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Joint Health Overview and Scrutiny Committee for Mount Vernon Cancer Centre

Monday 16 December 2024

10.00 am, The Council Chamber, County Hall, Hertford, SG13 8DE

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Agenda Reports & Other Papers

Presented to the
Meeting of the
Joint Health Overview & Scrutiny Committee
on
Monday, 16 December 2024

AGENDA

AGENDA FOR A MEETING OF THE JOINT HEALTH SCRUTINY COMMITTEE IN THE COUNCIL CHAMBER, COUNTY HALL, HERTFORD, SG13 8DE, ON MONDAY, 16 DECEMBER 2024 AT 10.00AM.

MEMBERS OF THE COMMITTEE (17) - QUORUM 5

COUNCILLORS (17)
Shade Adoh (Buckinghamshire), Fouzia Atiq (Bedford), TBC (Central Bedfordshire), Nigel Bell (Hertfordshire), Rita Chamdal (Hillingdon), Nick Denys (Hillingdon), Chetna Halai (Harrow), Maxine Henson (Harrow), Dee Hart (Hertfordshire),Teresa Heritage (Hertfordshire), Sital Punja (Hillingdon), Ketan Sheth (Brent), Robert Stedmond (Slough), Richard Underwood (Luton), Matthew Walsh (Buckinghamshire), Ben Wesson (Ealing), Chris White (Hertfordshire),

ANNOUNCEMENT

As required by law, the Council will be holding this meeting in person.

Webcasting: This meeting of the Council will be filmed and webcast live on the internet and will also be recorded and published on the Council's website. All parts of the room can be seen or heard by the camera or microphones and any members of the press and public present in the Council Chamber at any time during the meeting are likely to be included in the webcast and recording.

There may be occasions when the public are excluded from the meeting for particular items of business. Any such items are taken at the end of the public part of the meeting and are listed under "Part II ('closed') agenda".

Those wishing to watch the live broadcast should go here:
http://www.hertfordshire.gov.uk/watchmeetings

Members are reminded that:

(1) if they consider that they have a Disclosable Pecuniary Interest in any matter to be considered at the meeting they must declare that interest and must not participate in or vote on that matter unless a dispensation has been granted by the Standards Committee;

(2) if they consider that they have a Declarable Interest (as defined in paragraph 5.3 of the Code of Conduct for Members) in any matter to be considered at the meeting they must declare the existence and nature of that interest. If a member has a Declarable Interest they should consider whether they should participate in consideration and vote on the matter.

PART I (PUBLIC) AGENDA

1.	**ELECTION OF THE CHAIRMAN OF THE JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE**
2.	**ELECTION OF THE VICE-CHAIRMAN OF THE JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE**
3.	**TERMS OF REFERENCE** *TORs attached*
4.	**MOUNT VERNON CANCER CENTRE RELOCATION CASE FOR CHANGE** *Report attached*
5.	**MOUNT VERNON CANCER CENTRE REPROVISION – CO LOCATION OF SERVICES AT WATFORD HOSPITAL SITE** *Report attached*
6.	**MOUNT VERNON CANCER CENTRE – FUTURE MANAGEMENT BY UNIVERSITY COLLEGE LONDON HOSPITALS NHS FOUNDATION TRUST** *Report attached*
7.	**HOW JHOSC WILL SCRUTINISE NHSE CONSULTATION PROCESS** *Report attached*
8.	**WORK PROGRAMME OUTLINE** *Report attached*
9.	**OTHER PART I BUSINESS** Such Part I (public) business which, if the Chairman agrees, is of sufficient urgency to warrant consideration.

PART II ('CLOSED') AGENDA
EXCLUSION OF PRESS AND PUBLIC

There are no items of Part II (Confidential) business on this agenda. If items are notified the Chairman will move:

"That under Section 100(A)(4) of the Local Government Act 1972, the public be excluded from the meeting for the following item of business on the grounds that it/they involve/s the likely disclosure of exempt information as defined in paragraph/s … of Part 1 of Schedule 12A to the said Act and the public interest in maintaining the exemption outweighs the public interest in disclosing the information."

If you require a copy of any of the reports mentioned above or require further information about this agenda please contact Deborah Jeffery, by telephone on (01992) 555563 or by e-mail to deborah.jeffery@hertfordshire.gov.uk.

Agenda documents are also available on the internet here

QUENTIN BAKER
DIRECTOR OF LAW & GOVERNANCE

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HERTFORDSHIRE COUNTY COUNCIL

JOINT HEALTH OVERVIEW SCRUTINY COMMITTEE
MONDAY, 16 DECEMBER 2024 AT 10.00AM

TERMS OF REFERENCE

Agenda Item No.

3

Report of the Head of Scrutiny

Author: Tim Parlow, Head of Scrutiny, (Tel: 01992) 588171

1. Purpose & Summary of report

1.1 To provide the Committee with the Terms of Reference for the Joint Health Scrutiny Committee.

2.1 Following the work to establish the Joint Health Overview and Scrutiny Committee, officers have worked on the Terms of Reference, attached at Appendix A to the report.

3. Recommendation

3.1 *That the Committee notes the Terms of Reference (Appendix 1), which are due to go to Hertfordshire's Full Council on 10 December 2024.*

Background Information
None

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Appendix 1

TERMS OF REFERENCE AND PROTOCOLS
MOUNT VERNON JHOSC

1. TERMS OF REFERENCE

1.1 The Mount Vernon Cancer Centre (MVCC) JHOSC has the delegated powers from the ten Local Authorities as listed in Appendix A to undertake the necessary functions of health scrutiny in accordance with the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 ("the Local Health Scrutiny Regulations"), relating to reviewing and scrutinising the consultation proposals and consultation with regard to services currently delivered at the MVCC.

2. OBJECTIVES

2.1 To ensure that the needs of current patients of MVCC and the residents of the Local Authorities who access services at MVCC are considered as an integral element of the consultation proposals and consultation.

3. PROTOCOLS FOR WORKING

3.1 The Protocol for the MVCC JHOSC has been produced by the Local Authorities named in the appendix, NHS England, and NHS trusts. The Protocol provides a framework for scrutiny to take place.

3.2 The MVCC JHOSC will be positive, objective and constructive. It will concentrate on service outcomes and seek to add value.

3.3 The success of the MVCC JHOSC relies on key organisations working together in an atmosphere of mutual trust and respect, with an agreed understanding and commitment to its aims. The organisations involved in the scrutiny must be willing to share information, knowledge and reports which relate to the delivery and success of the scrutiny.

3.4 At all times councillors, officers and members of the organisation involved in the scrutiny, patient representatives and members of the public will be treated with respect and courtesy. Matters of confidentiality will be handled accordingly.

3.5 The MVCC JHOSC, whilst working in partnership with the NHS and the health scrutiny committees of the Local Authorities sitting on the JHOSC and the voluntary and community sector, remains independent.

4. MEMBERSHIP

4.1 The MVCC JHOSC has the delegated powers from the Local Authorities listed in Appendix A.

4.2 That participating Local Authorities have agreed that the number of members from each authority sitting on the JHOSC will be dependent on proportionality of patient flow to MVCC from the respective Local Authority.

4.3 The MVCC JHOSC comprises of councillors from Local Authorities as listed in the appendix. That each council appoints members to the JHOSC as per their own arrangements.

4.4 Members of the JHOSC cannot be an executive or cabinet member of their Local Authority.

4.5 A Local Authority may appoint a substitute to attend in the place of the named member on the JHOSC provided they are not an executive or cabinet member of the Local Authority or a member of an NHS trust.

4.6 Representatives from Local Authorities not sitting on the JHOSC but with residents that use services at MVCC are invited to attend all or selective meetings if they wish. They may be allowed to ask questions with the agreement of the chairman. Alternatively, they may wish to be kept informed through receipt of agenda papers.

4.7 Officers of individual health scrutiny committees of the Local Authorities siting on the JHOSC are invited to attend to support and advise councillors from their Local Authority on health scrutiny issues and will have access to all agendas, briefing notes and minutes.

5. CHAIRING, VOTING AND STANDING ORDERS

5.1 The Chairman and Vice Chairman of the MVCC JHOSC will be appointed by the MVCC JHOSC at its first meeting.

5.2 If a vote is taken only the Local Authorities sitting on JHOSC have voting rights. Any substitutes will have the same voting rights as the named member for their Local Authority. Each Member of the JHOSC will have one vote. Voting will be made by a simple majority; the Chairman will have the casting vote.

5.3 Quoracy for meetings of the JHOSC will be five members of the constituent councils of the joint committee. The five members must be from different constituent councils.

5.4 The requirement for political proportionality is waived. If eligible, each Local Authority may apply proportionality in their own appointment process if they wish.

5.5 The JHOSC will operate under the standing orders of the lead administrative Local Authority, Hertfordshire County Council.

5.6 The MVCC JHOSC will be open and transparent. Any person involved in the JHOSC will declare any personal or other pecuniary interest that they have in accordance with the Code of Conduct relating to standards of conduct and ethics of the lead administrative Local Authority.

6. MEETINGS AND REPORT

6.1 The intention is that the MVCC JHOSC will be time limited and run concurrently with NHSE public consultation and will scrutinise various aspects of the reprovision and relocation of services and feedback its findings as part of the public consultation process.

6.2 Dates of meetings will be confirmed at the first meeting of the MVCC JHOSC. In addition, extra meetings may be scheduled to effectively expedite the work. The MVCC JHOSC is responsible for setting its own agenda.

6.3 The dates and times of meetings of the JHOSC, agendas, minutes and reports will be circulated to members and partners in accordance with the Local Government (Access to Information) Act 1985. Agenda, minutes and committee papers will be published on the websites of all the local authorities sitting as part of the joint committee 5 working days before the meeting.

6.4 Once it has formed recommendations on the proposals and quality of the consultation the MVCC JHOSC will prepare a formal report. All members of the MVCC JHOSC will be consulted on the draft report before it is published. The final report will be published on organisational websites and circulated in accordance with the regulations on health scrutiny.

6.5 All members of the MVCC JHOSC to be informed of any press releases relating to the scrutiny.

6.6 Officers from Hertfordshire County Council and the London Borough of Hillingdon will provide advice and administrative support to the joint committee.

7. EXPECTATIONS UPON RELEVANT BODIES

The ICSs, NHS England, UK Health Security Agency (formerly Public Health England) and NHS trusts will:

- work in partnership with MVCC Joint Scrutiny Committee to provide objective and effective scrutiny.
- provide information required by the MVCC Joint Scrutiny Committee to undertake its work.
- provide the MVCC JHOSC with such information within one month of the receipt of the request.
- ensure that officers attending MVCC Joint Scrutiny Committee meetings are able to answer questions openly and are given appropriate support by their line managers.

Appendix A – JHOSC Membership

Local Authority	Number of patients per Local Authority (2023/24)	Number of councillors
Hertfordshire and West Essex ICB		
Hertfordshire County Council	5,599	4
North West London ICB		
Brent Council	684	1
Ealing Council	507	1
London Borough of Harrow	1,057	2
London Borough of Hillingdon	1,866	3
Bedfordshire, Luton and Milton Keynes ICB		
Bedford Borough Council	46	1
Central Bedfordshire Council	704	1
Luton Borough Council	726	1
Buckinghamshire, Oxfordshire and Berkshire ICB		
Buckinghamshire Council	929	2
Frimley Health ICB		
Slough Borough Council	205	1
Total: 10 Local Authorities	**12,323**	**17**

Number of councillors per patient flow	
Number of patients	Number of councillors
0-750	1
751-1500	2
1501 - 2250	3
≥2251	4

HERTFORDSHIRE COUNTY COUNCIL

JOINT HEALTH OVERVIEW SCRUTINY COMMITTEE
MONDAY, 16 DECEMBER 2024 AT 10.00AM

Agenda Item No
4

MOUNT VERNON CANCER CENTRE RELOCATION CASE FOR CHANGE

Report of the Head of Scrutiny

Author: Jessamy Kinghorn, Head of Partnerships and Engagement, Jessamy.kinghorn1@nhs.net

1. Purpose of report

1.1 To outline the case for change in relation to the proposed relocation of Mount Vernon Cancer Centre.

2. Summary

2.1 Plans have been developed to undertake a public consultation on proposals to relocate Mount Vernon Cancer Centre (MVCC) to the Watford General Hospital site to secure a sustainable future for modern, specialist cancer services for the populations of Hertfordshire, Luton and parts of Bedfordshire, Northwest and north central London, Buckinghamshire and Berkshire.

2.2 This report sets out the case for change for members of the Joint Health Overview and Scrutiny Committee, to ensure members have a comprehensive understanding of the drivers for change ahead of the public consultation.

2.3 It explains the background to the review and summarises the clinical advice received, and outlines the case for change in three broad categories:

- Quality / Patient Safety: The Mount Vernon site does not have the right clinical services, which means the team cannot provide the range of treatments or quality of care they would like.
- Buildings: Many of the buildings are over 100 years old and not designed for modern cancer care. Some of them need significant repairs and some can no longer be used for patient care.
- Opportunities: We want to make improvements to care, to provide more care closer to where people live when that is appropriate, and to undertake more trials and specialist treatments than we do now.

3. Recommendations

3.1 The Committee is asked to note the challenges and consider the case for change.

4. Background

4.1 Following concerns raised by clinicians at Mount Vernon Cancer Centre regarding the sustainability of the services, NHS England has been working jointly with NHS and other partners in Hertfordshire, North West London, Bedfordshire, Buckinghamshire, East Berkshire and North Central London, to lead a review of services and develop proposals to secure the future of specialised cancer services for these populations.

4.2 A 2019 Independent Clinical Advisory Group reported: *"There is increasing concern as to whether high quality, safe and sustainable oncology services can continue to be delivered within the existing organisational framework and there is an urgent need to address this concern."* They made several findings, including:

- Maintaining safety of patients cannot be guaranteed in the near future – status quo is not an option – there is a need for urgent action.
- To provide modern oncology care, comprehensive medical and surgical support services including ITU are needed – this is not now available at MVCC.
- Deskilling of existing inpatient nursing staff as acutely unwell patients transferred out. Loss of ability to undertake practical interventions on site e.g. draining ascites.
- Need for an inpatient integrated service in order to manage acutely unwell patients (due to unpredictable toxicities of immunotherapies, intensive chemotherapy / radiotherapy regimens and comorbidities). Concern about the quality of integrated care for patients currently transferred out to non-specialist DGHs impacting upon patient management.
- Dividing up the existing catchment to surrounding providers would be unacceptable due to disrupted patient flows, insufficient capacity and access concerns, loss of workforce cohesion and commitment.

4.3 The factors that give a clear case for the proposed changes fall into three broad categories: Quality / Patient Safety; Buildings; Opportunities

4.4 Quality / Patient Safety: The Mount Vernon site does not have the right clinical services, which means the team cannot provide the range of treatments or quality of care they would like.

4.4.1 The needs of cancer patients have become more complex over the last thirty years. Patients now live with cancer longer, as well as having other health conditions at the same time as their cancer treatment.

4.4.2 Many of the newer drugs can be extremely effective but have higher levels of toxicity and a greater risk of side effects, so they require the back up support of clinical teams and services that are not available on the current site, like critical care and high dependency services.

4.4.3 The lack of these services significantly hampers the delivery of comprehensive specialist cancer care. It also means the Mount Vernon Cancer Centre cannot offer all the newest treatments, as they become available - and this will become an increasing problem.

4.4.4 It further means patients at Mount Vernon are sometimes transferred to other hospitals for part of their treatment. This makes it very difficult for their Mount Vernon oncologists to manage their care.

4.4.5 Services for patients with blood cancers (haematological malignancy) have already closed at MVCC, with inpatient haematology ceasing to be delivered in early 2019 due to the lack of adequate supporting clinical services, and the limited outpatient consultation and treatment that remained transferring to other hospitals in August 2022. Many patients having more complex treatments, or planned inpatient care, have to be managed at a specialist centre such as UCLH in central London, resulting in a significant travel burden for patients and their families.

4.4.6 Some care is offered for some patients in hospitals closer to home, including haematology patients who become unwell and may be admitted to the acute hospital closest to their home. However, this can make specialist management difficult, given teams in these hospitals may be unfamiliar with the management of neutropenic sepsis, chemotherapy induced bowel problems or other common issues in haematological malignancy which may require inpatient care.

4.4.7 Whilst inpatient facilities for solid tumour oncology patients have been retained at MVCC, they are increasingly unable to manage all elements of patient care as a result of the lack of supporting clinical specialities on the site. Inpatient care was particularly highlighted as an area of concern by the independent clinical review.

4.4.8 While a number of measures were immediately put in place to address these concerns and ensure the services retained on the site are clinically supported and safe, an increasing proportion of patients who should be managed at the specialist cancer centre cannot be, and will instead be admitted or transferred to a non-specialist site instead, or another specialist centre further from home. This impacts treatment options for some patients, for example those recommended brachytherapy treatment which requires inpatient admission. If a patient does not meet the MVCC admissions criteria (for example due to a comorbidity), then they cannot receive brachytherapy at MVCC.

4.4.9 Historically, when the only available systemic anti-cancer therapy (SACT) was conventional cytotoxic chemotherapy, the severe side-effects (namely hair loss, nausea, vomiting, mucositis, myelosuppression and infection) associated with it ruled out its use in many older patients and those with comorbidities. Now, novel SACTs tend to lack the traditional toxicities of older cytotoxic chemotherapy, meaning those who would not have previously been considered for chemotherapy are now eligible for treatment. For many patients there are also more lines of treatment available to them.

4.4.10 However, new therapies have a diverse toxicity profile affecting a wide range of organs and require acute specialist support in severe cases. The future of SACTs will be in combining these novel therapies with each other (and with radiotherapy) which will likely result in unpredictable toxicities and require increased multidisciplinary team (MDT) input with non-oncology hospital-based specialists.

4.4.11 The independent clinical review team advised there was a need for:

- *The need for onsite surgical and comprehensive medical acute support services to quickly and safely manage treatment related toxicities / complications, acute illness linked to patient comorbidities and frailty as well as disease related sequelae.*
- *The need for the service to be flexible in the long term in order to cope with the different types of treatment likely to be introduced. For example, in just the next 12 months, NICE has 40 new cancer drugs being appraised, the majority of which are thought will be recommended for the Cancer Drugs Fund or routine commissioning.*
- *A need for a networked service with equitable patient access to consistent management protocols and appropriate trials for their condition.*
- *The recognition that research needs to be embedded with the clinical service to drive clinical developments and improved patient outcomes.*
- *An appropriate infrastructure of expert workforce, IT connectivity and accommodation.*
- *The need for daily consultant reviews of oncology patients acutely admitted to the oncology wards.*
- *An increasing patient awareness of what constitutes an appropriate environment for their medical needs.*

4.5 Buildings: Many of the buildings are over 100 years old and not designed for modern cancer care. Some of them need significant repairs and some can no longer be used for patient care.

4.5.1 In 2021, it was estimated that over 50% of the estate was in a poor condition and the backlog maintenance requirement was around £33m (around £14m of this deemed urgent).

4.5.2 During a series of public engagement events in the summer of 2019, negative views around the state of the buildings were identified, particularly in regard to the inadequacy of waiting rooms, unacceptable maintenance issues (such as leaks) and insufficient rooms for medical staff, specialist nurses, dietitians and speech and language therapists. The layout of the site was also identified as problematic, particularly for new patients, those with disabilities and those who have their care split across different sites.

4.6 Opportunities: We want to make improvements to care, to provide more care closer to where people live when that is appropriate, and to undertake more trials and specialist treatments than we do now.

4.6.1 Given the clinical and estates factors make it impossible for specialist cancer care to remain on the site, re-locating the services presents us with potential opportunities to further improve care through service changes.

4.6.2 The impact of travel distance to receive treatment on the outcomes of patients receiving non-surgical cancer care has been the subject of much investigation. Although evidence is inconsistent, there is a strong indication that longer travel distances negatively impact patient uptake of Chemotherapy and Radiotherapy. Studies in Europe have shown that individuals living in more deprived areas have a lower uptake of non-surgical cancer treatment and higher mortality than those

living in more affluent areas. This could be seen across the MVCC population in a review of radiotherapy uptake in 2021.

4.6.3 These inequalities within the MVCC population are further demonstrated by mortality figures which show that one year survival in areas referring patients to MVCC ranges from 69.3% in Luton to 78.3% in Barnet. Five year survival is lower for the East of England compared with London.

4.6.4 The redevelopment of MVCC on a different site, adjacent to an acute hospital, presents the opportunity to address these concerns by considering which sites reduce the journey times for patients attending the centre. It is clear that any move is going to make the journey longer for some patients, but if the move can shorten the journey times for the majority and for those who travel the furthest, this would be of benefit to patients.

4.6.5 Given that more deprived populations are disproportionately impacted by longer travel times (due to lower access to cars, higher dependence on public transport and lower economic freedom to take time away from paid employment to make journeys), redevelopment of the MVCC presents the opportunity to improve these health inequalities.

4.6.6 The impact of the new cancer centre would be furthered strengthened by networked oncology provision within these more deprived areas, facilitating a more equitable distribution of clinical service throughout the catchment whilst ensuring care is delivered closer to home.

4.6.7 This will include a new chemotherapy unit in Hillingdon Hospital, additional chemotherapy at Northwick Park, exploring opportunities for expanded chemotherapy at Luton and Dunstable Hospital, and a networked radiotherapy unit in the north of the patch – either at Luton and Dunstable Hospital or at the Lister Hospital in Stevenage.

4.6.8 The relocation also provides the opportunity to repatriate haemato-oncology services, reversing the closure of the service from 2019 and 2022 by opening a new ward for blood cancers as part of the new cancer centre.

4.6.9 MVCC clinical staff are highly motivated and work hard to deliver high quality clinical services. However, in its current form, recruitment and retention of a specialist cancer workforce is extremely challenging.

4.6.10 Staff want to be able to treat more complex patients to develop their skills and enable them to become experts in their fields. However, the lack of critical care facilities and clinical infrastructure to support more complex oncological cases results in patients being transferred elsewhere.

4.6.11 Many trials require supporting clinical facilities and higher dependency care than is available on the MVCC site. The current site does not allow for the full provision of research and innovative therapies and there are a number of examples of trials that could not be opened at MVCC due to its facilities. For example, the INTerpath-001 trial for which the first participant, treated at UCLH, was a MVCC catchment resident.

5. Proposals

5.1 The proposals for consultation centre on the relocation of the Mount Vernon Cancer Centre to an acute hospital site, with Watford being identified as the preferred solution. This followed a significant amount of patient and public involvement which has continued through the further development of proposals.

5.2 Alternative options considered including a do minimum option and closure of the cancer centre with dispersal of the service to other cancer centres but neither of these were considered a viable solution to meet the needs of patients.

5.3 Other acute hospital sites were considered, but only Watford met the key criteria.

Key Criteria table

Acute site	Critical Care (Note 1)	Co-located services (Note 2)	Average travel time (Note 3)	Increases in 30 min drive times (Note 4)	Public transport (Note 5)
Bedford	✓	✓			
Harefield	✓		✓	✓	
Hillingdon	✓	✓	✓	✓	
Lister	✓	✓			
Luton	✓	✓	✓		
Northwick Park	✓	✓	✓		✓
Stoke Mandeville	✓	✓			
Watford	✓	✓	✓	✓	✓
Wexham Park	✓	✓			

- Key Criteria: Critical Care Provision; Other co-located acute services; Geographical Accessibility
    - No more than 5-minute increase per journey in average travel times for the population served
    - No more than 5 percentage point increase in the proportion of patients with long (30 minutes or more) travel time
    - No more than 5-minute increase in travel time by public transport for the population served AND no increase in the proportion of patient travelling more than 75 mins (each way)

5.4 Watford is the closest acute hospital to the current site and so presents the smallest change in travel times of any option.

5.5 The consultation will also set out proposals for additional changes to facilitate care closer to home, and the option of a networked radiotherapy unit at either Luton and Dunstable Hospital in Luton, or Lister Hospital in Stevenage. In summary:

- From 2025*: Increased chemotherapy facilities at Northwick Park so that more patients can have chemotherapy nearer to where they live
- From 2025*: Increased radiotherapy capacity at Hammersmith Hospital to extend choice of treatment provider to patients in Brent, Ealing and the South of Hillingdon

- From 2027/28*: An additional networked radiotherapy unit serving the north of the area – at either Luton or Stevenage, opening ahead of the new MVCC when the next Linear Accelerators are due to be replaced
- From 2030*: A new chemotherapy service at Hillingdon Hospital – upon opening of the new Hillingdon Hospital
- Proposal for the preferred option of relocation of the specialist cancer centre into a purpose-built facility on a main hospital site in Watford as soon as funding is made available
- Bringing the haematology service for the population back into the area (to Watford from UCLH), once a new MVCC is constructed, and creating an acute haematology ward within MVCC for Watford General Hospital patients

*Best current estimate. Dates are subject to range of external factors and the availability of capital.

5.6 The independent panel also recommended the cancer centre should be run by a specialist cancer provider and not a district general hospital as at present. Following a process, UCLH was identified as the preferred future provider to manage the service once capital had been identified to proceed with the relocation. UCLH is working with commissioners and East and North Hertfordshire NHS Trust, the current provider) to develop proposals for the future.

6. Financial Implications

6.1 The capital cost of these proposals at current prices is £465m, which includes the relocation of the main cancer centre to Watford, with the repatriation of haemato-oncology from UCLH as well as a new networked radiotherapy unit at either Luton and Dunstable Hospital in Luton or Lister Hospital in Stevenage.

6.2 Assessment of the costs of dispersing the service to cancer centres in Cambridge, Oxford and London showed a similarly high level of capital would be required as the capacity is not currently available elsewhere.

6.3 Capital funding routes for the preferred option continue to be explored and a national planning committee has now agreed that this is a priority and that the proposals should be consulted on in public so that detailed planning can take place on urgent short-term and long-term changes to the services whilst the capital issue is resolved.

Background Information

Further information about the background to the review, why things need to change, what is happening, and how to get involved, can be found at www.mvccreview.nhs.uk

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HERTFORDSHIRE COUNTY COUNCIL

JOINT HEALTH OVERVIEW SCRUTINY COMMITTEE
MONDAY 16 DECEMBER 2024 AT 10.00AM

Agenda Item No

5

MOUNT VERNON CANCER CENTRE REPROVISION - CO-LOCATION OF SERVICES AT WATFORD HOSPITAL SITE

Report of the Head of Scrutiny

Author: Kathy Nelson, Deputy Programme Director Mount Vernon Cancer Centre Programme

1. Purpose of report

1.1 To provide the Committee with an overview of the importance of co-location of cancer clinical services. This is a key part of the clinical case for change given the recommendations of the independent clinical reviews undertaken in 2019.

2. Summary

2.1 Cancer treatment advances and rising incidence of cancer requires cancer care to be delivered differently. Treatment options are increasing each year particularly in chemotherapy drugs, for example, since July 2016 more than 150 new chemotherapy drugs have been introduced. Whilst many of these drugs have good clinical outcomes, they come with side effects which require rapid intervention by oncology teams.

2.2 Some of these side effects can affect different parts of the body and require specialist input from experts in other non-cancer specialities such as cardiology or respiratory teams.

2.3 The current location of the cancer centre does not lend itself to being able to access specialist input. The independent clinical advice concluded "*To best support the safety of the treatments it delivers to its patients, the central clinical hub of a cancer centre must now surround itself with established partnerships with a wide range of acute clinical disciplines. This dependence on such multidisciplinary care of the patient is only likely to increase in the future"*. The MVCC proposals seek to address this through co-location with Watford General Hospital.

2.4 MVCC clinical teams, Watford and UCLH have been working collaboratively to ensure that service developments affecting the reprovision proposals are aligned and to identify interdependencies across the 3 providers.

3. Recommendations

3.1 To note rationale for co-location of clinical services

3.2 To note the considerations identified to address the interdependencies between MVCC, Watford and UCLH as part of the MVCC reprovision.

4. Background

4.1 The clinical review concluded that the cancer centre must be capable of caring for its in-patients which have the treatments it delivers, the complications that arise from those therapies and the comorbidities which require acute clinical opinions from other specialties.
To do this, there must be the following:

- 24-hour inpatient emergency access to the assessment of need for escalation of care for in-patients, particularly by the on-call on-site acute medical team and also by the acute surgical on-call on-site team
- 24-hour on-site critical care outreach for in-patients with potential transfer to high-dependency and intensive care units located on the same geographical site
- On-site consultation capability for in-patients requiring acute care (diabetology, cardiology, respiratory medicine, gastroenterology, nephrology, endocrinology, dermatology, infectious diseases, ENT, haematology): for the complications of cancer, for the complications of treatment and to maintain timing of treatment plans such that interruptions are minimised (especially for radiotherapy fractionation)
- Immediate access to support pathological services (especially haematology and biochemistry)
- Outpatient access to a wide variety of clinical specialties: diabetes, cardiology, respiratory medicine, gastroenterology, renal medicine, endocrinology, dermatology, neurology, urology, ENT, gynaecology, palliative care, pain management services
- Rapid access for urgent physiotherapy services

4.2 It is also recommended that the adjacent acute hospital facility will have an Accident & Emergency department on the same geographical site.

4.3 MVCC, Watford and UCLH teams have been working together for some time to also work through the interdependencies between the 3 providers as part of the reprovision of services. Key considerations:

4.3.1 The timeline of the new MVCC build on Watford site and the proposed New Hospital Programme redevelopment of Watford Hospital. The teams have a plan to work through the scenarios of what would happen if Watford Hospital new build programme started before or after MVCC or if they were to happen at the same time.

4.3.2 Work with provider estates teams to identify where there are opportunities for non-clinical services to be shared between MVCC and Watford to create economies of scale.

4.3.3 Recognising the patient and public concerns raised in pre-consultation events about transport, travel and parking; it was agreed to undertake further work on the current arrangements at MVCC and impacts of move to Watford.

4.4 A working group has been established across the 3 providers with actions feeding into the MVCC programme governance. It is hoped to have a detailed action plan by the end of January 2025.

6. Financial Implications

6.1 There are no financial implications directly linked to the report but this is part of a wider capital investment for the reprovision of MVCC.

Background Information
None.

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HERTFORDSHIRE COUNTY COUNCIL

JOINT HEALTH OVERVIEW SCRUTINY COMMITTEE
MONDAY, 16 DECEMBER 2024 AT 10AM

Agenda Item No

6

MOUNT VERNON CANCER CENTRE – FUTURE MANAGEMENT BY UNIVERSITY COLLEGE LONDON HOSPITALS NHS FOUNDATION TRUST

Report of the Head of Scrutiny

Author: Emily Collins, Interim Director of Strategy, UCLH

1. Purpose of report

1.1 To detail the involvement of University College London Hospitals NHS Foundation Trust (UCLH) in the Mount Vernon Cancer Centre (MVCC) strategic review programme and proposals for future reprovision of these services, which are the subject of public consultation. This is to inform the Committee regarding the role of UCLH throughout the review to date and as expected in the future.

2. Summary

2.1 In 2020, UCLH was selected as the preferred provider to take on the management of MVCC services in the future. As a result, UCLH have been a key part of the development of proposals for future reprovision of MVCC services which are the subject of this public consultation.

2.2 Whilst the transfer of management to UCLH is not the subject of the public consultation, it should be noted that the proposals assume the future reprovision will be built, owned and run by UCLH. A final decision on transfer of management to UCLH will need to be taken by the UCLH Board once there is certainty on a number of areas, including an agreed and funded plan for a sustainable future for the service.

3. Recommendations

3.1 The Committee are asked to note the role of UCLH in this public consultation process. The proposed transfer of the management of MVCC to UCLH is not the subject of public consultation.

4. Background

4.1 The Mount Vernon Cancer Centre Strategic Review led by NHS England East of England regional team commissioned an Independent Clinical Review at its outset in 2019. One of the key recommendations from this review was that the specialist services at MVCC needed to be run by an organisation with experience of running specialist cancer services. MVCC is currently run by East and North Hertfordshire NHS Trust which is a district general hospital trust and not a specialist trust.

4.2 Following this, NHS England commenced a process to seek expressions of interest from providers who could take on this management responsibility.

4.3 In January 2020, following a competitive selection process informed by a wide range of stakeholder organisations, UCLH was selected as the preferred future provider to take over management of MVCC.

4.4 The selection panel included representatives from Healthwatch Hertfordshire and Healthwatch Hillingdon. Prospective providers were required to demonstrate experience of providing a wide range of tertiary cancer services, research excellence and access to clinical trials, performance against a number of quality metrics, and service stability. They were also assessed against criteria around patient experience, workforce, organisational commitment, service investment, clinical leadership, and experience of service transfer or merger, and they had to demonstrate how they would improve access, particularly for the large proportion of patients from Hertfordshire who had some of the longest journey times.

4.5 UCLH is a large provider of acute and specialist services to people from the local area and across the UK. It has 8 sites in central London as well as providing services in Buckinghamshire at the Epilepsy Society's Chalfont Centre. Cancer is one of its specialist areas of focus, and UCLH has a large portfolio of cancer research trials, delivered through working in close partnership with the university UCL (University College London).

4.6 UCLH has a longstanding informal relationship with MVCC, with some clinical staff working across the two organisations and a memorandum of understanding between the two organisations pre-dating the strategic review.

4.7 A final decision on this management transfer is subject to a number of conditions including the satisfactory conclusion of due diligence, an agreed funding settlement to ensure this transfer does not destabilise current UCLH services, and an agreed and funded proposal for a sustainable future for the MVCC service. At that point the UCLH Board are expected to consider the transfer proposal in its entirety and agree whether to move forward with the management transfer.

4.8 This has always been about transfer of management to an organisation with the experience and capability to manage these complex specialist services, not about any plan to transfer services to the main location of that organisation (in this case, central London). Indeed, it can be noted that the proposals put forward to public consultation include the proposal to transfer specialist blood cancer services for Hertfordshire and Bedfordshire patients from UCLH to the new MVCC facility at Watford.

4.9 UCLH has been a key part of the programme team since its selection as the preferred provider, and has played a key role in the development of the reprovision proposals which are subject to public consultation, and in providing ongoing support to the MVCC services in the meantime.

4.10 Following involvement in development of the clinical model and preferred future site selection, UCLH commissioned the feasibility study for a new

MVCC at Watford. It used its recent expertise in two cancer developments (the UCH Macmillan Cancer Centre which opened in 2012, and the Grafton Way building dedicated to Proton Beam Therapy, blood cancer inpatient services and surgery which opened in 2021) to inform this proposal, in collaboration with MVCC clinical teams, patients and other stakeholders.

4.11 It is proposed that the future service at Watford which is the subject of this public consultation would be built, owned and run by UCLH.

5. Financial Implications

5.1 There are no financial implications arising from this report specifically, however it can be noted that the expected capital cost of the reprovision proposals which are the subject of public consultation is £465m.

Background Information
None.

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HERTFORDSHIRE COUNTY COUNCIL

Agenda Item No **7**

JOINT HEALTH OVERVIEW SCRUTINY COMMITTEE
MONDAY, 16 DECEMBER 2024 AT 10.00AM

JHOSC SCRUTINY OF MVCC CONSULTATION

Report of the Head of Scrutiny

Author: Jessamy Kinghorn, Head of Partnerships and Engagement, Jessamy.kinghorn1@nhs.net

1. Purpose of report

1.1 This report sets out the proposed approach to health overview and scrutiny of the Mount Vernon Cancer Centre so Joint Health Overview & Scrutiny members know what to expect over the coming months.

2. Summary

2.1 A comprehensive consultation plan is being developed to enable members to consider the quality of engagement with patients and residents across the MVCC catchment.

2.2 A process for scrutiny of the consultation has been informally agreed by chairs of participating Health Overview and Scrutiny Committees. This will include a workshop to help shape the consultation plan and documentation.

2.3 This paper summarises the process, enabling members to express any views on the process itself before the consultation gets underway.

3. Recommendations

3.1 Members are asked to note the content of the report and comment on any further involvement or information that would be helpful to facilitate effective scrutiny of the consultation.

4. Background

4.1 Engagement with patients and the public has been core to the development of proposals for the relocation of Mount Vernon Cancer Centre. More than a hundred focus groups were run with patients, alongside other means of engagement in order to explore issues such as access, clinical models, care closer to home, building design, and more.

4.2 This has been supported for several years by a patient reference group, made up of Healthwatch nominated patients and local people, who have reviewed the patient and public engagement and influenced how the feedback has helped develop the proposals.

4.3 Since the beginning of this review in 2019, NHS England has kept scrutiny committees up to date with the challenges at Mount Vernon, development of proposals and progress in moving the programme of work forward, and those with the largest patient flows have had multiple briefings.

4.4 There is now a requirement to formalise this involvement through a period of public consultation.

4.5 A consultation strategy and plan has been developed to support the public consultation process. Its objectives are:

- To meet statutory duties - ensuring that the consultation process is inclusive and that those individuals and groups most likely to be impacted are fully engaged and their voices are particularly clearly heard.
- To gather feedback from patients, staff, stakeholders and local residents - making it as easy as possible to comment through a choice of channels and reaching out effectively to ensure people are aware of the consultation and how to contribute.
- To obtain feedback relevant to the consultation proposals while retaining flexibility for how people can participate and valuing all contributions - testing strengths and weaknesses, exploring how proposals will impact and potential mitigations, and considering issues relevant to implementation.
- To secure a mix of both quantitative feedback (e.g. through a questionnaire) and qualitative feedback (e.g. through noting discussion at meetings) - to develop understanding of participants' views which are as rich and detailed as possible.
- Where rooted in the data, to indicate where there is majority agreement and where there are differences of view held by different groups or people in different areas.
- To capture all feedback from the consultation within a single analysis and report to enable decisions to be fully informed.

4.5 The detailed consultation plan is under development and will continue to evolve in the lead up to, and throughout the public consultation. It will also be subject to the NHS England assurance process which is currently underway.

4.6 2023/24 patient activity figures have driven the geographical scope of the consultation.

4.7 Resource to support consultation will include:

- Support from an experienced independent consultation agency to run and independently analyse the public consultation
- Dedicated website
- Dedicated stakeholder management system

4.8 Consultation start and finish dates and key events will be confirmed and communicated prior to the consultation launch so that the consultation will hit the ground running. It is currently anticipated that the consultation would run for ten weeks, to finish as soon as possible prior to the local elections on 1 May 2025.

4.9 A Joint Health Overview and Scrutiny Committee has been established to oversee the scrutiny of this consultation. Ten local authorities have agreed to participate in this Committee which will have 17 members, proportionate to the number of patients referred to MVCC from each local authority. The terms of reference are subject to a separate paper.

4.10 The proposed approach is that NHS England who is leading the consultation on behalf of the NHS organisations involved, will attend each of four themed meetings of the Joint Health Overview and Scrutiny Committee (JHOSC), with NHS colleagues from across the programme as appropriate to the subject. The subjects are set by the JHOSC.

4.11 The final session before the consultation concludes will include a reflection on the quality of the consultation.

4.12 A further session will take place following the analysis of the consultation and the decision-making process for the JHOSC to consider the extent to which commissioners have adequately reflected on and responded to the views expressed during the consultation.

4.13 In addition to attending JHOSC meetings, NHS England will attend individual Health Overview and Scrutiny Committees as requested to discuss the engagement of specific populations. It is acknowledged that scrutiny members and their local authority colleagues are well placed to help ensure that local populations are reached and have the opportunity to be involved and the proposed approach is to work together to ensure meaningful engagement takes place across the catchment.

4.14 Three local authorities with MVCC patient numbers varying between 24 and 158 (2023/24 data) have opted to be kept informed of progress rather than participate in the JHOSC. Those that are participating had between 46 to 5,541 patients attend MVCC during 2023/24.

4.15 There are a small number of patients from other parts of the country – 345 of the total 12,972 patients in 2023/24. This includes places as far as Yorkshire and the Isle of Wight. Scrutiny committees in these areas will be informed of the consultation and given the opportunity to request a paper or presentation from NHS England. They will also be given details of how to get in touch with the MVCC JHOSC if they have any queries.

5. Financial Implications

5.1 NHS England has set aside some non-recurrent resource to support the consultation. This will include the production of consultation materials, as well as some resource to promote the consultation, particularly in under-represented areas, and to facilitate the independent analysis of the results.

Background Information
None.

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