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London and South East Clinical Senates Review

Proposed changes to children's specialist cancer services Principal Treatment Centre serving Brighton and Hove, East Sussex, Kent and Medway, South London and most of Surrey

19th July 2023

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Foreword

On behalf of the London and South East Clinical Senates we are pleased to share the final joint Senates' report of the proposed changes to the children's specialist cancer services Principal Treatment Centre Programme (PTC) serving Brighton and Hove, East Sussex, Kent and Medway, south London and most of Surrey.

We would like to thank our colleagues for their drive and passion to secure these improvements for patients. Significant work has been undertaken to develop these proposals which are grounded in national recommendations and best practice. Our thanks also to members of the review panel including national subject matter clinicians whose time and expertise have been invaluable.

The joint Clinical Senates' review panel found that the proposals were grounded in evidence and best practice as outlined by Sir Mike Richards' report on PTCs and subsequent service specifications.

They also identified several recommendations as the team move forwards which are detailed in the body of this report.

Of particular note the panel recognised that movement of such complex specialist services to a new provider is not without risks. We have made recommendations for further support for organisational development working with The Royal Marsden NHS Foundation Trust and the provider of the future Principal Treatment Centre to help mitigate these risks.

We are also keen this is used as an opportunity to link with the communities served to plan new co-designed ways to contribute to reducing inequalities as the new service is implemented. It should be remembered that coproduction is the combination of lived experience and learned experience.

Finally, we would like to thank our Senate teams for their work and diligence in bringing the review panel together and developing this report.

M W Gill

Dr Paul Stevens

Chair South East Clinical Senate

Dr Mike Gill

Chair London Clinical Senate

Executive summary and key recommendations

The London and South East Clinical Senates welcomed the work and input provided by NHS England Specialised Commissioning London in developing the Pre-Consultation Business Case (PCBC) which proposes reconfiguration of children's specialised cancer services for children with cancer living in Brighton and Hove, East Sussex, Kent and Medway, south London, and most of Surrey. The review panel found that the case for change was clear, with a sound evidence base. They also made recommendations to commissioners for further development of the PCBC, which are included in the body of the report.

The review panel noted that the interim Equality and Health Inequalities Impact Assessment undertaken to date was an important starting point, which would require expanding to cover all areas of inequalities with further work required to ensure the outputs are built into wider strategies.

The overarching findings against the four core areas the panel were asked to review are detailed below and restated as appropriate in the main body of the report.

A. Is the case for change clear from a clinical perspective?

The case for change is clear and the review team agreed it was sound from a clinical perspective. While it was recognised that change is necessary to meet the findings of the Sir Mike Richards review (Jan 20)[1] and Principal Treatment Centre (PTC) specification (Nov 21),[2] the ambition should stretch to the provision of one of the top PTCs in the country building on the experience and expertise that exists in all the current providers and preserving the unique strengths of The Royal Marsden NHS Foundation Trust.[3]

B. Is the clinical evidence set out in the PCBC clear about both options and do they meet the service specifications for a PTC?

The review team was impressed by the work both providers had undertaken to present plans which meet the PTC service specification and have the potential to go beyond this to improve services for children with cancer.

Notwithstanding these plans, the team have several recommendations to further strengthen the proposals submitted.

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[1] board-meeting-item-9-update-on-specialised-services-c-appendix-2.pdf (england.nhs.uk)

[2] NHS England » Children's cancer services: Principal treatment centres service specification

[3] Referred to as The Royal Marsden throughout this document.

C. Does the Integrated Impact Assessment provide sufficient mitigation to possible health impacts, particularly travel times that might otherwise increase inequities?

The interim Equality and Health Inequalities Impact Assessment (EHIA) is a key element of the overall Integrated Impact Assessment. It is, by its nature, a work in progress. We recommend this work continues through and after consultation.

There is potential to maximise the change opportunity and take the design beyond meeting the requirements in the national service specification. We recommend that, once a final decision has been made, the future provider develops and articulates a strategic approach to tackling health inequalities and improving inclusivity. The development of new systems and processes would be strengthened if coproduced with patients, their carers and the current providers to ensure all relevant learning is utilised.

When addressing access, we recommend that solutions in the PCBC should go further than transport and digital solutions. It is likely that mitigations put in place for groups facing health inequalities will need to extend to care they receive at Paediatric Oncology Shared Care Units (POSCUs) and from primary / community care. The team accepted that this would become more defined once a final decision has been made. Again, notwithstanding this we have made some recommendations.

D. Is there any further clinical evidence that NHS England should consider in making a final decision on the options?

The review team expressed some concern about the importance of transition of care and the complexity of managing this over two sites. The team supported the concepts of flexibility regarding age of transition, which is in line with the Teenage and Young Adult Cancer Clinical Network Specification,[4] tumour site, location of patient, and consistency of staff (with key staff following the patient through transition) to mitigate risks. A process for overseeing implementation and assuring the effective delivery of proposals will be essential.

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[4] tya-cancer-clinical-network-specification.pdf (england.nhs.uk) NB This was published after the Senate review

Key recommendations

R1. NHS London should support organisational development particularly at The Royal Marsden involving the whole workforce which currently provides children's cancer services. This should involve how the current PTC providers will work with the future provider of the PTC to ensure a smooth transfer. Specific areas to work through and agree are likely to include:

a. **How organisational memory, key skills and competencies are preserved and transferred to the new provider.**
b. **How research is maintained, planned, and developed and where possible enhanced with the new provider. This will include how research and charitable income can be secured and protected, and the rationale for "wet research" remaining at The Royal Marsden NHS Foundation Trust and the Institute of Cancer Research.**
c. **Once determined, the future provider of the PTC should work with patients / parents to design and develop the new service, so it aspires to improvement beyond the PTC specification. To ensure holistic care, it is essential that service users contributing their views span all geographies and demographic groups, including the 9 protected characteristics, as well as the type of cancer, stage of cancer, age of child and family circumstances.**
d. **How to preserve the memories and legacies which have underpinned the services on the Sutton site so that, if possible, they can be incorporated in the new provision.**

R2. The future provider of the PTC must commit not just to working with their colleagues from the current PTC providers but also to joint organisational development that gives opportunities for the incoming workforce and their patients / parents to co-design and develop the service not just transfer it.

Background[5]

Over the past 15 years national guidance documents and reports, and two reviews of services within London have been published with relevance to the configuration of services for children with cancer.[6] These culminated in the review by Professor Sir Mike Richards that recommended that all Principal Treatment Centres (PTCs) *must* be co-located with a Paediatric Intensive Care Unit (PICU) and other specialist children's services. This review was commissioned by the Chief Executive of NHS England to assist its Board in the evaluation of responses to a consultation undertaken in summer 2019 relating to a new draft service specification for children's cancers. Sir Mike Richards was asked to consider whether co-location of a PTC for children's cancer with a level 3 Paediatric Intensive Care PICU on the same site should be a mandatory requirement for an NHS England commissioned PTC. His conclusion, set out in his report which went to the January 2020 NHS England Board meeting, was that it should be a mandatory requirement.

Following the January 2020 meeting, NHS England London Region was tasked by the NHS England Board with making a recommendation on a compliant site option for the PTC serving south London, Kent and Medway, Surrey and Sussex.

A new service specification for PTCs was published by NHS England in November 2021,[7] reflecting Professor Sir Mike Richards' recommendations and sets out the requirements that the reconfiguration needs to meet. The specification includes a mandatory requirement for PTCs to be delivered on a site with a PICU, alongside paediatric cancer surgery, radiology, haematology and paediatric anaesthetics, with a range of other specialist children's services which, if not on site, must be readily accessible at all times.

The PTC specification aims to sustainably:

- improve integration between different services for children with cancer.
- improve the experience of care.
- increase participation in clinical trials, which is currently at around two thirds of patients.
- increase tumour banking rates.
- improve the transition between children's and teenagers' and young adults' services, in particular ensuring there is no age gap between different services.

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[5] Information based on the Terms of Reference agreed between London Specialised Commissioning and London and SE Clinical Senates

[6] Improving Outcomes in Children and Young People with Cancer (NICE 2005); Commissioning Safe and Sustainable Specialised Paediatric Services (Department of Health 2008); South London Paediatric Oncology: NCAT review (2011); London Paediatric Oncology Review (2015); On the Right Course? (2018)

[7] 1746-principal-treatment-centres-service-specification-.pdf (england.nhs.uk)

- embed genomic medicine within children’s cancer services.
- tackle variation, ensuring that patients get the same high-quality care, regardless of where they are treated.

The November 2021 service specification for Principal Treatment Centres was published alongside a specification for Paediatric Oncology Shared Care Units[8]: Together these two specifications set out a vision for coordinated children’s cancer care of the highest standard, balancing the PTC centre of excellence with closer access for families to effective, well-established, clinical shared care sites. It is this vision that London wishes to implement and informs the service change proposals in the PCBC. PTCs are expected to drive forward continued improvement for children’s cancer care across their networks.

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[8] 1746-paediatric-oncology-shared-care-unit-service-specification-.pdf (england.nhs.uk)

Approach to the review

This was a joint review undertaken by the London and South East Clinical Senates to reflect the fact that the service change proposed impacts the populations in south east London and the South East region.

Representatives from both Clinical Senates discussed the scope of the Senate review with NHS England Specialised Commissioning London and agreed the approach in a terms of reference document.

The review was held via TEAMS on 20th April 2023, co-chaired by Dr Paul Stevens and Dr Mike Gill, respective chairs of the South East Clinical Senate and London Clinical Senate.

To ensure a complete and independent panel, representatives for the panel were invited from both Senates alongside subject matter experts in cancer and associated services. All were asked to a sign confidentiality agreement and to register their interests. Whilst most review panel members were able to attend on the day, some were unable to due to unforeseen circumstances. Provision was made for these review panel members to contribute electronically (Appendix D).

Upon receipt of a draft PCBC as well as other supporting documentation from NHS England Specialised Commissioning London (Appendix C), Key Lines of Enquiry (KLOE) (Appendix A) were produced by the Senate teams.

The KLOEs were discussed in a panel pre meet on 31st March, with subject matter experts commenting and enriching the KLOEs to facilitate a rounded exploration. They were then shared with NHS England Specialised Commissioning London who produced a document, with input from The Royal Marsden and potential service providers capturing factual responses against the queries. These were available to the panel immediately prior to the review day and for ongoing reference thereafter.

The format of the review was a presentation from representatives of NHS England Specialised Commissioning London followed by questions from the review panel and finally an opportunity for the review panel to deliberate and draw together its conclusions (Appendix B).

To support NHS England Specialised Commissioning London’s desired timeline for consultation an initial and informal draft of the recommendations was provided to them on Tuesday 24th April with a meeting to discuss the recommendations held on Thursday 27th April. The recommendations are incorporated into this full report, with some changes in order and small modifications to provide additional clarity and richness.

Findings of the Senate Review Panel

The findings of the Senate review panel are structured against the four core areas that NHS England Specialised Commissioning London asked the Senate to focus on in the terms of reference. In all cases the discussion concludes with associated recommendations. Many apply to strengthening the business case, however, there are also some additional supportive actions and processes suggested for the short to medium term.

1. Is the case for change clear from a clinical perspective?

The case for change for reconfiguring the Principal Treatment Centre for children with cancer living in Brighton and Hove, East Sussex, Kent and Medway, south London and most of Surrey is based on the findings of the Professor Sir Mike Richards review paper (Jan 2020) that a level 3 PICU is a mandatory requirement for a children's cancer PTC. Professor Sir Mike Richards noted that separation presents an inherent geographical risk to patient safety that can only ever be partially mitigated, and that the safe delivery of complex and new intensive therapies will not be possible where there is separation.

The configuration of the current Principal Treatment Centre for this catchment area has been consistent since 2006. It is provided in partnership by The Royal Marsden NHS Foundation Trust at its site in Sutton and St George's University Hospitals NHS Foundation Trust, at St George's Hospital, Tooting. Most cancer care, including chemotherapy, radiotherapy and bone marrow transplants, takes place at The Royal Marsden's site in Sutton, Surrey. All intensive care, most cancer surgery, and some other specialist children's services for the centre are at St George's Hospital eight miles away in Tooting. The specialist paediatric oncology service provided by The Royal Marsden NHS Foundation Trust is based in a specialist cancer hospital. It does not have on site PICU or paediatric cancer surgery (Service Specification 7.2). Therefore, its location must change.

The case for change in the Pre-Consultation Business Case refers to and seeks to address the recommendations in the Richards report and subsequent service specification for Principal Treatment Centres developed by NHS England in partnership with patients, parents and professionals. There are two choices for the establishment of a compliant Principal Treatment Centre:

- St George's University Hospitals NHS Foundation Trust (St George's) which is part of St George's, Epsom and St Helier Hospitals and Health Group
- Evelina London Children's Hospital, which is part of Guy's and St Thomas' NHS Foundation Trust (Guys and St Thomas').

If St George's becomes the future Principal Treatment Centre, all children's cancer services currently at The Royal Marsden (except radiotherapy) will move there. There will be no other changes to St George's services.

If Evelina London becomes the future Principal Treatment Centre, all children's cancer services currently at The Royal Marsden (except radiotherapy) and the services provided for the centre at St George's will move there. Other children's cancer services at St George's will not change.

Examination of the Care Quality Commission (CQC) ratings reveals both organisations provide high quality care to the populations they serve.

The PCBC viewed by the panel demonstrated how the potential providers planned to meet the national service specification. It included the process which had been undertaken to develop and refine the options and subsequent evaluation criteria of:

- clinical service model
- patient and carer experience
- enabling (non-clinical factors)
- research

Each evaluation criterion was further broken down into sub criteria and were differentially weighted based on assessment by panel members. The overall scoring was Evelina London Children's Hospital 80.505% and St George's Hospital 75.267%.

The PCBC did not express a preferred option.

The panel felt that there was a strong case for change, but also the potential for a stronger, local narrative to describe this. The potential providers articulated plans that went beyond the technical aspects of the specification and the review panel considered that more could be included to demonstrate the proposed change as an improvement for children across south east England and London in the Business Case. This may include focus on number of transfers, and points of contact.

The panel highlighted that in their experience and to the best of their knowledge a move of this magnitude, involving the movement of a PTC has not happened previously. They considered it essential that The Royal Marsden, as experts in the field, have a central role in driving the change. As consultation begins, there is opportunity for The Royal Marsden to begin organisational development to prepare staff for the move, which should be ongoing with the future provider once identified. This should include discussing and documenting the essential features of the re-provision informed by clinical experience, learning, and organisational memory.

The panel recommended The Royal Marsden clinicians are significant contributors in development of clear clinical key performance indicators, including research metrics and outcome measures by which NHS England - London can track the change, risks inherent to the change, and support the delivery of improvements. These should be informed by the Quality Standards outlined in the PTC specification (PTC specification 4.1) and monitored in real time by the programme to track progress and inform real time modifications as necessary to improve care and mitigate risk.

The Senate panel welcomed that a Programme Board had been established to provide advice on the change and encourage the commissioners to carefully review membership to ensure an appropriate balance of representatives from The Royal Marsden, potential providers and patient and public representatives. Coproducing the shape of the new provision with patients and parents will be essential to ensure that the potential providers understand nuances, scale of challenges, pinch points and how to mitigate them.

Finally, in recognition of the international reputation of the brand of The Royal Marsden, association for both patients and research consideration might be given to the brand “The Royal Marsden” transferring with the children’s service.

Recommendations:

R3. Develop the narrative on the case for change within the PCBC, to go beyond compliance with the technical aspects of the specification and demonstrate the improvements that the proposed change would bring for children across south east England and south London.

R4. Provide assurance that the current PTC providers will work with the future provider of the PTC to bring a full understanding of the requirements of a paediatric oncology service to the implementation of the future PTC.

R5. Include clear quality measurements and metrics in the PCBC enabling progress to be measure and provide early warning of the destabilisation of the pathway to enable early mitigations

R6. Consider whether the brand “The Royal Marsden” should be incorporated in the identity of the future service provision.

2. Is the clinical evidence set out in the PCBC clear about both options and do they meet the service specifications for a PTC?

The Senate review panel was impressed by the work both providers had undertaken to present plans which meet and have the potential to go beyond the national PTC service specification.

The Senate review panel explored several key lines of enquiry, designed to consider the clinical model, quality and outcome and experience of patients across the whole pathway. This exploration led to recommendations to further improve plans which are discussed in the sections below. The subheadings for these sections are informed by a combination of the Senates' principles and KLOEs as well as the Cancer PTC specification.

Fundamentally, the Senate review panel noted that work to date had been primarily an intellectual, paper-based exercise which had produced clear plans for the physical space and an outline of the model of care. Whilst this was clear and did not raise concern about either provider meeting the PTC service specification, detail on the implementation is relatively light. It will be essential that the future PTC provider works closely with the current provider of the PTC to forge and extend productive relationships to ensure effective clinical models. This collaborative working between the current PTC providers and all elements of the cancer network for the benefit of patients is a key theme running throughout the Senate review panel discussion and recommendations.

2.1. Transitions - provision for children aged 0 to 15 years and moving the service.

The model currently described is for children under one to be treated at Great Ormond Street Hospital for Children NHS Foundation Trust, children aged 1-15 to be treated at the relocated PTC; and young people to receive treatment at The Royal Marsden, the exact age of transition requires a defined transition pathway for each tumour type while also acknowledging individual patient's needs. Good support for transition to Teenage and Young Adult services is vital and is a key requirement set out in the national service specification.

The Senate review panel stressed the importance of effective transition, recognising the risk that knowledge acquired by clinicians at either side of a patient's 16th birthday could be diluted by the separation of the service. Mitigating this will require effective working relationships and flexibility of both physical resources and staffing. The Senate review panel noted the written and verbal commitment from all providers to be flexible to the needs of the child or young person, and the importance of the network’s role in this area. They also considered that there may be transferrable learning from Evelina London Children’s Hospital to the cancer service from the non-cancer children’s networks the hospital supports.

As the practical arrangements for transition continue to be worked through, this should be monitored, and course corrected as required. An active risk register to record issues, inform action, and monitor progress will be essential.

A further complexity to treatment for children and young people being provided across more than one site is the impact on research trials; it may be particularly challenging for sponsors to capture data from more than one site in age agnostic studies (See 2.2. Research).

Lastly, the Senate review panel considered the wider impacts of transitioning a service. Recognising the issues highlighted in section 1, they recommended that implementation should be undertaken as soon as possible. Consideration of additional support will be required for children receiving a diagnosis and part way through treatment at this time. It is essential for continuity of care and to provide a clear plan for staff and patients (See 2.8. Workforce).

Recommendations

R7. For transitions of care (post age 15), the review team felt the risk of providing the services on another site needs mitigation. The suggestions already made regarding flexibility and age (perhaps even extending to 18 or beyond), geographical location of the patient and tumour site location will be important. It would be helpful to clarify current and future capacity to manage 16-18+ year old patients in appropriate facilities with appropriately trained workforce. Continuity of staffing support (e.g., nurse specialist) supporting patients and their families through transition may also help.

R8. It will be important to ensure an active risk register to oversee the development and the first few years of practice.

R9. The implementation is planned to be within 2.5 years. The team felt that it is important that once a decision is made the implementation is undertaken in a timely fashion to ensure safe transition that provides continuity of care and to relieve uncertainty amongst staff and patients.

2.2. Research

The Senate review panel were clear that the current partnership between The Royal Marsden and the Institute of Cancer Research (ICR) is critical to advancing academic knowledge that has national and international benefits. They considered that work would be required in the immediate future to mitigate risks of destabilising existing research studies during the transition process, and in the medium-term to mitigate risks associated with the fact that cross-age group clinical trials would need to be open on 2 sites.

It is important that this engagement and investment continues, which will require maintaining working practices between clinicians and scientists with time in job plans to facilitate this. Work should be undertaken to review how research is maintained, and where possible enhanced with the future provider.

The Senate review panel's view was that either potential provider would be able to deliver in the short term; they also noted that the Research Panel (as part of the Options Evaluation) scored the Evelina London Children's Hospital option more highly.

Recommendations

As indicated in key recommendation:

> **R1.b. How research is maintained, planned, and developed and where possible enhanced with the future provider. This will include how research and charitable income can be secured and protected, and the rationale for "wet research" remaining at The Royal Marsden, if that is to be the case.**

2.3. Operational Delivery Network, Primary and Community Care

In accordance with the service specification, the PTC is responsible for ensuring the provision of high-quality care through the effective coordination of integrated, disease specific pathways across different providers, known collectively as the Children's Cancer Network (PTC Service Specification 2.2).

The ability of the PTC to develop and maintain strong relationships to coordinate the network will be critically important. The presenting team all acknowledged there is work to be done on outreach to transform services in line with the new POSCU service specification once the future PTC provider is confirmed. Both St George's Hospital and the Evelina London Children's Hospital recognise there will be training needs for this to be realised, clearer articulation of how this will be achieved would be beneficial.

Commissioners advised there was not a planned change to the key primary care touchpoints / areas and that business as usual would continue. However, given the scale and complexity of the service change, the Senate review panel considered that engagement and involvement of primary care to maintain existing communication and effective pathways was essential. They also noted the importance of including in the PCBC how the connectivity and service in primary care might be built upon and improved.

For example:

- Considering opportunities to address inequalities with improved population health beginning in primary care with early diagnosis and early intervention.
- Maximising opportunities for primary care to advocate for families and arrange support with the wider system including the voluntary and community sector.
- Ensuring that there is clear advice for community clinicians regarding ongoing management including a child whose health might be deteriorating in the community.

It will be important for the future PTC provider to be clear about their support offer to primary care and community services for the whole family. St George's Hospital have current experience and referred to having a PTC link clinician with every POSCU to support maximum delivery. Evelina London Children's Hospital can draw on their experience of providing community services in local boroughs and engage with the Primary Care Networks to disseminate knowledge from tertiary centres and would seek to discuss with POSCUs at the appropriate time.

Recommendations

R10. Whilst there are no changes to existing arrangements to pathways with primary care, GPs, and community services, we recommend that given the magnitude of the change specific attention is given to communications and engagement with these groups directly in addition to rather than through POSCU and Integrated Care Boards.

2.4. Diagnosis, Treatment and Management of Cancer

The Senate review panel paid attention to the linkage and flexibility of services within the care pathway, particularly given potential destabilisation when the service is moved. They were broadly assured of the respective trusts' ability to deliver, whilst noting some areas where additional detail in the PCBC would be helpful. The Senate review panel accepted that the granularity of challenges will be different dependent on which provider is successful.

The Senate review panel also explored the ability for the respective PICUs to manage additional demand. St George's Hospital already provide the service within their capacity. Evelina London Children's Hospital plan to absorb the extra demand. The Senate review panel recommend that Evelina London Children's Hospital articulate in the PCBC how they would manage an increase of activity within current capacity, particularly alongside current need from cardiology and cardiothoracic patients.

Both potential providers also confirmed their plans included dedicated oncologists and haematologists and separate on call rotas for paediatric patients including post-operative review for surgical complications. Increased clarity regarding models and capacity of surgery and paediatric competent 24/7 interventional radiology rotas at Evelina London Children's Hospital would be helpful.

Further areas identified by the Senate review panel as warranting greater articulation in the Business case, some of which were provided in the KLOE response include:

- Availability and route for urgent diagnostic capacity over the weekend
- Flexibility within theatre space for urgent needs
- Isolation cubicles
- Responsiveness and availability of gamete storage
- Haematology - experience and ability
- Pharmacy - including links to community and NHS Discharge Medicines

The PTC specification also outlines that when the aim of treatment is not curative, palliative and end of life care and bereavement support should be provided. The PTC is expected to support the coordination of care outside specialist centres through shared care services and in liaison with local community and palliative care services. (PTC specification 2.3.2). The panel advised that further information is provided within the PCBC. Given the written evidence provided to the panel against the KLOE they were satisfied that plans regarding this aspect of the specification could be developed and recommend its inclusion in the Business case.

The panel considered that digital and effective interoperability will be a fundamental enabler to providing connectivity between all the aspects of the network and, where appropriate, care closer to home and digital appointments for patients.

The service has complex patient pathways spanning multiple POSCUs, ICSs, primary care providers and geographical areas and has a duty to furnish timely up to date information and to equip patients and parents with the tools and information required to co-manage their own health. It is important that plans are clearly developed, supported by wider infrastructure.

Recommendations

R11. Provide further assurance regarding: theatre capacity; paediatric surgical resource; isolation cubicles; and paediatric competent 24/7 interventional radiology rotas at the Evelina London Children's Hospital, articulating how this capacity and resource can be flexed to demand if required.

R12. To incorporate the learning from Covid 19, and current guidance around all emerging respiratory infections to inform the service model for this cohort of patients including managing transfers of patients in any future respiratory pandemic.

R13. Articulate in the PCBC how end of life care would be supported 24/7 at home and how they would plan to work collaboratively with children's hospices; this may refer to the information provided in the written response to the KLOE.

R14. Further detail from the potential providers to describe their acute care pathways / their oncology triage service and how they will offer advice to carers and clinicians (including paramedics) assessing unwell children in the community on the need for admission to hospital (ED/POSCU/PTC) and in what time frame. A pathway example of a patient(s) journey may be helpful for clarity during consultation. The Providers may want to consider how they can support the carers of these children contacting 111 for advice when required.

R15. Clearly describe how up to date information to equip patients and parents with the tools and information required to co-manage their own health will be addressed, especially for more geographically remote patients. A pathway example of patient(s) journeys may be helpful for consultation.

R16. Clarify how both providers would satisfy The Joint Accreditation Committee ISCT-Europe & EBMT (JACIE) for stem cell transplantation.

2.5. Survivorship, Mental Health, and Psychological Wellbeing

On completion of treatment, the PTC must ensure there is a comprehensive long term follow up package in place for every child or teenage cancer survivor (PTC Service specification 2.3.3).

The psychological impacts of cancer and potential mental health needs of families is also key. The panel were keen to stress that psychological distress may only arise after treatment finishes, and late effects clinics, if held at a different location to where the treatment was provided may not be recognised by the child as part of the same service and consequently be less effective. Continuity of care and staging at transition between child to adult services is essential and should be considered as part of these mitigations.

Recommendations

R17. The potential providers fully articulate the support they will provide to patients / parents and their primary care and community teams to provide safe and seamless care on a 24/7 basis. This should include longer term psychological support to patients and families where indicated or required.

2.6. Engagement with Patients and Public and Charitable Funding

The Senate panel, particularly the patient and public representatives, explored the engagement that had been held to date with service users and made recommendations for further consideration.

There was a clear overarching theme of strengthening coproduction, listening to the voices of previous and current patients and families, and reflecting these in the design of the new environment. There were several areas where parents of children in receipt of the service felt they could really support the re-provision process.

In the first instance, the panel welcomed clarity on the membership of the stakeholder group and ensuring that there was sufficient input and representation.

The panel were also keen to understand the wider social support for patients and families and emphasised the importance of holistic care for patients throughout their treatment journey. Some assurance was provided in the presentation given to the panel (especially slide 38), which included mitigations for vulnerable families, including close working with social care or health inclusion teams. This detail is not currently articulated in the PCBC, and the panel feel it will be important to reflect this.

The importance of positive relationships between staff and families was underlined. It is essential that families develop confidence and trust in healthcare professionals, enabling staff to recognise a family's changing needs, understanding where additional support may be required and where they can facilitate children with cancer to experience life as fully as possible.

The engagement of families with The Royal Marsden hospital charity should be noted and carefully considered. The children's ward has at least two areas fundraised by bereaved parents and a garden built recently, which is a legacy for a number of children. A carefully considered approach and sensitive discussions with families will be important in considering how this is preserved.

St George's Hospital and Evelina London Children's Hospital acknowledged this and expressed their wish to enable these legacies to be recognised and committed to work with families to find a way to bring these across sensitively (if required). They shared that they have a memorial garden for children who had died as well as memorial walls for organ donors.

The Royal Marsden clarified that the constitution of the charity does not allow for funds to flow to any other institution, so plans need to ensure alternative funding streams are found. Further discussion and clear plans will be imperative.

Recommendations

Recommendations for this section are of fundamental importance and are extracted from the key recommendations within the executive summary.

R2. The future provider of the PTC must commit not just to working with their colleagues from the current PTC providers but also to joint organisational development that gives opportunities for the incoming workforce and their patients / parents to co-design and develop the service not just transfer it.

R1.c. Work with patients / parents to design and develop the new service with the future provider of the PTC so it aspires to improvement beyond the PTC specification. To ensure holistic care it is essential that service users contributing their views span all geographies and demographic groups, including the 9 protected characteristics, as well as the type of cancer, stage of cancer, age of child and family circumstances.

R1.d. Preserve the memories and legacies which have underpinned the services on the Sutton site so that, if possible, they can be incorporated in the new provision.

2.7. Engagement - Clinical

Both potential providers on panel day spoke of the support and the excitement clinical teams have expressed to provide the service. The PCBC details a positive travel impact for most staff however cost analysis has not been carried out and there was a recognition that reductions in journey times are not synonymous with reductions in cost.

The Senate panel heard that there was the potential for approximately 170 staff from The Royal Marsden to transfer to the future PTC site and that further pre-engagement with staff will take place before the consultation launches. This greater focus on clinical engagement planned in the implementation phase of the reconfiguration will involve consideration of the impact on staff including benefits that would be offered compared with those they currently receive at The Royal Marsden, such as staff wellbeing offer and nursery provision. Whilst the Senates acknowledge the challenges of staff engagement the panel considered that this now needs to be given a higher priority; The Royal Marsden need to prepare their staff for transition and work with the chosen provider to facilitate a smooth process. Leadership and messaging will be crucial. The panel supported the suggestion that was heard from NHS England Specialised Commissioning London of a joint senior appointment between The Royal Marsden and the new organisation.

It is well documented that for patient safety, staff wellbeing and a positive workplace culture, staff need to feel in control and that they belong in a cohesive team.[9] It would be advantageous for staff to drive the change at the earliest possible stage. Through such co-design the Senate believe a service specification can be developed above and beyond that of the national specification which will serve to benefit all those working in and being cared for at the relocated PTC.

Recommendation:

R18. Stakeholders have identified successful change requires strong clinical leadership. For successful implementation those clinical leaders from The Royal Marsden and the future provider of the PTC will need to be identified, developed and supported.

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[9] Sources: caring-for-doctors-caring-for-patients_pdf-80706341.pdf (gmc-uk.org)
https://www.kingsfund.org.uk/sites/default/files/2020-09/The%20courage%20of%20compassion%20full%20report_0.pdf

2.8. Workforce

The service specification states each PTC must ensure that there is a consultant medical on-call rota in place which fulfils set requirements.

It also states there should be ready access to neuropsychology for the assessment and input for children with disease acquired or treatment related brain injury (PTC specification 2.3.6).

The PCBC outlines the proposed workforce models for both potential providers. Additional documentation provided to the Senates (KLOE feedback) showed how both potential providers would meet the workforce requirements. Both potential providers would provide an oncology only on-call medical rota if they became the site of the future PTC.

Recruitment and retention plans require further development in both proposals with a move to a focus on operationalising ambitions. There is an aspiration that children's cancer staff currently at The Royal Marsden who are eligible to transfer to the relocated PTC will do so, bringing their clinical expertise with them. However, experience from other service reconfigurations is that attrition rate can be high. Consideration of how to retain the very specialist Royal Marsden staff is crucial. The Senate panel wish to highlight the importance of clinical and non-clinical staff being considered and that the workforce in its entirety requires reflecting in workforce plans.

The Senate panel note all parties plan to work with Health Education England (now part of NHS England). Both Evelina London Children's Hospital and St George's Hospital spoke on panel day about long histories with associated universities, with Evelina London Children's Hospital highlighting that education funding that can be accessed by all staff. However, in both proposals there is a disproportionate focus on medical staff; multi professional education and training needs to be more adequately addressed and developed across all staff groups and involve the trainees and learners affected.

Recommendations:

R19. Retaining the specialist workforce across all staff groups both clinical and non-clinical needs to be a high priority and reflected in workforce plans.

R20. Both proposals mention education and development. The team highlighted that opportunities for education and development of all staff can be vital components to a successful future service. Plans to deliver this pre and post transfer should be in the organisational development plans and include all workforce groups.

2.9. Environmental Sustainability

The review panel noted the increase in extreme weather conditions and the importance of adaptation to these to maintain service continuity. Neither potential site is on high ground and the risk of flooding in the next twenty years seems likely to increase significantly with climate change.[10] It will be important for both sites to ensure robust resilience planning for such events for all services, particularly for time sensitive interventions, and also considering support services e.g., IT continuity and cooling. A key way of supporting this as well as reducing the overall carbon impact of providing the service is to offer treatment locally or virtually within patients' homes. As such, environmental sustainability recommendations connect closely to those on digital and transport (See 2.4 and 3.2) as well as the models of care and staffing with strong working relationship with primary, community care and POSCUs (See 2.3). London NHS England Specialised Commissioning, might also wish to refer to South East Clinical Senate's recent report "Embedding healthcare sustainability in major service change".[11]

The panel noted feedback provided in the response to the Clinical Senate KLOE. St George's Hospital described a network where care post diagnosis and initial treatment is via POSCUs. They observed that the nature of the diagnosis, and diagnostic requirements including advanced procedures, access to a wide range of professionals such as radiologists, pharmacists, psychologists, and the need to monitor for immediate complications mean that the most efficient way to deliver this care is on site at a PTC.

Evelina London Children's Hospital noted that this is an aspect of the clinical model they had not yet considered in detail, given detailed discussions with the POSCUs had not been possible, but believe that supporting care as close to home as possible and supporting the development of the shared care network, should be feasible (depending on individual clinical needs) and would seek to explore further with POSCUs bringing in their knowledge and experience of networked care.

The panel welcomed the news that NHS England Specialised Commissioning London will be working with the Mayoral Office on this impact in the next few months in readiness for the mayors' environmental tests.

Specific environmental considerations are detailed below.

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[10] Climate Central | Land below 1.0 meters of water
[11] Available from england.clinicalsenatesec@nhs.net

Recommendations

R21. Ensure that resilience plans are developed to manage the impacts of climate change including working during extreme weather: IT systems, cooling and management of flooding.

R22. Demonstrate how efficient local working with POSCUs and maximising remote consultations, usage of bloods and samples transported by drone can provide the same or better standard of care to patients whilst reducing the patient need to travel and associated carbon impact.

R23. Consider travel advisors to give advice on the cheapest and greenest routes, potentially offering travel cards for public transport if appropriate.

R24. Identify plans to increase active transport and decarbonise transport for staff. There is opportunity for units to further develop an emerging network of safe cycling/walking routes and plans with local authorities.

3. Does the Integrated Impact Assessment provide sufficient mitigation to possible health impacts, particularly travel times that might otherwise increase inequities?

3.1. Population and Inequalities

The panel welcome the work that has been carried out to date regarding population health and health inequalities. The information in the documentation currently has largely focused on the technical feasibility of whether providers can meet the PTC service standards in the national specification. From the evidence provided in the PCBC, it is not clear how the future providers have considered health inequalities in the preliminary design work, and it will be important for the future provider to consider how equality of opportunity can be built into the service as an aspect of the wider inequalities' strategy. Nevertheless, on panel day it was reassuring to hear each potential future provider's strategic plan for reducing health inequalities, not only with respect to physical access, but also patient experience across their organisations. Due to the broad geographical area, many patients accessing the PTC will face these problems to varying degrees and it is crucial that in the design and development of the new service groups affected by health inequalities will have their views considered and that they are not forgotten.

The strategic approach required by the provider to tackling health inequalities in the relocated service is an opportunity to build in systems and processes (including the consideration of data needs) to embed reducing health inequalities and increasing inclusivity as an ongoing process; this includes linking it with Trusts' broader health inequalities strategy and initiatives. It will also be a missed opportunity if the future provider of the PTC does not utilise learning from the current provider and patients and carers with respect to this agenda and what is working well and what they would do differently.

An additional opportunity would be to consider how the relocated service could tackle the broader determinants of health and increase social value, for example through their recruitment strategy which has for some time been identified as needing addressing in the NHS to help mitigate some service health inequalities[12] and its contribution to the broader goal of the Trust being an 'anchor institution'. St George's Hospital on panel day highlighted their aim for their workforce to represent the population they serve which is to be commended. It is also noted that the Evelina London Strategy provided to the Senates does state that they are "focusing on ensuring the equality, diversity and inclusion of staff is consistent across all our roles by changing our culture and priorities for staffing roles, especially those in senior leadership".

NHS England 2023/4 priorities and operational planning guidance[13] has prevention and health inequalities as a key objective. It is important the catchment areas Integrated Care Boards' (ICBs) understanding and awareness of inequalities within their populations, feeds into the PTC proposals.

Some of the areas impacted by the proposal have high levels of deprivation, including areas in the South of London and distributed along coastal/estuary areas such as Medway, Thanet and Hastings.[14] The Core20PLUS5[15] approach enables the biggest impact on avoidable mortality in the most deprived populations and contributes to an overall narrowing of the health inequalities gap.

The PCBC would also be strengthened by clear articulation of how bespoke support for ill children throughout the system for the poorest families will be ensured. In addition, current patients experiencing health inequalities are likely to need additional support during transition to the new service. For non-English speaking families, provision and good access to interpreting services will be necessary.

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[12] The-snowy-white-peaks-of-the-NHS.pdf.pdf (mdx.ac.uk)

[13] https://www.england.nhs.uk/wp-content/uploads/2022/12/PRN00021-23-24-priorities-and-operational-planning-guidance-v1.1.pdf

[14] The Index of Multiple deprivation (IMD2019): Headline findings for Kent

[15] NHS England » Core20PLUS5 – An approach to reducing health inequalities for children and young people

While specific transport and ambulance conveyance considerations are addressed in section 3.2 of this report it is important to emphasise here that certain population groups including those who are newly arrived in the country may find additional travel requirements challenging and require referencing in the Equality and Health Equalities Impact Assessment (EHIA). Close working with social care or Health Inclusion teams who can help to support such families / children will be needed. The panel also felt that the additional costs of families (and staff) of travelling to London had not been given sufficient consideration and this is an area to be developed in the PCBC and subsequent implementation plan.

The EHIA is by its nature, a work in progress, and we recommend this work continues through and after consultation. It is likely that mitigations to groups facing health inequalities, including travel, will need to extend to relationships with POSCUs and primary / community care. The panel understand this would become more defined when the future provider is agreed and will need in depth collaboration with the existing provider, patients, and carers to ensure approaches to reduce health inequalities and improve inclusivity are embedded in the new services.

Recommendation

R25. Consider and articulate how the future service will meet Core20PLUS5 and the five strategic objectives for health inequalities in the NHS operating plan:

- **Restoring NHS services inclusively**
- **Mitigating against digital exclusion**
- **Ensuring data are complete and timely**
- **Accelerating prevention programmes**
- **Strengthening leadership and accountability**

Particular areas of focus on the pathway may be: identification of need; inclusive communication; remote appointments; care coordinators, and shared care, including support from primary care, social care and other local stakeholders.

R26. Articulate how this future service could tackle the broader determinants of health and increase social value e.g., recruitment strategy (that may also help mitigate some service health inequalities) and its contribution to the broader goal of the Trust being an "anchor institution".

R27. Articulate metrics to evidence outcomes from the changes. Presumably the PTC will be recording a series of outcomes including patient reported outcomes and equalities data which can be used to compare and track performance and improvement.

R28. Articulate how additional support for patients experiencing health inequalities will be provided (as it is likely to be required) during transition to the new service.

R29. Articulate the mitigations proposed to help with travel times and access from the most disadvantaged communities including those who may be digitally excluded.

3.2. Transport

The travel time data used in the PCBC is good with secondary transfer between POSCUs and the PTC being considered. The support of patients who deteriorate in the community in terms of advice and transfer needs further consideration. Greater clarity is required regarding the non-emergency patient transport (routine transfers and repatriation) aspect of the proposed changes, as currently there is an absence of modelling addressing this area in the documentation. It is accepted that numbers may decrease given the co-location of the PICU. Both potential sites are located more centrally within London: considering the impact of congestion will be important as it is likely to lengthen journey times in non-emergency situations which may impact in terms of efficiency, resource requirements and patient experience.

Patients living in the south east will likely experience increased transport times when driving (although journeys by public transport are likely to be shorter). Further evidence to consider the resource implications of this and any mitigations would be welcomed. In the panel’s experience the current transport pathway requires improvement, they felt Great Ormond Street Hospital offer a successful transport model. NHS England Specialised Commissioning London and the future provider may wish to have a conversation with Great Ormond Street Hospital to enable learning and transferable practice to be shared.

The PCBC and panel day presentations highlighted how there is not a differential negative impact with regards to travel on deprived populations. For both the proposed relocated PTC sites public transport sees an improvement for patients and families although journey by car will be slightly more difficult to either of the proposed sites compared to The Royal Marsden. The NHS England Specialised Commissioning London team acknowledge the travel time can be quantified but are also cognisant of journey complexity and cost. It would be helpful to further articulate how travel for children and families may be reduced using digital technology (please see section 2.4 for further information/recommendations regarding digital).

Recommendations

R30. Greater clarity on how the providers would work with NHS emergency ambulance services / 111 and with alternative patient transport services to support patients who deteriorate in the community with advice and if required transfer.

4. Is there any further clinical evidence that NHS England should consider in making a final decision on the options?

The Clinical Senates have highlighted alongside the recommendations in the above text the clinical evidence they suggest that NHS England – London consider when making their final decisions. As already emphasised the panel considered that relationships and organisational development are fundamental to this transition.

The review panel recognised, to improve services, the need to support the PTC with appropriate critical care and where possible other co-located children's services is a requirement. However, the transfer of The Royal Marsden's children's cancer services to a new provider is not without risks. These can be mitigated by some of our recommendations regarding the respective roles of the current providers of the PTC and the future provider of the PTC, as well as joint organisational development. The successful transfer of expertise from The Royal Marsden will be vital for a safe transition and high-quality future PTC being established with the selected provider.

Appendices

Appendix A - Key Lines of Enquiry (KLOE) synopsis

The Clinical Senates developed Key Lines of Enquiry with reference to the *London Clinical Senate Principles;* South East Senate generic key lines of enquiry; the 5 NHS key tests for change as well as the London Mayor's tests as outlined in the Terms of Reference.

The primary focus of the Senate's review was the *Clear clinical evidence base.* However, consideration was also given to *Strong patient and public engagement* with input from the patient and public voice members on the panel.

The KLOE were shared with the commissioning team in advance of the panel day, and they provided written information in response. They were also discussed on the panel day and the information gained here and the PCBC informed the recommendations.

The areas covered by the KLOE included:

- Pathway considerations
- Areas of clinical specialty
- Medicines
- Social care and charitable support
- Research
- Workforce
- Environmental Sustainability
- Travel and Transport
- Digital
- Public Health and health inequalities
- Engagement
- Wider impacts

Appendix B – Panel Day Agenda

London and South East Clinical Senates Council Review:
Review of the pre-Consultation Business Case for Proposed changes to children's specialised cancer services Principal Treatment Centre
Microsoft Teams meeting
Click here to join the meeting
+44 113 486 0108,,977243732#   United Kingdom, Leeds
Phone Conference ID: 977 243 732#

Date: Thursday 20th April 2023
Time: 9:00am -14:00pm

	Time	Description	Papers	Lead
1.	08:50 am	**Convene on Teams** *(Clinical Senates Panel Only)*		Mike Gill, Chair of London Clinical Senate Paul Stevens, Chair of South East Clinical Senate
2.	9.00-9.30am	**Clinical Senates Review Panel pre-meet** • Welcome and Introductions • Key task/advice requested • Timeline and key activities • Conflicts of interest declaration and confidentiality agreement • Notes	• Terms of Reference • Key Lines of Enquiry	Mike Gill, Chair of London Clinical Senate Paul Stevens, Chair of South East Clinical Senate
		Specialised Commissioning and presenting team join the meeting		
3.	9.30-9.55	**Presentation(s) from Specialised Commissioning/ Children's Principal Treatment Centre Project team addressing the Key Lines of Enquiry:** Presentation 1: Summarising the strategic context, Case for Change, purpose of the proposed reconfiguration, clinical model and engagement	**Presentation/s** to be given on the day	Chris Streather, SRO. Regional Medical Director & CCIO, Medical & Digital Transformation Directorate NHS England (London) Chris Tibbs, Medical Director for Commissioning, South East NHSE Simon Barton, Medical Director of Commissioning, London Region NHSE
4.	9.55-10.25	**Panel Questions and Answers in relation to presentation 1** between the clinical senate Panel and the Specialised Commissioning team relating to key lines of enquiry and the presentation.	All documentation including PCBC and appendices	Mike Gill, Chair of London Clinical Senate Paul Stevens, Chair of South East Clinical Senate
5.	10.25-10.40	**Presentation(s) from Specialised Commissioning/ Children's Principal Treatment Centre Project team addressing the Key Lines of Enquiry:**		Chris Streather, SRO. Regional Medical Director & CCIO, Medical & Digital Transformation Directorate NHS England (London)

		Presentation 2: Integrated impact assessment- findings and mitigations Further clinical evidence for decision making		Chris Tibbs, Medical Director for Commissioning, South East NHSE Simon Barton, Medical Director of Commissioning, London Region NHSE
6.	10.40-11.45	**Panel Questions and Answers in relation to presentation 2 and wider questioning** between the clinical senate Panel and the Specialised Commissioning team relating to key lines of enquiry and the presentation.		Mike Gill, Chair of London Clinical Senate Paul Stevens, Chair of South East Clinical Senate
	11.45-12.15am	**Specialised Commissioning leave the meeting.** **Clinical Review Panel Break**		
7.	12.15-1.45pm	**Panel discussion and deliberation:** Key findings, evidence base and emerging themes for recommendations	All documentation- including PCBC and appendices	Mike Gill, Chair of London Clinical Senate Paul Stevens, Chair of South East Clinical Senate
8.	1.45-2.00 pm	**Summary and next steps** • Written report and advice- accuracy and timeline • NHSE Stage 2 assurance checkpoint		Mike Gill, Chair of London Clinical Senate Paul Stevens, Chair of South East Clinical Senate

Appendix C - Documentation provided by NHSE Specialised Commissioning London

Papers provided to Panel

- Review Terms of Reference
- Review Key Lines of Enquiry

Document Pack

1 St George’s CQC inspection
2 Guy’s and St Thomas’ CQC inspection
3 "St George’s GIRFT - Paediatric Surgery Review
4 "St George’s GIRFT - Paediatric Critical Care
5 Guy’s and St Thomas’ GIRFT - Paediatric Surgery Review
6 Guy’s and St Thomas’ GIRFT - Paediatric Critical Care
7 Guy’s and St Thomas’ GIRFT- Patient pathways of care in surgery in children
8 Evelina London Strategy
9 SGUH Strategy 2019-2024
10 Pre-Consultation Business Case: Draft 2.7 29 March 2023.
11 Options Evaluation Criteria Framework
12 Sir Mike Richards Review Paper - January 2020
13 John Stewart letter to Sir Mike Richards - November 2021
14 Children's Cancer Network - Principal Treatment Centres Service Specification
15 Teenage and Young Adult Cancer Networks - Principal Treatment Centres Service Specification
16 Interim Equality and Health Inequalities Impact Assessment
17 The catchment equalities profile
18 Travel time analysis
19 Association for Young People's Health Report
20 Consultation Plan
21 Consultation Document version 2.4 29th March 2023 (nb file name states 2.5)
22 Programme risk log
23 Activity data pack v2

Also provided was a document responding to the review panel’s Key Lines of Enquiry:

Reconfiguration of Children’s Cancer Principal Treatment Centre serving south London, Kent, Medway, Surrey, East Sussex, Brighton and Hove: NHSE London and South East Response to Clinical Senate KLOEs, 20th April 2023

Appendix D – London & South East Clinical Senates Review Panel membership and declarations of interest

Name	Roles	Interests Declared
Agbeko, Rachel	Consultant in Paediatric Intensive Care, Department of Paediatric Intensive Care, Great North Children's Hospital, Newcastle upon Tyne Hospitals NHS Foundation Trust	None
Bajwa, Raj	GP, Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board	Nothing noted
Bhatti, Naureen	GP, Partner and Trainer, Tower Hamlets & Head of School for General Practice, HEE NC&E London	None
Black, John	Medical Director, South Central Ambulance Service	None
Bullen, May	Patient and Public Partner South East Clinical Senate	Nothing noted
Campbell Hewson, Quentin	Consultant Paediatric Oncologist, Lead Clinician Great North Children's Hospital Clinical Research Unit, Lead Clinician North of England Principal Treatment Centre Early Phase Studies, Royal Victoria Infirmary	None
Capp, Adrian	Head of Therapies, Queen Square Division, UCLH	None
Carter, Sue	Clinical Effectiveness Lead, NHS Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board (contributed electronically)	None
Edgerton, Derrick	Patient and Public Voice Member, London Clinical Senate	Nothing noted
Edwards, Tim	Consultant Paramedic, Clinical Directorate, London Ambulance Service NHS Trust	None
Gill, Michael	Chair London Clinical Senate	None
Haji, Nazima	Radiotherapy Services Manager, Radiotherapy Department, UCLH NHS Foundation Trust	I would like to highlight to the panel that I am the Radiotherapy Services Manager at UCLH for the delivery of the Photon Service and run a joint service with the Proton Beam Service for delivery of radiation treatment.

Name	Roles	Interests Declared
Harber, Mark	Consultant Nephrologist and Associate Professor, Department of Renal Medicine UCL, Clinical Lead London Sustainability NHSE (contributed predominantly electronically)	None
Harris, Elaine	Patient and Public Voice representative, South East	Nothing noted
Lane, Sheila	Consultant Paediatric Oncologist, Programme Lead for Future Fertility Programme Oxford, Lead for Paediatric Long Term Follow Up, Children's Hospital Oxford	Nothing noted
Lotfi, Nosheen	Advanced Clinical Practitioner (nursing) CAMHS West London NHS Trust. Special interest in children's mental health following cancer diagnosis (contributed electronically)	Nothing noted
Menon, Geeta	Postgraduate Dean, South London, Health Education England	Nothing noted
Perring, Jeff	Medical Director, Responsible Officer & Caldicott Guardian, Sheffield Children's NHS Foundation Trust	I am married to Karen Perring - Children and Young People (CYP) Transformation Programme Clinical Lead, NHS England – North East & Yorkshire Region
Richards, Mike	Consultant Paediatric Haematologist, Leeds Children's Hospital	None
Scrace, Jacqui	Community Nurse Fellow, Specialist Practitioner in Community Children's Nursing, Nursing Directorate NHS England	None

Name	Roles	Interests Declared
Smith, Matt	Consultant in Public Health, Public Health Directorate - South East, NHSE	None (In my public health role in NHS England I support the Specialised Services National Cancer Programme of Care. In this role I supported the Children and Young People's Cancer Services Clinical Reference Group that led the development of the service specification for Principal Treatment Centres and for Paediatric Oncology Shared Care Units. In the South East I also support the regional specialised commissioning team but I have had no input in to the development of the proposed changes to children's specialised cancer services Principal Treatment Centre Programme – South London and South East England.)
Stevens, Paul	Chair South East Clinical Senate	None
Thorp, Nicky	Consultant in Clinical Oncology, The Clatterbirdge Cancer Centre and Honorary Consultant Clinical Oncologist at the Christie	None
Wheeler, Robert	Consultant Neonatal & Paediatric Surgeon, Associate Medical Director, Dept of Clinical Law, University Hospital of Southampton	None
Xavier, Gladys	Director of Public Health & Commissioning, London Borough of Redbridge	None

Notes

All panel members completed Confidentiality forms and Register of Interests forms.
Some members noted "None" on their forms
Some forms were left blank – this has been transcribed as "Nothing noted"
Where details were written, this has been noted

Appendix E - Presentation Panel

Name	Role
NHS England	
Dr Chris Streather	Regional Medical Director, NHS England (London)
Dr Simon Barton	Medical Director of Commissioning, NHS England (London)
Dr Chris Tibbs	Medical Director Commissioning, NHS England (South East)
Hazel Fisher	Director of Specialised Commissioning, NHS England (London)
Ailsa Willens	Programme Director, NHS England (London)
Michelle McLoughlin	Independent Consultant Advisor, NHS Interim Management and Support (IMAS)
Catherine Croucher	Consultant in Public Health, Specialised Commissioning NHS England (London)
The Royal Marsden	
Professor Nicholas Van As	Consultant Clinical Oncologist and Medical Director of The Royal Marsden and Professor of The Institute of Cancer Research
Karl Munslow Ong	Chief Operating Officer, The Royal Marsden NHS Foundation Trust
Dr Donna Lancaster	Consultant Paediatric Oncologist, The Royal Marsden NHS Foundation Trust
Dr Lynley Marshall	Consultant in Paediatric and Adolescent Oncology Drug Development, The Royal Marsden NHS Foundation Trust
Carly Snowball	Divisional Clinical Nurse Director – Cancer Services, The Royal Marsden NHS Foundation Trust
The Institute of Cancer Research	
Professor Kristian Helin	Chief Executive and President of The Institute of Cancer Research
Guy's and St Thomas'	
Dr Simon Steddon	Chief Medical Officer, Guy's & St Thomas' NHS Foundation Trust
Jackie Parrott	Chief Strategy Officer, Guy's & St Thomas' NHS Foundation Trust
Dr Sara Hanna	Medical Director, Evelina London Children's Hospital
St George's	
Dr Richard Jennings	Group Chief Medical Officer, St George's, Epsom and St Helier University Hospitals and Health Group
Kate Slemeck	Managing Director, St George's University Hospitals NHS Foundation Trust
Dr Sijo Francis	Clinical Chair- Children's, Women's, Diagnostics and Therapies Division and Consultant Neonatologist, St George's University Hospitals NHS Foundation Trust

Name	Role
NHS England – in attendance	
Sabahat Hassan	Head of Partnerships and Engagement NHS England (South East)
Chetna Patel	Senior Programme Manager, NHS England (London)
Elspeth Block	Transformation Project Manager, NHS England (London)
Natalie Hughes	Senior Transformation Delivery Manager for Childrens Specialised Services, NHS England (South East)
The Royal Marsden – in attendance	
Dr Lisa Pickering	Consultant Medical Oncologist, Renal and Skin Cancers, Associate Medical Director for Strategy, The Royal Marsden NHS Foundation Trust

Appendix F - Glossary

Glossary of Terms	
CQC	Care Quality Commission.
Evelina London Children's Hospital	Evelina London Children's Hospital, which is part of Guy's and St Thomas's NHS Foundation Trust.
EHIA	Equalities and Health Inequalities Impact Assessment.
ICB	Integrated Care Board.
ICR	The Institute for Cancer Research.
ICS	Integrated Care System.
NHSE Specialised Commissioning London	The programme team who have led the work and developed the PCBC, working closely with NHSE South East Specialised Commissioning.
Senate review panel	The London and South East Clinical Senate review panel. See appendix D for details of members.
PCBC	Pre-Consultation Business Case.
PICU	Paediatric Intensive Care Unit.
POSCU	Paediatric Oncology Shared Care Units.
PTC	Principle Treatment Centre.
The Royal Marsden	Royal Marsden NHS Foundation Trust.
St George's Hospital	St George's University Hospitals NHS Foundation Trust.
ULEZ	Ultra Low Emission Zone.
WTE	Whole Time Equivalent.

Appendix G - Summary of recommendations

Key recommendations

R1. NHS London should support organisational development particularly at The Royal Marsden involving the whole workforce which currently provides children's cancer services. This should involve how the current PTC providers will work with the future provider of the PTC to ensure a smooth transfer. Specific areas to work through and agree are likely to include:

a. How organisational memory, key skills and competencies are preserved and transferred to the new provider.
b. How research is maintained, planned, and developed and where possible enhanced with the new provider. This will include how research and charitable income can be secured and protected, and the rationale for "wet research" remaining at The Royal Marsden NHS Foundation Trust and the Institute of Cancer Research.
c. Once determined, the future provider of the PTC should work with patients / parents to design and develop the new service, so it aspires to improvement beyond the PTC specification. To ensure holistic care, it is essential that service users contributing their views span all geographies and demographic groups, including the 9 protected characteristics, as well as the type of cancer, stage of cancer, age of child and family circumstances.
d. How to preserve the memories and legacies which have underpinned the services on the Sutton site so that, if possible, they can be incorporated in the new provision.

R2. The future provider of the PTC must commit not just to working with their colleagues from the current PTC providers but also to joint organisational development that gives opportunities for the incoming workforce and their patients / parents to co-design and develop the service not just transfer it.

Specific Recommendations

R3. Develop the narrative on the case for change within the PCBC, to go beyond compliance with the technical aspects of the specification and demonstrate the improvements that the proposed change would bring for children across south east England and south London.

R4. Provide assurance that the current PTC providers will work with the future provider of the PTC to bring a full understanding of the requirements of a paediatric oncology service to the implementation of the future PTC.

R5. Include clear quality measures and metrics in the PCBC enabling progress to be measured and provide early warning of any destabilisation of the pathway to enable early mitigations.

R6. Consider whether the brand “The Royal Marsden” should be incorporated in the identity of the future service provision.

R7. For transitions of care (post age 15), the review team felt the risk of providing the services on another site needs mitigation. The suggestions already made regarding flexibility and age (perhaps even extending to 18 or beyond), geographical location of the patient and tumour site location will be important. It would be helpful to clarify current and future capacity to manage 16-18+ year old patients in appropriate facilities with appropriately trained workforce. Continuity of staffing support (e.g., nurse specialist) supporting patients and their families through transition may also help.

R8. It will be important to ensure an active risk register to oversee the development and the first few years of practice.

R9. The implementation is planned to be within 2.5 years. The team felt that it is important that once a decision is made the implementation is undertaken in a timely fashion to ensure safe transition that provides continuity of care and to relieve uncertainty amongst staff and patients.

R10. Whilst there are no changes to existing arrangements to pathways with primary care, GPs, and community services, we recommend that given the magnitude of the change specific attention is given to communications and engagement with these groups directly in addition to rather than through POSCU and Integrated Care Boards.

R11. Provide further assurance regarding: theatre capacity; paediatric surgical resource; isolation cubicles; and paediatric competent 24/7 interventional radiology rotas at the Evelina London Children’s Hospital, articulating how this capacity and resource can be flexed to demand if required.

R12. To incorporate the learning from Covid 19, and current guidance around all emerging respiratory infections to inform the service model for this cohort of patients including managing transfers of patients in any future respiratory pandemic.

R13. Articulate in the PCBC how end of life care would be supported 24/7 at home and how they would plan to work collaboratively with children’s hospices; this may refer to the information provided in the written response to the KLOE.

R14. Further detail from the potential providers to describe their acute care pathways / their oncology triage service and how they will offer advice to carers and clinicians (including paramedics) assessing unwell children in the community on the need for admission to hospital (ED/POSCU/PTC) and in what time frame. A pathway example of a patient(s) journey may be helpful for clarity during consultation. The Providers may want to consider how they can support the carers of these children contacting 111 for advice when required.

R15. Clearly describe how up to date information to equip patients and parents with the tools and information required to co-manage their own health will be addressed, especially for more geographically remote patients. A pathway example of patient(s) journeys may be helpful for consultation.

R16. Clarify how both providers would satisfy The Joint Accreditation Committee ISCT-Europe & EBMT (JACIE) for stem cell transplantation.

R17. The potential providers fully articulate the support they will provide to patients / parents and their primary care and community teams to provide safe and seamless care on a 24/7 basis. This should include longer term psychological support to patients and families where indicated or required**.**

R18. Stakeholders have identified successful change requires strong clinical leadership. For successful implementation those clinical leaders from The Royal Marsden and the future provider of the PTC will need to be identified, developed and supported.

R19. Retaining the specialist workforce across all staff groups both clinical and non-clinical needs to be a high priority and reflected in workforce plans.

R20. Both proposals mention education and development. The team highlighted that opportunities for education and development of all staff can be vital components to a successful future service. Plans to deliver this pre and post transfer should be in the organisational development plans and include all workforce groups.

R21. Ensure that resilience plans are developed to manage the impacts of climate change including working during extreme weather: IT systems, cooling and management of flooding.

R22. Demonstrate how efficient local working with POSCUs and maximising remote consultations, usage of bloods and samples transported by drone can provide the same or better standard of care to patients whilst reducing the patient need to travel and associated carbon impact.

R23. Consider travel advisors to give advice on the cheapest and greenest routes, potentially offering travel cards for public transport if appropriate.

R24. Identify plans to increase active transport and decarbonise transport for staff. There is opportunity for units to further develop an emerging network of safe cycling/walking routes and plans with local authorities.

R25. Consider and articulate how the future service will meet Core20PLUS5 and the five strategic objectives for health inequalities in the NHS operating plan:

- Restoring NHS services inclusively
- Mitigating against digital exclusion
- Ensuring data are complete and timely
- Accelerating prevention programmes
- Strengthening leadership and accountability

Particular areas of focus on the pathway may be: identification of need; inclusive communication; remote appointments; care coordinators, and shared care, including support from primary care, social care and other local stakeholders.

R26. Articulate how the future service could tackle the broader determinants of health and increase social value e.g., recruitment strategy (that may also help mitigate some service health inequalities) and its contribution to the broader goal of the Trust being an "anchor institution".

R27. Articulate metrics to evidence outcomes from the changes. Presumably the PTC will be recording a series of outcomes including patient reported outcomes and equalities data which can be used to compare and track performance and improvement.

R28. Articulate how additional support for patients experiencing health inequalities will be provided (as it is likely to be required) during transition to the new service.

R29. Articulate the mitigations proposed to help with travel times and access from the most disadvantaged communities including those who may be digitally excluded.

R30. Greater clarity on how the providers would work with NHS emergency ambulance services / 111 and with alternative patient transport services to support patients who deteriorate in the community with advice and if required transfer.