INNER NORTH EAST LONDON JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE

1. INEL JHOSC AGENA - 6.11.19 (C/O LB NEWHAM) (Pages 3 - 78)

Date of the next Meeting:
The next meeting of the Committee will be held on Monday, 27 January 2020 in the

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Agenda

Inner North East London Joint Health Overview and Scrutiny Committee (INEL JHOSC)

Date **Wednesday 6th November 2019**

Time **7.00 p.m.**

Venue **Council Chamber, Newham Town Hall, East Ham, E6 2RP**

Rokshana Fiaz OBE
Mayor of Newham

Althea Loddrick
Chief Executive

MEMBERSHIP:

Councillor Winston Vaughan (Chair)	London Borough of Newham
Councillor Ben Hayhurst (Deputy Chair)	London Borough of Hackney
Councillor Gabriela Salva-Macallan (Deputy Chair)	London Borough of Tower Hamlets
Common Councilman Michael Hudson	City of London Corporation
Councillor Patrick Spence	London Borough of Hackney
Councillor Yvonne Maxwell	London Borough of Hackney
Councillor Anthony McAlmont	London Borough of Newham
Councillor Ayesha Chowdhury	London Borough of Newham
Councillor Kahar Chowdhury	London Borough of Tower Hamlets
Councillor Shad Chowdhury	London Borough of Tower Hamlets
Councillor Nick Halebi	London Borough of Waltham Forest
Councillor Richard Sweden	London Borough of Waltham Forest
Councillor Umar Ali	London Borough of Waltham Forest

OBSERVER:

Councillor Neil Zammett	London Borough of Redbridge

SUBSTITUTES:

Common Councilman Christopher Boden	Substitute Member - City of London Corporation

Officers Usually In Attendance:

Chris Kelly	London Borough of Newham
Roger Raymond	London Borough of Newham

Rokshana Fiaz OBE
Mayor of Newham

Althea Loddrick
Chief Executive

Agenda

1. WELCOME, APOLOGIES AND INTRODUCTIONS

2. DECLARATIONS OF INTEREST

This is the time for a Member to declare any interest they may have in any matter being considered at this meeting.

3. MINUTES OF PREVIOUS MEETING

The Committee is asked to agree the accuracy of the minutes of the previous meeting.

4. INEL JHOSC WORK PROGRAMME

INEL JHOSC is asked to comment, discuss and approve items on the work programme.

5. SUBMITTED QUESTIONS

INEL JHOSC is asked to note and respond to questions submitted by the public.

6. NHS LONG TERM PLAN IN NORTH EAST LONDON

INEL JHOSC is asked to note, comment and discuss the North East London NHS Long Term Plan.

7. MOORFIELDS EYE HOSPITAL RELOCATION UPDATE

INEL JHOSC is asked to consider proposals and consultation on the relocation of Moorfields Eye Hospital.

8. DATE OF NEXT MEETING

INEL JHOSC meeting – Wednesday 27 November 2019, 1900-2100hrs, Old Town Hall, Stratford.

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INNER NORTH EAST LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE (INEL JHOSC)

Meeting held on 19th September 2019
in Will Thorne Chamber, Old Town Hall, Broadway, Stratford E15 4BQ

Present: Councillor Winston Vaughan (Chair, London Borough of Newham)

City of London Corporation
Common Councilman Michael Hudson

London Borough of Hackney
Councillors Ben Hayhurst, Yvonne Maxwell and Patrick Spence

London Borough of Newham
Councillor Ayesha Chowdhury

London Borough Tower Hamlets
Councillor Gabriela Salva-Macallan

London Borough of Waltham Forest
Councillors Richard Sweden and Councillor Umar Ali

In Attendance: Selina Douglas, Managing Director Waltham Forest, Newham and Tower Hamlets (WEL) CCGs
Satbinder Sanghera, Director of Corporate Services, Waltham Forest, Newham and Tower Hamlets (WEL) CCGs
Mark Scott, Deputy Director for Transformation, East London Health and Care Partnership
Dr. Dee Hora, Portfolio GP, Camden Named GP, Adult Safeguarding and Planned Care Clinical Lead, North Central London Planned Care Clinical Lead, London Clinical Senate Council Member
Nick Strouthidis, Consultant Ophthalmic Surgeon
Medical Director, Moorfields Eye Hospital
Chris Kelly, Senior Scrutiny Policy Officer
Roger Raymond, Senior Scrutiny Policy Officer

Apologies: London Borough of Newham
Councillor Anthony McAlmont

London Borough of Tower Hamlets
Ashton West, Scrutiny Officer

1. WELCOME AND INTRODUCTIONS

The Chair welcomed Members, witnesses and members of the public to the meeting.

2. DECLARATIONS OF INTEREST

Cllr Yvonne Maxwell declared that she was a Governor at Homerton University Hospital NHS Foundation Trust.

3. MINUTES OF PREVIOUS MEETING

The Committee considered the accuracy of the minutes of the meeting held on 3 April 2019.

One amendment was agreed. On page 6, the word ‘hoisted’ to be changed to ‘foisted’.

RESOLVED:
That the minutes of the meeting held on 3 April 2019 be agreed as a correct record, subject to the above amendment.

4. LONDON BOROUGH OF WALTHAM FOREST INCLUSION WITHIN INEL JHOSC

The Chair informed the Committee that the London Borough of Waltham Forest currently held Observer Status. It was proposed that the Borough should now have full membership of the Joint Committee, as a lot of its health services were provided by Whipps Cross Hospital and Barts Health NHS Trust. It was noted that they would still have one Member on the ONEL JHOSC.

RESOLVED:
The INEL JHOSC approved the inclusion of the London Borough of Waltham Forest to INEL JHOSC.

5. LONDON BOROUGH OF REDBRIDGE OBSERVER STATUS

The Committee discussed the proposal for the London Borough of Redbridge becoming an observer borough to INEL JHOSC.

RESOLVED:
The INEL JHOSC approved the inclusion of the London Borough of

Redbridge to INEL JHOSC with observer member status.

6. ELECTION OF VICE-CHAIR

The Chair informed the Committee that there was a vacancy for one of the Vice-Chair positions. The former holder of the position from the London Borough of Tower Hamlets was no longer a member of the Committee.

The Committee proposed the nomination of Councillor Gabriela Salva-Macallan, London Borough of Tower Hamlets.

RESOLVED:
The INEL JHOSC approved the appointment of Councillor Gabriela Salva-Macallan, London Borough of Tower Hamlets as Vice-Chair.

7. INEL JHOSC Terms of Reference

The Committee considered the amended terms of reference. The amendments reflected the inclusion of the London Borough of Waltham Forest as a member and the London Borough of Redbridge as an observer.

RESOLVED:
The INEL JHOSC approved the updated Terms of Reference, to acknowledge the inclusion of Waltham Forest and the London Borough of Redbridge.

8. INEL JHOSC PROTOCOLS

The Committee discussed the protocols and their effect on the work of the INEL JHOSC.

It was suggested that a sentence be added to the protocols to read that "the INEL JHOSOC PROTOCOLS operates underneath any legislation or NHS regulations that governs the scrutinising of any matter relating to the planning, provision and operation of the health services in joint areas and across boroughs."

RESOLVED:
The INEL JHOSC approved the updated INEL JHOSC protocols, subject to the amendment.

9. WORKPLAN

The Committee discussed the Workplan. The Committee agreed to

move the date and time of the next INEL JHOSC meeting, which was due to meet at the same time as the Outer North East London Joint Health Overview and Scrutiny Committee (ONEL JHOSC). However, the suggested time of the meeting on 30 October 2019 was not considered suitable. Officers advised that they would look to find an alternative date.

The Committee agreed the following items for the next meeting:

- Developing a North East London (NEL) response to the NHS Long Term Plan (including CCG Mergers)
- Consultation on proposal to move Moorfields Eye Hospital from its site in City Road, Islington – update from consultation
- Pathology Services

The Committee agreed the following items for the 27 November meeting:

- ELHCP - AO update
- Cancer Diagnostic Hub
- Update on Estates Strategy
- Pathology Services

It was noted that any additional items to the workplan would be discussed with the Chair.

RESOLVED:
The INEL JHOSC agreed the amended Workplan

10. SUBMITTED QUESTIONS

The following question was submitted to the Committee by:

Jan Savage, North East London Save Our NHS (NELSON):

The Inner North East London (INEL) Joint Health Overview and Scrutiny Committee (JHOSC) is one of the few forums for scrutiny of plans for the local health economy. We would be grateful for an explanation as to:

a) Why, particularly at this time of massive restructuring of health services and commissioning arrangements, has INEL JHOSC only met on two occasions since February 2018 (ie: February 2019 and April 2019)? and
b) How will regular meetings be ensured in future?

The officers informed the Committee that there were many reasons behind the limited number of meetings of the INEL JHOSC in the last

year. Notably, there were three significant factors:

- There was some delay caused by the change of Chair and the related handover of meeting support, which rotated with the Chair, partly due to Newham having to first appoint a Scrutiny Officer to undertake the additional support work;
- One meeting had been cancelled due to adverse weather conditions and concerns about the safety of attendees to that meeting; and
- There had been a meeting scheduled for July 2019 that had to be postponed and rearranged to later in the year (hence, the three dates in autumn/winter), due to reports not being ready

RESOLVED:
That the Committee:
1) Noted the question
2) Agreed that a written response would be provided to Jan Savage, North East London Save Our NHS (NELSON).

11. DEVELOPING A NORTH EAST LONDON (NEL) RESPONSE TO THE NHS LONG TERM PLAN

The Chair welcomed Selina Douglas, Managing Director, Waltham Forest, Newham and Tower Hamlets (WEL) CCGs, Satbinder Sanghera, Director of Corporate Services, Waltham Forest, Newham and Tower Hamlets (WEL) CCGs, and Mark Scott, Deputy Director for Transformation, East London Health and Care Partnership (ELHCP). He thanked them for attending INEL JHOSC to answer questions from Members.

The Chair invited Mark Scott to further explain the ELHCP's response to the NHS Long Term Plan before Members began asking questions.

Mark Scott told the Committee that the Government's NHS Long Term Plan was its proposal to ensure that local health services were working in a collaborative way. It hoped that CCGs, providers and local authorities would work together to provide high quality care and better health outcomes for patients and their families. He also told the Committee that the top three priority areas for the ELHCP and the local CCGs were:

- Improvement in Preventative Care;
- Improving the health and wellbeing; and
- Integration of all health services and increasing collaborative working

Mark Scott advised the Committee that the Government issued

implementation drivers for the NHS Long Term Plan in July. Further guidance had been issued in August and September 2019. The ELHCP would submit a first draft in response to the NHS Long Term Plan on 27 September 2019. The Regulator would provide feedback to the ELHCP in a timely manner. The ELHCP would also seek feedback from bodies such as Healthwatch bodies and Health and Wellbeing Boards. The ELHCP would submit its final plan by 15 November 2019.

The population growth in the ELHCP catchment area would be the highest in the country over the next 10 years. In light of this, the ELHCP will look to improve its preventative care, and increase the use of technology and collaborative work. Examples of successful collaborative work include the Barts Heart Centre at St Bartholomew's Hospital and the Barts Health Stroke Service. It was reported that the ELHCP was also conducting a number of case studies to investigate ways it could be innovative.

The ELHCP outlined its plans to invest in recruitment and training. It would promote recruitment from the local population through apprenticeships and training opportunities. It intended to develop new and exciting roles for their staff.

Selina Douglas, Managing Director, Waltham Forest, Newham and Tower Hamlets (WEL) CCGs told the Committee that the ELHCP's local priorities consisted of surgery, neurology rehab, mental health and rough sleepers. On the question of rough sleepers, Councillor Sweden noted that Waltham Forest had conducted a Scrutiny Review that looked at rough sleepers' access to primary care. Officers would send the NHS representatives a copy of the Scrutiny Report.

Members were advised that the ELHCP would be looking to expand its use of technology in delivering healthcare. They would look to invest in the infrastructure that supports this objective. A Digital Pathway was also being developed with local hospitals to enhance the use of technology. The way outpatient services were managed across the North East London (Barts Hospital and Homerton University Hospital) catchment area was an example of successful collaborative working. Another example provided was in regards to outpatient appointments for chronic kidney disease. Real-time testing results were relayed to GPs surgeries, which has meant fewer patients travelling to hospital appointments. The ELHCP are also working with out-of-hospital teams to encourage patients to use the online services.

The ELHCP reported that it would be looking to invest in the support for GPs. The ELHCP would be increasing the amount of training posts it offered and would implement a number of initiatives to encourage GPs to stay in the North East London area. It was noted that the London Boroughs of Newham and Tower Hamlets were investing in accommodation for health professionals.

The Committee was told that the ELHCP would be engaging with the INEL JHOSC plus Health and Adult Social Care Committees in the boroughs over proposals to merge CCGs in the North East London area. Some Members noted that some concerns had been raised locally about proposals to merge CCGs.

Selina Douglas noted that health professionals liked to test patients regularly. Whilst it may seem like there was over-testing, health professionals liked to be in possession of the most up-to-date results. The ELHCP intends to improve its ICT infrastructure to ensure that test results are relayed to health professionals quicker.

Mark Scott responded to a question about the funding of children and adolescent mental health services (CAMHS). The Committee was informed that children's mental health services were centrally funded. There were proposals from NHS England to delegate funding to the sustainability and transformation partnership (STP) level. Selina Douglas told the Committee that NHS England had amended the regulations in respect of purchasing medication. The amended regulations recognised that many medicines could be purchased much cheaper from Supermarkets (compared to pharmacists). The ELHCP told the Committee that there were no plans for PFI contracts in its local plan.

Selina Douglas responded to a number of questions about the Primary Care Network and GPs. The Committee was informed that there were a number of financial incentives available to GPs for joining a Primary Care Network. Members were advised that GPs had been working together across London for over 10 years as part of 'federations'. The ELHCP would continue to support GPs as they worked together in Primary Care Networks. The ELHCP had a programme in place to deliver Primary Care Networks over the next 18 months. Each Network had a clinical lead and would get support as part of a leadership programme to expand the Network. It was reported that even if a GP did not join their local Primary Care Network, any additional services they offered would be available to all patients who resided in that Primary Care Network catchment area.

RESOLVED:
THE INEL JHOSC agreed to receive an update on the Long Term Plan at its next meeting

12. CONSULTATION ON PROPOSAL TO MOVE MOORFIELDS EYE HOSPITAL FROM ITS SITE IN CITY ROAD, ISLINGTON – UPDATE FROM CONSULTATION

Dr. Dee Hora, Portfolio GP and Nick Strouthidis, Consultant Ophthalmic Surgeon Medical Director, Moorfields Eye Hospital informed the Committee about Moorfields Eye Hospital's public consultation.

Moorfields Eye Hospital is consulting about a proposal to move the hospital from its current location on City Road to a new building just north of King's Cross and St. Pancras stations. The rationale for the move was that the current hospital's site was no longer deemed fit for purpose. The hospital was founded in 1805 and had been at its current location since 1899. The nature of treating patients had changed a lot since 1899. The proposed centre would offer better care and significantly improve Moorfields' ability to prevent eye disease, make early diagnoses and deliver effective new treatments for more people.

Members were advised that the move would bring together excellent eye care with world-leading research, education and training with a number of benefits. Moorfields would also be close to research centres such as the Francis Crick Institute, the main campus of UCL, and leading eye charities such as Guide Dogs and the Royal National Institute of Blind People (RNIB).

The Moorfields Eye Hospital received patients from across London, from Croydon University Hospital, and St. George's Hospital in South London for example. It also received many patients from surrounding counties. The new location would also be more accessible for many of those patients from outside of the catchment area.

Dr. Hora said that the headline results from the consultation were:

- 1,111 survey responses had been received, mainly from patients, carers and the public (77%). Staff participation in the survey was at 17%. Key responses were as follows:
    - 73% said a new centre was needed;
    - 8% said they do not think a new centre was needed; the majority of whom agreed with the statement: "I am concerned moving the hospital from City Road to a new site may make my journey to the hospital more difficult";
    - 72% agreed or strongly agreed that the new site should be located at the St Pancras site; and
    - 11% disagreed or disagreed strongly; the majority of which stated they would like to see developments and expansion in outreach services and services closer to where people lived, or they provided examples of locations considered more

convenient to them (e.g. near where they lived, at or near the current location, amongst others)

- 4,833 people had visited the Oriel consultation website, resulting in 15,968 page views
- The main themes of feedback consisted of:
  - Clinical quality – the most important issue;
  - Accessibility – the top theme;
  - Patient experience – what matters most?
  - Improvements for staff;
  - Research opportunities;
  - Improvements in service models; and
  - Engaging people with protected characteristics.

Dr. Hora addressed questions about patient concerns regarding the move. Moorfields had held consultation events to engage with patients. They also had a user of Moorfields' services on the Advisory Board for the consultation. Consultation had also created a number of co-production workstreams to help coordinate and translate consultation feedback into proposed elements of programme delivery. Some examples of the co-production workstreams were 'Accessibility – getting to the proposed site', 'Accessibility – getting around the proposed new centre', and 'Improving the patient experience'.

Dr. Hora told the Committee that Moorfields did not write to all patients, but did engage with patients in focus groups. They also engaged with patients that used Moorfields' services during the periods of the consultation. Nick Strouthidis informed the Committee that the vast majority of funding for buying the new site would come from NHS England and there would need to be some bridging funds. The current Moorfields location was owned by a Special Trust. The financial modelling undertaken by Moorfields demonstrated that the capital investment for the proposal was affordable and the long-term financial position of the trust would remain sustainable. In terms of additional accommodation for the staff close to the new site, Moorfields would discuss further with Islington Council. Nick Strouthidis told the Committee that Moorfields did make an evaluation of the costs and benefits of developing the current site.

Dr. Hora said that Moorfields would engage with the local transport hubs about improvements to signage and other issues. One proposal involved having volunteers in the King's Cross and St. Pancras to help visitors to the hospital.

Dr. Hora invited all Committee members to its final consultation event on Thursday 3 October. Moorfields would return for the joint meeting with INEL/ONEL JHOSC meeting. This would give them an opportunity to consult with the larger catchment area. It would also give Members a further opportunity to contribute to Moorfields' consultation before its final submission.

13. DATE OF NEXT MEETING

The Committee noted that the October meeting would be re-arranged, to start in the evening. .

Chair: ……..

Date: ……

INNER NORTH EAST LONDON (INEL)
JOINT HEALTH and OVERVIEW SCRUTINY COMMITTEE (JHOSC)

Report title	**INEL JHOSC Work Programme 2019 – 2020**
Date of Meeting	Wednesday 6 November 2019
Lead Officer and contact details	**Roger Raymond** Senior Scrutiny Policy Officer DDI: 020 337 36779 roger.raymond@newham.gov.uk
Report Author	**Roger Raymond** Senior Scrutiny Policy Officer DDI: 020 337 36779 roger.raymond@newham.gov.uk
Witnesses	n/a
Boroughs affected	• City of London Corporation • Hackney • Newham • Tower Hamlets • Waltham Forest

Recommendations:

That INEL JHOSC is asked to:

- COMMENT on the work programme;
- APPROVE items on the work programme.

Background

Key Improvements for Patients

- n/a

Implications

Financial Implications

n/a

Legal Implications

n/a

Equalities Implications

n/a

Background Information used in the preparation of this report

- n/a

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Inner North East London (INEL) Joint Health and Overview Scrutiny Committee (JHOSC)

Meeting: Inner North East London (INEL) Joint Health and Overview Scrutiny Committee (JHOSC)
Chair: Cllr Winston Vaughan (Newham) **vice-Chair** Cllr Ben Hayhurst (Hackney)
Support: Robert J Brown, Senior Scrutiny Policy Officer
Venue: Old Town Hall, Stratford, 29 Broadway, LONDON E15

Dates of meetings:
1900-2100hrs

13	Feb-19	18	Sep-19
3	Apr-19	30	Oct-19
19	Jun-19	27	Nov-19

	13-Feb-19	03-Apr-19	31-Jul-19	19-Sep-19	06-Nov-19	27-Nov-19	26-Feb-20	24-Jun-20	30-Sep-20	25-Nov-20
APOLOGIES	Cllr Rohit DasGupta Common Councilman Michael Hudson Common Councilman Chris Boden Cllr Eve McQuillan	Cllr Rohit DasGupta Common Councilman Chris Boden moved from 20 March 2019 due to Tower Hamlets Full Council meeting	**CANCELLED**	moved from 18 September 2019	this meeting will now be the joint INEL / ONEL JHOSC meeting to discuss STP-wide issues, commencing at 7pm - this was rescheduled due to the NHS LTP deadlines for responses					
	AGENDA	**AGENDA**	**AGENDA**	**AGENDA**		**AGENDA**	**AGENDA**	**AGENDA**	**AGENDA**	**AGENDA**
STANDING ITEMS (20mins)	Chair's Announcement Welcome, Apologies and Introductions (inc substitutes) Declaration of Interest Register Minutes of Previous meeting Submissions Work Plan	Welcome and Introductions Apologies for Absence Declaration of Interest Minutes of Previous meeting Submissions Work Plan	Welcome and Introductions Apologies for Absence Declaration of Interest Minutes of Previous meeting Submissions Work Plan	Welcome and Introductions Apologies for Absence Declaration of Interest Minutes of Previous meeting Submissions Work Plan		Welcome and Introductions Apologies for Absence Declaration of Interest Minutes of Previous meeting Submissions Work Plan	Welcome and Introductions Apologies for Absence Declaration of Interest Minutes of Previous meeting Submissions Work Plan	Welcome and Introductions Apologies for Absence Declaration of Interest Minutes of Previous meeting Submissions Work Plan	Welcome and Introductions Apologies for Absence Declaration of Interest Minutes of Previous meeting Submissions Work Plan	Welcome and Introductions Apologies for Absence Declaration of Interest Minutes of Previous meeting Submissions Work Plan
AGENDA ITEMS (100mins)	Election of Chair Election of vice Chair Terms of Reference / Membership / Protocols NHS Long Term Plan - *Simon Hall / Alan Steward* Patient Transport - *Ellie Hobart*	NELCA / ELHCP - AO update and NHS Long Term Plan - *Jane Milligan, Simon Hall* STP / ELHCP Estates Strategy *- Henry Black, Chief Financial Officer* *- Tim Madelin, Estates* *- Anamarie Icleanu, Estates* *- Marie Burnett, NELSON* *- ???, NHS Property Services*	NELCA / ELHCP - AO update Election of vice Chair vote to include Observer Status for Redbridge Cllr updated Terms of Reference Early Diagnostic Centre for Cancer - *Sarah Watson* Update on Moorfields Eye Hospital consultation - *Denise Tyrrell* TO NOTE: INEL System Transformation Board - *Ellie Hobart (to discuss Sep2019)*	Election of vice Chair vote to include Observer Status for Redbridge Cllr updated Terms of Reference ELHCP - AO update on ICS and CCG status - *Jane Milligan* Review of Non-Emergency Patient Transport Service review - *Ellie Hobart* INEL System Transformation Board - *Ellie Hobart* Moorfields Eye Hospital - *Denise Tyrrell*	ELHCP / NHS Long Term Plan in North East London - *Simon Hall / Jane Milligan* Moorfields Eye Hospital - *Denise Tyrrell*	ELHCP - AO update Cancer Diagnostic Hub - *Tim Burdsey* Pathology Services update across NEL - Barts Health / Homerton Hospital / Barking, Havering and Redbridge Update on ELHCP Estates Strategy - *Henry Black / Ana Icleanu* Barts Surgical Surgery - Thelma E George Transformation Delivery Programme Co-Ordinator	ELHCP - AO update Homelessness Strategy - *Simon Cribbens* Feedback from Healthwatch Consultation - *tbc* Overseas Patients and charging - *Barts Health NHS Trust / Homerton University Hospital NHS Trust*	ELHCP - AO update Review of Non-Emergency Patient Transport Service review - Ellie Hobart Mental Health - *David Maher* Digital - *Luke Readman*	ELHCP - AO update	ELHCP - AO update
ADDITIONAL INFO				**Deadline for papers:** **Friday 6 September 2019**	**Deadline for papers:** **25 October 2019**	**Deadline for papers:** **Friday 15 November 2019**				

CoLC	City of London Corporation	C&HCCG	City & Hackney CCG
ELHCP	East London Health Care Partnership	NCCG	Newham CCG
LBH	London Borough of Hackney	NEL	North East London
LBN	London Borough of Newham	THCCG	Tower Hamlets CCG
LBTH	London Borough of Tower Hamlets	WEL	WF and East London
NELSON	North East London Save Our NHS	WFCCG	Waltham Forest CCG
RBR	London Borough of Redbridge		

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INNER NORTH EAST LONDON (INEL)
JOINT HEALTH and OVERVIEW SCRUTINY COMMITTEE (JHOSC)

Report title	**SUBMITTED QUESTIONS**
Date of Meeting	Wednesday 6 November 2019
Lead Officer and contact details	**Roger Raymond** Senior Scrutiny Policy Officer DDI: 020 337 36779 roger.raymond@newham.gov.uk
Report Author	**Roger Raymond** Senior Scrutiny Policy Officer DDI: 020 337 36779 roger.raymond@newham.gov.uk
Witnesses	n/a
Boroughs affected	• City of London Corporation • Hackney • Newham • Tower Hamlets • Waltham Forest

Recommendations:

INEL JHOSC is asked:

- to note
- to respond to questions submitted by the public.

Background

Key Improvements for Patients

- n/a

Implications

Financial Implications

n/a

Legal Implications

n/a

Equalities Implications

n/a

Background Information used in the preparation of this report

- n/a

Inner/Outer North East London Joint Health Overview and Scrutiny Committee (INEL JHOSC)

Stephanie Clark

North East London Save Our NHS,

We understand that STPs across the UK, including East London Health and Care Partnership (ELHCP), are proposing to merge CCGs within their area. Details are set out in the document "CCG mergers". Despite proposals for 'engagement', no formal consultation is proposed. We believe this is contrary to the clear legal requirement to undertake full consultation on proposed mergers. Details of the legal requirements are set out in detail in the letter from Dr Louise Irvine to Lewisham CCG.

Can the JHOSC assure us that the Committee will take all steps necessary including active support for a judicial review to ensure there is full consultation with all affected communities before any steps are taken to merge CCGs in the ELHCP area.

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Hackney Healthwatch: CCG mergers July 2019

http://www.healthwatchhackney.co.uk/news/are-city-and-hackneys-days-numbered/

Are City and Hackney's days numbered?

Speculation is mounting that City and Hackney's high performing clinical commissioning group (CCG) may cease to exist in its current form within two years.

According to recent reports in the *Health Service Journal*, a decision on the future of north east London's seven CCGs, including City and Hackney, is due in the autumn.

The *Health Service Journal* reports that almost of half of England's 191 English CCG are in talks about mergers by April 2020 and that London is 'seeking to merge its 32 CCGs into five by April 2020'.

To date, there has been no local public discussion or formal public consultation on plans to merge City and Hackney with its six north east London neighbours**.

Under any merger with neighbouring CCGs, the distinct legal duty to City and Hackney residents would end, potentially weakening local accountability and shifting away from local decision-making in health services.

City and Hackney outperforms most other CCGs in the country and has just achieved 'outstanding' against NHS England's 2018-19 improvement and assessment framework.

Healthwatch Hackney executive director Jon Williams said City and Hackney had consistently championed public involvement in shaping health and promoted transparency and accountability. He said this had 'contributed significantly' to the quality and effectiveness of local services.

'It is vital public involvement, local accountability and transparency are not lost with creation of any super-CCG for north east London. We want to see open conversation with City and Hackney residents about how NHS services will continue to be accountable and responsive to residents,' he added.

City and Hackney CCG was established under the Health and Social Care Act 2012 with clear legal duties to plan and commission healthcare for City and Hackney residents.

Currently, our CCG is a legally distinct NHS organisation operating within the East London Health & Care Partnership integrated commissioning system and retains legal responsibilities for local City and Hackney residents.

Last year City and Hackney, along with six other north east London CCGs, appointed Jane Milligan as 'single accountable officer' to oversee the emerging north east London integrated commissioning system (ICS).

Important healthcare commissioning decisions affecting City and Hackney residents are already being made by the north east London joint commissioning committee .

However, City and Hackney says it 'continues to decide how the vast majority of services are commissioned'.

We asked City and Hackney CCG and the EHCP to confirm if merger talks were taking place and what public consultation was planned.

In a detailed response, the CCG describes benefits to patients and residents of current joint commissioning arrangements with neighbouring north east London boroughs. It also points to the new 'Neighhbourhods Model', based on GP clusters, as a vehicle for ensuring services are focused or City and Hackney residents.

‘Our local vision is an integrated health and care system where local residents and patients have the healthiest, happiest lives possible. We want to improve health and wellbeing outcomes in our boroughs, by planning and delivering health, social care and public health services together,’ it said.

In response to our specific question on whether the public would be *consulted* on any merger plans, the CCG said: ‘As with all our work, we will be publishing papers and documents in relation to any future change in structure on our website and will be completing extensive engagement with partners, especially residents and patients.’

Our seven questions and City and Hackney CCG’s detailed response can be read in full here.

An ELHCP spokeswoman also directed us to a chapter in the NHS Long Term Plan entitled: ‘A new service model for the 21st century’ which states: ‘Every ICS (Integrated Commissioning System) will need streamlined commissioning arrangements to enable a single set of commissioning decisions at system level. This will typically involve a single CCG for each ICS area. CCGs will become leaner, more strategic organisations that support providers to partner with local government and other community organisations on population health, service redesign and Long Term Plan implementation.’

***North east London CCGs are: City and Hackney, Barking and Dagenham, Havering, Newham, Redbridge, Tower Hamlets, Waltham Forest. All seven CCGs are working as part of the East London Health and Care Partnership (EHCP) a (non-statutory) partnership which comprises local councils and healthcare providers including Homerton Hospital, Barts NHS Trust and East London Foundation Trust.*

We (Healthwatch) asked City and Hackney CCG the following questions about potential merger. Our questions and the CCG’s response are below:

1. How likely is it that City and Hackney will merge with neighbouring (NEL) CCGs in the next 2-3 years?

2. Is this being discussed with ELHCP and neighbouring CCGs at the moment? Are there any papers in the public domain where this is mentioned?

3. What legal process do you have to go through to merge with other CCGs?

4. Would such a decision require: a) local public consultation? b) Consultation with the local Health Scrutiny commission?

5. How would such a merger benefit local residents?

6. At what point would the local public be advised of any merger plans?

7. What proportion of commissioning for City and Hackney residents is now done by the NEL Joint Commissioning Committee

City and Hackney CCG’s response to Healthwatch Hackney’s questions

In 2017/18, the seven north east London (NEL) CCGs - City and Hackney, Newham, Tower Hamlets, Waltham Forest, Barking and Dagenham, Havering and Redbridge – came together to create the NHS North East London Commissioning Alliance (NELCA). NHS City and Hackney CCG continues to decide how the vast majority of local NHS services are commissioned and remains legally accountable for the delivery of their responsibilities, however, where it makes sense, and is in the best interest of patients, the seven CCGs work together (i.e. delivering commissioning efficiencies and developing an aligned approach to working with providers to ensure long-term sustainability and support in the delivery of effective integrated care systems).

In addition to this, and as part of the nationally led move to Integrated Care Systems (ICS) across the NHS (to support achieving the Long Term Plan), partners from City of London and Hackney including Hackney Council, the City of London Corporation, City and Hackney Clinical Commissioning Group, the Homerton, East London Foundation Trust, the GP Confederation and the voluntary sector are changing how they work together to improve health and care services. Organisations joining up to share their staff, money, expertise and services is called 'Integrated Commissioning and Care', and the process formally began in City and Hackney in 2017.

Our local vision is an integrated health and care system where local residents and patients have the healthiest, happiest lives possible. We want to improve health and wellbeing outcomes in our boroughs, by planning and delivering health, social care and public health services together. We want to ensure our service users are at the centre of everything we do, with local services joined-up and streamlined around them. Integrating what we do will enable us to design and transform services according to patients' needs not organisational boundaries.

A focus for 'Integrated Commissioning and Care', has involved GP practices joining up with

residents, local hospitals, community groups, mental health providers, social care, and voluntary sector organisations to create eight 'Neighbourhood' areas. Each Neighbourhood includes four to seven GP practices who will work as part of a team of local services to coordinate health and social care in the community to help improve the lives of around 30,000 – 50,000 residents who live in that neighbourhood area.

By working together better and more locally, we can make the most of our joint local knowledge and achieve our common goals. A model with a City focus and a Hackney focus means we can better tailor services to the needs of our diverse communities. We can also make the most of every City and Hackney pound in the context of increasing pressure on sector budgets. Central to this vision is our commitment to involve residents, patients, providers and our staff as equal partners at every step along this journey. We want to create people-focused services by listening more to residents' and patients' voices.

As with all our work, we will be publishing papers and documents in relation to any future change in structure on our website and will be completing extensive engagement with partners, especially residents and patients.

* City and Hackney CCG Annual Report 2017/18 can be found here: http://www.cityandhackneyccg.nhs.uk/Downloads/About%20Us/Plans%20Strategies%20and%20Forms/FINAL%20published%20CCG%20Annual%20Report%2017_18.pdf * More information on the NHS North East London Commissioning Alliance can be found here: http://www.cityandhackneyccg.nhs.uk/about-us/north-east-london-commissioningalliance.htm

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Dr Louise Irvine, Chair of Save Lewisham Hospital Campaign

Dr Faruk Majid, Chair of Lewisham CCG
Mr Martin Wilkinson, Managing Director, Lewisham CCG

25 August 2019

Dear Dr Majid and Mr Wilkinson,

Thank you for your response to our enquiry about public consultation on CCG merger in which you give as your reason for not carrying out a public consultation s14Z2 of the NHS Act 2006 because it applies "in relation to any health services which are commissioned by the CCG, as opposed to proposals for an organisational change such as a merger".

However we believe that s14Z2 is not the relevant legislation in the case of CCGs seeking to merge, and that the relevant legislation does require there to be public consultation for proposed CCG mergers.

The relevant legislation is contained in the 2006 NHS Act, as amended by the 2012 Health and Social Care Act, which legislated for the creation of CCGs, and the Regulations (Statutory Instruments) that govern how these laws are put into effect.

The Act says that merger of CCGs entails the dissolution of the pre-existing CCGs and the formation of a new CCG. The Regulations say that if a CCG is applying to the Board (NHS England) for dissolution then the Board has to take into account *the extent to which the CCG has sought the views of individuals who receive health services pursuant to arrangements made by the CCG in the exercise of its functions.* This means the views of the general population served by the CCG must be sought, and that would require public consultation.

Furthermore even if it were to be argued that the CCGs were not dissolving but were in fact changing to cover a different area and different membership then that would be considered a change in constitution and there are regulations requiring public consultation for a variation in constitution.

Here is the link to the NHS Act: http://www.legislation.gov.uk/ukpga/2006/41

The Act states that CCG mergers entail the dissolution of the pre-existing CCGs and the establishment of a new CCG.

Here is the relevant section, 14G:

"14G Mergers

(1) Two or more clinical commissioning groups may apply to the Board for—
(a) those groups to be dissolved, and
(b) another clinical commissioning group to be established under this section.”

Please note the word “and”. It is clear that applications for CCG mergers require the existing CCGs to be dissolved AND another CCG to be established.

The section of the Act governing Dissolution of CCGs is as follows:

“14H Dissolution
(1) A clinical commissioning group may apply to the Board for the group to be dissolved.
(2) Regulations may make provision—
(a) as to the circumstances in which the Board must or may grant, or must or may refuse, applications under this section;
(b) as to factors which the Board must or may take into account in determining whether to grant such applications;
(c) as to the procedure for the making and determination of such applications.”

Please note 14H (2b) which refers to Regulations that may make provision *“as to factors which the Board must or may take into account in determining whether to grant such applications”*

In addition, and in case it were to be argued that CCG merger does not entail CCG dissolution, but rather a change to the CCG constitution to vary the area or list of members, then this section of the Act would apply:

“14E Applications for variation of constitution

(1) A clinical commissioning group may apply to the Board to vary its constitution (including doing so by varying its area or its list of members).
(2) If the Board grants the application, the constitution of the clinical commissioning group has effect subject to the variation.
(3) Regulations may make provision—
(a) as to the circumstances in which the Board must or may grant, or must or may refuse, applications under this section;
(b) as to factors which the Board must or may take into account in determining whether to grant such applications;
(c) as to the procedure for the making and determination of such applications.”

Please note 14E(2b) which refers to regulations that may make provision as to “*factors which the Board must or may take into account in determining whether to grant such applications.”*

The relevant Regulations are the National Health Service (Clinical Commissioning Groups) Regulations 2012, and came into force immediately

after the commencement of section 25 of the Health and Social Care Act 2012.

Here is the link:

http://www.legislation.gov.uk/uksi/2012/1631/pdfs/uksi_20121631_en.pdf

Regulation 7, which covers factors relating to the granting of applications for establishment or merger of CCGs, is similar to section 14G of the NHS Act 2006 in referring to the merger of CCGs as entailing the dissolution of two or more CCGs for the establishment of another one.

"Regulation 7. Factors relating to the granting of applications for establishment or merger of CCGs

(1) This regulation applies in relation to—

(a) an application under section 14B of the 2006 Act for the establishment of a CCG, and

(b) an application under section 14G of the 2006 Act for the dissolution of two or more CCGs and for the establishment of another one. "

Regulation 9(2) and (3) and Schedule 2(f) and Schedule 3(e) of the Regulations state the factors that the Board (NHS England) must take into account when determining whether to grant an application to vary the constitution of a CCG or to dissolve a CCG. Please note the word "must" is used, not "may".

The relevant parts of the Regulations are quoted below:

Variation of CCG constitution and dissolution of CCG: factors etc.

9.—(1) This regulation applies if a CCG applies to the Board—

. *(a) under section 14E of the 2006 Act, to vary its constitution, or*

. *(b) under section 14H of the 2006 Act, for the group to be dissolved.*

(2) Schedule 2 sets out factors which the Board must take into account when determining whether to grant an application under section 14E.

(3) Schedule 3 sets out factors which the Board must take into account when determining whether to grant an application under section 14H.

Schedule 2 Factors relating to applications to vary CCG constitution
2(f) The extent to which the CCG has sought the views of individuals to whom any relevant health services are being or may be provided, what those views are, and how the CCG has taken them into account.
"Relevant health services" means any services which are provided as part of the health service pursuant to arrangements made by the CCG in the exercise of its functions.

Schedule 3 Factors relating to applications for CCG dissolution
3(e) The extent to which the CCG to be dissolved has sought the views of individuals to whom any relevant health services are being or may be provided, what those views are, and how the CCG has taken them into account.
"Relevant health services" means any services which are provided as part of the health service pursuant to arrangements made by the CCG in the exercise of its functions.

In summary, according to legislation, CCG merger entails the dissolution of CCGs and/or variation of the CCG constitution. Applications to merge CCGs are therefore governed by regulations about applications to dissolve a CCG or change its constitution. Such applications require the Board (NHS England) to take into account the extent to which the CCG has sought the views of individuals to whom any relevant health services are being provided. Relevant health services means any services provided pursuant to arrangements made by the CCG.

That means the people whose views must be sought are the population receiving health services arranged by the CCG i.e. the general population of the area. That would require a public consultation and not just an "engagement" with selected stakeholders, which is all that is currently taking place.

Interestingly, the NHS England guidance on implementing mergers (paragraphs 28-44 that you cited in your letter), does not, in our view, accurately reflect the law and regulations as it only refers to engaging with Healthwatch and undefined "stakeholders", and makes no mention of seeking the views of the whole CCG population, which we would argue is what the regulations require.

We believe that we have legal grounds to support our argument that the merger of the six CCGs in South East London requires public consultation and will be sending a version of this letter to the chairs of the six CCGs and to NHS England, as well as to the Joint Overview and Scrutiny Committees and our MPs.

We will be asking the six CCGs to agree to full public consultation before submitting their application for merger to NHS England.

We are doing this because we see the issue of CCG merger as of utmost importance in terms of NHS democratic accountability and should therefore be properly consulted on by all those affected, i.e. the general population covered by each CCG.

Yours sincerely,

Dr Louise Irvine, Chair of Save Lewisham Hospital Campaign

To Roger Raymond
From Christopher Sills

Dear Mr Raymond

JHOSC 6th November 2019

I expect to attend the JHOSC on 6th November and would like to ask the following question at the meeting. Although I am a Public Governor of the Homerton Hospital, I am attending in a personal capacity

The Government has announced that Whipps Cross Hospital is going to be rebuilt. What is the implication of this decision on the 10 year health plan. And what are the implications for other hospitals in the area both in the short and in the long term

For example it occurs to me that mothers may elect not to give birth on a building site, which will increase demand in other hospitals in the area in the short-term but reduce it in the long term

Yours Sincerely

Christopher Sills

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North East London Save Our NHS (NELSON)

QUESTIONS TO THE JOINT INEL AND ONEL JOSC ON 6th Nov. 2019

1. Have members of the joint INEL & ONEL JOSC received a copy of the two-page NELSON response to the ELHCP draft LTP as one of the papers on the Agenda for this JOSC meeting?

2. In the light of the concerns raised in the NELSON response, is the JOSC satisfied that the draft LTP contains sufficient information as a basis for consultation with local residents on the major reconfigurations planned for ELHCP services?

3. Will the JOSC please give their own responses to the concerns raised by NELSON?

Carol Ackroyd on behalf of NELSON and member of Hackney Keep Our NHS Public
Carol.ackroyd@talktalk.net

24 October 2019

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North East London Save Our NHS (NELSON)

22 October 2019

NELSON response to East London Health and Care Partnership (ELHCP)'s draft Long Term Plan[1]

1. INTRODUCTION

What is this Plan?

On 3 October 2019, ELHCP published its draft response to NHS England's (NHSE's) Long Term Plan, setting out ELHCP's own long-term plans for North East London. Comments on ELHCP's draft plan must be submitted by the end of October, with ELHCP's final submission to NHSE required by 15th November.
The Plan outlines ELHCP's ambition to become an Integrated Care System (ICS) by 2021, comprising three local systems involving 7 local authorities: BHR (Barking and Dagenham, Havering and Redbridge), WEL (Tower Hamlets, Newham and Waltham Forest), and City and Hackney (C&H). Some community elements of the Plan have been developed jointly with local authorities.

What is NELSON?

NELSON is an umbrella NHS campaign group with members representing NHS campaign groups based throughout NE London.

NELSON's response to the Plan

NELSON has three fundamental areas of concern about the Plan which are set out below.

2. Lack of essential information about resources (on a per 1,000 population basis).

The Plan lacks essential information that would be the basis for genuine consultation. We know from previous analyses and population projections (eg TST) that our area needs many MORE beds, and more staff – but that ELHCP plans reductions in both. However, the draft plan does not include any details of resources (based on per 1,000 population) relating to:

- Historical, current and projected services to be provided on each site
- Historical, existing and projected client catchment areas for services – particularly when this involves proposed development of specialist services serving the wider ELHCP area – or NHSE-commissioned specialised services that may take patients from a much wider area.
- Historical and projected financial information for specific services
- Historical, existing and projected staffing structures and levels
- Historical, existing and projected bed levels and other service levels
- Much is made of services being provided *in the community* or *at home* as an alternative to hospital, however no detail is given of what additional services will be developed to achieve this.

Without this detailed information it is impossible to make a reasoned response to this consultation.

3. Absence of information about potential reduction in services available locally.

An effective local health service has to provide easy access for patients as well as safe and effective clinical services. Nelson and local ELHCP-area campaign groups have repeatedly raised concerns that ELHCP's proposals to concentrate specific services on a single (or limited number of) sites will mean reduced access for patients with longer and more complex journeys. Reduced transport will create further problems.
*(Of course, we recognise and accept the need for **complex and specialised services** to be delivered in specialist units. **We are tired of hearing this duplicitous justification given for all centralisation** -ignoring the fact that most routine procedures can be carried out equally safely and effectively in general hospitals.*

[1] https://www.eastlondonhcp.nhs.uk/ourplans/draft-response-to-the-long-term-plan.htm

Evidence from Healthwatch England

In October 2019, Healthwatch England, in association with AgeUK and Kidney Care UK, carried out a 'nationwide conversation', engaging with over 30,000 people across the UK[2]. The introduction to the report states that:

> the best long-term outcomes of treatment can be seriously affected by other real-world factors ……. one of the most common and basic issues people face is physically travelling to and from appointments….. We found that travel was a key issue, with nine out of 10 people telling us that convenient ways of getting to and from health services is important to them. Indeed, people put transport above other things, such as choice over where to be treated and improving digital access to services. ……communities told us they wanted more focus in local plans on improving the links between transport and health and care services.

This is extremely important information – a national survey stressing that easy access to services is patients' top priority. It reinforces the messages that NELSON has repeatedly given. Despite this, ELHCP (along with the majority of other STPs) has failed to include any information in its LTP to inform local residents:

i) What services can residents of each borough expect from their local hospital (or community facility)
ii) Where will they need to travel to in order to access other routine and specialist services?
iii) Impact assessment of changes in travel to routine and specialist appointments & services.
iv) Impact assessment regarding reduced co-ordination with local social care (especially for elderly patients, those with mental health issues or people requiring ongoing rehabilitation support).

Such information is CRITICAL to enable local residents to make a reasoned response to service reconfiguration and transport changes.

Reduced training opportunities for staff: reduced generic provision in general hospitals will also have major implications for medical training and potentially poses problems of lack of generic skills required to support A&E departments.

4. Moves towards an Integrated Care System (ICS) and (ultimately) and Integrated Care Provide (ICP)

The Health and Social Care Act of 2012 demanded an aggressive pursuit of market competition in NHS services, resulting in fragmentation and difficulty achieving collaboration between NHS bodies.
We are happy that ELCHA clinicians and managers have worked hard to move away from this and towards a welcome collaborative approach involving networking and developing client pathways across providers. We applaud these moves towards a more streamlined and well-co-ordinated system across hospital, GP and community NHS services in North East London, including collaboration with local authority community and care services.

However, the longer-term intention, as set out in NHSE's Long Term Plan, is that **all ICSs across the UK should develop into Integrated Care Providers (ICPs),** ie unitary organisations with a single management structure encompassing all the health (and, potentially social care) bodies in the area. NHSE intends that ICPs will then be procured through long-term, £multimillion commercial contracts, on similar lines to US-style Accountable Care Organisations (ACOs).
NELSON strongly opposes this longer-term goal which will be the final nail in the coffin of the NHS as a national, publicly run service. We want an end to commercial procurements. We wish to see the NHS managed directly as a National public body, with local accountability on lines set out in the NHS (Reinstatement) Bill.

Report prepared by: Carol.ackroyd@talktalk.net

On behalf of NELSON.

[2] https://www.healthwatch.co.uk/report/2019-10-02/there-and-back-what-people-tell-us-about-their-experiences-travelling-and-nhs

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INNER NORTH EAST LONDON (INEL)
JOINT HEALTH and OVERVIEW SCRUTINY COMMITTEE (JHOSC)

Report title	**Developing a North East London (NEL) response to the NHS Long Term Plan**
Date of Meeting	Wednesday 6 November 2019
Lead Officer and contact details	**Simon Hall** **Director of Transformation for the East London Health and Care Partnership** 020 3688 2537 / simonhall2@nhs.net
Report Author	**Roger Raymond** **Senior Scrutiny Policy Officer** DDI: 020 337 36779 / roger.raymond@newham.gov.uk
Witnesses	n/a
Boroughs affected	• City of London Corporation • Hackney • Newham • Tower Hamlets • Waltham Forest
Recommendations: **That INEL JHOSC is asked to:** • NOTE this update; • COMMENT on update.	

Background

Key Improvements for Patients

- n/a

Implications

Financial Implications

n/a

Legal Implications

n/a

Equalities Implications

n/a

Background Information used in the preparation of this report

- n/a

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East London Health & Care Partnership

Developing a local response to the NHS Long Term Plan

Update for INEL and ONEL joint health overview and scrutiny committee

Simon Hall
Director of Transformation

6 November 2019

NHS Long Term Plan

East London Health & Care Partnership

- The NHS Long Term Plan was published in January 2019 and sets out an ambitious vision for the NHS over the next ten years and beyond.
- It outlines how the NHS will give everyone the best start in life; deliver world-class care for major health problems, such as cancer and heart disease, and help people age well
- We have been working locally to plan how we will deliver the Long Term Plan's commitments over the next five years. We are calling this our Strategy Delivery Plan (SDP)
- On 27 September 2019 we submitted a draft document to NHS England.
- Draft on our website www.eastlondonhcp.nhs.uk to allow people the opportunity to have their say on the content.
- Now in the process of incorporating feedback ahead of a final version being submitted to NHS England on 15 November 2019, which will also include commitments on finance and key service targets.

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Our challenges

Our challenges cannot be addressed simply by doing more of the same:

- We are facing substantial population growth (from 2.02m to 2.28m by 2028, 13% growth over the next 10 years).
- There are significant variations in clinical quality and outcomes across our health and care economy that need to be tackled in order to make a real impact on health inequalities.
- We already have a significant workforce challenge across both health and care services and our population growth will exacerbate demand for services if we continue to deliver them in the same way.
- Demand is projected to outstrip our resources and capacity which means we need to look at how we provide care and our financial models and systems. These challenges span both health and social care, and mean we need to agree a different way across all our partner organisations to manage financial risk.

In order to continue to respond to the health and care needs of our local population we need to do things radically differently.

Responding to our challenges

East London Health & Care Partnership

- Greater emphasis on preventing ill health, and empowering local people to take more control over their health and lifestyle choices (prevention and personalisation)
- Ensuring the health and care services we do provide are integrated, joined up and appropriate for people's needs (integrated care)
- Rapidly modernising local approaches to health and care provision, utilising the academic and research base we have in north east London for the good of our local population (modernisation).

One page summary

East London Health & Care Partnership

Our key challenges	➢ Growing population and increasing demand – 13% projected growth in the next 10 years, we need to respond to demand differently if we're going to manage this successfully ➢ Health inequalities – we need to make more progress in tackling the health inequalities of our local population. ➢ An unbalanced delivery system– we are set up to respond to illness and need to refocus towards prevention and population wellness ➢ Workforce – we currently have 11% vacancies across our system putting pressure on the existing workforce and our ability to recruit and retain staff; we need to grow our own going forward and think about different roles.				
Our top priorities	✓ Improving quality of care delivery and reducing unwarranted variation – working together with our communities to create an integrated care system that will improve the quality of care they receive and make it much more joined up and person-centred ✓ Invest in local integrated primary and community infrastructure – help people stay well for longer and support them at home when they need it ✓ Population Health management and intelligence – using the information we have to direct resources and action where it is most needed and maximise our impact ✓ Digital revolution – taking advantage of advances in technology to radically change the way we access and provide care (e.g. information technology, artificial intelligence) ✓ Workforce transformation – changing how we work, the skills we need, what we offer our workforce so that we can attract the workforce we need, and developing new roles that are more relevant to 21st century health and care provision				
Our change programmes	**A better start in life** Improving maternity services and supporting young people to have the best start in life they can.	**Living well** Supporting people to live healthy and happy lives, to manage any long-term health problems, and to age well.	**A good end to life** Helping people as they get older, and supporting people and their families through death ensuring dignity and choice of where to die.	**Better mental health** Putting mental health on an equal footing to physical health, removing stigma and providing better support in the community.	**Seldom heard communities** We are committed to working in partnership with patients and communities who experience health inequalities to help reduce these, help them to access the support that suits them, and promote environments that are fair and free of discrimination.

Our ambition: What we will deliver for…

East London Health & Care Partnership

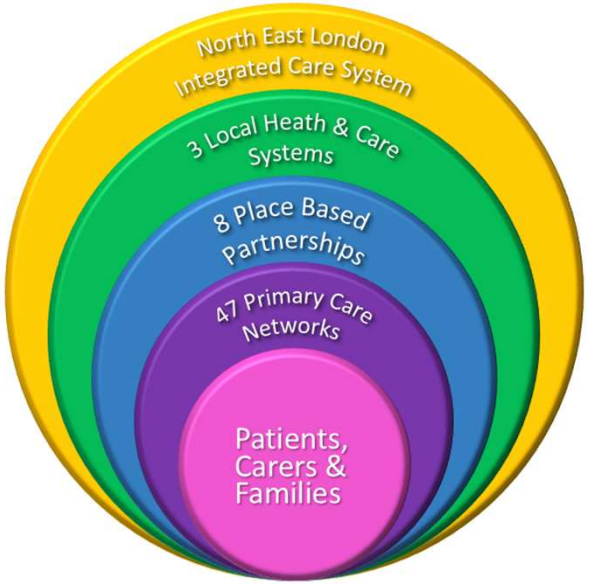
Local people	Health and care staff
don't notice organisational boundaries – it is all one health and care system working together to provide the best care	can easily talk to and share information with staff working in other organisations so they can provide the best care
are supported to stay well	support people to stay healthy, with a focus on longer-term health and wellbeing and prevention
can access the best care possible in modern, fit for purpose facilities	work in modern, fit for purpose facilities that make it easy to do their jobs well
can view their patient record online, and are confident it is stored securely	can easily and securely access patients records in order to provide knowledgeable, consistent care, and don't have to ask people to repeat themselves
access care provide by skilled, motivated, kind staff with a culture of continuous improvement	are supported to provide the best care by continually developing their skills and expertise and are offered training want to work in north east London because there are flexible, innovative roles with opportunities to develop
benefit from world class research and innovation which means earlier diagnosis and more effective treatments	can use research and innovation to provide the best care

How we will make change happen:

East London Health & Care Partnership

Strategy delivery plan

- Integrating care for our local residents through improved and responsive out of hospital services.
- Tackling demand in a meaningful way, focused on addressing the social determinants of health.
- Developing our clinical services to support our population needs, taking a different approach to services for the young and the old in our communities
- Delivering a 21st century NHS for our local population using the opportunities afforded to us by new technology, quality improvement, urban regeneration and research opportunities.



Through our Integrated Care System

Working better as a "System"

- Developing collective responsibility for population health across all partners
- Strengthening clinical leadership from network to ICS level and across all health and care disciplines
- Enhancing place-based partnerships, particularly with local authorities and embedding patient and public engagement.
- Empowering local people to take more control over their health and lifestyle choices
- Utilising the centres of excellence and models of good practice that exist already across NEL for the maximum benefit of our local communities

System enablers

- **Workforce** Addressing retention through supporting our current workforce to thrive, improving our leadership culture, developing new roles, and embedding a culture of learning and development
- **Digital** Further developing our capability to share records and accelerating the use of digital for patients in primary care.
- **Estates** Working together to delivery care in modern, fit for purpose buildings
- **Finance & analytics** Taking a visionary approach to finance, making population health our key financial driver

Delivering by developing an ICS

We have all committed to working together in a collaborative way to deliver local health and care services which mean local people have more options, better support and properly joined up care at the right time in the best care setting.

Integral to this will be how we develop our north east London Integrated Care System (ICS) by April 2021.

ICSs bring together local organisations in a pragmatic and practical way to deliver the ‘triple integration’ of primary and specialist care, physical and mental health services and health with social care. They will have a key role in working with local authorities at ‘place’ level and through systems, commissioners will make shared decisions with providers on population health, service redesign and Long Term Plan implementation.

What is our plan?

East London Health & Care Partnership

We want to make some changes to how we are organised to provide better and more joined-up services as an **integrated care system (ICS)**. This will include:

- all GP practices working together in **primary care networks**
- seven **place-based partnerships** drawing together all the NHS organisations in a given area and working more closely with local authorities
- Three **local systems** looking more strategically at what makes sense to be provided across a wider geographical area
- a **single commissioning group** for north east London, led by local doctors, to take a bird's eye view and look at where we can tackle shared challenges together, such as cancer and mental health

These changes support the commitments set out in the NHS Long Term plan.

NEL Integrated Care System

East London Health & Care Partnership

An integrated care system is a new way of working together:

- The old ways of working, with the separation of commissioners and providers, independent organisations following their own agendas and competition between providers is being replaced by a new culture of co-operation, collaboration, integration and system-based working.
- There will be a new focus on population health, and this will become everyone's business. Providers will not just be responsible for the people they treat but have a collective responsibility for the whole population's health alongside commissioners
- We are still at the beginning of considering how this will work across NEL. We will need the support of our local partners, communities and staff to develop how this will work.
- This will only be achieved by sharing the responsibility with local authorities and other partners.

A single NEL CCG

East London Health & Care Partnership

- We currently have **seven clinical commissioning groups** in north east London buying and planning services – this can **lead to variation**
- **No birds eye view** in north east London. A single commissioner would **focus on health needs of the whole population**
- Primary care networks, place based partnerships and local systems will take a **local view** in future
- Will look to retain what's working well locally and share best practice across NEL

- Single commissioner could also **commission some specialist services** for the whole of north east London, for example cancer care and children's services
- Single commissioner would be **led by doctors** and other healthcare professionals
- All **seven CCGs need to agree this approach.** If they do, we will apply to NHS England in autumn 2020 to create a single CCG to **start in April 2021.**

Why change?

East London Health & Care Partnership

People with several health conditions can find that no one sees the whole picture or supports their individual needs

Some duplication in services, which is inefficient, and some gaps which can mean people don't get the treatment and care they need

There's no single organisation with an overview of health needs of the whole of north east London, with the funding to deliver change

Our current system means health and care organisations can be competing - this can stop them working together in the wider interest of local people

There are lots of health and care service organisations which can be complicated to navigate

Next steps

East London Health & Care Partnership

- See the plan as a working document rather than something that will sit on a shelf
- Develop a plain English summary and easy read version
- Maximise opportunities for engagement and involvement – for local people, health and care staff, and our partner organisations
- Agree an accountability framework with each part of our ICS in order that we are all clear on what is being delivered where
- Work more closely with our elected representatives, particularly to secure integrated service delivery and to provide independent scrutiny
- Report annually on progress and what we've achieved.

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INNER NORTH EAST LONDON (INEL) AND OUTER NORTH EAST LONDON (ONEL) JOINT HEALTH and OVERVIEW SCRUTINY COMMITTEE (JHOSC)

Report title	A report from NHS Camden Clinical Commissioning Group (CCG) in partnership with NHS England Specialised Commissioning on behalf of all commissioners of Moorfields' services.
Date of Meeting	6 November 2019, 7:00 PM
Lead Officer and contact details	
Report Author	Denise Tyrrell, Consultation Programme Director. Denise.tyrrell@nhs.net
Witnesses	n/a
Boroughs affected	• City of London Corporation • Hackney • Newham • Tower Hamlets • Barking and Dagenham • Waltham Forest • Havering • Redbridge
Recommendations: The joint INEL and ONEL JHOSC is asked to: • **NOTE** this update • **NOTE** the responses draft summary of findings from the public consultation on the proposal • **PROVIDE** feedback on draft summary of consultation findings • **CONSIDER** INEL/ONEL JHOSC representatives attend the scrutiny of the consultation by the North Central London Joint Health and Oversight Scrutiny Committee on 29 November 2019	

Purpose and scope of report

NHS Camden CCG and NHS England Specialised Commissioning, working in partnership, are leading a public consultation on a proposed new centre for Moorfields Eye Hospital.

The consultation, which ran between Friday 24 May and Monday 16 September 2019, gave patients, residents, staff and other key stakeholders the opportunity to comment on the proposal to create a new centre for eye care, research and education in King's Cross with project partners UCL and Moorfields Eye Charity.

This report provides an update on the progress on the formal public consultation proposal to relocate Moorfields Eye Hospital from its site in City Road, Islington to St Pancras. The report includes the draft summary of findings from the public consultation on the proposal, highlighting the key themes expressed through the consultation; plans in place to respond to those views; and the next steps for decision-making.

For further information and consultation documentation and the draft consultation outcome report, please refer to the consultation website https://oriel-london.org.uk/consultation-

documents/ where you can read or download the consultation document, draft consultation findings and other background information.

Proposed move of Moorfields Eye Hospital's City Road services - feedback on the proposal

1. Introduction

1.1. On 24 May 2019, a consultation was launched to seek the views from as many people as possible about the proposal to move services from Moorfields' City Road site and build a new centre bringing together excellent eye care, ground-breaking research and world-leading education in ophthalmology.

1.2. This centre would be a multi-million pound development on land that has become available on the site of St Pancras Hospital, just north of King's Cross and St Pancras stations.

1.3. NHS Camden CCG, on behalf of all clinical commissioning groups with NHS England/Improvement Specialised Commissioning, together with Moorfields Eye Hospital, led the consultation, which will influence and inform the Decision-Making Business Case (DMBC).

1.4. The DMBC will be instrumental in gaining Clinical Commissioning Group and NHS England Specialising commissioning support for the proposed relocation, which must demonstrate that proposals for service change demonstrate evidence to meet four tests before they can proceed. These tests include strong public and patient engagement, patient choice, clinical evidence base and support from clinical commissioners.

1.5. The Moorfields consultation programme received: 1,511 survey responses to the consultation questions, 212 other forms of responses including emails, telephone and social media and formal responses; feedback through 99 open discussion workshops, and meetings. Responses have been received from as far as Devon and Dundee, which indicates that the consultation approach has reached the national patient/resident population.

1.6. In line with scrutiny regulations, the North Central London Joint Health Overview and Scrutiny Committee is leading a joint scrutiny process for the consultation and proposed move.

2. Case for change – the story so far

Clinical case for change

2.1. Moorfields provides eye health services to more than 750,000 people each year. Its main site at City Road in Islington has a 24-hour ophthalmic A&E and provides a range of routine elective eye care for London residents and specialised services for patients from all over the UK.

2.2. The current facilities at City Road date from the 1890s. There is very little space to expand and develop new services; the lay-out of the buildings affects efficiency and patient access, and the age of the estate creates difficulties for installing new technologies.

2.3. The proposed centre would offer better care and significantly improve Moorfields' ability to prevent eye disease, make early diagnoses and deliver effective new

treatments for more people for locally or in primary care, as well as in specialist hospital clinics.

2.4. It would bring together excellent eye care with world-leading research, education and training with the following benefits:

- Greater interaction between eye care, research and education – the closer clinicians, researchers and trainees work, the faster they can find new treatments and improve care
- More space to expand and develop new services and technology to improve care, including at home or locally, without the need for a hospital visit
- A smoother hospital appointment process, particularly where there are several different tests involved
- Shorter journeys between test areas and instantly shared results between departments, reducing waiting times and improving communications between patients and staff
- Modern and comfortable surroundings that would provide easier access for disabled people and space for information, counselling and support.

2.5. The independent London Clinical Senate has stated its support for the pre-consultation business case and, in discussions with patients and public leading up to the consultation, people were supportive of the proposed new centre, which would greatly improve care and the patient experience.

Financial case for change

2.6. Financial modelling for Moorfields undertaken at the time of developing the pre-consultation business case (PCBC) demonstrated that the capital investment for the proposal was affordable and the long-term financial position of the trust would remain sustainable.

2.7. This was based on capital costs of £344m (which includes 19% of optimism bias as well as normal planning and related contingencies), planned to be financed by a combination of proceeds from the sale of the City Road site, STP capital funding, philanthropy, and trust internal cash.

2.8. The commissioners considered the capital investment for this proposal to be affordable on the basis of assumed annual activity growth of 3%, which is consistent with historic growth levels at Moorfields based on the financial statements presented in the PCBC, which showed the latest financial year (2018/19) plan and committed to updating the baseline for the outline business case.

2.9. Additionally, projections for NHS income assume a capped income growth of 3% following occupation of the new facility in 2025/26, which is consistent with the commissioner assurance letters provided in support of the PCBC. Income growth up until occupation is assumed at 2% falling to 1% from 2022/23 due to capacity constraints at the City Road site.

2.10. Since approval of the PCBC, commissioners in partnership with Moorfields, have appointed an independent consultancy to provide analytical support to develop a detailed model to show future demand, capacity and activity. This model will also provide clarity on the likely impact of known education, workforce and technological innovations that will result in new models of care affecting the type and levels of service to be provided within the Moorfields site with more granularity.

2.11. The scope of this work involves looking at trends in historic activity by clinical sub-specialty and examining how new models of care could meet projected demand, both in terms of service delivery changes planned by Moorfields, specialised commissioning pathway changes and STP plans designed to shift activity from hospital to primary and community settings. In addition, it looks at possible optimisation in workforce education and technological advances.

2.12. The outputs of this updated demand, capacity and activity analysis will inform the financial and economic case and provide commissioners with further assurance about the sustainability and affordability of the proposed relocation.

Commissioning of Moorfields Services at City Road

2.13. 14 CCGs from London and Hertfordshire hold material (defined as >£2m per annum) contracts with Moorfields for activity at City Road, accounting for 45% of all patient activity in England. Services at Moorfields City Road are also commissioned by NHS England Specialised Commissioning.

2.14. The following table refers to spend by INEL and ONEL CCG area on services and patients attending at Moorfields' City Road site only.

CCG area	NHSE Specialised Commissioning spend (£)	SpecComm patients (number)	CCG spend (£)	CCG patients (number)
City & Hackney	£677,839	3,179	£5,682,412	30,290
Newham	£580,861	2,436	£3,787,005	19,867
Tower Hamlets	£390,978	1,790	£3,795,769	18,864
Barking and Dagenham	£233,842	1,036	£1,557,353	8,064
Waltham Forest	£328,000	1,351	£2,365,141	12,607
Havering	£302,236	1,039	£2,036,798	9,529
Redbridge	£509,221	1,911	£3,039,622	16,342
*West Essex	£227,957	797	£1,345,930	6,541

*West Essex covers Epping Forest District Council which is a member of the ONEL JHOSC

INEL and ONEL residents – summary

2.15. This summary provides an overview of the INEL and ONEL residents that use Moorfields' eye care services at the City Road site.

- Of the 14 CCGs with the highest spend on services at Moorfields' City Road site, east London CCGs are expecting to see a higher increase in people under 65 with serious visual impairment and people over 75 with registrable eye conditions from 2019 to 2035 than other CCGs in the Moorfields catchment area
- The relocation of Moorfields to St Pancras may result in more patients from other CCG areas with a higher proportion of patients living with blindness (e.g. Newham) attending Moorfields

- The prevalence of type 2 diabetes indicates that, within the Moorfields catchment area, Ealing, Enfield, Newham and Redbridge have the highest prevalence, significantly higher than the London and national rates. The likely driver for the prevalence rates is ethnicity, certainly in the case of Redbridge and Newham which have the largest proportions of black and minority ethnic (BAME) residents, and specifically South Asian and Black African ethnicities
- In the Moorfields catchment area, Tower Hamlets is in the top 10% most income deprived boroughs in England, with five others in the top 20% most income deprived; it is likely that income deprivation-related presentations to the Moorfields service will most likely arise from these areas
- Newham and Redbridge have large numbers of people in temporary accommodation or dispersal accommodation respectively, when compared to other CCGs in Moorfields catchment area. This would need consideration when making strategies to engage homeless, rough sleepers or asylum seekers
- Camden and the City of London have the highest numbers of rough sleepers in London (there are 599 rough sleepers in the surrounding areas of Moorfields City Road site).

2.16. To ensure we are fully considering the impact of equality of the proposal, we have undertaken an integrated health inequality and equality impact assessment (HIEIA) process which is designed to ensure that a project, policy or scheme does not discriminate against any disadvantaged or vulnerable people or groups.

2.17. We have worked with organisations that led us to people with a range of protected characteristics, so that we captured their views on the proposal itself and any potential impact on equality. Assessment of the impact of the proposals on these groups, as well as its ability to reduce inequalities between patients, has been undertaken in two phases. Both have been led by independent organisations and represent an objective assessment of the likely impact of the proposals.

2.18. We will continue to investigate the impacts on equality and consider any issues as part of the decision-making business case following consultation.

3. The preferred way forward

3.1. The main consultation document explains how Moorfields and its partners have considered various options for developing a new centre, including rebuilding and refurbishment at the City Road site.

3.2. For specialised services, London is the most accessible UK location for patients and for recruiting and retaining specialists, technicians, researchers and students. There are critical benefits from close links with other major specialist centres, research and education facilities.

3.3. Of eight potential sites on the London property market that are close to public transport hubs, the proposal for consultation puts forward the view that land available at the current St Pancras Hospital site has greater potential benefits, including:

- Enough space for the size required and potential for future flexibility
- Proximity to two of the largest main line stations in London, King's Cross and St Pancras, with Euston station also in the area

- Proximity to other major health and research centres, such as the Francis Crick Institute, the main campus of UCL, and leading eye charities, such as Guide Dogs and the Royal National Institute of Blind People (RNIB).

Accessibility

3.4. Insights from people have also raised potential challenges around the change to their journey to the proposed new centre for people who have used Moorfields services for many years.

3.5. Moorfields commissioned an independent travel analysis in September 2018 which identified that for some patients travelling to the St Pancras Hospital site, rather than the City Road site, travel times could increase on average by just over 3 minutes.

3.6. The analysis showed that overall a relatively small number of patients would see travel times increase by more than 20 minutes (less than 1.5%), with the maximum increase being 25 minutes. Most of the increases are postcode areas that are to the east of London, where access to the proposed new site could involve a longer route for some people via bigger and more complicated rail and underground stations than Old Street.

3.7. We recognise the need to engage widely with our patient community in respect of patient access and wayfinding to and from the proposed site at St Pancras, and are engaging with patients, carers, Transport for London, Network Rail, the Local Borough of Camden and other stakeholders as we progress designs for the new site.

3.8. For more information on access and travel times to the proposed location at St Pancras, please visit http://oriel-london.org.uk/public-consultation/travel-and-access/.

4. Consultation update – what we have learned so far

4.1. To ensure the findings of the consultation were interpreted and presented in an objective way an independent third-party provider, Participate, was appointed to manage the receipt of responses, analyse findings and produce an independent report of the process and outcome of the consultation. The findings in the draft consultation report from Participate can be found on the consultation website https://oriel-london.org.uk/consultation-documents/ and summarised here.

Overview of consultation responses

4.2. Between 24 May to 16 September 2019, the consultation programme received 1,511 survey responses to the consultation questions, as well as 212 other forms of response including: emails, telephone, social media and formal responses. Ninety-nine discussion groups were held and themes noted from those were also recorded.

Who responded?

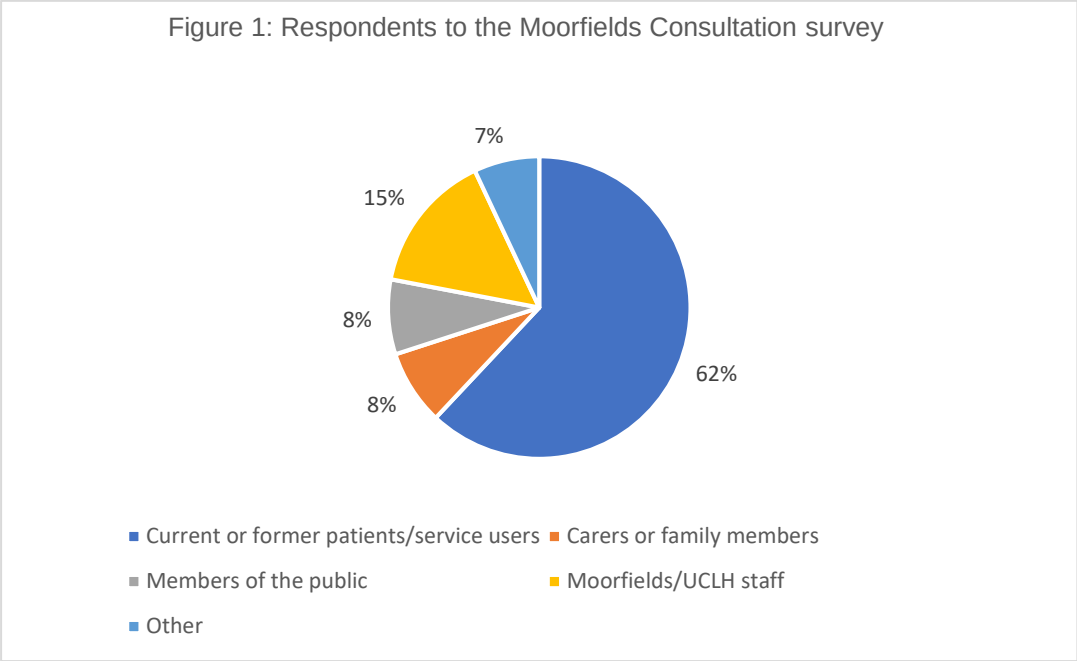


Figure 1: Respondents to the Moorfields Consultation survey

4.3. The survey responses represent a high number of current or former service users at 62% (935). Additionally, a wide range of teams, groups and organisations responded; many of which were health-related, had close links with Moorfields, or were charities related to eyecare (Figure 1).

What do they think of the proposals?

4.4. Overall there is strong support for moving to the St Pancras Hospital Site.

4.5. From the survey responses 73% (1,098) think a new centre is needed with 8% saying they don't think a new centre is needed (Figure 2)

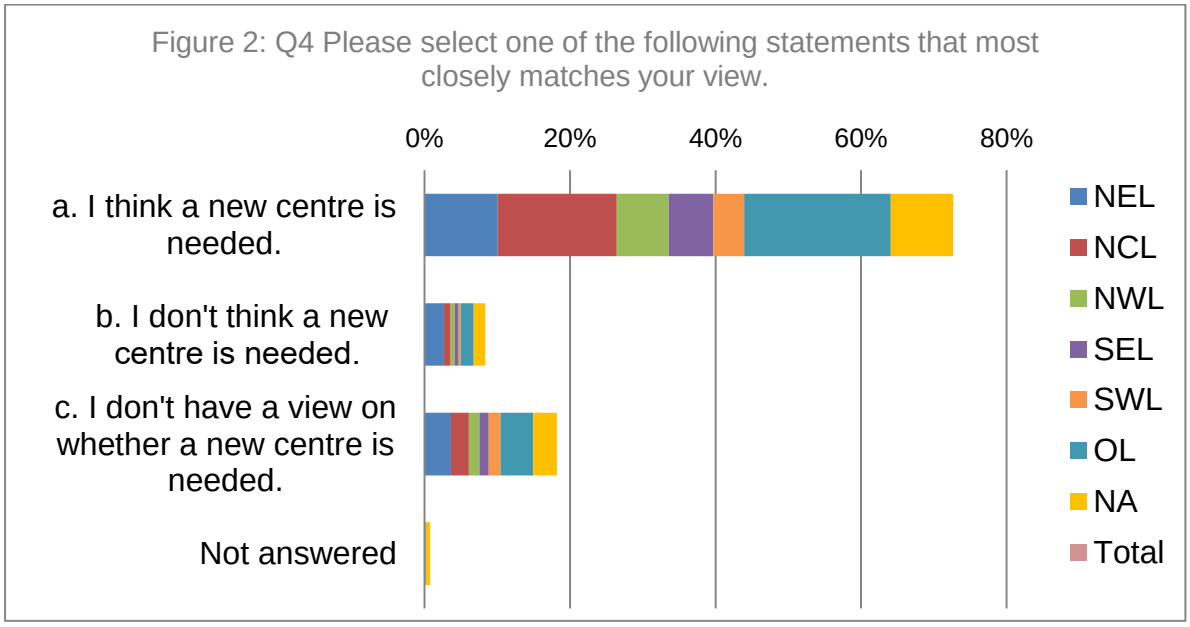
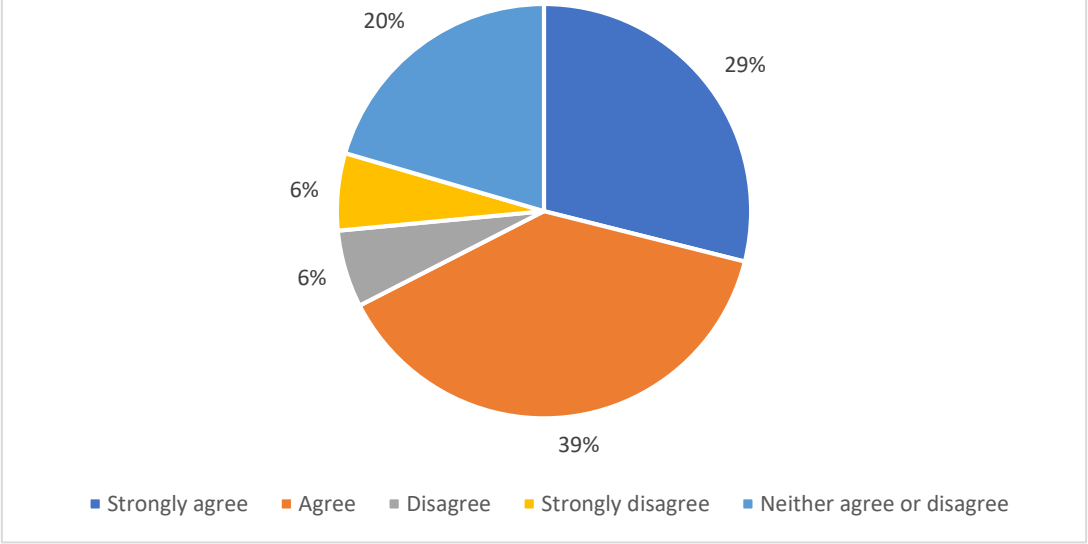


Figure 2: Survey question 4 response rates to whether a new centre is needed

- The minority of responses not in favour of the move are concerned with losing a historic building, loss of NHS assets and moving away from a facility and route with which they are familiar
- Some concerns were also voiced about the new site relating to:
    - The last half mile of the journey as public transport stops short of the site entrance
    - Accessibility, both in terms of travelling to the new hospital site, and in terms of navigating around it
    - A busy and heavily congested area meaning it could present difficulties for visually impaired, elderly and disabled patients
- Staff and patients expressed an interest to be kept informed of the development of the project and to have a voice in the design of the new hospital
- Stakeholders are generally positive about the move to the St Pancras site with organisations such as Royal National Institute of Blind People (RNIB) keen to be involved in the project
- 73% agree or strongly agree that it should be at the St Pancras Hospital Site with 10% stating they disagree or disagree strongly

Figure 3: Extent to which respondents agreed or disagreed with the location at St Pancras Hospital site



- Additionally, 81% of staff respondents strongly agreed or agreed with the proposed location, with just 7% strongly disagreeing/disagreeing that the centre should move to St Pancras
- We received feedback on alternative locations. These are being considered as part of the options review process

- Stakeholders also provided an extensive list of suggestions relating to the implementation of the new hospital
- Some stakeholders expressed a desire for ophthalmology services to be delivered locally where possible, and were keen to seek reassurance around the future of Moorfield's satellite sites
- The relationship between the Oriel programme and Transport for London and Camden Council were highlighted as key to the success of the project, especially around integrated transport and planning permission.

5. How we have engaged with people

5.1. Our approach has been an emphasis on active participation, as well as seeking written responses to the proposals. The programme of consultation activities included open discussion workshops, discussions with key groups and meetings on request.

5.2. We understand from listening to people that they are apprehensive about how any change would be managed with minimal disruption, smooth transition and continuity of service. To make sure that we address these concerns we have considered how issues of equality affect service users in the proposed changes.

5.3. The Equalities Act 2010 places duties on health and care organisations to reduce health inequalities and ensure that service design and communications should be appropriate and accessible to meet the needs of diverse communities.

5.4. To ensure that the NHS has paid 'due regard' to the matters covered by Public Sector Equality Duty, we have undertaken an integrated health inequality and equality impact assessment (HIEIA) process which is designed to ensure that a project, policy or scheme does not discriminate against any disadvantaged or vulnerable people or groups.

5.5. We have worked with organisations that led us to people with a range of protected characteristics, so that we captured their views on the proposal itself and any potential impact on equality. There were 38 meetings and conversations with people with protected characteristics and rare conditions. They included networks of children and young people, older people, people with learning disabilities, mental health problems, physical disabilities, multiple disabilities and sensory impairment. We also met people from LGBTQ+ and BAME groups, including people with these characteristics and who have sight loss.

5.6. Assessment of the impact of the proposals on these groups, as well as its ability to reduce inequalities between patients, has been undertaken in two phases. Both have been led by independent organisations and represent an objective assessment of the likely impact of the proposals.

5.7. We have also engaged with partners in London, Essex, Hertfordshire and Kent, as well as further afield; providing briefings to overview and scrutiny committees and Healthwatch.

5.8. And we have heard from residents in north, south, east and west London, Essex, Hertfordshire, Bedfordshire, Suffolk and Norfolk. Over a quarter of survey responses have come from people who live outside London.

Main feedback from engagement

5.9. The main themes of feedback during this engagement have not changed during the consultation, and remain as follows:

Clinical quality

5.10. The issue most highlighted as "very important" by people is high quality clinical expertise. Overall, it was stated that clinical quality is more important than any travel issue, which could be overcome.

Transport to and from the proposed St Pancras site

5.11. There were several aspects listed that were key concerns for people in regard to travel and transport to and from the St Pancras site. The main themes included:

- Travelling the last half mile
- Engaging with Transport for London
- Help with travel
- Difficulties posed by King's Cross being a busy area

Accessibility to the proposed site

5.12. A number of suggestions and solutions were listed to help with accessibility to the proposed new centre. For example, having a green line and tactile flooring, moving bus stops, operating a meet and greet facility, installing better signage.

Accessibility around the proposed site

5.13. Improved accessibility around any potential new centre was identified as important. It was considered crucial that staff, service users, carers and representatives from supporting groups and charities are involved in the design and development of the proposed centre to ensure it meets a wide range of needs.

Patient experience

5.14. Improving patient experience the through:

- Good communication
- Better patient facilities for treating service users and allowing for improved privacy. There were comments on the benefits and drawbacks of gender specific wards, toilets and non-gender specific areas.

Transition to the proposed new centre

5.15. Managing the transition to the proposed new centre included communicating progress updates using a multi-channel communication approach. Some groups expressed the need to include people with disabilities and other protected characteristics in the design

of the new centre. It was felt that no-one knows better about what is accessible and what doesn't work than the users themselves. The breadth of involvement during the consultation was commended.

Key INEL/ONEL highlights

5.16. Out of total 1,511 survey responses received, 248 responses were from north east London. 65 % of those who responded to survey are those who currently use eye health (ophthalmology) services at Moorfields or have you used them in the past three years. There was a majority agreement with 61 % think a new centre is needed and 16% of respondents disagree or strongly disagree.

5.17. Forty out of the 126 (32%) respondents who said they don't think a new centre is needed live in the north east London area. This finding could infer there are more concerns from those living in the north east London area about building a new centre with the perceived potential for disruption to services and travel difficulties. In addition, some felt that a facility is missing in the east of London.

5.18. Overall, there were slightly higher levels of disagreement with the proposal of a new centre from those living in north east London. Some stakeholders were keen to help develop services in their locations to reduce patient flow to Moorfields.

5.19. In addition to completing the survey, around 300 people were contacted through over 17 focus group meetings and discussions that were held with number of organisations and charities. This included Protected Characteristics groups and seldom heard groups across INEL/ONEL. Below are list of groups from north east London who were involved in these discussions through consultation process:

- Hackney Informed voices enterprise
- Beyond Sight Loss - Tower Hamlets (60 people)
- Newham CCG patient participation group (20 people
- Community Commissioning Panel, Tower Hamlets
- Meeting with Newham CCG patient participation group
- East London Co-production Forum (Older People)
- North East London Patient Reference Group
- City and Hackney PPI Committee
- Beyond Sight Loss family social, Tower Hamlets
- Newham Council and CCG Co-production Forum
- Waltham Forest CCG Patient Reference Group (PRG)
- City and Hackney Older Person's Reference Group (OPRG)
- NE London Older People's Reference Group(70 people)
- Tower Hamlets Older People's Reference Group
- HIVE (Hackney Informed Voices Enterprise)
- Action on Hearing Loss
- East London Local Optical Committees (35 people)

5.20. Feedback from the majority of the groups was that most are in favour of building a new centre, with similar issues reflected in the meetings as identified from the survey feedback.

5.21. Engagement also included an hour long radio interview about Moorfields proposal in Forest Gate whose target audience is north east London residents.

6. How we are responding to what people say

6.1. Since the consultation was launched in May 2019, we have been seeking responses from a wide range of people from across the country, using both online and face-to-face channels.

Co-production workstreams

6.2. Given the repeating pattern of feedback, which has continued since January 2019, a clear and consistent view is emerging about how the proposal could affect people.

6.3. To respond to this, we have set up six co-production workstreams to help coordinate and translate consultation feedback into proposed elements of programme delivery. These six workstreams are as follows:

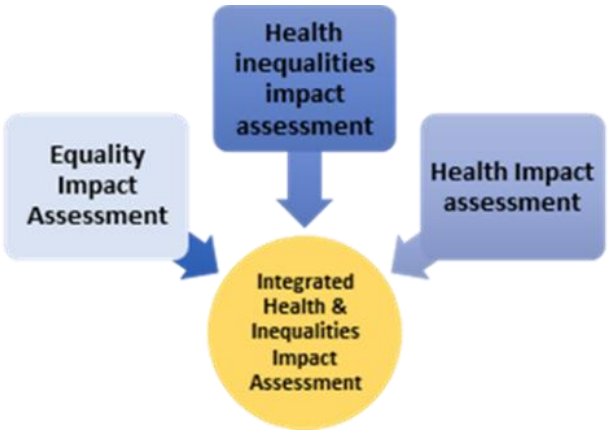
- Accessibility – getting to the proposed site
- Accessibility – getting around the proposed new centre
- Improving the patient experience
- Managing transition
- Innovation and research
- Options refresh – a task and finish group of patient and public representatives is already involved in the options refresh.

6.4. These co-production workshops, whose membership includes representatives from the Oriel Advisory Group (patient group), patients and residents, as well as experts from RNIB, Transport for London, and other interested parties, began in July and will continue through into October and beyond.

Integrated health inequalities and equality impact assessment

6.5. As part of the consultation process, we have commissioned a full integrated health inequalities and equality impact assessment.

6.6. An integrated impact assessment supports decision-making by evaluating the impact of a proposal, informing public debate and supporting decision makers to meet their Public Equality Sector Duty.



6.7. The assessment uses techniques such as evidenced based research, engagement and impact analysis to understand the impact of change on the population, the impact on groups with protective characteristics and the impact on accessibility and quality of services.

6.8. The aim of the report is to understand and assess the consequences of change whilst maximising positive impacts and minimising negative implications of the proposed change.

Phase 1	Phase 2	Phase 3
A rapid scoping report to identify potentially impacted groups to inform pre-engagement activities	A desktop review of "best practice evidence" to identify and develop relevant health outcomes and understand priorities and challenges for key groups.	A revised and final Integrated Health and Inequalities Impact Assessment published to reflect the results of the public consultation

6.9. We have already completed phases 1 and 2 and this assessment, with phase 3 being scheduled for completion in November 2019, post consultation.

Accessibility workshops

6.10. The first co-production workshop took place on 31 July. The group, was attended by people with sight loss, carers and members of the Royal National Institute for the Blind (RNIB), Guide Dogs, South East Vision, London Vision, Organisation for Blind African and Caribbean's, Thurrock CCG, Herts Vision and Beyond Sight Loss as well as building designers AECOM. The group discussed the current routes to the proposed new site, as well as some of the new technologies that could be used to support people on their journey.

6.11. Further accessibility workshops have taken place in September and October designed to build on these initial discussions.

Intensive engagement periods

6.12. As a result of this earlier engagement, we have undertaken an intensive two-week engagement period at Moorfields City Road site, with 'talk to me' volunteers, tasked with one clear mission – to get visitors and staff talking about Oriel and the proposal. A special Oriel information hub in the centre of the City Road site was set up, staffed by the Oriel team with clinicians on hand to answer questions about the proposed relocation and how it may affect patients was held. This was combined with increased social media and media outreach work, as well as a mailing to stakeholders via the Oriel mailing list and OAG as a final push for views and responses.

6.13. The inclusion of a letter about the proposal in all appointment letters continues to generate a steady number of emails and phone calls to the consultation team from people keen to provide their views.

6.14. This resulted in an impressive level of engagement despite the summer break. In just one week, the number of survey responses rose significantly with 156 surveys completed, plus an additional 100 conversations about Oriel had by colleagues with patients, carers and staff throughout the week.

Stakeholder communications update

6.15. In August, we issued a strategic update email to stakeholders across England, which covered the main themes from consultation so far together with a summary of the proposal. It also explained how we are engaging with people and gave information on the co-production workstreams.

6.16. **All STP and CCG leads** were asked to forward it to their local authority/ OSC and other local stakeholders, such as Healthwatch and other voluntary organisations to provide an update on progress and reminding them of the end-date of the consultation in writing, to ensure they responded within the timescales.

6.17. **The 14 CCG communication and engagement leads** were asked to arrange for an agenda item on their patient and public reference groups and other representative groups.

6.18. On 23 October, we published on our website, and issued an email to stakeholders across England inviting them to share views on the findings in the draft Consultation Outcome Report, in particular highlighting anything that has not been captured in this initial draft. Comments are to be sent to moorfields.oriel@nhs.net by Wednesday 6 November.

7. Assurance and scrutiny

Quality assurance

7.1. The Consultation Institute (tCI) is a well-established not-for-profit best practice institute, which promotes high-quality public and stakeholder consultation. It provides an independent quality assurance service for consultations and was commissioned by the consultation programme board to review documentation, plans and processes prior to consultation, ensuring best practice standards are observed.

7.2. In July 2019, the tCI's quality assistance team undertook a mid-term review, which confirmed the programme's compliance with best practice standards at that stage.

7.3. Preparations for the review and the main meeting with the tCI involved members of the consultation team from Moorfields, Camden and Islington CCGs and NHS England Specialised Commissioning. It was an opportunity to consider our reach, adapt our approach and respond to feedback. We have subsequently taken actions to close identified gaps.

7.4. The tCI assessor noted our improvements in process and commended our plan to develop the initial proposal for consultation through the co-production workstreams.

The Secretary of State's four tests

7.5. The 2014/15 mandate from the Secretary of State to NHS England outlined that any proposed service changes by NHS organisations should be able to demonstrate evidence to meet four tests before they can proceed.

- Strong public and patient engagement
- Patient choice
- Clinical evidence base
- Support from clinical commissioners.

7.6. NHS England's bed closures test: In April 2017, NHS England introduced a new test to evaluate the impact of any proposal that includes a significant number of bed closures.

7.7. Appendix A has the detail of how the programme is meeting these five tests.

The Mayor of London's six tests

7.8. The King's Fund and Nuffield Trust published a report in September 2017 which recommended that greater city-wide leadership is needed to successfully implement the five NHS Sustainability and Transformation plans (STPs) for London. In response to this, the Mayor of London set six assurances required to give his support to major service reconfigurations in London. While not directly required for this public

consultation, compliance with these when implementing service change is considered best practice. The summary of the Mayor of London's six tests are:

- **Patient and public engagement –** Proposals must show credible, widespread and ongoing patient and public engagement including with marginalised groups.
- **Clinical support –** Proposals must demonstrate improved clinical outcomes, widespread clinical engagement and support, including from frontline staff.
- **Impact on health inequality –** The impact of any proposed changes to health services in London must not widen health inequalities. Plans must set out how they will narrow the gap in health equality across the capital.
- **Impact on social care –** Proposals must take into account the full financial impact any new models of healthcare, including social care, would have on local authority services, particularly in the broader context of the funding challenges councils are already facing.
- **Hospital capacity –** Given that the need for hospital beds is forecast to increase due to population growth and an ageing population, any proposals to reduce the number of hospital beds will need to be independently reviewed to ensure all factors have been taken into account. Any plans to close beds must be an absolute last resort, and must meet at least one of the NHS' 'common sense' conditions.
- **Sufficient investment –** Proper funding must be identified and available to deliver all aspects of the STP plans.

7.9. This is the first time that the Mayor of London's six tests have been applied. The Mayor of London has responded to the consultation confirming that he considered the first four tests (above) and is broadly content with the proposed move for Moorfields Eye Hospital's City Road services. The final two tests will be considered later in the year, after the commissioners have published the formal consultation report and reached a decision.

8. Post-consultation steps and decision-making process

8.1. The consultation closed on 16 September 2019 following an extensive 16 week consultation period to the offset any negative impact of running a consultation during the month of August. Responses received have been independently analysed and a draft consultation outcome report has been developed for the Consultation Programme Board.

8.2. This draft report was published on 23 October 2019 and shared widely as we seek feedback on the outcome and any recommendations.

8.3. Following this, representatives from the Consultation Programme Board, CCG Governing Body members and NHS England Specialised Commissioning will consider the report in the context of the Decision Making Business Case as well as other influencing factors, such as the Secretary of State's 4 tests and Mayor's 6 tests to determine whether they will support the proposal.

8.4. These will then be summarised in the Decision-Making Business Case to assist CCGs, through the Committee in Common to be held on 19 December 2019, in their decision-making on the proposals. Specialised commissioners will follow NHS England's governance processes in their decision-making.

8.5. The outcomes of the consultation will also be presented to North Central London Joint Health Oversight and Scrutiny Committee on 29 November 2019 for assurance that the consultation process has been completed satisfactorily.

8.6. Subject to approval of the Decision-Making Business Case, Moorfields would then proceed to develop its Outline Business Case. Feedback provided during the consultation process will be used to inform the Trust's proposals in the business case and next steps. Should the Outline Business Case and Full Business Case receive approval from NHS England/Improvement, Moorfields will go on to implement the proposal, taking into consideration themes from the consultation and recommendations from commissioners.

8.7. NHS England/Improvement requires Moorfields to submit a Strategic Outline Case, Outline Business Case and Full Business Case for approval for their capital investment proposals.

9. Timeline

16 September	Consultation closed
23 October	Publish draft consultation outcome report for feedback to make sure the summary is an accurate reflection of views https://oriel-london.org.uk/consultation-documents/
November	Publish final consultation outcome report Approval of economic and financial cases Socialisation of draft DMBC Scrutiny and assurance
December	Decision-making by Committee in Common and NHS England/Improvement
January 2020	Announcement of decision.

Appendix A

The Secretary of State's four tests

The 2014/15 mandate from the Secretary of State to NHS England outlined that any proposed service changes by NHS organisations should be able to demonstrate evidence to meet four tests before they can proceed.

- **Strong public and patient engagement:** Robust and strategic stakeholder engagement has been undertaken since 2013. Strengthening patient engagement for the project has been a priority in 2018/19, hearing from more than 1,000 people, including people of varying ages, interests and backgrounds; people living with mental health problems, learning disabilities, physical disabilities and sensory impairment; and included professionals such as optometrists, social care staff and sight care experts from the voluntary sector.
- **Patient choice:** Access to the current care pathways would remain the same, with the existing full range of services continuing to be delivered from a new site, including the transfer of emergency surgery and ophthalmic A&E care. Based on the current proposals to relocate the hospital from City Road to the St Pancras hospital site, there would be no change to district hubs, local surgical centres and community-based outpatient clinics. Patient choice would be improved from a quality perspective as the proposed streamlined, modern and fit-for-purpose estate footprint would allow a more efficient patient journey time through the hospital and provide a higher quality experience for patients.
- **Clinical evidence base:** The proposal gives the opportunity for integration between cutting-edge clinical care and cutting-edge research. This would have a huge impact on the quality of clinical care with patients having more access to the research from UCL. This will be central to the design of the proposed new hospital, providing a platform to create more efficient clinical journeys and continue to deliver innovative care currently hampered by the ageing estate. The London Clinical Senate has reviewed these proposals and confirmed that the proposal has a clear clinical evidence base for the proposed move from Moorfields' City Road site to a new, purpose-built integrated facility at the St Pancras hospital site.
- **Support from clinical commissioners:** Moorfields' services are commissioned by 109 CCGs across the country and NHS England Specialised Commissioning. Some 14 CCG commissioners hold significant contracts. NHS Islington CCG and NHS Camden CCG have been significantly involved in the process to consult on the proposal to transfer services to the St Pancras hospital site. NHS England specialised commissioners are the single largest commissioner of services at the trust.

NHS England's bed closures test: In April 2017, NHS England introduced a new test to evaluate the impact of any proposal that includes a significant number of bed closures. There are no plans to reduce beds, therefore this test does not apply.

ENDS

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