East of England Clinical Senate

Mount Vernon Cancer Centre: revised clinical model with reprovision on an acute hospital site

Report of the East of England Clinical Senate independent Clinical Review Panel held on 23 June 2021

Glossary of abbreviations used in the report	
AOS	Acute Oncology Service
CCG	Clinical Commissioning Group
CT	Computed Tomography
ICS	Integrated Care System
IT	Information Technology
MDT	Multi-Disciplinary Team
MRI	Magnetic Resonance Imaging
MVCC	Mount Vernon Cancer Centre
NHS EI	NHS England and Improvement
PACS	Picture Archive and Communication System
PET-CT	Positron Emission Tomography- Computed Tomography
UCLH	University College London Hospitals
WHHT	West Hertfordshire Hospitals NHS Trust

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EXECUTIVE SUMMARY

The Clinical Senate have been asked to undertake an independent clinical review of a proposal for a revised clinical model for Mount Vernon Cancer Centre (MVCC) services, with reprovision to be provided on an acute hospital site.

The Clinical Senate Review Panel, after assessing the evidence presented and the clinical principles, made several recommendations for the MVCC Reprovision teams.

As the plans for the reconfiguration are further developed and there is a move towards implementation, the Panel recommend that there is specific focus on the areas within these recommendations. The Panel recognised that to different degrees a considerable amount of work had already been undertaken in relation to each of these areas, but further significant work was still required.

Recommendation 1 – The MVCC reprovision team should continue with the development of a comprehensive Information Technology (IT) solution to ensure the timely and accurate bi-directional flow of information between the new MVCC and all key sites especially Watford General Hospital.

The most important IT interface would be between the new MVCC and the Watford General site, which will both be on different electronic patient record systems. It will also be important to make sure the information flows to each of the peripheral (spoke) sites and primary care will be timely and accurate. This should include medication information and access to Picture Archive and Communication System (PACS) images.

Recommendation 2 – The MVCC Reprovision team should ensure that access to services and transport for all patients is carefully considered and made as convenient as possible.

This should especially focus on those patients with the longest potential access times and lack of personal transport. This should include consideration of the most convenient referral pathways for patients, with a potential re-drawing of expected usual cancer centre catchment areas (whilst accommodating patient choice). This should also include delivering diagnostic tests and treatments at

peripheral sites, in patient's homes and via mobile services, where appropriate, to minimize the necessity of patients having to travel significant distances. The plans to work with local transport providers and transport planners to further mitigate access difficulties is supported and consideration to the provision of NHS transport services to bridge any remaining gaps is recommended.

Recommendation 3 – The MVCC Reprovision team should ensure that social and health inequalities are addressed thoroughly.

The impact of inequalities on health outcomes has become an even greater focus for the NHS following the COVID-19 pandemic. The MVCC covers geographical areas with poor health outcomes for the local population. The reasons behind this are multifactorial and include some of the wider determinants of health. However, the Panel agree that the MVCC team need to work with other stakeholders to improve early recognition of symptoms, early presentation and better take up of screening, diagnostic and treatment services.

The recommendations above should be read in the context of the broader findings of the clinical review panel as laid out in the key findings section of this report.

1 Foreword from Clinical Senate Review Panel Chair

I would like to thank all members of the MVCC Reprovision teams who engaged with the Clinical Senate, prepared their evidence and presentations, responded to the Key Lines of Enquiry identified through our pre-panel teleconference and responded openly and honestly to questions from the Panel on the day.

I would also like to thank all of the Clinical Senate's Review Panel members for engaging in such an active way with the process, asking searching questions and contributing with their wide and varied expertise and of course in giving up their time.

We wish the MVCC Reprovision Teams well with their ongoing work and hope we can assist them again in the future as they continue to work towards Reprovision of MVCC services.

Dr Bernard Brett

East of England Clinical Senate Chair and Clinical Review Panel Chair

2 Review background and scope

2.1 The East of England Clinical Senate was approached during 2020 with a request to undertake an early stage review of the high-level proposals for reprovision of the MVCC services. However due to the COVID-19 pandemic, the Clinical Senate was unable to provide a Clinical Review Panel service at this time due to many members of the Clinical Senate Council, Assembly and staff members being fully utilised in supporting management of the pandemic. During summer 2021 the Clinical Senate was once again able to provide a panel review function.

2.1.1 A revised clinical model for Mount Vernon Cancer Centre services is proposed, which would see reprovision on an acute hospital site. The preferred site, after an options appraisal, is West Hertfordshire Hospitals NHS Trust (WHHT) Watford site. The preferred future provider of the cancer centre services at the WHTT Watford site, which will be managerially accountable is University College London Hospitals (UCLH) NHS Foundation Trust, which is an existing tertiary cancer centre provider.

2.1.2 The Clinical Senate were asked to review the clinical model principles and proposals which form the business case, and which will form the basis of public consultation. The Clinical Review Panel have been requested to assess the strength of the evidence base of the clinical case for change and proposed models and make clear its key findings and recommendations in a report to the commissioning organisation.

2.1.3 The scope of this independent Clinical Senate review is non-surgical clinical cancer services provided from the current Mount Vernon site, and the proposed clinical model for service re-provision on the WHHT Watford site.

2.2 Background and Case for Change:

2.2.1 The review of Mount Vernon began in 2019 following concerns about the future sustainability of services. An Independent Clinical Review concluded there needed to be immediate and longer-term changes, including re-locating some or all specialist cancer services to a new centre on an acute hospital

site, and short-term recommendations to make the current service safer in the meantime.

2.2.2 Previous reviews have taken place over the past forty years which have also concluded that significant changes to services are required to the buildings, facilities and the clinical model. However, a lack of funding for re-building the cancer centre and lack of agreement on the best way forward, have prevented the necessary improvements from taking place.

2.2.3 Over time, the supporting clinical services and adjacencies on the Mount Vernon site have reduced, resulting in the number of patients who are able to be treated on the site being limited, and newer and experimental treatments being unavailable at the site, leading to even longer journeys for patients to other cancer centres. Should a patient's condition worsen whilst at the site, or need significant input from other clinical specialties, they then need to be transferred to another, non-specialist hospital. This is becoming increasingly challenging given the ageing cancer population with increasing numbers of additional health conditions, and the complexities of new and emerging anti-cancer therapies. Additional independent advice on appropriate service co-location was subsequently commissioned.

2.2.4 Staff at MVCC continue to work hard to provide excellent services for patients, but the ability for them to deliver specialist, new and world-leading treatments for patients is becoming increasingly challenging. The longer the issues remain unresolved, the greater the challenges for recruitment and retention of skilled clinical staff and the impact that will subsequently have on patients and on the future for these services.

2.2.5 NHS England and Improvement is working with East and North Hertfordshire NHS Trust, which is currently responsible for the services; University College London Hospitals (UCLH) NHS Foundation Trust, who have been named the preferred future provider; Hertfordshire and West Essex Integrated Care System (ICS); Bedfordshire, Luton and Milton Keynes ICS; North West London ICS; North Central London ICS: Buckinghamshire, Oxfordshire and Berkshire West ICS; Frimley Health and Care ICS; East of England Cancer Alliance; RM Partners Cancer Alliance; Healthwatch and others, to find a

long-term solution. This must meet the needs of the MVCC population, reduce avoidable lengthy travel times, reduce inequalities and improve outcomes.

2.3 Plans for Change:

2.3.1 The Programme Board supported the recommendation of the Clinical Group for a new, single-site specialist cancer centre on the Watford hospital site – the only hospital site that met all of the essential criteria. The Programme Board also agreed that there should be improved local access to services such as chemotherapy and radiotherapy at linked sites. Plans for a new cancer centre and the new local services have now been developed with input from clinicians, patients and local people, and are estimated to come to a cost of £229 million (excluding VAT). Proposals will be finalised over Summer 2021, ahead of public consultation later in the year once funding has been identified. (Note: since the Senate review this timeline has changed as an opportunity has arisen to apply for capital funding through the New Hospitals Programme. The timeline for shortlisting means that public consultation would be more likely to take place in 2022.)

2.4 Developing the main Cancer Centre at Watford General Hospital:

2.4.1 A plot of land has been provisionally identified on the Watford General Hospital site that would enable the MVCC to be built at the same time as the new Watford Hospital development.

2.4.2 The new Cancer Centre would be separate to the Watford hospital (linked by corridor or bridge) and run by a different provider. It would include all the services provided at the current centre, as well as a new therapies space, a brachytherapy theatre and interventional radiology service (which is not currently provided), a small number of additional oncology inpatient and clinical trials beds, and a new haematology service (patients currently attend services in London for haematological cancers).

2.5 Care Closer to Home:

2.5.1 In addition to a new cancer centre, the proposals being put forward include a number of additional developments to enable people to be treated closer to where they live when they do not need the specialist facilities of the main cancer centre. This is something that has been raised by patients and carers, many of whom travel extremely long distances or with long travel times for relatively simple treatments.

2.5.2 This includes developing plans for blood tests, other minor tests and procedures and most diagnostic imaging to be carried out locally, which will considerably reduce the number of visits to the main site. Improved patient transport services are also being looked at for those who need to attend the main site, along with plans for discussions with local transport providers regarding access to the site.

2.6 Transfer of Cancer Centre management:

2.6.1 The Independent Clinical Report stated Mount Vernon Cancer Centre services should be run by a specialist cancer provider, not a district general hospital as it is now. A lot of work has been undertaken with UCLH who were identified as the preferred provider. A decision is now expected in September 2021 to enable detailed planning for the transfer to begin. This decision will require certainty on funding for the proposals outlined above. (Note: since the Senate review, the timetable has been adjusted to fit with national decisions on capital.)

2.7 Timescales:

2.7.1 Timelines for some elements of the programme have slipped a little because of the second wave of COVID-19. However, significant progress has been made and it is anticipated that the proposals will be finalised over Summer 2021 with public consultation on the plans taking place in the Autumn if funding for the development has been agreed. (Note: since the Senate review, an opportunity has arisen to apply for capital through the new hospitals programme. This will impact on timelines, with public consultation expected in 2022 if the scheme is successful.)

2.8 Out of Scope of the Clinical Senate Review:

2.8.1 Capital funding is out of scope for the Clinical Senate Review. Identification of the capital funding that will be used to re-provide the new cancer centre is critical to the development of these plans, and to going ahead with the public consultation. Good progress is being made with these discussions, but no capital funding has yet been identified. This is critical to both the transfer of services from East and North Hertfordshire NHS Trust to UCLH, and to the re-provision of service. This is out of scope for the Clinical Senate Review.

2.8.2 Networked radiotherapy is also out of scope for this Clinical Senate Review. Whilst the wider service review is also considering proposals for networked radiotherapy, networked radiotherapy is out of scope for this current Clinical Senate review but may form the focus of a future review.

3 Methodology and Governance

3.1 Clinical Review Panel members (Appendix 2) from within and outside of the East of England and a patient representative (expert by experience) were identified by their clinical expertise and background and invited to join the review panel. All panel members signed Conflict of Interest and Confidentiality declarations (Appendix 3).

3.2 Terms of Reference for the review were agreed between Dr Bernard Brett, Chair of the East of England Clinical Senate and Ruth Derrett, Programme Director, MVCC Review, East of England Specialised Commissioning, NHS England and NHS Improvement – East of England (Appendix 1).

3.3 The evidence, received on 1 June 2021, was discussed at the pre-panel teleconference on 10 June 2021 to prepare panel members and discuss potential key lines of enquiry which were shared with the Programme Director of the MVCC review.

3.4 The Clinical Review Panel took place on 23 June 2021. The MVCC Reprovision teams from NHS EI, MVCC and UCLH, gave an overview and context setting presentation to the Panel which included addressing some of the questions raised in the key lines of enquiry that had been identified by the Clinical Senate Panel. The proposals were discussed with the Panel in more detail, the MVCC Reprovision Teams responding to questions providing further supporting and contextual detail.

3.5 Sections of the draft report were sent to Clinical Review Panel members for review and confirmation of accuracy and to the MVCC Reprovision Commissioner for review for points of accuracy.

3.6 The final draft of the report was submitted to an extraordinary meeting of the East of England Clinical Senate Council on 2 November 2021. The Senate Council agreed that the Clinical Review Panel had fulfilled the Terms of Reference for the review and confirmed the report. The Clinical Senate Council in their deliberations requested that two addendums were added to the report. These are noted in Section 5 of this report.

3.7 The East of England Clinical Senate will publish this report on its website at the appropriate time as agreed with the commissioning organisation.

4 Key findings: General and overarching

4.1 The Clinical Senate Review Panel unanimously agreed that the presenting team were obviously well prepared and had provided the Panel with a comprehensive and detailed evidence set. The presenting team was also thanked for its prompt and comprehensive response to the key lines of enquiry raised by the Panel on its pre-panel call on 10 June 2020.

4.2 Following the submission of evidence, the presentation session to the Panel and discussion between the MVCC Reprovision presenting Teams and the Panel, in the form of question and answers, the Panel have developed this report which includes the key findings of the Panel and also recommendations for consideration by the sponsoring organisation. Overall, the Panel is very supportive of the proposed clinical model and the extensive work that has already been undertaken.

4.3 The Panel found there was a clear and well documented account of why this clinical model was being proposed. The patient, staff and stakeholder engagement from MVCC was considered to be excellently undertaken and presented. The Board to Board meetings of clinicians and management as well as the bi-monthly joint clinical meetings with Watford General Hospital, demonstrate good evidence of joint working and collaboration to make the MVCC service reprovision successful.

4.4 Throughout the presentation and discussions with the Panel, the amazing teamwork between the organisations involved was apparent. The presenting team were honest, recognised and acknowledged the significant challenges and the Panel are confident that the MVCC Reprovision teams will attend to the challenges with the thoroughness and integrity they demonstrated to the Panel. The Panel are of the view that the clinical model proposed should be of great benefit to the patients if implemented successfully. The complexities of the challenges are recognised and being addressed.

4.5 Information Technology

4.5.1 The Panel considered that whilst there has been a significant amount of work in developing IT solutions, this area will still require continued extensive work to plan and implement solutions for the future to ensure safe and efficient services. The Panel felt this was an extremely important component of the plans, hence the rationale for this also being included in the recommendations.

4.5.2 The Panel questioned how staff within the Watford General Hospital, being adjacent and connected via a bridge or corridor to the new proposed MVCC site, will access IT related to MVCC patients and vice versa for MVCC staff accessing information from the Watford general site. Patients, particularly those with more complex problems and co-morbidities will relatively frequently need to move between the two sites to access services.

4.5.3 The Panel were informed that the plan is for MVCC at the Watford General Hospital site to use the same Electronic Health Records system as that used by UCLH. The system used by UCLH for sharing of clinical information is well developed and can be accessed remotely with records able to be viewed and added to from multiple locations, which is felt to be a great positive feature. The Panel were advised that implementation of this system has been revolutionary, with real time access to information and has positively changed working practices with UCLH clinicians greatly in favour. This clinical information system also allows access for the patient's GP and a patient portal. The UCLH team already have a large team in place to support this system, and it is envisaged this team will increase when the MVCC services are transitioned to UCLH.

4.5.4 The Panel were also advised that the portal that enables patients to access their own information and blood results is already in place.

4.5.5 The Panel were aware that the flow of information from other systems into this system, however, isn't always straightforward and could cause potential difficulties if not fully addressed.

4.5.6 In considering diagnostic imaging, there is already a hub and spoke model for the oncology service for several sites, MVCC PACS images can be accessed by clinicians at each of these sites and MVCC Consultants can access PACS images from each of the spoke sites. The Panel also advised that consideration should be given to when PACS and Radiology Information System (RIS) renewals are due. The current solution seems to work well but perhaps could be even better if there was more uniformity around PACS and RIS systems.

4.5.7 The Panel considered that sharing of imaging information should not be labour intensive, and should be seamless, efficient, and accurate.

4.5.8 As it is anticipated to still be a few years from now until the MVCC move to a new site happens, it is equally anticipated that in this time period there will be digital innovations. The Panel were advised that the UCLH IT teams are tenacious and will treat the requirements of the MVCC as a very high priority.

4.6 Vision

4.6.1 The Panel heard that MVCC has remained as a distinct MVCC brand, although they have been under the management of East and North Hertfordshire Trust for many years. The Review Panel were told that it is anticipated that the MVCC brand will become even stronger under the management of UCLH and will not be lost. The Panel felt that it is clear there is a will to retain the history and brand of MVCC. Ownership of patient pathways need to be retained by MVCC teams and the strong branding identified could be enhanced and strengthened in satellite centres. The Panel agreed there was a need to incorporate the established strong MVCC brand in a clear, well-articulated and compelling vision of the new future for cancer services the team are planning. The vision should be less about the future buildings but more about the model of clinical care, future working partnerships and the enhancements for patients and the MVCC populations in terms of experience and outcomes. The Panel were clear that it is important for the MVCC to remain a system leader in their local area with the satellite centres maintaining the same clinical and organisational standards.

It is understood that this is part of a long journey to provide reprovision of the MVCC.

4.6.2 The evidence presented to the Panel identifies a high loyalty from patients to the MVCC with good continuity of care and a "familial" feeling. The Panel were informed of many excellent patient and staff engagement initiatives – indeed the Panel were highly impressed with the depth and breadth of engagement that has and is being conducted. It was demonstrated to the Panel how patients and carers are made to feel welcome and that it is important that this positivity is continued to maintain and improve still further patient and carer experience. It was felt from the Panel that articulation of a clear, shared vision, articulating the benefits for patients of how experiencing the new MVCC will feel and make a really positive difference.

4.6.3 From the perspective of Organisational Development, the Panel recognises that there will need to be careful planning and continued strong engagement to ensure that relationships between the staff at MVCC, UCLH and the preferred site of WHHT Watford General Hospital continue to be built upon. This work has started through patient and staff engagement but must remain a key focus going forward.

4.7 Research and Development

4.7.1 The Panel explored with the presenting team about the relationship moving forward between MVCC and UCLH about Research and Development and were greatly encouraged to hear the anticipated plans which will give flexibility, autonomy and agility when taking on new initiatives. The MVCC team will be viewed as an entity whilst having greater and more direct access to UCLH including collaboration to the UCLH research groups and access to new funding streams.

4.7.2. The Panel heard from the presenting team about the importance of a cohesive approach across both UCLH and MVCC sites with joint reach meetings for tumour groups. This is considered to strengthen the MVCC brand and open up new opportunities for Research and Development.

4.8 Horizon Scanning

4.8.1 The Panel were highly impressed with the presentation and acknowledged the thinking and planning that has and continues to be given to this programme. The Panel also felt that whilst this programme is key, it may be also be an opportunity to look at cancer services in the Region, particularly where current patient flows to commissioned centres may not be as convenient for patients as they could be. The presenting team have already started conversations with some Clinical Commissioning Groups (CCG's) and ICS's about their ambition for their populations and the responsibility for the entire patient pathway is part of these developing conversations. The Panel heard that these conversations will continue to be strengthened and pursued in tandem with the MVCC reprovision planning.

4.8.2 The Panel heard that there is on-going work with the Cancer Alliances in understanding demography and future growth of patient populations to make the model fit for purpose and aiming as much as possible for future proofing. The estates planning is still at a high level and not yet at a detailed drawing stage to be clear on the capacity and layout for services including for treatments and diagnostics. When considering future proofing within the approach to planning there will also be a need to include close working with other cancer networks. The Panel were assured that UCLH are a partner who will aim to provide maximum flexibility in the designing of the services going forward.

4.9 Transport and Access

4.9.1 The Panel were presented with a large amount of information on travel mapping and times. It was recognised that for many parts of the patient pathways in diagnostics, treatments and on-going follow-up investigations, this needs to occur at places that are convenient for patients to access with ease and to enable patient choice. This is not always the case currently, particularly for patients who have to use public transport to travel into and out of London and for rural communities. The presenting team advised that there is still on-going work, including working with a range of partners including Local Authorities to understand public transport and other potential

initiatives and to work with these bodies to influence where possible. Included with one of the recommendations within this report is for the MVCC Reprovision team to work with CCG's and ICS's to consider alternative provision for NHS initiated transport to bridge any remaining gaps for patients. The Panel were of the view that a relatively small amount of funding for such a service may have a much more positive impact for patients overall than some of the higher cost treatments.

4.9.2 The Panel felt this also links to the horizon scanning, new treatment and diagnostics and working with commissioners to look at patient flows and pathways.

4.10 Watford General Hospital site capacity and relationships

4.10.1 The Panel explored with the presenting team about the planned capacity of the new MVCC and the impact on capacity at WHHT Watford General Hospital as the proposed new co-located site. There are plans for redevelopment of the Watford site and the planning for the MVCC move needs to fit in with these. The presenting team spoke about a proposed bridge between the new MVCC and the Watford Hospital. It was understood that there needs to be clear recognition of how the co-dependencies will work in both directions across the bridge. This is already recognised by the presenting team as an area that will require on-going work.

4.10.2 The Panel agreed that areas that need to be focused upon going forward include understanding the relationship between the MVCC and WHHT Watford General Hospital in terms of services, clinical policies and clinical staff relationships. This includes the provision of Critical Care, enhanced care and Critical Care outreach support; relationships with clinical service support teams such as Interventional Radiology and endoscopy; cultural differences; working between professional teams where interdependencies exist e.g. specialty support, surgical, medical and support services.

4.11 Workforce

4.11.1 The Panel heard that a significant amount of engagement has already occurred and is still underway with the existing MVCC workforce and more detailed and focused work is committed to in the future. The aim is to keep the MVCC teams together as much as possible as well as ensure there is full clinical engagement in developing the services for the future. There are monthly staff and patient events around co-design and reprovision and there is a significant keenness to retain clinical and non-clinical staff in the MVCC team. There are also workforce specific groups e.g. Consultant Oncologists and Radiologists. Since December 2020, due to COVID-19 not permitting face-to-face events, staff engagement has continued online which has been well attended. The Panel was also advised of the recent very positive responses from the NHS staff survey.

4.11.2 The Panel explored in depth about the plans for the current and future workforce and Organisational Development input required to ensure the appropriate skill mix and capacity to deliver services for the future proposals. The Panel heard that the majority of staff are excited and enthusiastic about the MVCC Reprovision with an anticipatory eagerness for this to happen as soon as possible. However, there are a very small number of staff members who are not in support, several of whom have the desire to work locally as their key driver.

4.11.3 To ensure all staff have the opportunity for their views to be heard regarding the MVCC Reprovision there is an option for feedback to be given anonymously rather than openly, which very few staff have taken up. The willingness of staff to openly provide their feedback, the Panel felt, demonstrated a positive culture and engagement with the planning process.

4.11.4 Recruitment of specialised staff is becoming increasingly difficult, so the retention and attraction of the appropriate workforce is viewed by the MVCC team as an extremely important element of their plans.

4.11.5 The Panel are keen to strongly encourage the MVCC Reprovision planning team to continue working in an integrated way with the workforce and to articulate the benefits to the workforce.

4.12 Service development

4.12.1 The Panel explored many aspects of service development which will be delivered as part of the MVCC reprovision.

4.12.2 The Panel heard that WHHT Watford General Hospital are developing an Interventional Radiology service and are keen to work with UCLH in this development. This planning is currently at a high level and with the details being worked up.

4.12.3 For the acute oncology service (AOS), including out of hours, the model is already of a hub and spoke, with advice already being provided by MVCC to other hospitals such as Watford General Hospital. There is ambition to develop and grow this model further with an increase in the existing collaboration.

4.12.4 The care of the deteriorating patient was explored, and the Panel heard about the existing provision and use of robust guidelines. The existing education and training programme in place is planned to continue in the MVCC Reprovision. The Panel explored the fact that thresholds are likely to change with the co-location alongside Watford General Hospital and higher acuity patients are likely to remain under the primary care of the MVCC team with easier access to support services. The Panel discussed the need for training to be put in place in order to ensure that staff felt comfortable managing this more acutely unwell patient group.

4.12.5 The Panel were advised that there are existing improvements already implemented in Acute Oncology Services with the majority of patients being seen within 14 hours, which is an improvement since the 2019 review. There is a plan to create more Consultant led AOS sessions.

4.12.6 The deployment of a new electronic patient record system, which should enable seamless access to patient information with UCLH as it is on the same system, will enable significant changes to patient care. The implementation will require significant process redesign and going forwards the need for staff to provide pathway coordination, which will require the use of different skills sets within administration teams, but not necessarily with any less staff.

4.12.7 The multidisciplinary (MDT) structure was also explored by the Panel to which the presenting team demonstrated a convincing response, highlighting specialty and site-specific MDT's which will remain in place. In future-proofing the MDT service, the use of Cancer protocols to enable efficient and effective working was highlighted by the Panel.

4.12.8 The Panel advised the MVCC Reprovision team to ensure that at least as much, if not more, emphasis is placed on aspects of governance and IT as it is to new physical buildings. As the non-building aspects of the MVCC Reprovision develop, the Panel advised, that where possible, changes are implemented prior to the building move.

4.12.9 The presenting team highlighted that feedback from patients is used for on-going service development and this was supported by the Panel.

4.13 Pathology Networks

4.13.1 With regards to the MVCC reprovision and current and future Pathology Networks there was an acknowledgment that more interaction needs to happen to ensure that diagnostic pathways, connectivity, information flows and timely access to results work for the benefit of patients. As well as seamless connectivity between UCLH and MVCC, there needs to be appropriate information sharing and access between MVCC and WHHT Watford General Hospital.

4.14 Treatment and diagnostic facilities – PET-CT, CT and MRI provision

4.14.1 The Panel heard that there is consideration currently for how there will be provision of PET-CT, CT, and MRI for the MVCC population. These discussions are at a relatively early stage but are recognised as of high importance by the MVCC reprovision team.

4.15 Inequalities

4.15.1 Throughout the presentation the Panel heard how the MVCC team are identifying and mitigating inequalities. The Panel were informed of the significant amount of work that is in progress with regards to addressing inequalities.

4.15.2 Transport and access to services was explored in depth and features as a recommendation for further and on-going work. This needs to be continued to ensure the best solutions are reached to improve access for patients who are disadvantaged through geography and/or deprivation.

4.15.3 In terms of referral pathways and communication with GP services, this is an area that the MVCC Reprovision team acknowledge that there is more work to be done.

4.15.4 The presenting team advised the Panel that a Health and Equality Impact Assessment is in the final stages of completion. It will consider how to address equality of outcomes for patients from different socio-economic areas and with a range of protected characteristics in the MVCC catchment. The business case will then consider where the most impact can be gained and how best to provide for this. The Panel heard that understandably a big focus was on the deprived populations within and around Luton but the Panel recognised that there are other significant areas within the wider MVCC catchment area where inequalities are impacting on health outcomes.

4.15.5 Although Networked Radiotherapy is outside the Terms of Reference for this Clinical Senate, addressing inequalities of access to this service will be key in this new development. The MVCC Reprovision team are however keen to ask for a Clinical Senate review at a later stage when proposals for

networked radiotherapy are being developed. The Panel consider the facility of satellite networked radiotherapy is key within the development of the MVCC Reprovision but as this is outside the scope of this review, it does not feature within the Panel's recommendations.

4.15.6 Provision of services to patients with learning disability was explored by the Panel. In response the Panel heard that there is a specific workstream on this with Learning Disability nurses involved who are advising on how to capture and include the views of people with learning disabilities. Additionally, the workstream has other learning disability bodies as part of its membership as well as persons with learning disability who have been cancer service patients.

4.15.7 The Panel also heard about how access for people with physical disabilities is being addressed through design considerations, listening and acting on people's stories and involving people with the planning. Additionally, there is patient engagement work underway with other groups such as those with other protected characteristics and other groups such as homelessness and travelling people.

5 Clinical Senate Council

5.1 The Panel report was reviewed at an extraordinary Clinical Senate Council meeting on 2 November 2021 to consider whether the agreed Terms of Reference for the Clinical Senate Panel review has been met. As stated in Paragraph 3.6 of this report it was agreed that these had been met. However, the Council wished two addendums to the report to be noted.

5.2 Addendum 1: Genomics

The Clinical Senate Council wished it to be noted that the Genomics Board for Herts and West Essex (North Thames) is chaired by UCLH. The Council noted the importance of recognising the inter-connectivity between the genomics work and new and up-coming cancer treatments. This work will become more important for future-proofing. This was not discussed during the Clinical Senate Panel Review.

5.3 Addendum 2: Integrated Psychological Service Provision

The Clinical Senate Council wished to be noted a question on how cancer patients will be supported with integrated provision of psychological services with the move to the Watford General site as currently MVCC provide these services on site. This is both in terms of workforce and services provided. This was not discussed during the Clinical Senate Panel Review.

6 Conclusion

6.1 In conclusion and to set the context of the recommendations, the Clinical Review Panel made the following response to the questions asked of the Clinical Senate. The questions asked were:

a) Does the proposed clinical model meet the requirements of the independent clinical review advice in 2019, and subsequent separate advice on required acute adjacencies?

b) Is the proposed clinical model appropriate to ensure the safe and effective provision of services for patients and the population covered?

c) Does the proposed clinical model, to be re-provided on the WHHT (Watford) site, meet requirements for the future sustainability of cancer services?

6.2 The Clinical Review Panel was very supportive of the significant amount of work that had been undertaken and were impressed by the clear collaborative working between organisations and the degree of engagement with staff and patients.

6.3 In response to question a) the Panel agreed that the clinical model and site chosen meet the requirements recommended by the independent clinical review "Mount Vernon Cancer Centre Strategic Review, Clinical Advisory Panel Review and Recommendations (2019), NHS England and Improvement – East of England July 2019" and the subsequent advice on the requirement for co-dependencies.

6.4 In response to question b) the Panel felt that the MVCC Reprovision plans demonstrated that, whilst recognising the model is currently at a high level, it is appropriate to ensure the safe and effective provision of services. However, the safety and effectiveness needs to be continually reviewed by the MVCC Reprovision team as more detailed plans are developed with continued clinical and patient engagement. And the final plans will also need to be implemented effectively.

6.5 In response to question c) the Panel felt that whilst the model has demonstrated at a high level that it should deliver the future sustainability of cancer services, the other workstreams such as networked radiotherapy, diagnostic plans for PET-CT, CT and MRI and Pathology Networks must all align going forward.

7 Recommendations

7.1 As the plans for the reconfiguration are further developed and there is a move towards implementation, the Panel recommend that there is specific focus on the areas within these recommendations. The Panel recognised that to different degrees a considerable amount of work had already been undertaken in relation to each of these areas but further significant work was still required.

7.2 **Recommendation 1**: The MVCC reprovision team should continue with the development of a comprehensive IT solution to ensure the timely and accurate bi-directional flow of information between the new MVCC and all key sites especially WHHT Watford General Hospital.

7.3 The most important IT interface would be between the new MVCC and the Watford General site, which will both be on different electronic patient record systems. It will also be important to make sure the information flows to each of the peripheral (spoke) sites and primary care will be timely and accurate. This should include medication information and the access to PACS images.

7.4 **Recommendation 2**: The MVCC Reprovision team should ensure that access to services and transport for all patients is carefully considered and made as convenient as possible.

7.5 This should especially focus on those patients with the longest potential access times and lack of personal transport. This should include consideration of the most convenient referral pathways for patients, with a potential re-drawing of expected usual cancer centre catchment areas (whilst accommodating patient choice). This should also include delivering diagnostic tests and treatments at peripheral sites, in patients' homes and via mobile services, where appropriate, to minimize the necessity of patients having to travel significant distances. The plans to work with local transport providers and transport planners to further mitigate access difficulties is supported and consideration to the provision of NHS transport services to bridge any remaining gaps is recommended.

7.6 **Recommendation 3:** The MVCC Reprovision team should ensure that social and health inequalities are addressed thoroughly.

7.7 The impact of inequalities on health outcomes has become an even greater focus for the NHS following the COVID-19 pandemic. The MVCC covers geographical areas with poor health outcomes for the local population. The reasons behind this are multifactorial and include some of the wider determinants of health. However, the Panel agree that the MVCC team need to work with other stakeholders to improve early recognition of symptoms, early presentation and better take up of screening, diagnostic and treatment services.

APPENDIX 1: Terms of Reference for the review

East of England Clinical Senate

East of England Clinical Senate

Independent clinical review of proposed service reprovision of Mount Vernon Cancer Centre

DATE 23 June 2021

Terms of Reference

CLINICAL REVIEW: TERMS OF REFERENCE

CLINICAL REVIEW:
FOR MOUNT VERNON CANCER CENTRE (MVCC) TERMS OF REFERENCE

Terms of Reference agreed by:

Title: **Ruth Derrett, NHSE Programme Director, MVCC Strategic Review**
Commissioning organisation: **NHS England and NHS Improvement (NHSEI)**

Signature:

Date: 04/06/2021

And
Title: **Dr Bernard Brett, East of England Clinical Senate Chair,** on behalf of East of England Clinical Senate

Signature
Date: 08/06/2021

Supporting / background information for the clinical review for completion by commissioning organisation.	
When is the advice required by? Please provide any critical dates	Subject to capital we are hoping to go to public consultation on reprovision proposals in September 2021.
What is the name of the body / organisation commissioning the work?	NHSEI
How will the advice be used and by whom?	Advice will be used by the MVCC Strategic Review (NHSEI, MVCC, University College London Hospitals- UCLH) in relation to the clinical model and business case, and will also be shared with the NHSEI Assurance team who are required to support proposals prior to any consultation.
What type of support is Senate being asked to provide: a) Assessment of clinical services b) Early advice to inform a clinical service model c) Review of proposed clinical model (or follow up review from b above) d) Support for case for change, including the appraisal of the clinical evidence within e) Informal facilitation to enable further work f) Clinical reconfiguration or integration related to merger of trusts g) Advice on complex or (publicly) controversial proposals for service change g) Other?	(c), (d) and (g)
Is the advice being requested from the Senate a) Informal early advice or a 'sense check' on developing proposals b) Early advice for Stage 1 of the NHS England Assurance process c) Formal clinical review to inform Stage 2 of the NHS England Assurance process and/ or your Consultation Business Case d) Other?	We are not yet formally in the NHSEI Assurance process (awaiting capital) but welcome (b) please.
Does the matter involve revisiting a strategic decision that has already been made? If so what, by whom and when?	No
Is the matter subject to other advisory or scrutiny processes?	Proposals will be subject to statutory public consultation in due course

Aims and objectives of the clinical review:

MVCC is currently a standalone cancer centre providing non-surgical cancer treatment to a catchment population of approximately 2 million people, drawn (primarily) from six Integrated Care Systems.

An independent clinical review in 2019 concluded that the current service provision is not sustainable and that part or all or the services should be co-located with acute service provision.
A revised clinical model is proposed which would see reprovision on an acute hospital site. The preferred site is West Hertfordshire
Hospitals NHS Trust (WHHT) (Watford site)
The Clinical Senate are asked to review the clinical model principles and proposals which form the business case and will form the basis of public consultation.

Scope of the review:

The scope of this independent Clinical Senate review is non-surgical clinical cancer services provided from the current Mount Vernon site, and the proposed clinical model for service re-provision on the WHHT (Watford) site.
The wider service review is also considering proposals for networked radiotherapy. It is proposed that networked radiotherapy is out of scope for this Clinical Senate review but may form the focus of a future Clinical Senate review.

Out of scope:

Networked radiotherapy options (see above)

Purpose of the review:

The Clinical Senate is being asked to review the available evidence, discuss with the members of the programme and make appropriate recommendations to the programme from its findings. This is a stage one assurance review and a further stage review may be necessary once further progress has been made with the proposals.
The central questions the Clinical Senate is being asked to address in this review are:

- **Does the proposed clinical model meet the requirements of the independent clinical review advice in 2019, and subsequent separate advice on required acute adjacencies?**
- **Is the proposed clinical model appropriate to ensure the safe and effective provision of services for patients and the population covered?**
- **Does the proposed clinical model, to be re-provided on the WHHT (Watford) site, meet requirements for the future sustainability of cancer services?**

When reviewing the case for change and options appraisal the clinical review panel (the panel) should **consider whether these proposals deliver real benefits to**

patients. The panel should also identify any significant risks to patient care in these proposals. The panel should consider benefits and risks in terms of:

- Clinical effectiveness
- Patient safety and management of risks
- Patient experience, including access to services
- Patient reported outcomes.

The clinical review panel is not expected to advise or make comment upon any issues of the NHS England Service Change Assurance process that will be reviewed elsewhere (e.g. financial elements of risk in the proposals, patient engagement, GP support or the approach to consultation). However, if the panel agreed that there was an overriding risk in any of those areas that should be highlighted in the panel report.

Questions that may help the panel in assessing the benefit and risk of the proposals include (but are not limited to):

- Is there a clear vision for the proposals, i.e. what is the intended aim?
- Are the expected outcomes and benefits of delivery for patients of this proposed model clear and are there clear plans for how it / they will be measured?
- Is there evidence of clinical leadership and engagement in the development of the options/ preferred model?
- Is there evidence that the proposals will improve the quality, safety and sustainability of care? (e.g. sustainability of cover, clinical expertise).
- Is there evidence that the proposed model will ensure equity in access to services for the population you serve, and how it could reduce inequalities in health?
- If there is a potential increase in travel times for some patients, is this outweighed by the clinical benefits?
- Do the proposals support better integration of services from the patient perspective?
- Do the proposals explain how the model be staffed? Is there appropriate information on recruitment, retention, availability and capability of staff and the sustainability of the workforce?
- Do the proposals reflect up to date clinical guidelines and national and international best practice e.g. Royal College reports?
- Will these proposals meet the current and future healthcare needs of their patients within the given timeframe of the planning framework (i.e. the next ten years or more)?
- Do the proposals align with the local strategies and delivery plans (e.g. Sustainability and Transformation Plans / Integrated Care System strategy and plans)? Do they demonstrate alignment / integration of services (e.g. the link between primary care / social care / mental health services and acute provision including information systems)?

- Do the proposals demonstrate good alignment national policy and planning guidance?
- Does the options appraisal consider a networked or Alliance approach - cooperation and collaboration with other sites and/or organisations?
- Will the proposals reflect further the delivery of the NHS Outcomes Framework?
- Do the proposals uphold and enhance the rights and pledges in the NHS Constitution?
- Is there an analysis of the clinical risks in the proposals, and is there an adequate plan to mitigate identified risks?

The clinical review panel should assess the strength of the evidence base of the clinical case for change and proposed models and make clear its key findings and recommendations in a report to the commissioning organisation.

Timeline:

The clinical review panel will be held on the 23 June 2021. The panel date was rearranged from January 2021 due to the COVID-19 incident.
A schedule of agreed key dates can be found at Appendix A.

Reporting arrangements:

The clinical review panel will provide a report to the Clinical Senate Council which will ensure the panel met the agreed Terms of Reference, agree the report and be accountable for the advice contained in the final report.

Methodology:

The review will be undertaken by a combination of

- desk top review of the documentation (evidence) provided,
- a pre-panel Microsoft Teams meeting for panel members to identify the key lines of enquiry and
- a review panel meeting using Microsoft Teams to enable presentations and discussions to take place.

Report of the clinical review:

A draft report will be made to the commissioning organisation for fact (points of accuracy) checking prior to publication.
Comments / correction must be received from the commissioning organisation within ten working days.
The report will be submitted to Clinical Senate Council on 14 September to ensure it has met the agreed Terms of Reference and to agree the report. If required, an extraordinary Clinical Senate Council meeting may be convened prior to the 14 September to consider and review the report.
The final report will be issued to the commissioning organisation following the Council Senate Council meeting at which the report is reviewed. The commissioning organisation forthwith becomes the owner of the report.

Communication, media handling and Freedom of Information (Act) requests:

Communications in respect of the review will be managed by the commissioning organisation. Clinical Senate will publish the report once the service change proposal has completed the full NHS England process, or at a time that is appropriate to the proposals. This will be agreed with the commissioning organisation.

The commissioning organisation, as the owner of the report and any evidence and or data provided for the review, will be responsible for handling any formal requests for information under the Freedom of Information Act 2000, irrespective of whether the request is received by either the Clinical Senate or commissioning organisation. (note: NHS Commissioning Board known as NHS England is the statutory body with responsibility for Freedom of Information requests received either directly or by the Clinical Senate and will be advised of all such requests received directly by the Clinical Senate and confirmation that the commissioning organisation will be responding to the request).

Confidentiality:

Notes of the discussion will be taken on the day in order to develop a report. Once the final report has been issued to the commissioner of the review, they will be securely destroyed along with the evidence set provided.

All clinical review panel members will be required to sign a Confidentiality Agreement and declare any interests, potential or otherwise. The detail of any potential, or actual, conflict of interest will be discussed with the commissioning organisation and agreement made between them and the Clinical Senate as to whether or not the member may join the review panel.

Resources:

The East of England Clinical Senate will provide administrative support to the clinical review panel, including setting up the meetings and other duties as appropriate.

The clinical review panel may request any additional existing documentary evidence from the commissioning organisation. Any requests will be appropriate to the review, reasonable and manageable. The review panel will not ask the commissioner of the review to provide new evidence or information that it does not currently hold.

Accountability and governance:

The clinical review panel is part of the East of England Clinical Senate accountability and governance structure.

The East of England Clinical Senate is a non-statutory advisory body and will submit the report to the commissioning organisation, who will be the owners of the final report.

The commissioning organisation remains accountable for decision making but the clinical review panel may wish to draw attention to any risks that the commissioning organisation may wish to fully consider and address before progressing their proposals.

Functions, responsibilities and roles of the parties

The commissioning organisation will

i. provide the Clinical Senate review panel with the clinical case for change, options appraisal and relevant background and current information, identifying relevant best practice and guidance. It is recommended that the evidence supports the questions laid out above. The level of detail though will be appropriate and in proportion to the stage of development of the proposals. For NHS England Service Change Assurance process 'Stage 2' reviews, Clinical Senate provides supporting information on the evidence it would expect to see
ii. respond within the agreed timescale to the draft report on matter of factual inaccuracy
iii. undertake not to attempt to unduly influence any members of the clinical review panel during the review
iv. be responsible for responding to all Freedom of Information requests related to the review and proposals and
v. arrange and bear the cost of suitable accommodation (as advised by Clinical Senate support team) for the panel and panel members.

Clinical Senate Council and the commissioning organisation will

i. agree the Terms of Reference for the clinical review, including scope.

Clinical Senate Council will

i. appoint a clinical review panel, this may include members of the Clinical Senate Council and Assembly, external experts, and / or others with relevant expertise. It will appoint a Chair of the review panel
ii. consider the review recommendations and report and consider whether the clinical review panel met the Terms of Reference for the review
iii. provide suitable support to the panel
iv. issue the final report to the commissioning organisation and
v. promptly forward any Freedom of Information requests to the commissioning organisation.

Clinical review panel will

i. undertake its review in line with the methodology agreed in the Terms of Reference
ii. follow the report template and provide the commissioning organisation with a draft report to check for factual inaccuracies
iii. submit the draft report to Clinical Senate Council for comments and will consider any such comments and incorporate relevant amendments to the report.

Clinical review panel members will undertake to

i. declare any conflicts of interest and sign a confidentiality agreement prior to having sight of the full evidence and information
ii. commit fully to the review and attend all briefings, meetings, interviews, panels etc. that are part of the review (as defined in methodology
iii. contribute fully to the process and review report
iv. ensure that the report accurately represents the consensus of opinion of the clinical review panel and
v. comply with a confidentiality agreement and not discuss the scope of the review nor the content of the draft or final report with anyone not immediately involved in it. Additionally, they will declare to the Chair of the clinical review panel and the Head of Clinical Senate, any conflict of interest that may materialise during the review.

Clinical Review Panel members:

Members of the clinical review panel sit in their own personal or professional capacity; they do not represent the opinion of their employing or professional body. All clinical review panel members sign an agreement of confidentiality and declare any potential interests.

Clinical Review Panel members		
Name	**Area / organisation**	**Role / area of expertise**
Bernard Brett	Chair, East of England Clinical Senate	Clinical Review Panel Chair
Dr Clare Beadsmoore	Norfolk and Norwich University Hospitals NHS Foundation Trust	Consultant Radiologist and Radionuclide Radiologist
Fiona Carey		Expert by Experience
Gillian Donohue	Southend University Hospital, Mid and South Essex University Hospitals Group	Senior Nurse, Critical Care Unit and Resuscitation Services
Charlotte Etheridge	Ipswich Hospital, East Suffolk and North East Essex NHS Trust	Lead Macmillan Urology Nurse Specialist
Dr David Gilligan	Royal Papworth Hospital, Cambridge University Hospitals	Consultant Oncologist
Dr Melissa Hubbard	University Hospitals of North Midlands NHS Trust	Divisional Chair
Anna Morgan	Norfolk and Waveney Health & Care Partnership	Director of Workforce
Dr Stuti Mukherjee	Cambridge and Peterborough CCG	GP, Macmillan GP & Joint Clinical Lead, Cancer

Appendix A – Key Dates		
Action	**Date**	**Who**
1. Commissioning team request clinical review –date & methodology agreed with Senate	Require minimum of 8 weeks lead in for review	• Ruth Derrett (NHSEI) • Senate Office
2. Terms of Reference for review completed, agreed and signed off	**7 June 2021**	• Commissioning Organisation - NHSEI, Ruth Derrett, • Clinical Senate Chair Bernard Brett
3. All panel members identified and confirmed, confidentiality agreements and declarations of interest signed	**7 June 2021**	• Senate Office (Mary Parfitt, Isabel Kerrison)
4. All papers and evidence for the review panel to be with Mary Parfitt and Isabel Kerrison	**1 June 2021**	• Ruth Derrett
5. Panel papers and Terms of Reference to panel members	**7 June 2021**	• Mary Parfitt, • Isabel Kerrison
6. Pre panel teleconference call	**10 June 2021**	• Panel members only • (MVCC/ UCLH/ NHSEI Ruth Derrett not involved)
7. Lines of Enquiry / Agenda for Clinical Panel review day issued to panel members and Ruth Derrett to forward to MVCC and UCLH	**11 June 2021**	• Mary Parfitt, • Isabel Kerrison
8. Clinical Panel Review	**23 June 2021**	• All Panel members, • MVCC/ UCLH/ NHSEI Ruth Derrett team (6 members)
9. Draft report to Ruth Derrett for points of accuracy	**7 July 2021**	• Mary Parfitt • Senate Project Officer
10. MVCC response on points of accuracy	**21 July 2021**	• Ruth Derrett • Panel Member
11. Clinical Senate Council consider report	**14 September 2021**	• Senate Council

APPENDIX 2: Membership of the Clinical Review Panel

Clinical Review Panel Chair:

Bernard Brett
Dr Bernard Brett, Chair of East of England Clinical Senate, is Deputy Medical Director and a Consultant in Gastroenterology and General Internal Medicine based at the Norfolk and Norwich University Hospitals NHS Foundation Trust, he is the Quality Improvement Lead for the British Society of Gastroenterology and also works as a Gastroenterologist at the James Paget University Hospitals NHS Foundation Trust.

Bernard has held several other senior management posts over the last twenty years including that of Medical Director, Responsible Officer, Deputy Medical Director, Divisional Director, Director of Patient Flow and Appraisal lead. He continues with an interests in Quality Improvement, Major Service Redesign, Appraisal and Revalidation. Bernard has spoken at regional and national meetings on the topics of the BSG Quality Standards Framework, the future of Gastroenterology services,7-day working and been an invited speaker on the topic of improving colonoscopic adenoma detection rates.

Panel Members:

Clare Beadsmoore
Clare is a consultant radiologist and radionuclide radiologist at the Norfolk and Norwich University Hospital Foundation NHS Trust.

She specialises in Oncology, in particular haematology, cancer of unknown primary, colorectal cancer and PET-CT imaging.

Clare is a member of the ARSAC committee (PHE) advising the secretary of state on matters concerning the administration of radioactive substances; the chair of the expert working group (NHS Digital) advising on HRG, coding and tariffs; a member of the intercollegiate standing nuclear medicine committee, advising the Royal colleges of radiologists and physicians on all matters concerning nuclear medicine; a member of the Alliance Medical Clinical Governance board overseeing the PET-CT national contract and the lead editor for the nuclear medicine chapter of the on line radiology learning platform (RITI).

Fiona Carey

Fiona worked for 30 years as a professional editor in publishing and higher education. She spent a couple of decades at the Open University where she was first an editor, and latterly an Assistant Director of Communications.

She was diagnosed with renal cancer about 20 years ago, and is still dealing with oligometastatic disease, and the consequences of repeated treatment. She retired about 9 years ago, and 'accidentally' got involved in service improvement, first at Addenbrookes Hospital, then at a regional level, and also nationally. Her particular objectives are:

1. To make patient-centred care a reality, particularly for those with long-term conditions.
2. To ensure that strategic improvement and development projects systematically include the voices and view of patients and carers, preferably "from the blank piece of paper stage".
3. To turn co-production (patient involvement) from 'a workstream' into a basic, default methodology.

Gillian Donohue

Gillian is a Senior Nurse and Lecturer Practitioner in Southend Critical Care, Mid and South Essex NHS Trust.

Gillian has extensive experience in acute care settings, working in a variety of clinical settings across hospital patient settings, including intensive care, high dependency, surgery and theatres.

Gillian's focus throughout her nursing career has been to develop her teaching skills and this interest has led to her developing and delivering multi-professional study programmes to improve the deteriorating patient pathway.
Gillian has specialised in Critical care for the past 23 years but has maintained a passion for education and has been instrumental in developing the East of England Critical Care Network transfer course. The interest in improving the deteriorating patient pathway has been consistent and Gillian has been supportive of the development of the Critical Care outreach service.
Gillian has also been part of the team that designed a new High Dependency Unit and was actively involved in the associated workforce planning.
Gillian has an Honours degree in Nursing and a Masters Degree in Health and Medical Simulation.

Charlotte Etheridge

Charlotte is a Macmillan Urology Nurse Specialist at East Suffolk and North Essex NHS Foundation Trust (based at Ipswich Hospital).

Charlotte has spent 25 years working in the field of Urology and has experience of working in both a teaching hospital setting and in a district general hospital setting.

She has worked in a number of different roles including as an Advanced Nurse Practitioner, a Lead Nurse and a Clinical Nurse Specialist. Charlotte's current role centres on the provision of specialist information and support, to patients with a diagnosis of a urological cancer, as their keyworker.

Outside of the clinical setting Charlotte's main interest is that of Cancer Peer Review, as the benefit of this programme on patient care and service development cannot be underestimated. Charlotte has been a Reviewer since 2005 and has been fortunate to be a member of a number of different Peer Review panels across a wide range of hospitals and cancer networks.

David Gilligan

Dr David Gilligan is a Consultant Oncologist at Cambridge University Hospitals & Papworth Hospitals, Cambridge, UK and an Associate Lecturer at the University of Cambridge. He trained in Oncology at the Christie Hospital, Manchester, Royal Marsden Hospital, and University College Hospitals, London.

His main clinical interests are in Thoracic Oncology and Upper Gastrointestinal Oncology. He is an enthusiastic participator in clinical trials and has a keen interest in patient engagement and patient information.
He has been a member of the NCRI Lung Cancer Studies Group. From 2016-2019 he was elected to the Council of the Royal College of Radiologists (RCR). He currently sits on NHS England Lung Cancer Clinical Expert Group (CEG). He is a Senior Medical Editor to Macmillan Cancer Information and Specialist Advisor to CancerHelp UK, a Trustee and Chair of Grants Committee of the Roy Castle Lung Cancer Foundation, the major patient facing UK wide lung cancer charity.
He has been a member of British Thoracic Oncology Group (BTOG) Steering Committee Since May 2017 and is an auditor and inspector to the European Organisation of Cancer Institutes (OECI).

Melissa Hubbard
Dr Melissa Hubbard has been a Consultant Paediatrician at Royal Stoke Hospital for 20 years. She is the Divisional Clinical Director for CWD division, including the following directorates - Women and Children's, Imaging, Pathology, Oncology and Haematology, Pharmacy and Mortuary and Bereavement Services.

Melissa is a member of the Northern ICP Clinical Assembly, a GP communication group and RCPCH examiner.

Melissa has experience in managing large scale reconfiguration with the highly political and publicly resisted merger of Stafford Hospital and Royal Stoke to form University Hospital of North Midlands

Anna Morgan

Anna Morgan, MBE is a Registered General Nurse and Director of Workforce for the Norfolk and Waveney Health and Care Partnership. In her role as Director of Workforce Anna has developed a system wide workforce strategy which focuses improving the workplace and growing the future workforce across health and care services, including volunteers.

Anna was Director of Nursing and Quality at Norfolk Community Health & Care NHS Trust, for nine years prior to her current role. Anna was delighted to have contributed to enabling the Trust to gain an Outstanding CQC rating in 2018, the first community trust in the country to achieve this. She was awarded an MBE in the 2019/20 New Year's Honours for her services to Nursing.

Anna has over thirty-five years' experience in nursing mainly in the NHS, five years working in the private Care Home sector and two years in the Department of Health. Anna's area of clinical expertise is within Gerontology. She is passionate about older peoples' care and the care for people with dementia. Anna has experience as an Executive reviewer for well-led inspections with CQC and is a member of the East of England Clinical Senate Council.

Anna is the main carer for an 89-year-old lady who suffers with dementia and other long-term conditions. In addition to her formal caring role Anna keeps her clinical practice up to date, most recently by volunteering to support the COVID-19 Vaccination campaign.

Stuti Mukherjee

Dr Stuti Mukherjee is a General Practitioner, a Macmillan GP and Joint Clinical Lead for Cancer at Cambridgeshire & Peterborough CCG.

She enjoys working as a Generalist, and has a special clinical interest in cancer, dermatology and end of life care.

Clinical Senate Support Team:	
Mary Parfitt	Interim Head of Clinical Senate, East of England, NHS England
Shelagh Cunningham	Clinical Senate Senior Project Officer, East of England, NHS England
Isabel Kerrison	Interim Clinical Senate Senior Project Officer, East of England, NHS England

APPENDIX 3: Declarations of Interest

All panel members were required to declare any interests.

David Gilligan, Consultant Oncologist CUH NHS FT declared he had a financial investment in Genesis Care Cambridge Centre. Investment is in the Cambridge Centre only (no other part of Genesis). After a discussion with Bernard Brett (Chair) the outcome was the agreement for David Gilligan to sit on the panel as the declaration does not raise any conflict of interest.

Clare Beadsmore, Consultant Radiologist and Radionuclide Radiologist at the Norfolk and Norwich University Hospital declared a direct non-pecuniary interest and an indirect pecuniary interest. Clare is a member of the Alliance Medical Clinical Governance committee; this is a voluntary, non-funded role. Alliance Medical holds the NHS England contract for PET-CT. Clare also reports for this company on a fee per case basis. Clare advised she would withdraw from any decision which included a proposed change in provision of PET-CT services in favour of Alliance Medical or which included a proposed change in provision of services that involved the NNUH. After a discussion with Bernard Brett (Chair) the outcome was the agreement for Clare Beadsmore to sit on the panel as the declaration does not raise any conflict of interest.

The remaining panel members claimed not to have any
a) Personal pecuniary interest
b) Personal family interest
c) Non-personal pecuniary interest or
d) Personal non-pecuniary interest.

APPENDIX 4: Clinical Review Panel agenda

Agenda

Independent clinical review of proposal for reprovision of Mount Vernon Cancer Centre services

Wednesday 23 June 2021

Time:
09.30 – 16.30 for panel members
09.50 – 13.00 for NHSEI/ Mount Vernon Cancer Centre team/ UCLH team

MS Teams Meeting

Clinical Senate is asked to review the available evidence, discuss with the members of the centre and make appropriate recommendations from its findings on the proposals for a revised clinical model for the reprovision of non-surgical cancer services from Mount Vernon Cancer Centre (MVCC).

The central questions Clinical Senate is being asked to address in this review are:

- **Does the proposed clinical model meet the requirements of the independent clinical review advice in 2019, and subsequent separate advice on required acute adjacencies?**
- **Is the proposed clinical model appropriate to ensure the safe and effective provision of services for patients and the population covered?**
- **Does the proposed clinical model, to be re-provided on the WHHT (Watford) site, meet requirements for the future sustainability of cancer services?**

Time	Item	Who
09.25	Sign in and arrival Teams call	Panel members
09.30 - 09.50	Welcome, introductions & outline of the proceedings for the review panel from panel chair	Dr Bernard Brett
09.50 – 10.00	NHSE/MVCC/UCLH team- welcome & introductions	NHSEI/ MVCC / UCLH
10.00 - 10.30	Overview presentation 30 mins by NHSEI/ MVCC/ UCLH team to the panel	NHSEI/ MVCC / UCLH

10.30 – 10.45	Preparation of questions by panel NHSE/MVCC/UCLH team leave meeting	Panel members
10.45 – 11.00	Short break	
11.00 – 12.30	General questions from the panel	Panel members & NHSEI/ MVCC / UCLH
12.30 – 13.00	Lunch break NHSE/MVCC/UCLH team depart after lunch.	Panel members & NHSEI/ MVCC / UCLH
13.00 – 14.30	Confidential Panel discussion	Panel members
14.30-14.45	Short Break	
14.45 – 15.15	Panel discussion and questions with NHSE/MVCC/UCLH team members if required	Ruth Derrett and Emily Collins
15.15 – 16.00	Confidential Panel discussion Panel summary – key findings and recommendations	Panel members
16.00 - close	Panel summary – key findings and recommendations and closing.	Panel members/ Dr Bernard Brett

Next steps – information for clinical review panel members:

1. A draft report will be sent to the MVCC team and clinical review panel members for points of accuracy check no later than 7 July 2021 for response by 21 July 2021 turnaround for panel members and MVCC team.
2. The report will be submitted to Clinical Senate Council on 14 September to ensure it has met the agreed Terms of Reference and to agree the report.

If required, an extraordinary Clinical Senate meeting may be convened prior to the 14 September to consider and review the report.

The final report will be issued to the commissioning organisation following the Council Senate Council meeting at which the report is reviewed. The commissioning organisation forthwith becomes the owner of the report.

KEY LINES OF ENQUIRY

The clinical review panel raised a number of areas for further exploration on its pre-panel call on 10 June 2021. These have been developed into key lines of enquiry for the commissioning organisation to address through its presentation and discussion with the Panel on 23 June 2021. The Commissioning organisation is welcome to address any of these by email prior to the Panel day. Please note, the discussion on 23 June 2021 will not be restricted to these areas alone.

1. **Patient pathways and patient flows:**

- The panel would like further detail on patient pathways. It would be helpful

to see what would be different for patients and in what way would their experience be improved? This should ideally include illustrative patient journeys on

- specific patient pathways related to geography, including patients living far from the proposed Watford site
- cancer types
- community and outreach chemotherapy
- emergency 24/7 access
- "Hub and spoke" model, how this will work from the Watford site and will this model be maintained and supported
- What opportunities will be created and taken to redesign and provide more diagnostics and therapies in localities nearer to patients' homes?

- The panel would like assurance on the how it will work and delivery of
  - 'One stop shop' for cancer
  - Communication with GP's regarding treatment and discharge, particularly for those patients who live further away from the Watford locality and also in relation to medications

2. **Digital Infrastructure:**

- With UCLH operating from the Watford site the panel would like an understanding of
  - Information flows.
  - Will there be different IT operating systems between MVCC and Watford General? If so, how will the information flows be managed?
  - How will information flow from and to Primary Care and other Trusts?
  - What will be in place to avoid paper documentation?
  - How will patients have access to their records and results?

- The panel would like assurance on integrated PACS and imaging particularly when the patient has been identified from another hospital.
  - How will the imaging flows be managed, including follow-up scans and those from community diagnostic hubs?
  - How will any diagnostic capacity issues in local Trusts be managed for this patient
    population?

3**. Travel:**

- The panel recognise that there is significant work that has been undertaken and shared on travel times for patient. To improve the understanding of the Panel an overall summary of this would be welcomed. This should include recognition of public transport to attend diagnostics and therapies from rural localities. What percentage of patients would have an increased travel time and which geographical locations will be most affected?

4. **Governance:**

- MDT's
  - How will the MDT's work?
  - Will they be supra-regional or local?
  - What are the proposed staffing models for the MDT's?

- LINAC's

  Whilst recognising that networked radiotherapy is out of the scope of this Clinical Senate Panel review, nevertheless the panel would like to explore, if possible, about the LINAC's, to broaden the understanding of the Panel and to consider this from the patient perspective. Specifically,
  - How many LINACs will there be, and where will these be sited?
  - Which organisation will be responsible for the governance and overall control of the LINAC's?

- What advantages will UCLH offer as the new organisation accountable for MVCC services.

5. **Research and Development:**

- What will the relationship be between UCLH and MVCC with regards to R&D?
- Will a degree of autonomy for the MVCC be maintained and if so, how will this be developed and ensured?
- How will new MVCC cancer R&D initiatives be developed and not stifled under the umbrella of the larger UCLH organisation?

6. **PET- CT:**

- The Panel understands there is a PET-CT on the current MVCC SITE.
  - Is this provided under charitable means, or who commissions it?
  - What are the plans for PET-CT and who will the governing body be for PET-CT?

7. **Patient Experience:**

- How will the 'familial' and positive reputation of the MVCC patient experience be maintained?

8. **Pathology networks:**

- When the MVCC moves site, how will this fit and link with the pathology network?

9. **Workforce:**

- What will be the employment model for the MVCC staff?
- Will all staff be employed by UCLH or Watford Hospital?
- Will all staff be based and /or working from the Watford site? What assurances and plans will be in place to enable staff to travel to the Watford site?
- What are the plans to ensure that staff retention is ensured in the move of MVCC to Watford site?
- What are the plans to enhance multi-professional working including development of nurse-led work?

10. **Inequalities**:

- The Panel wish to understand how the proposed new provider intends to tackle inequalities.

Clinical Review Panel members		
Name	**Area / organisation**	**Role / area of expertise**
Dr Bernard Brett – Chair	Clinical Senate Chair	
Fiona Carey		Expert by Experience
Dr David Gilligan	Royal Papworth Hospital, Cambridge University Hospitals	Consultant Oncologist
Charlotte Etheridge	Ipswich Hospital, East Suffolk and North East Essex NHS Trust	Lead Macmillan Urology Nurse Specialist
Anna Morgan	Norfolk and Waveney Health & Care Partnership	Director of Workforce

Dr Stuti Mukherjee	Cambridge and Peterborough CCG	GP, Macmillan GP & Joint Clinical Lead, Cancer
Dr Melissa Hubbard	University Hospitals of North Midlands NHS Trust	Divisional Chair
Clare Beadsmoore	Norfolk and Norwich University Hospitals NHS Foundation Trust	Consultant Radiologist and Radionuclide Radiologist
Gillian Donohue	Southend University Hospital, Mid and South Essex University Hospitals Group	Senior Nurse, Critical Care Unit and Resuscitation Services
In attendance		
Mary Parfitt	NHS England and NHS Improvement	Interim Head of Clinical Senate
Isabel Kerrison	NHS England and NHS Improvement	Interim Clinical Senate Project Officer
Shelagh Cunningham	NHS England and NHS Improvement	Clinical Senate Project Officer

NHSEI/ MVCC/UCLH team Presenting Team		
Name	**Role**	**Organisation**
Ruth Derrett	Programme Director, MVCC Review	East of England Specialised Commissioning, NHS England and NHS Improvement
Emily Collins	Project Director, MVCC Transition	University College London Hospital
Sarah James	Hospital Director	Mount Vernon Cancer Centre
Professor Peter Hoskin	MVCC Transition Clinical Lead	Mount Vernon Cancer Centre
Dr Kirit Ardeshna	Clinical Director	University College London Hospital
Dr Suzy Mawdsley	Clinical Director	Mount Vernon Cancer Centre
Jessamy Kinghorn	Head of Partnerships & Engagement	East of England NHS England and NHS Improvement

APPENDIX 5: Summary of evidence set provided

Ref	Evidence	Explanation
01	Overview of the case for change.	This briefing provides an overview of the stages in the proposals for reprovision of the Mount Vernon Cancer Centre Strategic Review.
02	Document A - MVCC Clinical Advisory Panel Review and Recommendations - FINAL v1.2 08 July 2019.	The report was commissioned by NHS England as an urgent review of Mount Vernon Cancer Centre (MVCC) in May 2019, due to increasing concern regarding the sustainability of a safe and high quality oncology service provided at the site. This was chaired by Professor Nick Slevin. This reviewed the options previously identified by key stakeholders and made recommendations to the MVCC Programme Board meeting.
03	Document B - Future siting of the central hub of the Mount Vernon Cancer Centre What directly adjacent clinical services best support optimal cancer care?	This report considers what clinical services are required to be on the same geographical site as the inpatient central hub of the MVCC to provide the clinical expertise at the hub for the optimal management of cancer patients receiving care by MVCC.
04	Document C - Mount Vernon Cancer Centre Activity Review v1.1	A review of patient activity at MVCC
05	Document D - The Clinical Model of Care for services at Mount Vernon Cancer Centre.	Details the work of the MVCC Programme Board Clinical Workstream to reach a recommendation on the future clinical model for MVCC services.
06	Document E – Travel times analysis.	This analysis is based on all activity delivered on the Mount Vernon Cancer Centre site in 2019, covering the full range of services delivered on the site (primarily Chemotherapy, Radiology, Non-elective inpatient, Elective inpatient, Day case, Outpatients and Brachytherapy).
07	Document F – Mount Vernon Cancer	NHS England, working together with

	Centre Strategic Review.	hospital trusts and local commissioners, has been leading a review of the services provided at the Mount Vernon Cancer Centre. The review is to find a solution to the quality of the buildings as well as clinical challenges such as the limited hospital support there is for patients who are very unwell or have additional health needs. The review has focused on the model of care provided at the centre. This includes the range of services provided, clinical leadership and operational management, and where and how patients can access them.
08	Document G - Mount Vernon Cancer Centre: Patient and Public Involvement. Draft Interim Phase 2 Public and Patient Engagement Report.	This interim report addresses the feedback received during engagement events held during October, November and December 2020. Patient and public engagement for Phase 1 is the subject of a separate report, published September 2019.
09	Document H - Redevelopment of the Mount Vernon Cancer Centre. Preliminary Re-provision Business Case.	This Preliminary Re-provision Business Case describes the proposals for the future of the services delivered at Mount Vernon Cancer Centre (MVCC).
10	Document I - Redevelopment of the Mount Vernon Cancer Centre: A Preliminary Re-provision Business Case. Appendices for circulation.	These are the appendices for the Preliminary Re-provision Business Case.
11	Document J - Interim report: EHIA.	An Equality and Health Inequalities Impact Assessment (EHIA) is underway, assessing the impact of a potential relocation of the Mount Vernon Cancer Centre to the proposed Watford site on health inequalities. This interim report sets out the early, high-level findings to accompany the business case dated 13th May 2021.
12	Independent clinical review of proposal for reprovision of Mount Vernon Cancer Centre services.	Presentation from the MVCC Transition Team.