Proposals for the future location of very specialist cancer treatment services for children in south London and much of south east England

Decision-Making Meeting

14 March 2024

Agenda

#	Agenda Item
1	**Welcome**
2	**Introduction to proceedings**
3	**Conflicts of interest declaration**
4	**Executive discussion of the DMBC presentation**
a)	Purpose and Scope of the DMBC
b)	Summary of work to date
c)	The consultation process and feedback received
d)	Themes arising from consultation and responses within the DMBC
	BREAK
e)	Impact of proposals
f)	Arrangements for implementation
g)	Discussion and Decision-making resolutions
5	**Any other business and close**

Welcome

Decision-Making Meeting - Attendees

NHS England, London Region Executive - Present

Name	Role
Caroline Clarke **(Chair)** *	Regional Director, London
Will Huxter *	Regional Director of Specialised Commissioning, London
Jane Clegg	Regional Chief Nurse, London
Chris Streather	Regional Medical Director and Chief Clinical Information Officer, London
Hannah Witty	Regional Director of Finance, London
Lizzie Smith	Interim Director of Workforce Training & Education, London
Helen Pettersen	Director of Recovery, London
Martin Machray	Director of Performance, London

NHS England, South East Region Executive - Present

Name	Role
Anne Eden **(Deputy Chair)** *	Regional Director, South East
Caroline Reid *	Regional Director of Commissioning, South East
Andrea Lewis	Regional Chief Nurse, South East
Vaughan Lewis	Regional Medical Director, South East
Louise Hall	Workforce, Training and Education Interim Joint Director, South East
Steve Gooch	Regional Finance Director, South East
David Radbourne	Regional Director of Strategy & Transformation, South East

Also in attendance:
Simon Barton, Medical Director for Specialised Commissioning, London Region
Ailsa Willens, Programme Director, London Region
John Stewart, National Director for Specialised Commissioning, NHS England
Catherine Croucher, Public Health Consultant, NHS England, London Region
Sabahat Hassan, Head of Partnerships and Engagement, South East Commissioning Directorate
Fiona Gaylor, Engagement Lead
Paul Plummer, Financial Strategy Manager, NHS England, London Region

Apologies:
Alison Barnett, Regional Director of Public Health, South East
Dan Bradbury, Regional Director of Performance & Improvement, South East
Mark Watson, Director of Workforce, London
Kevin Fenton, Director of Public Health, London

*** Executives accountable for the decision under the Scheme of Delegation**

Introduction to proceedings

Proceedings

- The **purpose of the meeting** today is to consider all the information and come to a decision on the future location of the children's cancer Principal Treatment Centre for children in south London and much of the south east of England
- **Our objective** in this meeting is to come to a decision on the option that we believe will provide the best quality care for children with cancer for decades to come
- The **agenda for the meeting was published a week in advance of the meeting**. Supporting papers have been published this morning and are available on the website
- **During the consultation we received a large number of questions**, and answers to these can be found in a comprehensive Frequently Asked Questions document on our website. Others may be found in the decision-making business case.
- Any **further questions may be submitted to our email address** (england.childrenscancercentre@nhs.net) and they will be answered and published with our current Frequently Asked Questions after the meeting

Conflicts of interest declaration

Declaring conflicts of interest

- All members around the table and wider team that have been involved in the programme have completed conflict of interest forms.
- All members are asked to declare any new potential conflicts in relation to items on the agenda.

DMBC presentation and discussion

Structure

Purpose and scope of the DMBC

Process to date

The consultation process and feedback received

Themes arising from consultation and responses within the DMBC

Impact of proposals

Arrangements for implementation

The DMBC describes the work we have undertaken to inform a decision on the future location of services

The **purpose of the DMBC** is to enable the leaders of NHS England (London and South East regions) to take an informed and evidence-based decision about the location of the future Principal Treatment Centre.

This **DMBC is based on the evidence reflected in the pre-consultation business case, consideration of feedback from the public consultation**, and other relevant information.

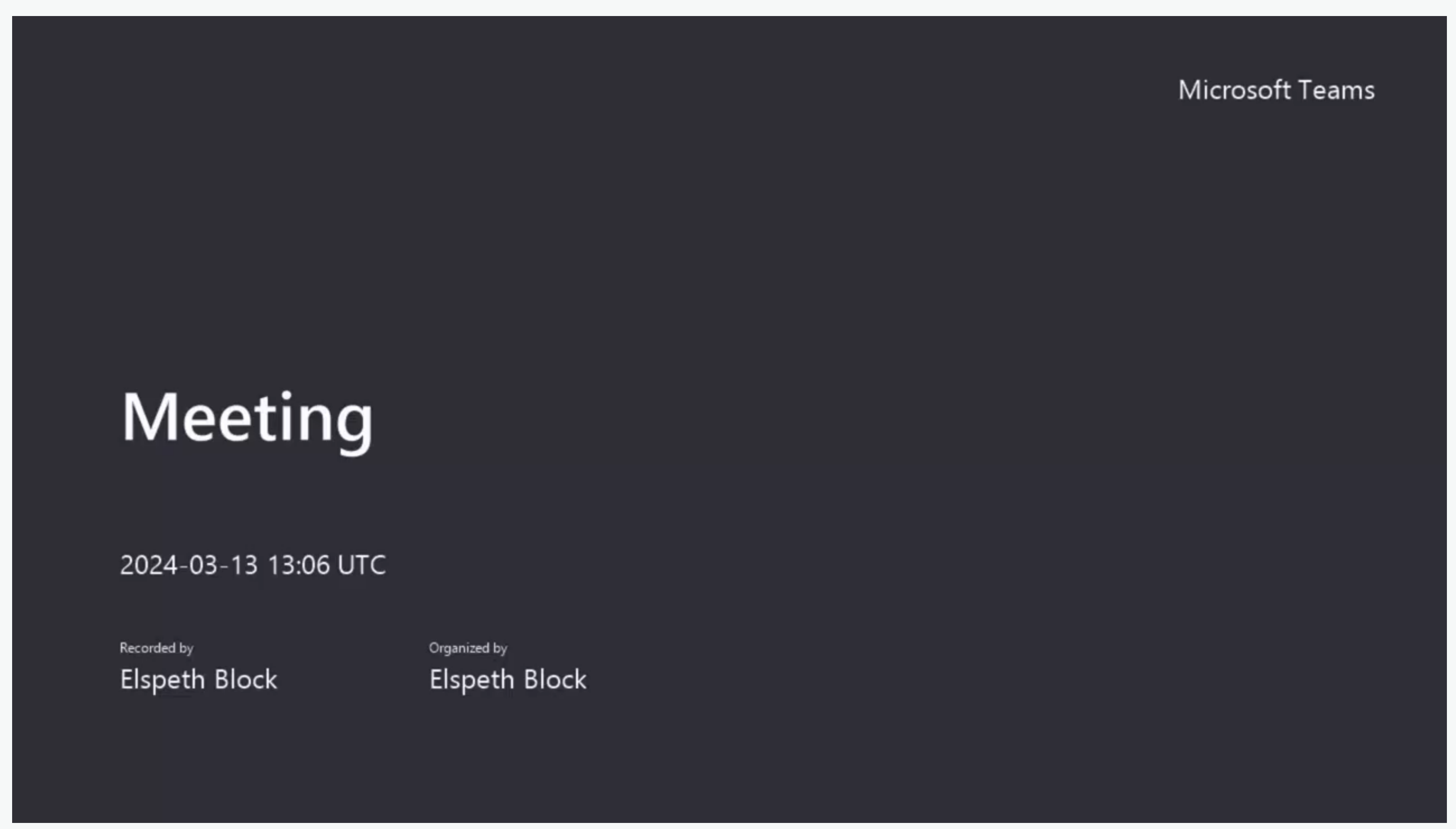
The DMBC includes:

- **Information about both options for the proposed future PTC** including our proposal for conventional radiotherapy services.
- An **overview of the feedback** NHS England received from patients, parents/carers, NHS staff directly or potentially affected by the proposals and other staff, Health Overview and Scrutiny Committees, public representatives, NHS Trusts, research organisations and many other key stakeholders during our public consultation.
- **Consideration of feedback**
- **Information about the potential impacts on other services** of our proposals, along with mitigation for the impacts. This includes additional information gathered during and after consultation.
- **Resolutions for service change for consideration by the decision makers**, and associated recommendations for implementation based on all the information gathered during this process.

Summary of work to date

Professor Sir Terence Stephenson,

Nuffield Professor of Child Health, UCL Great Ormond Street Institute of Child Health
Consultant Paediatrician, University College Hospital and Great Ormond Street Hospital



Background and context

- Specialist children's cancer services in England are led and coordinated by **Principal Treatment Centres.**
- The service for children living in Brighton and Hove, East Sussex, Kent, Medway, south London and most of Surrey is provided in partnership between **The Royal Marsden NHS Foundation Trust** at its site in Sutton, and **St George's Hospital** in Tooting, south west London.
- The current Principal Treatment Centre **does not and cannot comply with the new national service specification** which means very specialist cancer services currently provided on The Royal Marsden site need to move.
- It is our view, shared by The Royal Marsden, that it **would not be clinically or financially sustainable for The Royal Marsden to establish a children's intensive care unit.** The South Thames Paediatric Network agreed.

The new national service specification for PTCs, which was published in 2021, duly states that very specialist cancer treatment services must be co-located with a level 3 paediatric intensive care unit and other specialist children's services.

- A public consultation in summer 2019 about the **draft specification** (which did not mandate co-location for PTCs with a level 3 children's intensive care unit) was **subject to significant criticism** from cancer specialists, children's cancer charities and NHS Trusts.
- As part of Professor Sir Mike Richards' independent review on the appropriate design of these services, he said: ***"I believe that without co-location there is an avoidable geographical risk to patient safety and poor patient experience and potentially poor outcomes."***
- The **NHS England Board accepted the recommendations of the report in full**
- **Other literature and internal reports also support the change (NICE, Commissioning Safe and Sustainable Specialised Paediatric Services Framework, endorsed by Royal College of Paediatrics and Child Health)**

We have developed a case for change, which has fed the development of our clinical vision for the future Principal Treatment Centre

Case for change

- The current Principal Treatment Centre **does not meet the national service specification.**
- **Hospital transfers** of very sick children with cancer for intensive care **add clinical risks and stress to what is already a difficult situation.**
- The intensive care team is not currently able to **provide face-to-face advice** on the care of children on the ward.
- There is a need to **improve children and families' experience** when patients require intensive care and other specialist children's services.
- Although it offers a wide range of innovative treatments, **The Royal Marsden is excluded from giving a specific type of new treatment**, and others expected in the future.

Case for change for radiotherapy

It is proposed that conventional radiotherapy services should be provided by UCLH because:

- It would be **difficult to sustain the conventional radiotherapy service for children at RMH** without the staff and facilities of the PTC available on site.
- We expect the **number of children requiring conventional radiotherapy services in the future to fall**, as more children have proton beam treatments instead, meaning a high-quality service would be even harder to sustain.
- Specialist staff needed to provide paediatric radiotherapy **might not want to work for a standalone service at RMH** once the PTC for children's cancer was no longer there. Given the reduced number of children expected to require conventional radiotherapy, it could also be more challenging for staff to maintain (and build) their skills and experience to a sufficient degree.

Our vision for the future centre is that it will:

- **Comply with the national service specification** with all the benefits that brings, including removing the avoidable underlying risks associated with the current service arrangement where, every year, a small number of very sick children are transferred from one hospital which is part of the Principal Treatment Centre to the other for level 3 intensive care services that can give life support.
- **Build on all the strengths of the existing service** – high quality care by expert staff, good access to clinical trials, a family-friendly centre for children and young people, and ground-breaking research working very closely with the Institute of Cancer Research (ICR). These things are very important to children, families and staff.
- Give **best quality care to achieve world-class outcomes** for children with cancer for decades to come.

The changes will affect patients across the catchment area

Around 1,400 children, aged one to 15, are under the care of the Principal Treatment Centre. In 2019/20, 35 children were transferred from The Royal Marsden to St George's because they needed or might need intensive care.

In 2019/20, the Principal Treatment Centre treated 536 children as inpatients. Children also receive some of their care closer to home in local shared care units. More than 60% of the center's patients are from outside London.

1,373 children were treated by the Principal Treatment Centre in 2019/20

536 had inpatient care (they were admitted to The Royal Marsden or St George's for day care or a stay of at least one night)

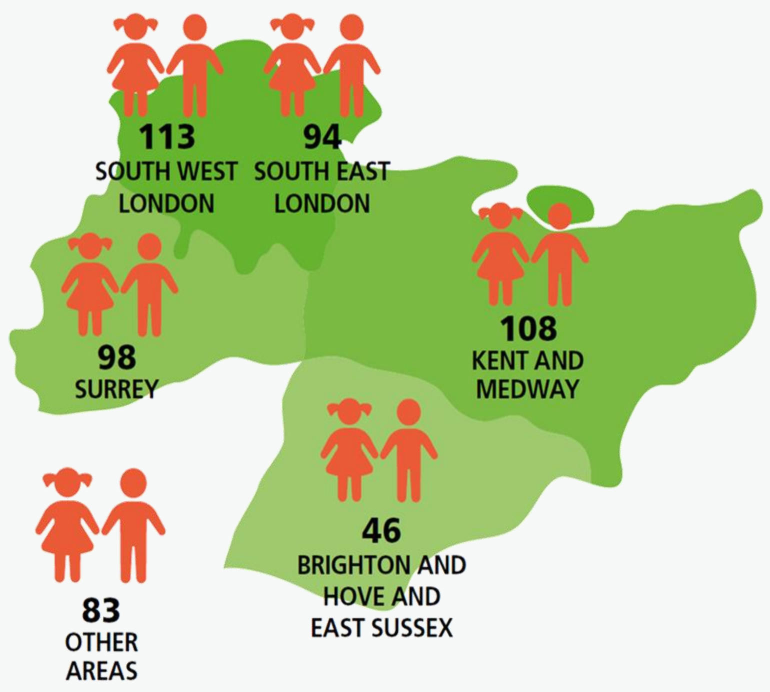
1,367 had outpatient care (they came to The Royal Marsden or St George's for an appointment)

84 had intensive care (15 came from The Royal Marsden, others were at St George's or transferred from their local shared care unit)

41 had conventional radiotherapy at The Royal Marsden.

- **113** children from south west London
- **108** children from Kent and Medway
- **98** children from Surrey
- **94** children from south east London
- **46** children from East Sussex and Brighton and Hove
- **83** children from other areas.

The number of children attending for outpatient care followed a similar pattern.



Shared care units operate across the catchment area and provide supportive care working closely with the children's cancer centre. These are not impacted by this consultation.

*In line with the PCBC, the DMBC uses data from 2019/20 (i.e., the year before the full impact of the COVID-19 pandemic was felt). A 'data lake' was established between Guy's and St Thomas', St George's and The Royal Marsden with NHS England London, to ensure that a single set of data is used to plan for this service. At PCBC we reviewed the appropriateness of continuing to use this data as the baseline for planning and evaluation and confirmed it was appropriate to do so.

We have been through a process to develop the PCBC, consult with the public, and develop the DMBC

1. **Clinical model, options development, options evaluation supported by stakeholder engagement:** Development and assessment of options for the future location of service
2. **Pre-consultation engagement:** The pre-consultation period ran from mid-April to the end of August 2023. We heard from over 680 individuals on a 1:1 basis, via email, through surveys or at meetings. We also attended formal meetings with local council Overview and Scrutiny Committees to discuss the programme and our plans and carried out 7 ward visits to speak to parents and families.
3. **PCBC development**: Development of pre-consultation business case; assurance and advisory processes
4. **Public consultation:** Between 26 September and 18 December 2023. We received 2,669 responses to the consultation through questionnaire responses, face to face engagement, official organisational responses and emails/phone calls. We commissioned an external company to receive and analyse the consultation data.
5. **DMBC development**: The decision-making business case is based on the evidence compiled in the pre-consultation business case, consideration of feedback from the public consultation, and other relevant information.
6. **Decision-making process**: The decision-making meeting is taking place today (14 March 2024)

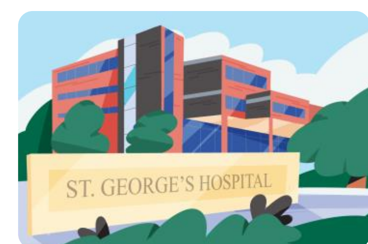
There were two ways that the identified solution could be delivered

A short list of options for the relocated Principal Treatment Centre was developed from a long list of all potential options by applying fixed points (things that cannot be changed) and hurdle criteria (to establish viability). Fixed points include co-location with PICU and services at other sites. Two options were identified:

At **Evelina London Children's Hospital, Lambeth, south London**, with **conventional radiotherapy services at University College Hospital**

Evelina London is a purpose-built specialist children's hospital. In 2019/20 it treated almost 120,000 young patients living in Kent, Medway, south London, Surrey and Sussex. All the staff are experts in children's care. They have very broad and in-depth expertise and experience in children's clinical care, including intensive care and surgery.

At **St George's Hospital, Tooting, south London**, with **conventional radiotherapy services at University College Hospital.**



St George's Hospital is a large teaching hospital that provides specialist care for adults and children. In 2019/20 it treated almost 60,000 children, mainly living in south west London, Surrey and Sussex. All its children's service staff are experts in children's healthcare. It has 25 years experience of caring for children with cancer as part of the current PTC.

We are assured that if chosen as the future Principal Treatment Centre, both Evelina London and St George's Hospital would:

- **End hospital transfers from the specialist centre for sick children with cancer who need or might need intensive care**, eliminating the added risks and stress these transfers bring, and could help other children avoid intensive care.
- **Reduce distress and improve experience** for children and families by providing more specialist services on site than now.
- Create a Principal Treatment Centre which is **capable of giving cutting-edge treatments that need a children's intensive care unit** to be on site.

We are assured that both options offer outstanding-rated children's services and outstanding-rated education. They both:

- Have provision for **sufficient age-appropriate ward, outpatient, day case, theatre, diagnostic, and pharmacy capacity** to meet the requirements of the service specification and accommodate the transferring service.
- Have formally **confirmed they would have the flexibility to provide the number of beds and isolation cubicles that could be needed for the future centre**. Both say final capacity designs would be developed and agreed with key stakeholders, if they became the future Principal Treatment Centre.
- Have **given detailed consideration to supporting research** following transfer of The Royal Marsden service.

Neither of them currently delivers the specialist cancer services that are based at The Royal Marsden. Both would rely on staff transferring from The Royal Marsden, bringing their knowledge and expertise with them, if they became the future Principal Treatment Centre, in addition to direct recruitment and training.

Evelina London scored higher in the pre-consultation options evaluation

- Evaluation criteria were developed with input from a range of stakeholders over 2020/2022, reflect requirements of the service specification incorporating research, patient and carer experience, capacity and resilience. They also reflected our ambition for the PTC.
- During December 2022, the topic-specific expert panels scored the submissions against each of the sub-criteria for their specific domain.
- The final scores were calculated by taking the median score for each criteria and applying the weights which were pre-established by the four panels for the sub criteria within the four domains, and the Programme Board for the overall domain weighting.

Domain	Weighting	GSTT weighted score	St George's weighted score
Overall Score	**100%**	**80.51%**	**75.27%**
1. Clinical	36%	29.63%	27.01%
2. Patient and carer Experience	26%	20.59%	21.84%
3. Enabling	19%	15.42%	15.27%
4. Research	19%	14.88%	11.16%

1. Clinical

- **Evelina London** scored higher on network effectiveness, needed for leading and coordinating children's cancer care through the children's cancer network.
- **Evelina London** scored higher for the number of the services that must be 'readily available' that it would have on site if it became the future PTC.
- **Evelina London** scored higher for its support for children to move on to TYA services, especially its example of how this already works for children with kidney problems.

2. Patient and carer experience

- **St George's** scored higher on quality of facilities – specifically privacy and dignity.
- **St George's** scored higher on patient travel times, especially by road.

3. Enabling

- **Evelina London** scored higher on ongoing support for staff.
- **St George's** scored higher on two aspects of impact on staff: its training offer and travel times.

4. Research

- **Evelina London** scored higher on people, which assessed research workforce; staff development programmes; income supporting research staffing; research networks and collaboration; previous impact on collaborating to advance international health policy.
- **Evelina London** scored higher on place, which assessed current capacity and excellence - physical space for research, including infrastructure to support and enhance transferring research teams, capacity for trials and tissues studies, ability to link with industry; plans to improve existing provision and capacity to scale.
- **Evelina London** scored higher on capability and performance, which assessed current research performance and capability, providers' ambition and future vision for research and innovation.

*Scores based on a total of 39 panel members scores (clinical panel: 10, enabling panel: 10, research panel: 9, patient and carer experience panel: 10).

The consultation process and feedback received

At pre-consultation stage, our proposals received assurance and advice

At the pre-consultation stage, our proposals were scrutinised by:

- ✓ **The London and South East Clinical Senates** who jointly tested our proposals and gave us helpful advice.
- ✓ **NHS England.** Any proposal for service change must satisfy the government's four tests, NHS England's test for proposed bed closures (where appropriate), best practice checks, and must be affordable in capital and revenue terms. The NHS England assurance process was conducted by a team of reconfiguration experts who are not involved in the programme.
- ✓ **The South East London, and South West London and Surrey Joint Health Overview and Scrutiny Committees** (JHOSCs) which see our proposals as a substantial change for their residents and responded formally to our consultation.
- ✓ **The London Mayor** who has six tests to apply when giving a view of any substantial health service changes in London.

In line with our statutory duty to enable review and scrutiny from local authorities, we also engaged with Health Overview and Scrutiny Committees (HOSCs) in the catchment area of the PTC before and during the consultation. We engaged with the following HOSCs:

- ✓ **Kent HOSC**
- ✓ **Surrey Adults and Health Select Committee**
- ✓ **Medway Children and Young People Overview and Scrutiny Committee**
- ✓ **East Sussex HOSC**
- ✓ **West Sussex HOSC**
- ✓ **Sutton Scrutiny Committee**
- ✓ **Brighton & Hove HOSC**

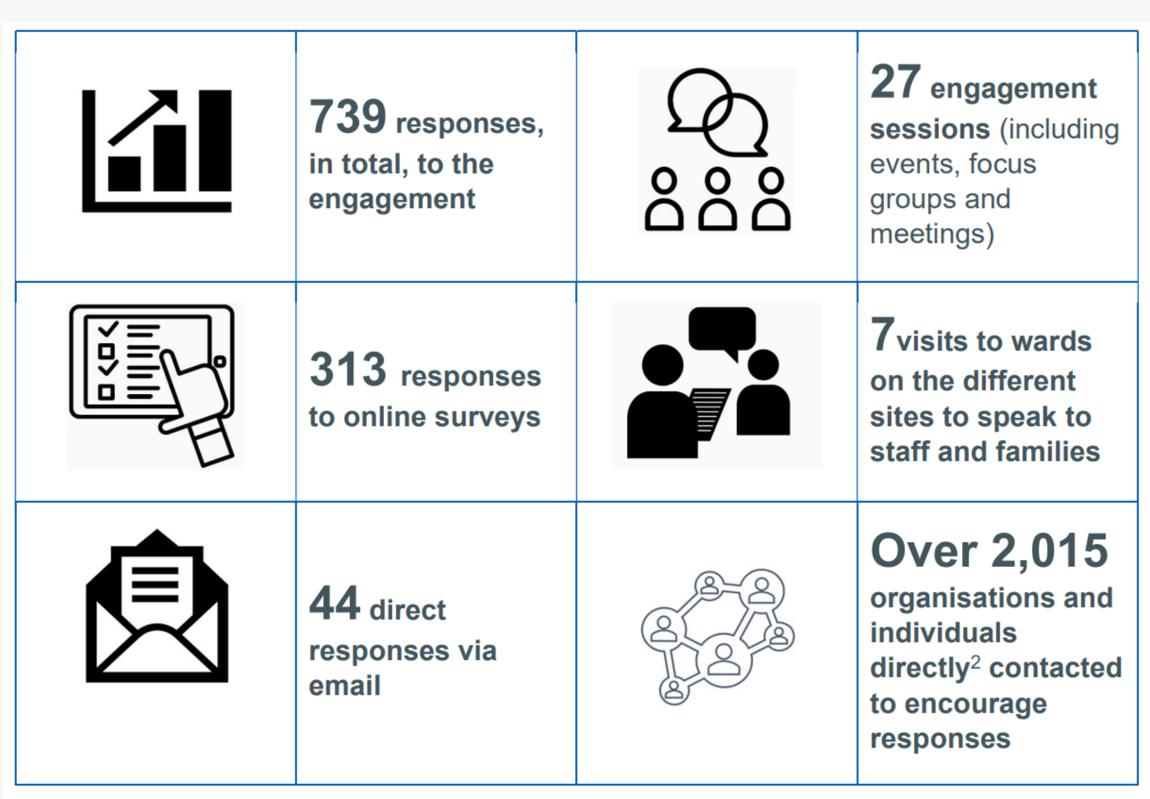
An **interim Integrated Impact Assessment** was also undertaken.

Pre-consultation helped us to refine and update our consultation materials

Pre-consultation (April to August 2023) helped us to refine and update our consultation materials, inform our consultation plan and build our understanding.

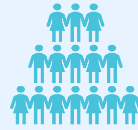
We engaged on a 1:1 basis, via email, through surveys or at meetings – mostly with those with direct experience of receiving or providing the service as well as voluntary and community organisations and specialist children's cancer charities. Including people:

- from all ICB areas within the PTC catchment,
- from a range of ages,
- who have physical or mental health conditions, disabilities, or illnesses other than their cancer,
- are from black, Asian and other ethnic minority communities,
- who do not speak English as their first language, and
- who have had experiences of receiving treatment at, or working for, the current PTC.



Consultation report: responses & reach

The consultation has captured feedback from a diverse range of people across stakeholder types, ages, ethnicities, socio-economic groups, and geographical areas within the catchment area for the future Principal Treatment Centre.



2,669 Formal responses to consultation *

604,895 Prompts to organisations and individuals to share their views**

Consultation survey

- **1,763 survey responses** of which:
  - 319 from affected staff working within the PTC
  - 233 from children, young people (CYP) and their families/carers

Face-to-Face engagement

- **831 people** reached through face-to face activities across **115 engagement sessions**
- **144 people** were children, young people, their families and staff currently experiencing/working in the PTC - engaged over **58 community sessions**
- **309 people were from equalities groups** highlighted in the early equalities impact assessment - engaged over **25 community sessions**

Other feedback

- **45 official organisational responses**
- **30 emails/ telephone calls** from a range of stakeholders (e.g. members of the public, charity and community organisations, research/academic staff, NHS staff, councillors)

Alongside the consultation a group of parents also launched a petition:

Petition

- #HeartheMarsdenKids campaign: 10,394 signatures / 304 written comments at the consultation close***

Although these have not been presented to NHS England we are aware of two petitions to keep services at St George's, these were launched by Dr Rosena Allin-Khan MP for Tooting; and Eleanor Stringer (Wimbledon Labour Party). We are also aware of a pre-existing petition #MustBeMarsden that was started in February 2020 and focusses on retaining services at The Royal Marsden. It has attracted over 35,000 signatures.

* Comprised of 1,763 survey responses, 831 individuals through face-to-face work, 45 official organisational responses, 30 emails/telephone calls
** Comprised of social media reach, email distribution, social media campaign views
***The petition has 11,813 recorded signatures as of 12/03/24

Consultation report: overview of the reach to different stakeholder groups

Affected Children and young people

Children and young people affected by cancer and their families/ advocates

Total engaged: 379

- 227 — Q'naire [1]
- 150 — F2F [2]
- 2 — Email response

Staff

Affected clinical and non-clinical staff from The Royal Marsden, St. George's Hospital and Evelina London

Total engaged: 562

- 472 — Q'naire [1]
- 87 — F2F [2]
- 3 — Email response

Other clinical and non-clinical staff

Total engaged: 601

- 362 — Q'naire [1]
- 228 — F2F [2]
- 11 — Email response

Key

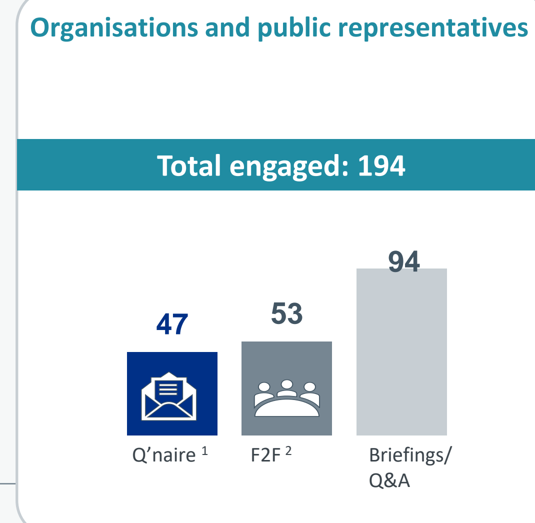
1 Q'naire = Questionnaire

2 F2F – Face-to face engagement work

Organisations

Organisations and public representatives

Total engaged: 194



Members of the public

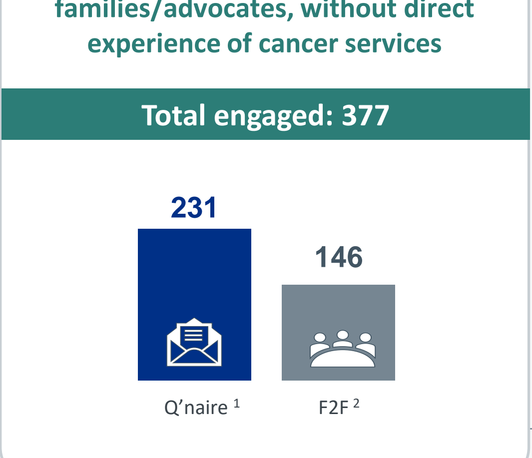
Individuals with specific equalities characteristics

Total engaged: 789

- 571 — Q'naire [1]
- 218 — F2F [2]

Children and young people and their families/advocates, without direct experience of cancer services

Total engaged: 377



Members of public

Total engaged: 300

Our consultation process was effective and met the Gunning Principles

- Explain Market Research concluded that the consultation **reached a good range of stakeholders** – particularly affected staff, and children and families including those with experience of cancer services – supported by the additional steps taken after the mid-point review.
- Children and families reached were **broadly representative of the current patient cohort** in terms of geography and demographics.
- Responses to our consultation tended to be from **older consultees**, those from higher socio-economic groups and from females. These trends were **expected**.
- We feel confident that we have **heard sufficiently from younger respondents** and their representatives through face-to-face engagement work. We offered a **range of opportunities** for children and young people to participate using creative methods.
- There was a **mix of consultees from deprived areas across the geographies**.

Gunning Principle	How this is met by our consultation process
1. Proposals are still at a formative stage	• For transparency reasons, following a robust options evaluation process, a preferred option formed part of the information shared for public consultation– the preferred option directly reflected the scores awarded based on information available when the options evaluation was conducted. • Having a preferred option does not impact on our ability to maintain an open mind as to the right final decision for the benefit of patients.
2. There is sufficient information to give 'intelligent consideration'	• During the pre-consultation phase of our work, we tested, with a broad range of stakeholders, our approach to providing information. Learning from what we heard, we produced a range of information in different formats to help consultation respondents give intelligent consideration to the materials. • We actioned feedback (to make changes to our approach to make information even more accessible, such as embedding information about both options into the online survey) from our mid-point review as a priority.
3. There is adequate time for consideration and response	• We discussed and sought feedback on the duration of the consultation from external experts such as The Consultation Institute, legal advice and Overview and Scrutiny Committees. • Although the consultation was set for 12 weeks, at the mid-point review we took stock of responses to date to consider whether an extension was needed. The independent consultation analysts felt that an extension was not needed.
4. 'Conscientious consideration' must be given to the consultation responses before a decision is made	• Prior to and upon publication of the independent consultation feedback report on 31 January 2024, decision-makers were engaged to consider and discuss findings of the consultation. • They were also given the full report for review and given the opportunity to ask questions/seek clarity on any feedback within the report.

Consultation report: key themes

Clinical model

- Positive comments that Evelina London is a **dedicated children's hospital** with many specialisms.
- Positive comments that St George's is already **part of the PTC** and has experience and expertise providing children's cancer care.

Patient pathways

- Concerns about the **disaggregation of services for children and teenagers** were raised by staff members and RMH.
- The **importance of having a focus on teenagers aged 16-18** years was raised in consultation, including to ensure pathways for this age group are clear and high quality.
- Concerns were raised that although the transfers between the specialist cancer centre and the children's intensive care unit would be eliminated, **transfers for off-site services such as radiotherapy** would still be required.

Travel and access

- **Ability to travel to either future location easily and the costs associated with this** was a key concern and comparison point between the options for many.
- Main challenges highlighted were time and convenience, the potential **infection risk on public transport, concerns around parking capacity** and drop-off zone arrangements.
- **Increased need for parental accommodation** on or near site was raised for both options.

Workforce sustainability

- General feeling that **staff recruitment and retention could be challenging for both Trusts** (as no guarantee that staff will move from RMH) and that there are potential associated impacts on other nearby NHS services.
- Feedback concerning **respective experience / skills** of staff and what plans will be in place for training and development.
- **Incentives and requirements** for relocation of staff.

Radiotherapy

- Concerns that radiotherapy would be delivered off-site at UCLH which could lead to **fragmentation of care, lack of capacity and increased travel to central London to UCLH.**

Impact on other services

- **Importance of considering the impact on other services** and desire to take this into account as part of decision-making.
- **Concerns around future provision of mIGB therapy**

Estates and facilities

- Respondents concerned about **capacity** of both Evelina London and St George's to take on the PTC, in particular the PICU spaces.
- **Desire for equivalent play; education, outdoor space** and a separate schoolroom for children with cancer was raised.
- Although St George's would refurb a wing of their hospital to create a children's cancer centre, some concerns were highlighted about the **current estate being outdated**. The provision of private rooms at St George's was raised as a positive.

Research

- **Research facilities and capability** were considered an important factor for respondents, with questions around future provision of the paediatric research and clinical trials, including the **Experimental Cancer Medicines Centre** currently at RMH.

Strength of case for change

- Reflecting a strength of feeling about the current service, many patients and carers felt strongly that the **specialist cancer services for children should not be moving from The Royal Marsden**.
- **Staff and organisations were more positive** about the case for change (despite some objections to losing radiotherapy) confirming that centralising children's cancer services with intensive care is a good idea.
- Survey respondents **favored a single-site solution** and thought the proposals did not go far enough to deliver this, resulting in ongoing fragmentation of the service.

Deliverability

- Concerns around additional **funding** [for estates improvements for out-of-scope areas] would be required to make the necessary changes.
- Concerns that the future provider wouldn't be able to meet the current levels of **charitable funding** for the service.
- Implementation should be undertaken in a **timely fashion** to ensure safe transition.

NB. This list is indicative only and not exhaustive - there is much more detail in the consultation report.
NB. The consultation carried out was on the two options (Evelina and St George's), not the current model
NB: The size of the boxes do not reflect the amount of feedback received on that theme

Consultation response from Guy's and St Thomas', The Royal Marsden and St George's

The Royal Marsden

- Outlined the benefits of the current services at RMH.
- Highlighted concerns surrounding the proposed move.
- Reflections included:
  - The relocation **will not provide a single site solution** and the proposed model will **increase the number of transfers** that children experience.
  - A **more fragmented** oncology service for children, specifically for patients requiring **radiotherapy.**
  - A **lack of future resilience** with only a single site for radiotherapy in London and the South East for children with cancer.
  - Impact on **clinical research.**
  - Families need assurance that there is a **fully funded delivery plan** which enables all of the benefits of the current service to be made available in the new location.
  - **Retention of a very specialist and expert workforce is not guaranteed.**
  - Impact on **TYA services.**
  - Concern around **funding arrangements**

Guy's and St Thomas'

Supported the proposal for the services to be located at Evelina London.

Key points included:

- Evelina London is the **only dedicated, purpose-built specialist children's hospital in South London** and South East region.
- Evelina London was the first children's hospital in the country to be rated '**Outstanding' by the CQC**.
- A new **Children's Day Treatment Centre** has been recently opened at Evelina London.
- Evelina London has the ability to share **electronic patient records** across the main NHS Trusts, to improve patient safety and provide continuity of care
- Evelina London is located **close** to the radiotherapy hub at **University College Hospital**.
- Track record of Evelina London in de**livering research and clinical trials for children.**
- **Staff give positive feedback** about working at Evelina London.
- Evelina London is supported by one of the largest **healthcare charities** in the UK, Guy's & St Thomas' Foundation.

St George's

Supported the proposal for the services to be located at St George's.

Key points included:

- St George's Hospital has **25 years' experience of delivering paediatric cancer care.**
- The services that matter most for children with cancer are available **on site** at St George's Hospital.
- St George's Hospital is located **outside of central London, with good parking provision**, meeting the needs of many parents who have said they want to travel by car.
- Consolidating the children's cancer centre at St George's Hospital will be **easier and less costly** for the NHS to deliver; it will also be **less disruptive** for staff.
- If the service moves from St George's Hospital, this will have a **detrimental impact on other children's services** at St George's Hospital.
- **Research** at St George's Hospital is strong
- The Government has given its support to build a new hospital in Sutton. This would see the St George's Hospital, Epsom and St Helier Group **co-located with the ICR.**

NB. Further detail in the independent consultation report and decision-making business case, including University College London Hospitals response

Joint Health Overview and Scrutiny Committee consultation responses

Found the change substantial

South East London JHOSC

The response addressed six key areas:

- Travel and parking arrangements
- Accommodation and other incidental costs
- Workforce concerns
- Local support officer
- Delivery timeline
- Public consultation feedback

The Committee's formal response indicated that their conclusion was non-unanimous, however by significant majority and based on the evidence presented and considered, the Committee's preferred option is for **Guy's and St. Thomas' NHS Foundation Trust's Evelina London Children's Hospital to be the future location of the PTC.**

South West London and Surrey JHOSC

The informal response highlighted the evaluation criteria, access and travel as key areas for concern.

The formal response aligns to the following themes:

- Our identification of a preferred option
- The options evaluation process
- Travel and access
- Staffing concerns
- Funding
- Impacts on patients of services not being on the same site, including radiotherapy

The unanimous view of the South West London and Surrey JHOSC Sub-Committee in its formal consultation response was that, should the service be required to move from RMH, then **St George's would be the preferred future provider.**

The JHOSC agrees with this statement on the grounds that there is insufficient evidence to support Evelina London as the preferred option, whereas St George's Hospital has demonstrated its ability to work with RMH's clinical teams.

Didn't find the change substantial

East Sussex, West Sussex, Brighton and Hove, Kent HOSCs and Medway CYP OSC

East Sussex felt that Evelina London's lack of experience in paediatric cancer surgery would be a key challenge. For St George's Hospital, they were most concerned about potentially complex journeys by public transport from East Sussex, and the current staff turnover rates. They highlighted travel and access support (including provision of information) for families as a particularly important consideration for the PTC reconfiguration.

Prior to consultation, **West Sussex** felt that the proposals would improve clinical outcomes but was concerned that travel would be an issue for some families. The committee responded to the consultation to say it had no further comments to make.

Brighton and Hove set out their support for reconfiguration of the current Principal Treatment Centre, and for it to happen at pace, but did not express a preference for either option. They said both offer similar access challenges for Brighton and Hove families and the HOSC is not qualified to judge if one offers better clinical services than the other. Areas of concern they reiterated for our attention were:

- travel including public transport costs, and the availability and cost of parking
- family accommodation for parents/carers
- continuity of care from clinicians.

The HOSC reflected positively about NHS England's engagement.

Kent's formal response to our consultation described our approach to engagement with HOSCs as exemplary. They recognised the drivers for change and highlighted the benefits of our proposal. Their response did not express a preference for either option.

Medway gave a "nil return" response to our consultation.

Consultation response from Local Authorities

London Borough of Bexley

- Expressed its support for the service to be located at **Evelina London**, with conventional **radiotherapy** services located at **UCLH**.
- Noted that Evelina London is a dedicated children's hospital.
- States that Evelina London would be the most accessible options for families living in the Borough.
- Emphasis was placed on providing support with transport for families.

London Borough of Sutton

- Expressed their support for the service to be based at **St George's Hospital**.
- They highlighted:
- SGUH is already part of the Epsom and St Helier Hospitals Trust, offering consistency of care.
- SGUH has been part of the current PTC for more than 25 years
- SGUH is the only site in South London already delivering children's cancer care.
- SGUH is far more accessible for Sutton residents (patients, their families and staff).

Lewisham Council

Expressed their support for services to be located at **Evelina London**.

They highlighted:

- Evelina London has an 'Outstanding' rating from CQC.
- Evelina London is committed to providing interdependent, specialist services.
- Evelina London is committed to continuity of care, support for families and shared care.
- Evelina London's research track record and collaboration with KCL.

London Borough of Merton

- Expressed their support for the service to be based at **St George's Hospital**.
- They highlighted:
- SGUH has been delivering excellent specialist cancer care for over 25 years.
- It is essential to have access to skilled and experienced neurosurgeons.
- SGUH can offer dedicated parking spaces.
- The evaluation of the bids placed SGUH ahead of Evelina London on patient and carer experience.
- The capital cost of redeveloping St George's is lower.

Wandsworth Council

- Expressed their support for the service to be based at **St George's Hospital**.

They highlighted:

- SGUH already delivers part of the current PTC.
- The existing service at SGUH offers ground-breaking and innovative treatment.
- SGUH is the paediatric centre in South London where pathologists regularly undertake cancer pathology.
- SGUH can deliver neurosurgery on site.
- Moving the service away from SGUH would impact its existing service delivery.
- SGUH's proposal offers dedicated parking.
- Evelina London does not have experience in delivering cancer care for children
- SGUH is the most cost-effective option

Southwark Council

- Expressed their support for services to be located at **Evelina London**.
- They said this would offer a more integrated and localised cancer service.
- Highlighted the disproportionate disadvantage that falls on families living in deprived areas when their child is diagnosed with cancer.
- Stated that the specific needs of these families should be addressed in the planning and delivery of the future service.

NB. Further detail in the independent consultation report and decision-making business case

Consultation response from the Mayor

Test 1: Health and healthcare inequalities	The Mayor of London made the following **recommendations**: • Set out **greater analysis of existing inequalities** within the current service in access to diagnosis and treatment, experience of care and outcomes from treatment. • Commit to specific plans for how the future service will maximise opportunities to reduce health and **healthcare inequalities**, with **clear targets** and mechanisms for monitoring progress. This should be informed by analysis of existing inequalities, and engagement with patients, families and carers. • Provide an **analysis of travel costs** and a **strengthened analysis of travel times**, with plans set out to mitigate any potential negative or inequitable impacts on patients and families.
Test 2: Hospital beds	• The Mayor of London welcomed that there would be no changes to bed capacity as a result of the proposals. He asked for **sensitivity analysis around population growth and future required capacity**.
Test 3: Financial investment and savings	• The Mayor of London found that capital funding is identified and appears affordable in the context of site consolidation and the efficiencies expected from this. He asked that **revenue affordability should be further detailed** in the decision-making business case. • The Mayor of London also asked that further assurance be provided that **additional private patient activity** will not impact NHS patient access.
Test 4: Social care impact	• The Mayor of London confirmed that there were **no concerns related to the impact of the proposed changes on social care**.
Test 5: Clinical support	The Mayor of London made the following recommendations: • Put forward a **more detailed case for change** that clearly sets out in more detail the expected benefits that the changes will generate for patients and families. • Set out detailed analysis of the **potential impacts of the proposed changes on other services**, particularly wider children's inpatient services. He also explained that there is a concern for the careful management of the **transition services for children aged between 0-15 and 16-25** years as the proposed change would result in these services no longer being on the same site.
Test 6: Patient and public engagement	• The Mayor of London noted, at this stage, that he is **pleased to see extensive pre-consultation activities** were conducted and that these meaningfully informed the format and content of consultation materials. • He also notes that, following the mid-point review of the consultation process, **plans were developed to better reach groups** that had been heard from less at that point.

NB. Further detail in the independent consultation report and decision-making business case

Themes arising from consultation and responses within the DMBC

Consideration of feedback

NHS England Programme Team have supported you to consider feedback from the consultation, including (but not limited to):

- Programme and Executive workshops to consider all feedback received including evaluation of information, discussions around mitigations and development of recommendations

- Requesting supplementary information from Trusts where applicable

- Continued work on reviewing the risks and mitigations in relation to both options

We went through a defined process to assess any new evidence and its materiality

1

- **Overview of evidence previously considered**

Review of evidence related to the sub-theme that was considered when conducting the pre-consultation options evaluation.

2

- **Review of further evidence**

Review of evidence that has arisen since the assessment of the options was conducted.

3

- **Is this information new?**

Is the information provided considered or accounted for when assessing the options?

4

- **Does the information potentially have a material impact on our understanding of the options (specifically, differences between them)?**

If information is 'new', does this information affect what we know about the options and our comparison.

5

- **Is the information material to implementation?**

Does this information affect how the Principal Treatment Centre should be transitioned / what activities need to take place in this process?

Clinical model

'New' Information for consideration of decision makers

Interdependent services:

- New information has increased our understanding of **mitigations for interdependent services** that will not be on site, depending on the option that is chosen as the location of the future Principal Treatment Centre, **particularly neurosurgery.**
- *Interdependent services formed part of our pre-consultation options evaluation; the information does not differentiate further between our understanding of the options.*

Evidence & Benefits

You Said

Benefits should be articulated more clearly, with provision of metrics to *monitor PTC outcomes.*

We Did

- Consultation feedback validated benefits reflected in consultation documentation and **provided further evidence**
- **National metrics** to monitor Principal Treatment Centre outcomes and performance will be in place from summer 2024 and these will provide a benchmark for future monitoring.
- Monitoring these metrics will sit alongside processes for ensuring patient safety, evaluating equity of access to the service and other travel and access monitoring mechanisms.

Mandatory Services

You Said

Can the Trusts provide all the mandatory services, and associated interdependencies?

We Did

- **Both Trusts would meet the national specification mandatory requirements** and could deliver the associated critical infrastructure.
- **Planning and preparation** will be needed to support this
- The adherence of this will be monitored through ongoing quality assurance.

Interdependent Services

You Said

The two potential providers provide different interdependent services. Evelina London provides specialist cardiology and nephrology services on site. *It does not provide neurosurgery*. St George's provides neurosurgery but *does not provide specialist cardiology or nephrology*.

We Did

- **Both providers have different strengths in particular service areas.** We have reviewed these strengths as compared to the understanding in the PCBC.
- This process has confirmed that it will be important that **robust plans are put in place** by the future provider (working with partners) to develop their mitigations for those services which are not on the same site so that patients receive excellent care.

Clinical Expertise

You Said

There are *differences in the respective expertise and experience* of the potential providers in some key areas, and this should be clearly laid out and taken into account for decision making.

We Did

- The experience of providers was **considered as part of the pre-consultation evaluation** of the options. Information about the experience of both providers was included in the PCBC and is in the DMBC.

Networked care provision

You Said

The future Principal Treatment Centre should have *experience of networked care provision,* managing care across the system.

We Did

- **We reviewed the networked care experience and arrangements** for both providers, noting that the future Principal Treatment Centre will have an important role ensuring the delivery of high-quality care across the Children's Cancer Operational Delivery Network.

Further detail: DMBC 7.2 Clinical Model

Recommendations - Clinical model

Clinical model

Benefits	Further development of plans for the future Principal Treatment Centre should focus on delivering and maximising benefits associated with the reconfiguration. **Monitoring of benefits realisation** and of clinical outcomes/service standards through resources such as the Specialised Services Quality Dashboard (SSQD) should form part of the oversight framework (described in Section 10.1 of the DMBC). This should be owned by the future Principal Treatment Centre.
Mandatory services	Future Principal Treatment Centre to ensure that, prior to the current services transferring, **detailed planning and service development work** is undertaken to deliver mandatory services to the standard set out in the National Service Specification as a minimum, with consideration for 'future proofing' services to meet changing demand. This is expected to be done in partnership with clinicians and experts currently providing these services as well as patients and families.
Interdependent services – on site	**Appropriate capacity and resilience needs to be in place for all aspects of care for interdependent services** to support the delivery of care to future Principal Treatment Centre patients; more detailed service planning will need to be carried out by the future Principal Treatment Centre during the service transition phase.
Interdependent services – off site	Clear patient pathways and targets for access to these services need to be set out prior to implementation, with **appropriate mitigations in place for when patients need to be transferred.** The future provider (supported by the wider system) should work collaboratively across the system to design patient pathways that minimise transfers.
Neurosurgery	Irrespective of the decision, **further consideration of specific neurosurgery arrangements** would be needed to optimise pathways for patients of the future Principal Treatment Centre and ensure good patient experience.
Networking	The future provider should focus on the development of **effective networking arrangements** with providers across the networks, most importantly paediatric oncology shared care units (POSCUs) across the Children's Cancer Operational Delivery Network. This will support continuity of care and the development of effective communication approaches as well as the transformation programme associated with the delivery of the national service specification for POSCUs. Where there are opportunities to align governance and deliver synergies through the two programmes of work, these should be explored.

Patient pathways

'New' Information for consideration of decision makers

Patient Transfers

You Said

Principal Treatment Centre reconfiguration *doesn't solve the problem of patients requiring transfer.*

We Did

- **Either option will result in more services being on the same site than now.**
- However, **movements of patients cannot be eliminated** due to the configuration of services across London.
- While there will be some transfers in the future, **no children will be avoidably transferred** for intensive care.
- UCLH clinicians have shared further detail on pathways for **bone marrow transplant** patients who need treatment at UCH

Moving on from children's services to teenage and young adult (TYA) services

Moving the Principal Treatment Centre may have a negative impact on patient experience, due to the need for *patients to transition from a different site* to The Royal Marsden which will remain the Principal Treatment Centre for TYA services.

- Both providers have **explained their current approach to transition to TYA services** and adherence to NICE guidelines *(we took this into account during the pre-consultation evaluation)*
- **Detailed planning work would be needed in the service transition phase** to design pathways and ensure these are well managed. There is precedent for this in other parts of the country.
- In 2019/20, there were **190 15-year-old patients being treated by the current Principal Treatment Centre**. This provides an indication of how many patients may transition to TYA services per year.

There would also be an *impact on the existing TYA service* which is provided from the Oak Centre for Children and Young People with some of the same staff who run the paediatric service.

The Royal Marsden is **currently developing an impact assessment of relocation** of the children's cancer Principal Treatment Centre on its TYA service. The outputs of this will inform the work programme for the transition and implementation phases of the Programme.

Transition from children's services to teenage and young adult services:

- *Consultation feedback has **strengthened our awareness of the risks of the reconfiguration** to the process to support children moving on to teenage and young adult services.*
- *Feedback emphasised the importance of managing this during implementation.*
- Impacts on RMH's TYA services are likely to be **similar regardless of which provider is selected** as the future children's cancer PTC.
- *Our evaluation of the options looked at how both options currently support children and young people to move on to teenage and young adult services. This does not differentiate further between our understanding of the options.*

Further detail: DMBC 7.3 Patient Pathways

Recommendations - Patient pathways

Patient pathways		
	TYA transition arrangements	Effective transition from the Children's Cancer Principal Treatment Centre to the Teenage and Young Adult Cancer Principal Treatment Centre must be considered during service planning. The future provider should **work in close collaboration with The Royal Marsden and wider network**, with input from patients, parents and carers, to agree how pathways can be optimised with a particular focus on the 16 to 18 age group. The Implementation Oversight Board should monitor progress and support any barriers to be addressed.
	Impact on TYA services	NHS England and Integrated Care Boards to **continue to work with The Royal Marsden and other stakeholders** to support ongoing sustainability of the teenage and young adult service at Sutton, including through the **provision of stranded costs**.

Travel and access (1/2)

Parking

You Said

There needs to be *sufficient parking provision* at the future providers which is dedicated to the service and is comparable to the current provision at The Royal Marsden.

We Did

- Both the potential providers have confirmed **parking capacity would be available** at the future Principal Treatment Centre. NHS England has made a recommendation around provision of parking and will monitor progress and feedback.

Travel time and cost

You Said

***Travel time is an important and pressing issue*, and increased costs associated with travelling to the future Principal Treatment Centre are a concern. Information needs to be provided about what help is available to support staff and patients.**

We Did

- We have **refreshed travel time analysis and travel cost analysis** as well and associated mitigations.
- We have clarified the **reimbursements and support** that is available regarding travel costs.
- We have updated recommendations based on this.

Non-emergency hospital transport

You Said

There needs to be *adequate hospital transport provision*. Hospital transport can often be unreliable, and eligibility criteria need to be reviewed.

We Did

- Providers have clarified their hospital transport arrangements, and **we have made a recommendation that the future provider should develop a family-centred strategy around non-emergency transport**, including monitoring of performance.

'New' Information for consideration of decision makers

Travel Time & Cost Analysis:

- We understand that families are concerned about the cost of travel.
- We have **analysed the costs of driving to both potential sites** for the future PTC and to UCLH.
- Travel costs analysis shows **both options cost less to get to than RMH by car, on average,** with the average journey being £2-3 cheaper. Travel to **UCLH is about the same**. However, there is variation across patient journeys and some families would see travel costs increase, some substantially.
- *The **reduction in average driving costs is slightly greater for St George's Hospital**.*
- *This **does not impact on our understanding of the differences between the two options** as we already understood from the pre-consultation options evaluation that travel by car was likely, on average, to be quicker to SGUH and therefore this finding is in line with that.*

Further detail: DMBC 7.4 Travel and access

Travel and access (2/2)

You Said

We Did

Impact on equality groups

***Patients in deprived areas and ethnic minorities are likely to experience different impacts* on travel time and cost compared to the rest of the population.**

- The EHIA describes mitigations around possible impact on health equity, including separate analysis for different ethnic groups, which shows that **ethnic groups other than white have a lower travel time impact** compared with the white population.
- Analysis shows that, on average, **there would be decreased travel costs for patients from deprived areas,** compared to travel to the current Principal Treatment Centre.
- *This does not negate the fact that some individual families will experience longer travel times or higher costs and that this impact needs to be mitigated as much as possible.*

Providing care as close to home as possible

***Ongoing communication and coordination* of care between the Principal Treatment Centre reconfiguration and the paediatric oncology shared care unit (POSCU) Transformation Programme should be encouraged.**

- We have developed the description of the relationship between the Principal Treatment Centre reconfiguration and the POSCU Transformation Programme and articulated the enablers for shared care through Principal Treatment Centre reconfiguration.

Safety of patients when travelling (via public transport)

Concern that *travelling by public transport can present an infection risk* for patients who are very unwell.

- **Mitigations have been developed to make alternatives to public transport as easy as possible** including; through provision, improved processes and methods of reimbursement, recognising, however, that some patient's journey times by car will increase.
- It will also be important to ensure patients, families, staff and others are aware of the **existing guidance** on when public transport should be avoided so that people who choose/need to use it can do so with confidence.

'New' Information for consideration of decision makers

Impact of reconfiguration on equality groups – travel times and costs:

- New analysis has been undertaken of **driving times and costs for socio-economic groups and ethnic groups.** Analysis indicates that the change could improve ability to access services for these populations.
- The reduction in average driving costs for the most deprived population is **slightly greater for SGUH.**
- *This does not impact on our understanding of the differences between the two options as we already understood from the pre-consultation options evaluation that travel by car was likely, on average, to be quicker to SGUH and therefore this finding is in line with that.*

Sufficiency of on-site accommodation:

- We understand that it is important for families to have **access to accommodation close to the PTC.**
- We have received new information on the level of Ronald McDonald House provision at each site and arrangements for payment for family accommodation. While both have capacity, SGUH has a much smaller facility than Evelina London, although it is recognised that this benefit for Evelina London is likely to be offset by higher demand.
- Both providers have access to alternative accommodation which is used to support excess demand.
- *This isn't differentiating on current information. Further consideration and development of accommodation plans and mitigations are reflected in our recommendations for implementation.*

Recommendations - Travel and access

Topic	Recommendation
Parking	Parking possibilities **must be available for patients and carers at the future provider and University College London Hospitals**, and they must be easily accessible from the hospital. **Processes around payment must be easy to understand and accessible** (catering for families experiencing digital exclusion and available in inclusive formats).
Hospital transport	**Family-centre patient transport to and from hospital should be provided and its performance monitored** (e.g., reliability of timing) by the provider of the future Principal Treatment Centre and University College London Hospitals.
Equity of access	The provider of the future Principal Treatment Centre and University College London Hospitals should **ensure that accessibility arrangements meet the needs of equality groups** (for example, cost reimbursement for those experiencing financial difficulties, translation and inclusive communications for those that require it or reasonable adjustments for those with disabilities) and are regularly monitored against equality frameworks.
Children's cancer shared care units	The provider of the future Principal Treatment Centre should **work with the Children's Cancer Network** to support the development of plans and model of care within paediatric oncology shared care units so that all children and young people have the same experience of care, delivered close to home whenever this is possible.
Travel and accommodation costs	The future provider and University College London Hospitals should **further consider mechanisms to support families or staff who can't pay for travel costs or hotel accommodation**, such as easier access to automatic reimbursement mechanisms or collaboration with local hotels if appropriate.

Topic	Recommendation
IIA recommendations	Establish a Travel and Access group with representatives across providers and commissioners to implement the recommendations set out **within the Integrated Impact Assessment.**

Workforce Sustainability

Workforce risks and mitigations

You Said

Risks associated with transition need to be appropriately managed, as some *staff may not TUPE to either proposed site*, or University College Hospital, in the future. Mitigations for expected staffing recruitment gaps should be considered and strengthened.

We Did

- Trusts provided **further plans to bridge workforce gaps and more detailed mitigations if staff eligible for TUPE decided not to transfer**, including further detail on key challenges and their plans to mitigate against these risks.
- We recognise that the risks associated with transition (including the staffing gaps within the wider cancer workforce) are significant and need to be managed**.**
- Alongside trust mitigations, recommendations have been developed for regional oversight to monitor impact in real time, this would include **the co-development of sustainable long-term workforce solutions.**

Pay and benefits packages

Consideration should be given to the benefits staff currently receive (such as on-site nursery care and training), and how that will be delivered in future. Staff should have *financial assurance related to the impact* of the Principal Treatment Centre reconfiguration on their net pay.

- We understand the im**portance of staff being involved in the development of plans** for the future PTC.
- In particular, staff need to be able to advocate for key aspects of service change that may **affect their roles and pay**. Therefore, clear recommendations have been set out for the future provider, which will be monitored via the Implementation Oversight Board.
- For further assurance **we have reviewed the impact on net pay and recommended that the future provider should undertake a clear impact assessment** on salary and benefits to inform their mitigations. Our workforce experts confirmed that **additional spending on fares may be claimed via the travel policies** of the future provider of the PTC and UCLH on a case-by-case basis.

'New' Information for consideration of decision makers

Workforce sustainability:
No new information has been identified for workforce sustainability; however consultation reinforced our understanding that:

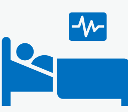
- There will be a time and cost impact of the changes on staff – while a systematic public transport cost analysis across the entire staff cohort is not possible, illustrative journeys indicate that the costs of travel are likely to be greater for the majority of staff than their current travel costs. Under TUPE protections, relocated staff will be eligible to receive support for excess costs for up to four years (claims will be reviewed by the future provider on a case by case basis) and will also receive inner London high cost area supplement. There will need to be **robust retention, training and recruitment plans** to ensure the wide range of skills and competencies required to provide high-quality care for patients of the Principal Treatment Centre both before and after service transition are available.
- We have **detailed recommendations** in place to address these, and other concerns regarding workforce sustainability during implementation. This **does not differentiate further** between our understanding of the options.

Further detail: DMBC 7.5 Workforce sustainability

Recommendations - Workforce Sustainability

Workforce Sustainability

Risks to current workforce	The Implementation Oversight Board should continue to **develop mitigations and contingency plans** for the potential changing profile of the existing workforce (for example, if fewer staff are retained than expected, fewer staff transfer or staff resign), monitoring resilience and support delivery of the current service. Where needed, identify mitigating actions to ensure that the services can continue to deliver high quality care.
Supporting staff to transfer	As a high priority, the future provider should **support retention of the current workforce**, including through clear and timely communications, close engagement and providing assurance about future arrangements. Salary and benefits should also undergo a clear impact assessment, with financial mitigations provided where possible.
Integration and Organisational Development	The future provider should work with The Royal Marsden (and St George's if applicable) to develop an **organisational development strategy to preserve and support the transfer of organisational memory**, key skills, and competencies and support integration of multiple teams. Ensure staff working in the future Principal Treatment Centre receive **equivalent benefits**, with appropriate onboarding processes, organisational culture and values integration, and buddying processes between staff.
Workforce strategy	A **workforce strategy should be co-developed** between organisations and collaboratively with support from the wider network, aligned to regional workforce strategies. This should be developed through the workforce workstream, with staff and HR representation, and should include detailed training and education plans (including engagement with relevant leads for training posts in service), as well as recruitment and retention plans. The Royal Marsden to work with the future provider to consider value of @Marsden model as a vehicle for continuity, collaboration and making best use of available skills and expertise.
Workforce Planning	The future provider should develop a **detailed workforce modelling baseline and plan**, against competencies required to deliver the Principal Treatment Centre and recruitment and retention gaps. They should also carry out a mapping exercise to determine any gaps or new roles that will be required to deliver the services with the appropriate workforce as part of transition planning.



Radiotherapy

Radiotherapy

You Said

If radiotherapy services are all provided at University College Hospital, this could lead to fragility and resilience risks, due to capacity and resourcing challenges.

We Did

- University College London Hospitals have worked with us to develop more **detailed mitigations for these concerns –** including fragility and plans around enhancing capacity should this be required.
- An implementation plan has been shared by the Trust which allows for service development within the transition period.

Consultation feedback included:	Proposed Mitigation include
Concerns around travel into central London	IIA detailed mitigations. Patients > 1 hour away can stay in accommodation close by during treatment.
Sufficiency of capacity at UCH	Current constraints to be resolved through commissioning of fifth LINAC. Further capacity requirements to be determined during implementation – could include productivity opportunities and/or sixth LINAC.
Fragility risk	Development of business continuity plans alongside fifth LINAC to be commissioned
Fragmentation of services	UCLH staff work closely with each PTC through MDTs, handover protocol and development of clear and agreed pathways
Chemotherapy pathways	UCH currently use a day case unit to provide chemotherapy. Agreed pathways would be developed with future PTC.
Arrangements for BMT patients	Current models involve patient care/transfers being coordinated between hospitals including the use of pre-booked patient transport

'New' Information for consideration of decision makers

Arrangements for radiotherapy:

- Concerns raised in public consultation have **prompted us to gather extra information, including around LINAC capacity** from UCLH to provide further assurances over how these would be managed.
- *Both options propose that conventional radiotherapy is* ***provided at UCH*** *and this information does not differentiate between the options.*

Recommendation - Radiotherapy

The future provider should work closely with University College London Hospitals, The Royal Marsden, commissioners, and other stakeholders to **develop detailed patient pathways, capacity and resourcing plans** for conventional radiotherapy services, drawing on the experience of providing care for patients from other Principal Treatment Centres.

Further detail: DMBC 7.6 Radiotherapy

Impact on other services

Newly identified impacts

You Said

It is important to reconsider the impact of the Principal Treatment Centre reconfiguration on other services to ensure all potential impacts have been identified.

We Did

- We reviewed the impacts outlined in the pre-consultation business case to ensure that due consideration is given and risks and mitigations for each are clearly set out.
- We identified **two additional potential impacts of reconfiguration (on recruitment and retention at Great Ormond Street Hospital and on mIBG therapy).** We have outlined plans for addressing these additional impacts and continue to work with key organisations that would be impacted to further understand the implications of the Principal Treatment Centre reconfiguration.

Organisation	Potential impacts include	Mitigations include:
Royal Marsden	• TYA services (discussed in patient pathways) • mIBG therapy • Wider cancer services (inc. medical education)	• Further work needed during transition to determine the best option for providing mIBG therapy to children. • Medical placements for all affected providers will continue to be monitored • Support with stranded costs
St George's	• Paediatric surgery • Pathology • Lost opportunities and synergies	• Sessional working, recruitment and organisational development • Wider paediatric network to support with workforce planning and activity flow review for service sustainability • Support with stranded costs • Development of networked solutions & collaboration
Evelina London	• Lost opportunities for new therapies	• collaborative and close working with partners across the paediatric network
University College London Hospitals	• Risk to fragility & capacity for other UCLH services	(Discussed in radiotherapy)
Great Ormond Street	• Impact ability to recruit/retain staff if they end up 'competing' for staff with the future PTC. • Flow of patients to South Thames PTC	• GOSH has set out that it would work collaboratively with the future PTC to support workforce planning for the PTC and is supportive of one joined-up paediatric cancer workforce strategy • Patient flows will be monitored
Others	• University Hospital Southampton • South Thames Retrieval Service (STRS) • Community & voluntary services	• Patient flows will be monitored • STRS will continue to provide seamless service • Young Lives vs Cancer would develop plans for service transition

Recommendation - Impact on other services

The future provider, along with NHS England, Integrated Care Boards and other system partners should **work with organisations/services which could be impacted** by Principal Treatment Centre reconfiguration to ensure that risks are monitored so that mitigations can be identified in a timely way, including through collaborative working and existing networks.

Further detail: DMBC 7.6 Impact on other services and Section 8 Impact

Estates & Facilities

Ensuring appropriate physical capacity

You Said

Further assurance needed around capacity including for children's intensive care and inpatient beds.

We Did

- **Comparative analysis of existing population growth analysis**, to 2021 population forecasts, supports our expectations of 0% demand growth based on population growth and incidence forecasts.
- RMH has advised that the service experiences **surges in demand** and we recognise there could be changes in the model of care. We have run a **sensitivity analysis** and both potential providers have provided assurances around their flexibility to provide further capacity if required.
- Critical care capacity across London needs to be actively managed with particular peaks over winter, but, **London is implementing changes to the delivery of paediatric critical care**, enabling those who require lower levels of care to receive it locally.

Safe spaces / play areas (to ensure effective infection control)

You Said

Equivalent play, education and outdoor play spaces should be provided by the future Principal Treatment Centre.

We Did

- We have asked the potential providers **clarification questions** to confirm their safe spaces and play area arrangements – both have confirmed arrangements with some differences in provision.
- We have made **recommendations** around provision of this space and will monitor progress and feedback.

'New' Information for consideration of decision makers

Ensuring appropriate physical capacity:

- **New information has been shared providing assurance that both options could expand capacity should baseline growth assumptions change.**
- *This does not differentiate further between the options as both Evelina London and SGUH have demonstrated adequate capacity.*

Estates solution:

- The proposed location for the Evelina London option was updated in April 2023.
- **Evelina London's updated proposal is for the children's cancer ward to be on the third floor of the main children's hospital building .**
- This space is currently being used by other clinical services with the impact that a series of four decants would be required. **GSTT has provided mitigations** for this, including staggering of decants and construction work, alongside robust programme management.
- The capacity and facilities offered in the updated estates solution is the same as assessed at options evaluation. *This information doesn't materially impact our understanding of the options.*
- In response to consultation feedback around the configuration of proposals for Evelina London's proposed cancer centre, the trust has **developed plans to demonstrate it has flexibility on the configuration of ward space** and also for outpatients.

Further detail: DMBC 7.8 Estates and facilities

Recommendations - Estates & Facilities

Estates	Estates solution	The estates solution for the future provider should continue to be developed during the service transition phase, with **clinical, patient and carer input to the design.**
	Accommodation and wider spaces	The future provider should develop detailed design work to ensure appropriate space is provided for **accommodation, education, indoor and outdoor play space** drawing on engagement with patients, carers, staff and wider stakeholders on their needs, in line with advice from the London and South East Clinical Senates.
Capacity		Sufficient capacity for beds, theatres, and clinical support services should be in place for Principal Treatment Centre, with potential for future capacity expansion should this be required. **Ongoing review of capacity requirements** for the future service should take place with associated **demand/capacity planning and consideration of POSCU transformation**, new treatments/therapies and other changes to models of care to enable this.

Research

Research

You Said

You have concerns about potential impacts on research and clinical trials if these are not carefully managed.

We Did

- Both proposals were previously scored against the **research domain evaluation criteria** to inform an understanding of their respective strengths.
- We reviewed **'new' research risks/mitigations**. This emphasised the importance of close, and collaborative working between stakeholders during the Implementation phase.
- It has further **informed our understanding of the risks** which will be important during the next phase of the programme.

Risk	Mitigations include
Research grant income is lost	• Meet with research funders to discuss proposed reconfiguration. • High impact research has previously recruited patients from all over the UK or in pan-European trials.
Access to research trials for children's cancer is impacted	• Evaluation criteria reflected research risks associated with transfer. • Co-location not considered essential.
Specialised workforce may be lost if staff do not move	• Providers outlined specific mitigations for this - recruitment important. • The Royal Marsden @ model approach may be explored.
Challenges providing equitable access to clinical research for 15/16/17 year olds	• The future PTC will need to work closely with the TYA service. • RMH's TYA services reputation is world renowned, this won't change.
Loss of research knowledge	• Retention of staff will help ensure research knowledge is not lost.
Decline in charitable funding	• We will work with the ICR/RMH to meet with charitable funders. • Research funding was part of the pre-consultation evaluation of the options.
Discontinuity associated with cross-site working	• Learning from other sites across London including GOSH. • Mitigations may include joint appointments, split site working etc.
Loss of ability to facilitate access for patients to innovate medicines where no open clinical trial is available	• Future PTC will need to work closely with the ICR/RMH/others to support continued access on a similar basis to current provision.

Recommendation - Research

Work closely with the ICR, RMH and other key stakeholders to **maintain and support the development of research and access to clinical trials** for children and young people. We suggest that a dedicated work programme focused on enabling this through the management of risks is established with support from an Expert Advisory Board. The future provider should also work with The Royal Marsden to explore potential for a **@Marsden model** as a vehicle for supporting collaboration, continuity of research and clinical trials.

'New' Information for consideration of decision makers

Research capability and capacity:

- Concerns were raised about the impact of reconfiguration on research capacity and capability, echoing pre-consultation engagement.
- **New information about a potential merger** between SGUH, University of London and City, University of London was provided by SGUH. We note this reflects potential opportunities for SGUH to broaden its research platform *but do not, at the moment, have evidence to suggest this would have a material impact on our understanding of the options.*
- There are **no changes to the Evelina London research offer** since pre-consultation evaluation of the options.

Strength of case for change

Alternative ideas/proposals

You Said

Several alternative proposals could be considered, including a risk-adapted solution, making use of the potential new hospital to be built at Sutton, or a suggested 3-stage solution involving adopting new technologies.

We Did

- We have, at this point and at previous points in the process, **previously considered these alternative proposals**, which unfortunately do not remove the risks inherent to a children's intensive care unit not being located at The Royal Marsden nor comply with the national service specification.
- The **future Sutton hospital will not have a level 3 children's intensive care unit**, as it would not be clinically sustainable.

Single site solution

Throughout the consultation there were calls for a single site solution, with concerns related to radiotherapy not being available on-site in either of the proposed options.

- University College Hospital is the **only viable option** with relevant scale and breadth of expertise to provide the future service.
- It would **not be feasible** for either Evelina London or St George's to build an equivalent radiotherapy service to that provided at University College Hospital which has benefited from significant investment and infrastructure, including the Proton Beam and a highly specialised workforce.

'New' Information for consideration of decision makers

Case for change:

- **No new information** was identified.
- We have set out consultation feedback about the case for change and considered alternative solutions that were raised in consultation.

Further detail: DMBC 7.10 Strength of case for change

Deliverability

You Said

We Did

Timelines to deliver

Implementation should be undertaken in a timely fashion to ensure safe transition. Realistic timelines for this should be provided, and mitigations for implementation risks should be developed.

- The providers have provided **updated implementation timelines,** with updated risks and supporting mitigations.
- We continue to assume a transition period of **2.5 years** before the future PTC transfers.
- Delivery of plans will be monitored by the **Implementation Oversight Board** to ensure that the service transfer is safe and sustainable, conducted in a timely manner so that benefits of the change can be realised.

Information sharing

Important to give clear, open communication about the timeline, key milestones and ways to get involved. Reassurance around staff retention and impact on care should be given on a regular basis.

- The Trusts have shared implementation plans with **key milestones** (included within the DMBC).
- **Regular reporting** will be required as part of implementation on delivery of the plans and recommendations, including comprehensive information sharing.

'New' Information for consideration of decision makers

Financial impact assessment:

- The financial impact assessment confirmed that **both options remain affordable** in terms of revenue and capital. Both options propose to refurbish existing space within their hospitals to create dedicated areas for children with cancer to be cared for. Work to develop the future PTC would use £20m national capital contribution from NHS England plus a contribution from their local health commissioners, of c.£11 to £14m. The Evelina London would also use £10m of grant funding from the Trust Charity.
- Both options for the future location of the PTC have been costed and **remain subject to robust financial scrutiny**. Recurrent capital and revenue affordability have been tested and assured at an appropriate level within the PCBC. Both Trusts have provided reasonable sensitivity analysis showing how downside income and cost scenarios would be managed. The DMBC outlines a commitment to fund non-recurrent stranded and transitional costs.

Risks and mitigations for delivery

Recognise, and mitigate for, the fact that establishing a new service brings risks and may negatively impact the service as it transitions to the new site.

- While there are risks to the delivery of the future PTC, the case for change is strong.
- We will **continue to monitor the risks** and mitigations to them throughout implementation.

Funding and financing

There is general concern around funding for the options (including research and charitable funding), and financial sustainability challenges for both of the options.

- Both options are **affordable from both a funding and financing perspective**.
- As the future provider develops its OBC/FBC, it will need to continue to demonstrate affordability with mitigations in place for associated risks.

Further detail: DMBC 7.11 Deliverability

Recommendations - Deliverability

Implementation

Timely delivery of benefits	In order to realise benefits of the service change in a timely way it will be important that the future provider of the Principal Treatment Centre **works proactively** to enable the safe transition of the service in line with plans. **Collaborative working** with partners will be a key enabler to this and should support the development of more detailed plans and business cases informed by and co-designed with staff, patients, families and other stakeholders.
Governance	Work with NHS England/Integrated Care Boards through the identified governance processes to ensure recommendations and mitigations are **implemented** with necessary support in place. This should include active **management of risks** including over the transition period and early implementation phase.
IIA recommendations	Establish a Travel and Access group with representatives across providers and commissioners to implement the recommendations set out within the **Integrated Impact Assessment.**
Leadership	Successful change requires **strong clinical leadership**. To enable successful implementation, clinical leaders from the current Principal Treatment Centre and future provider will need to be **identified, developed and supported**. **Joint roles** between organisations are also likely to be an important enabler to effective integration between teams and should be established to support the change process.
Support to families throughout transition	Consideration and plans developed to **support families preserve memories and legacies**, and support families throughout the transition and implementation period.
Affordability	The future provider should **demonstrate capital and revenue affordability** of the scheme through development of the outline business case and full business case, with mitigations in place for associated risks.

BREAK
(10 mins)

Impact of proposals

The Integrated Impact Assessment has been updated

The Equalities and Health Inequalities Impact Assessment (embedded within the overall IIA) builds on the interim report and incorporates evidence gathered through:

Sensitivity analysis of travel time: this involved sensitivity analysis against updated algorithms and peak travel times.

Additional analysis on ethnicity groups: this considers the impact of the proposed changes on ethnic groups other than white and whether there is a potential disproportionate impact.

Additional analysis on travel cost: this considers the financial impact of the new travel arrangements from the proposed options on patients*.

Cumulative travel time and cost: this considers the likely cumulative impact of changes in both travel costs and time over a given time period.

Review of the consultation responses: this enabled the final IIA to incorporate any additional impacts or mitigating actions which had not been identified as part of the interim report. This review also considered responses from those in certain protected characteristic groups and/or living in particular areas where a potential disproportionate impact has been highlighted

*We also conducted additional analysis of the impacts on travel costs for staff. This is described in the DMBC.

Further detail: DMBC Section 8 and Integrated Impact Assessment Appendix 4

The EHIA indicates that both options have similar impacts when compared to current provision, but there are differences in the scale of impact

The impacts assessed in the EHIA are summarised below:

Health inequalities	• For deprived populations, there are longer travel times by driving and shorter times by public transport, however these impacts are proportionately smaller than for the general population. Travel costs for populations living in the most deprived areas would be lower than their current estimated driving cost, however their costs are still higher than those estimated for the general population. • For ethnic groups other than white, the increase in travel times is less than for the white population. The change could therefore be argued to be narrowing health inequalities in this respect. • Travel time analysis shows that children living in rural areas experience a disproportionately negative impact on journey times for driving but a positive impact for travel via public transport. • For other protected characteristics and/or groups who typically face inequalities in health or healthcare access, travel time analysis has not been possible due to data availability. It is recognised that travel, access and experience of change may pose challenges for these groups.
Longer journey times for patients and visitors	• Modelled travel times by road vehicle to either potential future PTC location are longer than current travel times to RMH. Non-London residents are the most negatively impacted, with increases in average travel time of up to 30 minutes. • Modelled travel times by public transport to either potential future PTC location are shorter than current travel times to RMH. There would be a reduction in travel time for both London and non-London residents to either location.
Radiotherapy	• For those living in areas categorised as the most deprived, journey times to University College Hospital (as compared to The Royal Marsden) will increase on average by 20 minutes by road and reduce by an average of 40 minutes by public transport.
Patient provision	• There is no impact on the level of provision or patient choice through the proposed change in location of the PTC. • The development of paediatric oncology shared care units (POSCUs) under the POSCU Transformation Programme may provide patients with the choice to access some elements of care more locally.
Transportation cost	• The proposed change reduces median transportation cost (for the Principal Treatment Centre catchment population as a whole) by road vehicle for both options, with the average journey being >£2 less expensive. Travel costs to St George's Hospital are around 70p less expensive (population weighted) than to Evelina London.

The environmental impact in relation to capital build and transport access has been assessed and summarised

Both organisations have published environmental strategies which detail how they will support the national NHS commitment to delivering a 'Net Zero' Health Service:

Guy's and St Thomas' has an established Environmental Sustainability Strategy for 2021-2031 which sets out a path forward, in line with NHS commitments to reach net zero direct carbon emissions by 2040, and net zero indirect carbon emissions by 2045.

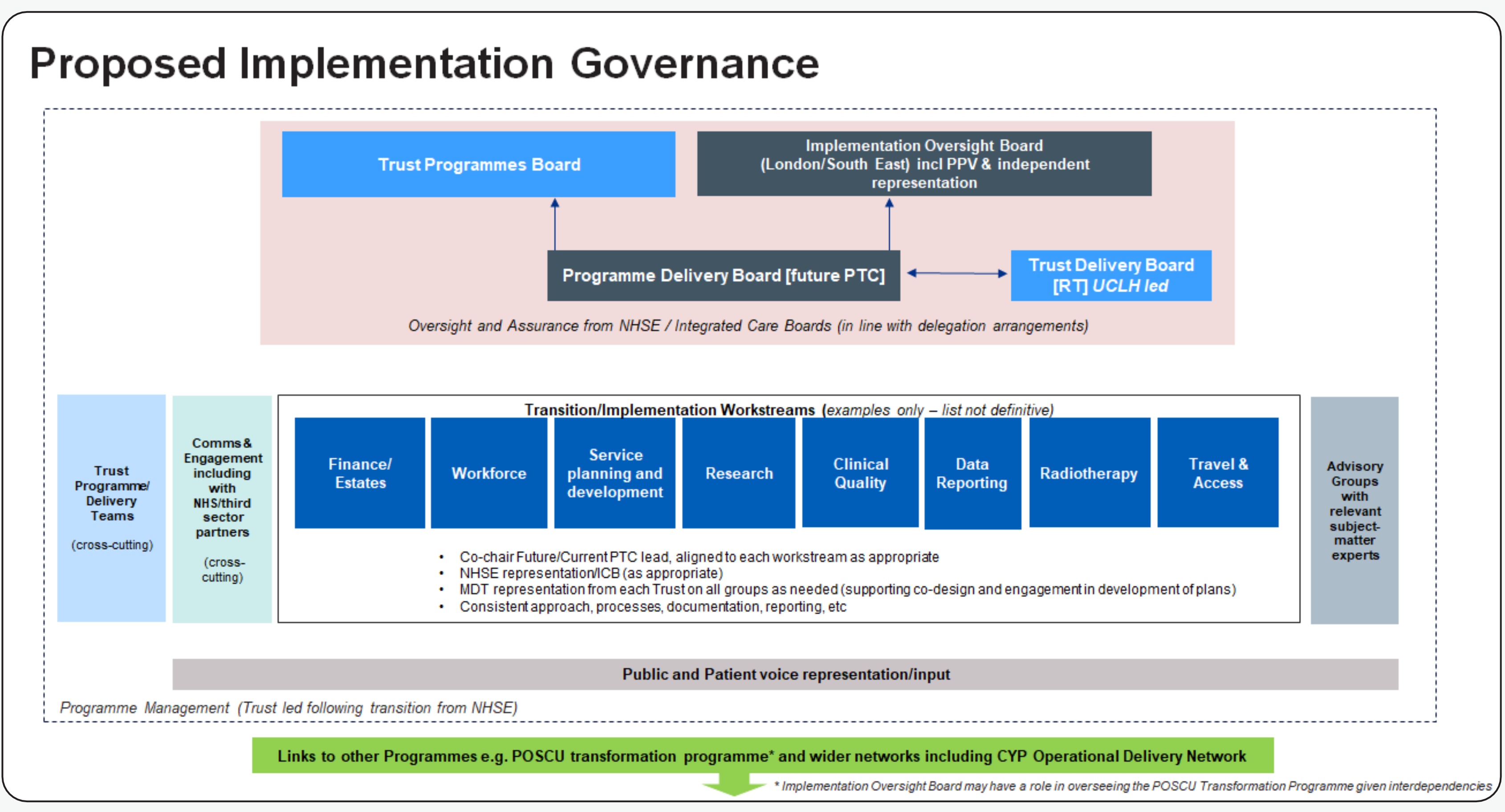
St George's Hospital has a Green Plan which describes its commitment to delivering its contribution to the net zero plan and to adopt the broader principles of sustainable development.

Both strategies **outline plans to reduce emissions from all sources**, contribute to improving local air quality, develop sustainable use of resources, and enhance green spaces. A **detailed environmental impact assessment will need to be conducted as part of the planning and implementation phase**. Ensuring sustainability and reducing carbon emissions will be a key part of the design process, ensuring that everything is completed to the NHS Net Zero Building Standard.

Models of care	The future PTC will have a lead role with regard to the transformation of POSCU (shared care) services and peripheral diagnostic services. This will increase the opportunity for care closer to home, improving patient experience (by reducing travel requirements).
Estates and facilities	Both Trusts are proposing internal refurbishment projects where they do not envisage either change of use or modifying the building façade: both should be able to offer developments with lower environmental impact, complying with the NHS Net Zero Building Standard.
Travel and transport	The vision for the future of the service is that travel to the specialist centre will reduce, with enhanced POSCUs able to provide a wider range of care, closer to many children's homes. Higher population densities in proximity of potential PTC locations (with shorter journeys), could lead to an overall reduction in emissions related to travel. Both organisations have developed Green Travel Plans which cover conversion of fleet vehicles (including patient transport) to electric vehicles, supporting use of public transport patients (for those who are able to use it) and active travel plans for staff.
Environmental resilience	Both organisations are developing plans to improve operational resilience regarding climate change (in particular, extreme warm weather). Both organisations were rated as being fully compliant in recent EPRR assurance process.

Arrangements for implementation

Our governance arrangements for implementation will support monitoring and management of recommendations, risks, benefits and outcomes



It is envisaged that an **Implementation Oversight Board** will be established. Their role will be to:

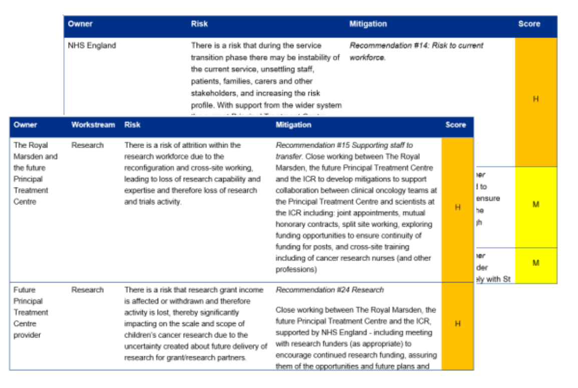
- Ensure the **delivery of the benefits** associated with the reconfiguration programme.
- Performance manage and **monitor service quality and standards** during the implementation phase.
- Ensure the programme delivers within its agreed parameters.
- Oversight to ensure any potential impacts on other NHS services are identified in a timely way and mitigated.
- Resolve strategic and directional issues between workstreams.
- Support the **resolution of escalated risks and issues.**
- Oversee any external dependencies of the programme.
- Provide formal approval in relation to deliverables and services produced by the programme.

We will monitor and manage recommendations, risks, benefits and outcomes during implementation and first years of service delivery

Risks

The transfer of the reconfiguration of the Principal Treatment Centre brings **risks which will need to be carefully managed** throughout implementation and beyond.

The **Implementation Oversight Board** will take responsibility for managing risks supported by other groups who will regularly review risks to delivery.



Owner	Risk	Mitigation	Score
NHS England	There is a risk that during the service transition phase there may be instability of the current service, unsettling staff, patients, families, carers and other stakeholders, and increasing the risk profile. With support from the wider system	*Recommendation #14: Risk to current workforce.*	H
			M
			M

Owner	Workstream	Risk	Mitigation	Score
The Royal Marsden and the future Principal Treatment Centre	Research	There is a risk of attrition within the research workforce due to the reconfiguration and cross-site working, leading to loss of research capability and expertise and therefore loss of research and trials activity.	*Recommendation #15 Supporting staff to transfer.* Close working between The Royal Marsden, the future Principal Treatment Centre and the ICR to develop mitigations to support collaboration between clinical oncology teams at the Principal Treatment Centre and scientists at the ICR including: joint appointments, mutual honorary contracts, split site working, exploring funding opportunities to ensure continuity of funding for posts, and cross-site training including of cancer research nurses (and other professions)	H
Future Principal Treatment Centre provider	Research	There is a risk that research grant income is affected or withdrawn and therefore activity is lost, thereby significantly impacting on the scale and scope of children's cancer research due to the uncertainty created about future delivery of research for grant/research partners.	*Recommendation #24 Research* Close working between The Royal Marsden, the future Principal Treatment Centre and the ICR, supported by NHS England - including meeting with research funders (as appropriate) to encourage continued research funding, assuring them of the opportunities and future plans and	H

Recommendations

Our **recommendations serve as mitigations** for the significant programme and delivery risks, as well as to enable full benefits to be realised.

- Requirements for the future service, including recommendations agreed as part of decision-making, will be managed via **NHS standard contract terms and conditions**. the service will be referenced in **Schedule 5A** (Documents Relied Upon) of the contract between NHS England/Integrated Care Boards and the receiving Trust.
- Key Reporting Indicators will be reviewed and ratified by the Implementation Oversight Board
- Once the contract is awarded, the main Integrated Care Board contract for the provider will be amended to include a specific schedule for this new service

Outcomes

It will also be important to monitor other measures to ensure that the reconfiguration does not have an adverse impact including on patient groups. We have made the following recommendations for future monitoring of access and outcomes.

1. **Benchmark quality and outcome metrics against other Principal Treatment Centres and The Royal Marsden baseline (using SSQD)**
2. **Conduct regular Health Equity Audit of access to the service**
3. **Develop and implement a mechanism for monitoring uptake (by socio-economic group) of mitigating actions and processes**
4. **Use patient experience metrics to monitor experience between demographic groups**
5. **Consider use of Schedule 2N within the NHS Standard Contract.**

Benefits

- The **future provider of the Principal Treatment Centre will have overall accountability** for the delivery of the benefits associated with the service change.
- Through the DMBC, we have set out proposed metrics for the realisation and monitoring of the benefits identified through the reconfiguration to date, alongside their proposed owner.
- It is expected in the next stage of the programme that a **baseline and target** will be formally identified and agreed – this will likely require a detailed data audit of The Royal Marsden and St George's data including activity, transfer data, clinical trials data and funding data.

Discussion

Decision-making resolutions

Decision-making resolutions

On the balance of information reflected in this business case, decision-makers for NHS England London and South East regions are therefore asked to consider the following resolutions:

1. To agree that, if chosen and implemented as the future Principal Treatment Centre, either option under consideration could **meet the national service specification** for Children's Cancer Principal Treatment Centres, issued by NHS England in November 2021.
2. To agree whether the future location for the Principal Treatment Centre should be **Evelina London Children's Hospital** or **St George's Hospital.**
3. To agree that conventional (photon) **radiotherapy** services for the future Principal Treatment Centre will be delivered by University College London Hospitals NHS Foundation Trust at **University College Hospital**.
4. To agree and **adopt the recommendations** that will support the smooth transfer of services, enable continuity of care for patients and deliver the benefits of the clinical model.
5. To establish a **London and South East Implementation Oversight Board** (including patient and public voices, and independent representation) to oversee the service transition and monitor the delivery of the recommendations throughout implementation.

Any other business

Meeting closed