA document contains full list).

For each group, using the information referenced below, plus professional and personal experience, the sub-group assessed any potential differential impacts of the proposed changes in relation to both the Public Sector Equality Duty and inequalities in access to, and outcomes from the service.

Sources of information used:

1. An equalities profile for the PTC catchment population
2. A travel time analysis report
3. Qualitative insight collected through patient engagement activities

Equality and Health Inequality Impact Assessment: overall findings

Impacts of travel time differences on health inequalities (access)
When comparing travel times to the current Principal Treatment Centre main site (The Royal Marsden) to either future PTC location, travel time analysis shows:

- there are differential positive impacts for children living in the most deprived areas and rural areas when travelling by public transport.

- there are differential negative impacts for children living outside London or in rural areas when driving.

Other impacts Several population groups (full list in EHIA) may experience a differential impact in terms of:
- complexity or cost of their journey
- uncertainty brought on by the prospect of the service change process itself
- on-site accessibility

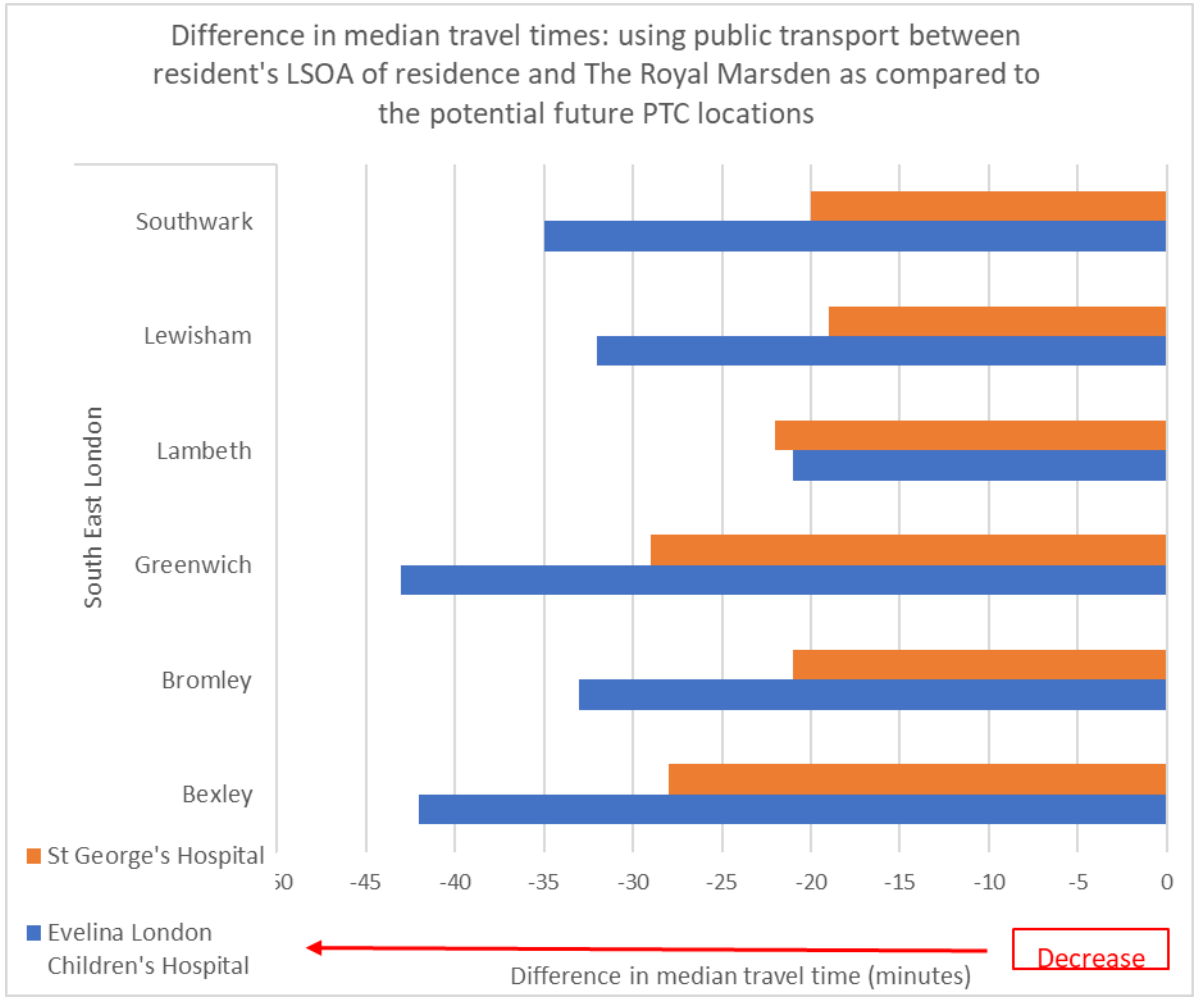
For example, patients and/or families:
- where a family member is disabled (or has a spectrum disorder)
- who are on a low income/living in more deprived areas
- with poor literacy and/or language barriers
- who experience digital exclusion

The Equalities profile document includes an estimated quantification of the size of each population group within the PTC catchment area.

Benefits for improving outcomes and reducing inequalities:
Compliance with the service specification will mean that healthcare related outcomes (in terms of patient experience and safety) are likely to be enhanced through receipt of co-ordinated, holistic care with a reduced requirement for treatment transfers at a time of crisis and the risk that certain types of transfers involve.

While this will benefit all children attending the PTC, the EHIA sub-group concluded that there may be a differential positive benefit for certain groups who may have a higher need for additional paediatric specialties (e.g. those with complex cancer care needs, co-morbidities, who are disabled or have or other conditions) or with communication difficulties (e.g. language barriers or poor literacy) where the reduced need for treatment transfers/multi-site appointments may be beneficial.

Equality and Health Inequality Impact Assessment: Public transport



On average, the residents of all boroughs within South East London would see a reduction in travel time to either Evelina London or St George's via public transport, compared to travelling to The Royal Marsden.

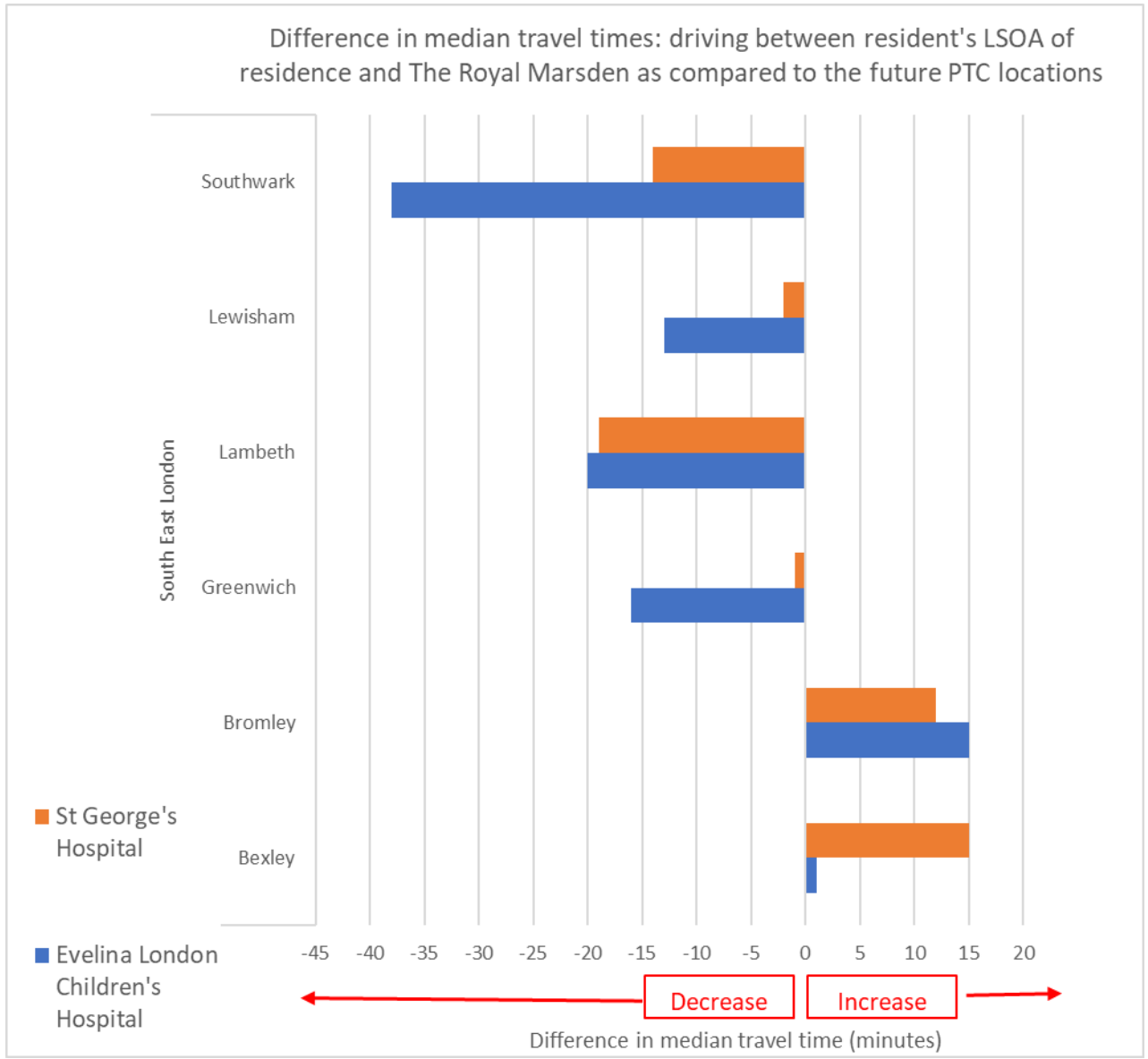
Travel times to Evelina London would reduce by 34 minutes on average.

Travel times to St George's would reduce by 23 minutes on average.

For context, the estimated current public transport travel time to The Royal Marsden for South East London residents is on average 1 hour 24 minutes.

Please see Appendix for travel time analysis methodology

Equality and Health Inequality Impact Assessment: driving



On average, the residents of most boroughs within South East London would see a decrease in travel time for driving.

However, this masks a difference within the area, with residents of Bromley likely to experience an increase in travel time of around 14 minutes on average to either potential future location.

Meanwhile, residents of Bexley would be likely to experience an increase of around 15 minutes travel time to St. George's.

For context, the estimated current drive time to The Royal Marsden for South East London residents is on average 54 minutes.

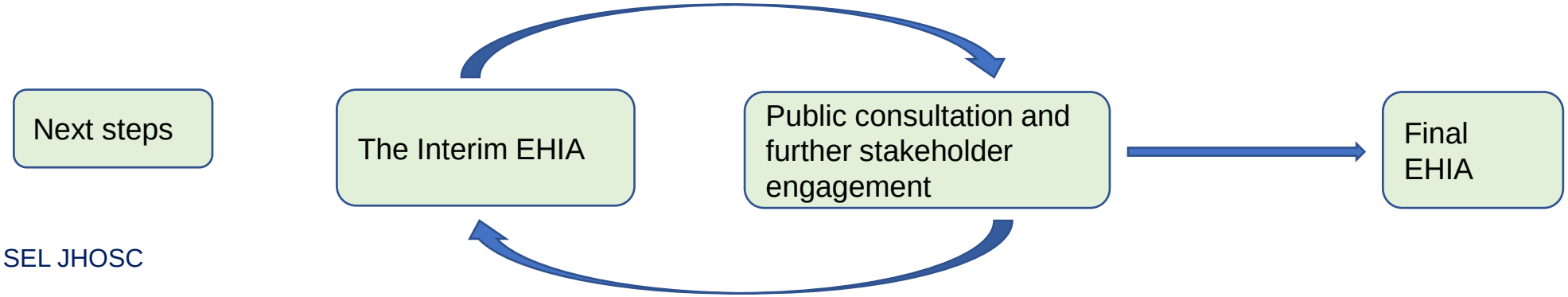
Please see Appendix for travel time analysis methodology

Equality and Health Inequality Impact Assessment: mitigation & next steps

It is important to note that the travel analysis can only capture impacts in terms of travel time. It is not possible to systematically quantify impact in terms of complexity of journey, reliability of transport services and costs. **The most important aspect of the EHIA is the recommendations for mitigation**. The EHIA sub-group has put forward a range of potential systems, processes or programmes that could serve to mitigate the adverse impacts of a longer, more complex, more costly journey.

The main themes include:

1. Systems and processes aimed at helping patients and families plan their journeys to hospital, including provision of inclusive and accessible information and translation services.
2. Systems and processes aimed at reducing the financial impact of travel, such as reimbursement schemes for travel costs (including Ultra Low Emission Zone - ULEZ charges) or supporting patients to access other financial support.
3. Transport services provided directly to patients and their families (with clear eligibility criteria) and family accommodation.
4. High quality onsite accessibility arrangements, including parking and drop-off facilities.
5. Other aspects of care planning including flexibility for appointment times, shared care closer to home, strong communication systems between different health and social care teams, and remote (non face to face) appointments (that take into account aspects of digital capability)
6. An excellent implementation plan for the service change process, to support patients through the transfer period, with high quality continuity of care. Implementation plans should consider meeting NHS duties around health inequalities and take a Core20Plus5 approach.



Other impacts

Alongside the duty to reduce inequalities of outcomes, NHS England – London, have, and will continue to give due regard to:

- The wider impact of the decision made
- The need to contribute towards compliance with the UK net zero emissions target (s. 13NC NHS Act)

5. Consultation plan and document, including stakeholder engagement

Overview of engagement to date

Early engagement
(March 2020 – January 2023)

Fed into the development of the case for change and options appraisal process.

Pre-consultation
(March 2023 – August 2023)

Helping us to plan the consultation and understand what some of the key issues may be, so that we can provide information to help people respond, during consultation.

Consultation
(Autumn 2023)

Will help us to understand the potential impact that implementing either proposal would have on children, young people, families, staff and individual organisations.

Post-consultation
Decision-making and implementation
(Winter 2023/4)

All engagement feedback will be considered, alongside other evidence, to support the decision-making process.

These are indicative timescales and are subject to change.

We seek to ensure an inclusive engagement approach

Planned engagement (during pre-consultation and consultation) is focussing on reaching professionals and different groups from across the region

Professionals and groups include:

- **Current and recent service users and their families and carers**
- **Voluntary and community organisations** (those support children and young people and other communities, including Healthwatch)
- **Staff** (those working in these services and wider staff groups)
- **Health and care partners** (connected services and other nearby Trusts)
- **Children and young people from Black and minority ethnic communities**
- **Children with physical and/or learning disabilities or autism**
- **Scrutiny and assurance bodies** (Overview and Scrutiny Committees and both Clinical Senates across south London and south east region)
- **Focus on all geographic areas patients currently come from**
- **Focus on all age band between 0-15 years old**

Our approach

- Working with **experts in the voluntary and community sector** to include a range of views.
- Commissioning specialist expert organisations to ensure we reach EIA groups and children and young people in an effective and appropriate way.
- Learning from Trust and ICB engagement colleagues to develop **relationships** with key stakeholders to be **inclusive of seldom heard**, **minority and deprived population groups**
- **Using intelligence** from the IIA **to inform engagement plans** to focus on those most affected and impacted groups
- Historic engagement (via both surveys undertaken) has reached a **range of ages, ethnicities and geographies**

Pre-consultation activities – progress so far includes:

Activity undertaken	Upcoming activities
• **Contacted over 300 organisations across south London, Kent, Medway, Surrey and Sussex**, to let them know about the project and to encourage feedback (detailed list in the appendix) • **Attended The Royal Marsden teenage and young adult forum** • **Session with POSCU staff across the catchment area** • **Working with engagement leads from all three Trusts** to reach their patient groups, forums and volunteers • **Visit to The Royal Marsden and Guy's and St Thomas' wards** to directly engage with children and young people and families • **Staff engagement session** at The Royal Marsden • **Stakeholder information session with VCS organisations across the catchment area**	• **Further visits to wards at St George's** to directly engage with children and young people and families • **Further work with Children with Cancer UK and Young Lives VS Cancer** to reach a broader range of families • **Further sessions for staff at St George's and Guy's and St Thomas'** • **Follow up communications to all groups we originally contacted** • **Working with colleagues across the catchment area to understand further engagement opportunities** during the pre-consultation period

For further detail on how we have contacted see Appendix

Consultation: Aims

We have two strong options for the future PTC.

The consultation aims to inform NHS England – London on our decision on which option will offer the best service for children with cancer in the future.

The **purpose of the consultation** is to:

- engage with as many people as possible in the geography affected by this service change and hear their views on the proposals for the future location of the children's cancer PTC
- understand the impact of implementing either proposal and any mitigations or enhancements that could be put in place
- ensure NHS England - London, as decision-maker, is made aware of any information which may help to inform the options and the decision-making process.

Public consultation is not a vote or referendum, and we are asking stakeholders to consider each proposal in its own right.

Outside scope of consultation:

- Shared care units which provide cancer care to children in local hospitals are not affected by this consultation.
- Cancer services for teenagers and young adults (generally for 16 to 25-year-olds but with some flexibility around ages) will continue to be provided at The Royal Marsden.

Consultation document

Consultation document: proposed content includes	Appendices/other supporting documents include:
• How people can get involved (including hard copy questionnaire) • What the consultation is about (and what services won't change • Why a change is needed and benefits • Our proposals • What the proposed changes would mean • What children, parents and staff have told us about the impacts • Developing and assessing our shortlist • The options • Other impacts (including travel and other services) • Scoring outcome • Our preferred option • Timetable and next steps	• Summary consultation document • Easy read document • Consultation questions • Consultation plan • Early engagement feedback report • Animation • Factsheets on development, summary and evaluation of the proposals, financial aspects including costs, getting to the two potential sites, transition offer to teenage and young adult service • Initial Equalities and Health Inequality Impact Assessment (EHIA) • Feedback from the Clinical Senate and programme actions

Our preparations for consultation remain ongoing, this includes ongoing review and assurance of our pre-consultation business case and associated consultation materials as part of NHS England's Stage Two assurance process. In parallel with this, we have received a lot of feedback during the pre-consultation phase, there remains ongoing work to review this and reflect it in our documentation.

Details of how feedback is influencing our consultation plans and document is set out in the Appendix.

Consultation: Engagement methodology & key questions

Engagement methodology

- **Writing to current and recent service users and their families/carers**
- **Online events**
- **Targeted sessions** with the **stakeholder group and other charities/ Voluntary and Community Sector (VCS) organisations** already closely involved with us
- **Community outreach to children and young people and their families with specific characteristics** identified in the equalities impact assessment
- **Creative activities on existing sites with children and young people currently accessing services** (through working with a play therapy organisation)
- **1:1 interviews/ survey completion on existing sites with parents/carers**
- **Attending existing meetings** in the community
- **Survey** (including an easy read version)
- **Wide use of simple animation** to raise awareness and encourage feedback
- **Sharing information through existing contacts and networks** including Facebook group for RM parents
- **Posters with QR codes** linking to online materials
- **Briefings**
- **Offering non-digital channels:** completion of surveys by post, interviews by phone, printed documents in wards/given out by Royal Marsden volunteers/in flats used by long-stay parents

Consultation questions will focus on:

- Understanding of the case for change
- Views on key aspects of both proposals such as travel, access and research
- Ideas around how to mitigate or enhance impacts
- Understanding how we could make implementing the change easier for those currently in the service

Appendix: Supporting slides

- Case for Change - references
- Travel time analysis – methodology
- Pre-consultation engagement – who we have contacted
- How stakeholder feedback is influencing our consultation plans and documents

Case for change – references used in presentation

Transferring critically unwell patients is associated with a risk of physiological deterioration and adverse events[1] and the emotional and psychological stress for parents should not be underestimated[2]. Although specialist transport services have been shown to enhance safety and quality[3], the 2008 "Safe and Sustainable" framework, produced by clinicians and endorsed by the relevant Medical Royal Colleges, states that paediatric oncology and paediatric intensive care have "absolute dependency, requiring co-location". It is this clinical advice, backed up by subsequent expert reviews[4] that underpins the national service specification requirement.

References:

1. Droogh, J.M., Smit, M., Absalom, A.R. *et al.* Transferring the critically ill patient: are we there yet?. *Crit Care* **19**, 62 (2015). https://doi.org/10.1186/s13054-015-0749-4
2. Harvey, Edmunds, Ghose. Transporting critically ill children. Anaesthesia & Intensive Care Medicine Volume 21, Issue 12, December 2020, Pages 641-648
3. Gwyn Hancock. Referral and transfer of the critically ill child. BJA Education, 16 (8): 253–257 (2016)
4. NHS England board-meeting-item-9-update-on-specialised-services-c-appendix-2.pdf (england.nhs.uk)

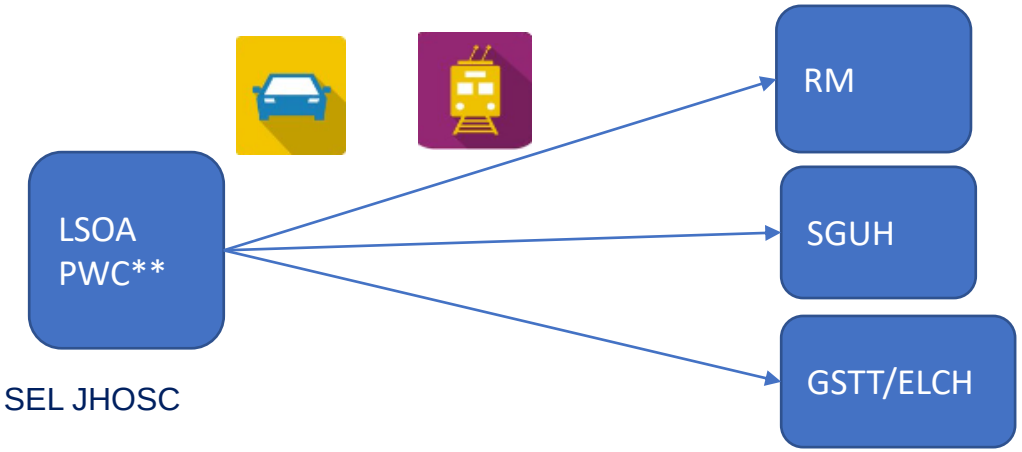
Travel time analysis: methodology

Travel time modelling software was used to generate public transport and car journey travel times for all children (aged 15 and under) living in the PTC catchment to each of the three provider locations, from their "origin" (based on their Lower Super Output Area* (LSOA) of residence). There are 4,000 LSOAs within the PTC catchment area.

Travel times are for the fastest trip departing from resident origin for arrival at midday on a Wednesday. Metrics used in the analysis are median and longest travel times (minutes) and the proportion of the population within a 60 minute journey time of each provider, by public transport and driving.

The modelling uses both road networks and timetabled transport networks. The potential combination of travel modes for each journey by public transport are national rail, tram, light rail, tube, bus, coach, ferry, and walking to and from stops and interchange, and walking alone if quicker. A public transport journey was only measured if a station or stop was reachable within an initial 20 minute walking time (only 0.2% of LSOAs did not meet this criteria).

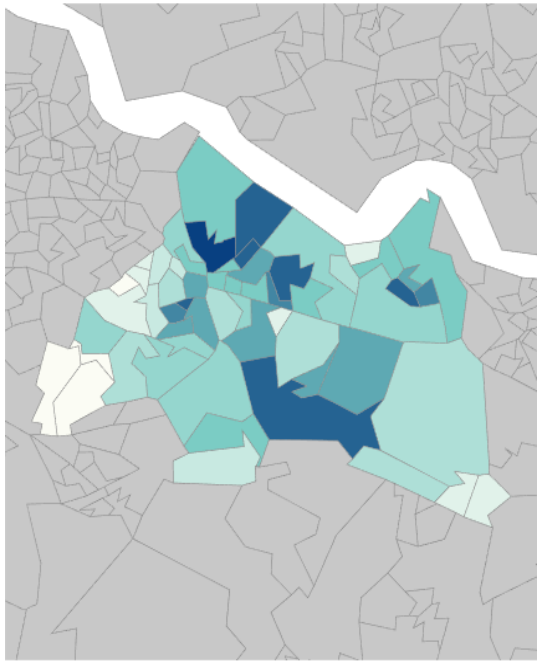
The travel measures are intended to provide a typical indication of the quickest journey from origin to destination for people travelling with no additional requirements. Individual experiences may not completely align with the estimated times.



*** Note: Lower Super Output Areas (LSOAs)** are a small area geography averaging approximately 1,500 people. Each LSOA has a PWC (population weighted centroid) which represents the centre of the distribution of residents across the LSOA.

Population estimates are available at LSOA level and each LSOA is assigned an Index of Multiple Deprivation (IMD) score and an urban/rural classification. This allows for travel time analysis by these classifications. More information on the IMD is in Appendix B

Illustration of Lower Super Output Areas (Dartford)



Pre-consultation engagement – who we have contacted

Below is a list of the different types of organisations we have contacted as part of our pre-consultation engagement:

- Specialist Children & Young People (CYP) cancer charities/groups (including parent-led organisations)
- Youth Forums/Councils/ Parliaments
- Healthwatch organisations
- Maternity Voice Partnerships
- Mental health umbrella organisations
- Black and minority ethnic forums/ groups
- Pan-geography organisations supporting; refugees or asylum seekers, addiction and/or substance misuse issues, people involved in the criminal justice system, people experiencing homelessness and gypsies or travellers)
- Learning disability and autism groups
- Groups supporting people with physical impairments
- Carers (young and adult)
- Community groups in the most deprived areas within the catchment

Stakeholder feedback is influencing our consultation plans and documents

What we've heard through our pre-consultation engagement

- **How we engage during consultation** – taking a mixed approach to and offering different information in different format to suit everyone's information needs.
- **The information we need to provide during consultation** – short, engaging documents as well as more detailed information covering off topics like; the case for change, travel and access, costs involved, impacts on wider services and research.
- **A need to understand the impact on the service model** – what will this mean for The Royal Marsden, the range of supporting services that will be provided in future, whether the care will be of the same or improved quality.
- **Case for change** – identifying benefits and challenges
- **Impact of relocating services** – how transition to the new location will be managed, impact on travel times and access and wider challenges.
- **Process to date** – concerns over options appraisal process and stakeholder involvement
- **Decision-making process** – desire for transparency around how the final decision will be made
- **Important factors for a future service** – highlighting areas such as facilities and access requirements, as well as the availability of family support and workforce.

How our plans have been influenced:

- **Adjusting our consultation plan**
  - to include surveying families in waiting rooms
  - offering visits to both sites so that people can find out more about the organisations and locations of services
  - adding new organisations to our database who are affected/interested
  - offering posters with QR codes so that people can respond online
  - recognising and reaching those who will be most affected – potentially those who are not aware of/ not currently using services. Focus on broad engagement with wide equalities groups and pregnancy and maternity groups.
- **Ensuring our materials are children, young people friendly**
  - testing our animation script with children and young people
  - looking at working with specialist children's cancer charities to develop social media content that may reach children and young people on a peer-to-peer level.
- **Ensuring our materials are accessible and easy to read**
  - Removing jargon in our documents and presenting information through diagrams
  - Slimming down the consultation document and signposting to other sources of more information, like our fact sheets, for more detail
  - Outlining the impact on individuals through patient stories
- **Creating new materials to respond to FAQs and early concerns**
  - Fact sheets about topics like finance and access will be produced.
- **Adding to our consultation questions**
  - Hearing clearly that travel and access are key concerns and adding questions on these to understand the impacts.

SOUTH EAST LONDON INTEGRATED CARE BOARD

South East London Integrated Care Board Joint Forward Plan

1. Context

Integrated Care Boards were asked by NHS England to develop a Joint Forward Plan by end of June 2023, with draft plans developed for the end of 2022/23 and engaged upon during Quarter 1 of 2023/24, to enable final plans to be published at the end of June 2023 (Draft). The purpose of the plan is to set out our medium term objectives and plans, at both a borough level and from the perspective of our key care pathways and enablers, to ensure that we are developing a service offer to residents that:

- Meets the needs of our population.
- Demonstrates and makes tangible progress in addressing the core purpose of our wider integrated care system:
  - improving outcomes in health and healthcare
  - tackling inequalities in outcomes, experience and access
  - enhancing productivity and value for money
  - helping the NHS support broader social and economic development.
- Delivers national Long Term Plan and wider priorities, for example in mental health, all of which resonate from a south east London population health perspective.
- Meets the statutory requirements of our Integrated Care Board.

Our Joint Forward Plan has been developed bottom up with three key building blocks:

- Borough based plans secured through our six Local Care Partnerships, reflecting and consistent with borough based Health and Well Being Plans.
- Care pathway plans e.g. for pathways such as urgent and emergency care programme or population groups such as children and young people, developed through our ICB care pathway boards, focussed on the whole care pathway from prevention through to specialist care.
- Enabler plans e.g. workforce, digital and finance, developed through our ICB Enabler Boards.

In developing the plan we have worked to ensure a link and join up across these three key building blocks, as well as ensuring that the Joint Forward Plan is reflective of the work underway to develop our wider Integrated Care Strategy and our more immediate 2023/24 operational plan commitments.

The draft plan was published on the ICB website on 19th April 2023, marking the start of a period of wider engagement on the plan before finalisation at the end of June.

This is our first Joint Forward Plan, and we expect to be asked to refresh the plan annually to:

- Take account of implementation and outcomes over the previous year, including any learning to be applied to our future plans.
- Reflect any changes required due to new or emerging issues or requirements, be they related to population health, feedback from our communities and service users or service delivery issues and opportunities.

2. Content and build of our Joint Forward Plan

How it all fits together

Our Joint Forward Plan builds on the work we have been doing as a wider system and is driven by the following key areas:

- Our Integrated Care Partnership integrated care strategy: the Joint Forward Plan includes clear commitments around our Integrated Care Board contribution to the delivery of the ICS's strategic objectives, outcomes and priorities that we have collectively agreed we will work, as a wider partnership, to secure.
- Our borough based Local Health and Well Being Plans; the work our Local Care Partnerships will take forward to secure these plans jointly agreed plans, harnessing the benefits of joint working and integration to do so.
- A consideration of the full breadth of underpinning care pathways and enablers that we will need to develop, improve and transform to meet these priorities.
- Plans to secure the key objectives of ICBs, including delivery of national and local priorities and our allocative approaches (medium term financial plan), with a focus on short term delivery milestones across all key areas of the ICB's planning functions. This includes the planned delegation of key services to Integrated Care Boards from NHS England.

The Plan is a lengthy document, given the scope and breadth of our planning requirements. We have however sought to organise it in to clear and discrete sections which should help navigate the document and enable people to focus in on areas of specific interest.

Engagement process

Our draft and final Joint Forward Plan has been developed using existing insight from previous engagement activity and events, including those gained through the extensive engagement that took place as part of the development of the ICS strategic priorities, and these insights are documented in the draft plan.

During the period mid-April – mid June we held additional engagement events to seek input to and feedback on the draft Joint Forward Plan. It is important to recognise that some areas of the plan are guided by national requirements and national guidance, so the scope for local influence is in some areas reduced. We have therefore focussed our engagement questions on approaches to delivery, how we should measure success as well as general feedback on key care pathways from a resident and service user perspective.

The summary below sets out the additional engagement at both SEL and borough level:

- **Two SEL level webinars** on 19th and 23rd May, covering a general overview of the Joint Forward Plan and breakout groups to allow for more detailed discussion on four topics which have not been covered as part of the South East London ICS strategy development or where we have less insight – planned care, urgent and emergency care, cancer, frailty and end of life care.
- A project page with a short survey on the **Let's Talk online engagement platform**. Here
- Engagement discussions in each borough.
    - **Bexley:** Discussion at Bexley Wellbeing Partnership (25th May) prior to being presented and discussed at the Health and Wellbeing Board. Discussions will also take place with Community Champions and PPG members.

    - **Bromley:** Engagement event 22nd May with invited stakeholders including Healthwatch, community groups, community champions, faith groups, with a focus on neighbourhood working.
    - **Greenwich:** Local Care Partnership public forum on 18th April and discussion as part of Healthier Greenwich Partnership on 26th April, as well as a stall at the Greenwich Get Together public event on 3rd June and Together 23 on 10th June.
    - **Lambeth:** discussion as part of the public forum of the Local Care Partnership Board on 18th May as well as discussion at three local alliances and through a local Equalities, Diversity and Inclusion Group, which includes VCSE members.
    - **Lewisham:** discussion as part of Lewisham Health and Care Partnership Seminar on 27th April and at the People's Partnership face to face event on 11th May
    - **Southwark:** discussion as part of a Healthwatch event on 3rd May, and Partnership Southwark Board meeting in public on 4th May.
- All boroughs further engaged with local **Health and Wellbeing Boards.**
- Attendance and discussion at two **Healthwatch** meetings to discuss the Joint Forward Plan, on 15th May (Healthwatch managers) and 5th June (Healthwatch SEL Reference Group) plus the VCSE Strategic Alliance meeting on 24th April.
- Particular sections of the plan have been discussed at **other forums including**:
    - Mental Health VCSE Steering Group
    - Maternity Voice Partnership Chairs forum
    - Learning disability and autism service user and carers forum

The additional insight we have gained from this engagement has been reflected in the final Joint Forward Plan document, noting in the main the feedback received did not result in material changes to the key priorities and objectives set out in the plan, but will instead inform continued development of area specific workplans and how we operationalise key actions.

3. Next steps

- The ICB's Joint Forward Plan was published in final form at the end of June 2023 and is accessible through the ICB website. Here (Draft)
- In line with the requirement to update the Joint Forward Plan annually by end of March, we will undertake a light touch refresh for 24/25 which will include reflecting progress made over 23/24, the further development of the more detailed priorities and work plans within the integrated care strategy that is currently underway plus feedback on the plan through our on-going engagement and feedback processes.

South-East London (SEL) Joint Health Overview and Scrutiny Committee (JHOSC)

Report title- SEL JHOSC Work Programme Report

Date: 6 July 2023

Outline and recommendations

This report asks the members of the Joint Health Overview and Scrutiny Committee (JHOSC) to discuss & agree agenda items for the committee's work programme.

The Committee is asked to:

- Discuss the committee's priorities and the strategic issues that impact all of South-East London (SEL) and then to recommend items for the Committee's work programme.
- Ensure that the topics that are selected for discussion are appropriate for South East London level scrutiny, can add value, and do not duplicate scrutiny activity happening within individual participating authorities.
- Note opportunities for scrutiny between formal meetings.

1. Summary

1.1. This report asks members to discuss and agree agenda items for the committee's work programme for the year ahead.

1.2. The work programme should be reviewed at each meeting to take account of changing priorities.

2. Recommendations

2.1. The Committee is asked to:

- Discuss the committee's priorities and strategic issues that impact all of SEL and then to recommend items for the Committee's work programme.
- Ensure that the topics that are selected for discussion are appropriate for South East London level scrutiny, can add value, and do not duplicate scrutiny activity happening within individual participating authorities.
- Note opportunities for scrutiny between formal meetings.

3. The Committee's Work Programme

3.1. After the significant formal changes brought about by the Health and Care Act 2022 and the placement of Integrated Care Systems on a statutory footing, there have been changes to the role of the JHOSC. Therefore, the work programme of the Committee needs to allow for greater scrutiny of the wider, system level issues that relate to the planning, provision and operations of health services across the ICS footprint area.

3.2. The Committee has a key role in having oversight of, and scrutinising, the health of the overall system including how the ICB and ICP work together, and in reviewing how system-wide plans and strategies will be operationalised and whether outcomes are being delivered at system level.

3.3. The Work Programme will cover formal and informal meetings and can also include information updates that can be circulated by email.

3.4. It has been agreed that the committee will have two formal meetings a year to undertake deep dives into strategic issues that impact all of South-East London. Alongside these two formal meetings, the JHOSC can also have informal meetings that will provide an opportunity to receive updates, discuss the work programme and discuss local health matters more informally.

3.5. The Committee should assess what is the most effective way for receiving information on / considering issues of interest. This could be scrutinising the issue at a formal meeting, discussing it in an informal meeting or receiving a written update that is circulated to Members by email.

3.6. This report asks the members of the Committee to discuss the priorities of the JHOSC, consider the key services and programmes within the committee's remit, and recommend items for the Committee's work programme.

3.7. Members of the JHOSC will need to ensure that the topics selected for discussion are appropriate for South East London level scrutiny. In other words, those matters where the joint Committee is the best way of considering how the needs of a local population, which crosses council boundaries, are being met.

3.8. For each item on the work programme, the Committee should clearly define the information and analysis it wishes to see in the officer reports.

3.9. The Committee should also consider whether to invite any expert witnesses to provide evidence, and whether site visits or engagement would assist the effective scrutiny of the item.

4. Suggestions for the SEL JHOSC's Work Programme

4.1. The members of the Committee had an informal meeting on the 5th of April 2023 which included a discussion on the Committee's work programme. The following suggestions were discussed:

- Workforce- Challenges with recruitment and retention of staff.
- Prevention and early intervention in Mental Health
- Budget discussions and winter arrangements
- Acute care and GP appointments
- Hospital Capacity Planning (particular concerns around Queen Elizabeth Hospital)
- A&E pressures
- The Discharge process and tackling the elective backlog
- Approach to resolving medication shortages
- Access to dentistry appointments and in particular NHS appointments

4.2. The following suggestions for the work programme were received from South-East London Integrated Care Board (SEL ICB) officers:

- Integrated Care Board 'Joint Forward Plan'
- Elective revovery
- Focussed discussion on workforce

5. Financial implications

5.1. There are no direct financial implications arising from this report. When items for the Committee's work programme are agreed, those items may have financial implications, and these will need to be considered as part of the reports on those items.

6. Legal implications

6.1. There are no direct legal implications arising from this report. When items for the Committee's work programme are agreed, those items may have legal implications, and these will need to be considered as part of the reports on those items.

7. Equalities implications

7.1. The Equality Act 2010 brought together all previous equality legislation in England, Scotland and Wales. The Act included a new public sector equality duty, replacing the separate duties relating to race, disability and gender equality. The duty came into force on 6 April 2011. It covers the following nine protected characteristics: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation.

7.2. There are no direct equalities implications arising from this report. When items for the Committee's work programme are agreed, those items may have equalities implications, and these will need to be considered as part of the reports on those items.

8. Climate change and environmental implications

8.1. There are no direct climate change or environmental implications arising from the implementation of the recommendations in this report. Items on the work programme may have climate change and environmental implications and reports considered by the Committee should acknowledge this.

9. Crime and disorder implications

9.1. There are no direct crime and disorder implications arising from the implementation of the recommendations in this report. Items on the Committee's work programme may have crime and disorder implications, and these will need to be considered as part of the reports on those items.

10. Health and wellbeing implications

10.1. There are no direct health and wellbeing implications arising from the implementation of the recommendations in this report. Items on the Committee's work programme may have health and wellbeing implications, and these will need to be considered as part of the reports on those items.

11. Report author and contact

If you have any questions about this report please contact the Scrutiny manager (Lewisham Council):

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