

Agenda

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UPON THAMES

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South West London and Surrey Joint Health Overview and Scrutiny Committee

Date: Wednesday 7 June 2023
Time: 7:00 pm
Place: The Guildhall, Kingston upon Thames

Members of the Committee

Councillor Agatha Akyigyina, Councillor Richard Chatterjee, Councillor Qasim Esak, Councillor Kate Forbes, Councillor Daniel Ghossain, Councillor Jenifer Gould, Councillor Lesley Heap, Councillor Trefor Hogg, Councillor Edward Joyce, Councillor Jim Millard, Councillor Bernie Muir, Councillor Eunice O'Dame, Councillor Stephen O'Shea and Councillor Anita Schaper.

Everyone is welcome to attend the meeting

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AGENDA

1. Appointment of a Chairman and Vice Chairman

To appoint a Chairman and Vice Chairman for the 2023/2024 municipal year.

2. Apologies

3. Declarations of Interest

Members are asked to declare any disclosable pecuniary interests or any other registrable or non-registrable interests relevant to items on this agenda.

Should Members require any advice on declarations of interest, please contact the relevant Democratic Services Officer in advance of the meeting.

4. Minutes

To approve as a correct record the minutes of the last meeting on 25 January 2023.

5. Principal Treatment Centre - Update on plans for consultation

A presentation on the Reconfiguration of Children's Cancer Principal Treatment Centre including an update on plans for the public consultation.

6. Urgent Items authorised by the Chair

7. Exclusion of the Press and Public

This item is included as a standard agenda item which will only be relevant if any exempt matter is to be considered at the meeting:

To exclude the public from the meeting under Section 100(A)(4) of the Local Government Act 1972 on the grounds that it is likely that exempt information, as defined in Part I of Schedule 12A to the Act *, would be disclosed.

(*relevant regulatory paragraph to be indicated eg paragraph 1 for information relating to any individual)

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By entering the meeting room and using the public seating area, you are consenting to being filmed and to the possible use of those images and sound recording for webcasting and/or training purposes.

Information about the Committee

The Committee is made up of two Councillors from each of the constituent areas.

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- Toilet facilities will be easily accessible from the meeting room.
- For people who are deaf or have hearing impairments, there is an induction loop (depending on the building, this may only be available in the first two or three rows).
- **A large print copy of the agenda can be requested in advance**

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Interests

Councillors must say if they have an interest in any of the items on the Agenda. Interests may be personal or pecuniary. Depending on the interest declared, it might be necessary for the Councillor to leave the meeting during the debate on any given item. Further information regarding declarations of interest can be found in Part 5A of the Constitution - Members' Code of Conduct.

Minutes

The Minutes briefly summarise the item and record the decision. They do not record who said what during the debate.

South West London and Surrey Joint Health Overview and Scrutiny Committee

7 June 2023

Principal Treatment Centre - Update on plans for consultation

Recommendation(s)

The Committee is asked to RESOLVE that:

1. a Sub-Committee should be established to formulate and submit a formal response to the consultation on the service reconfiguration on behalf of the Joint Health Overview and Scrutiny Committee; and
2. the membership of the Sub-Committee be approved as one Member from each authority; and
3. the Chair and Vice-Chair of the Sub-Committee be appointed for the lifetime of the Sub-Committee; and
4. the formal Terms of Reference of the Sub-Committee be finalised in consultation with the Chairs of the Joint Health Overview and Scrutiny Committee and the Sub-Committee.

Background:

The Committee will receive a presentation from the NHS England Specialised Commissioning Team on the Reconfiguration of Children's Cancer Principal Treatment Centre including an update on plans for the public consultation.

It is recommended that a Sub-Committee be established to formulate a formal response to the consultation on the service reconfiguration on behalf of the Joint Overview and Scrutiny Committee.

The Committee may wish to consider any particular areas of focus it wishes the Sub-Committee to consider. The lifetime of the Sub-Committee would be for the duration of the consultation period and would end after the submission of the formal response.

Reconfiguration of Children's Cancer Principal Treatment Centre serving south London, Kent and Medway, most of Surrey, East Sussex, Brighton and Hove

Presentation to the South West London and Surrey Joint Overview and Scrutiny Committee

Structure of our presentation

Agenda

1. Background and case for change
 2. Where are we now
 3. Equality and Health Inequality Impact Assessment
 4. Consultation plan and document, including stakeholder engagement
- Annex

1. Background and case for change

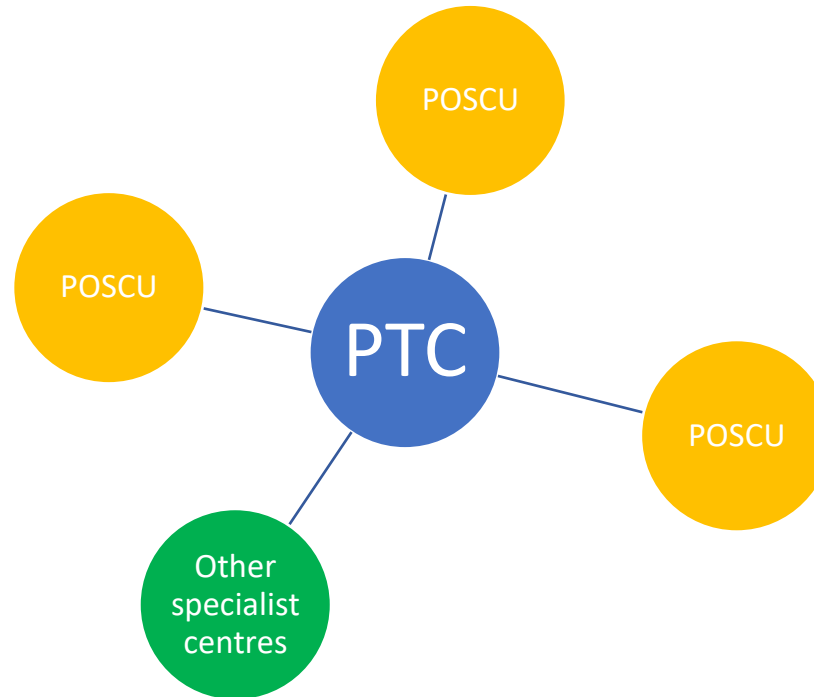
Caring for children with cancer

Principal Treatment Centres

Children with cancer in England receive some of the best care in the world, at the forefront of cutting-edge treatments and technology.

Their care is coordinated and led by Principal Treatment Centres, which provide diagnosis, treatment plans, and highly specialised care for children aged 15 and under with cancer.

Principal Treatment Centres are responsible for making sure each child gets the specific expert care they need for their particular cancer, and for coordinating treatment by different hospitals, if needed. Treatments for cancer in children can be complex and intensive and are often delivered as part of a clinical trial. Children can become acutely ill during treatment, requiring a high level of medical support.



Shared care

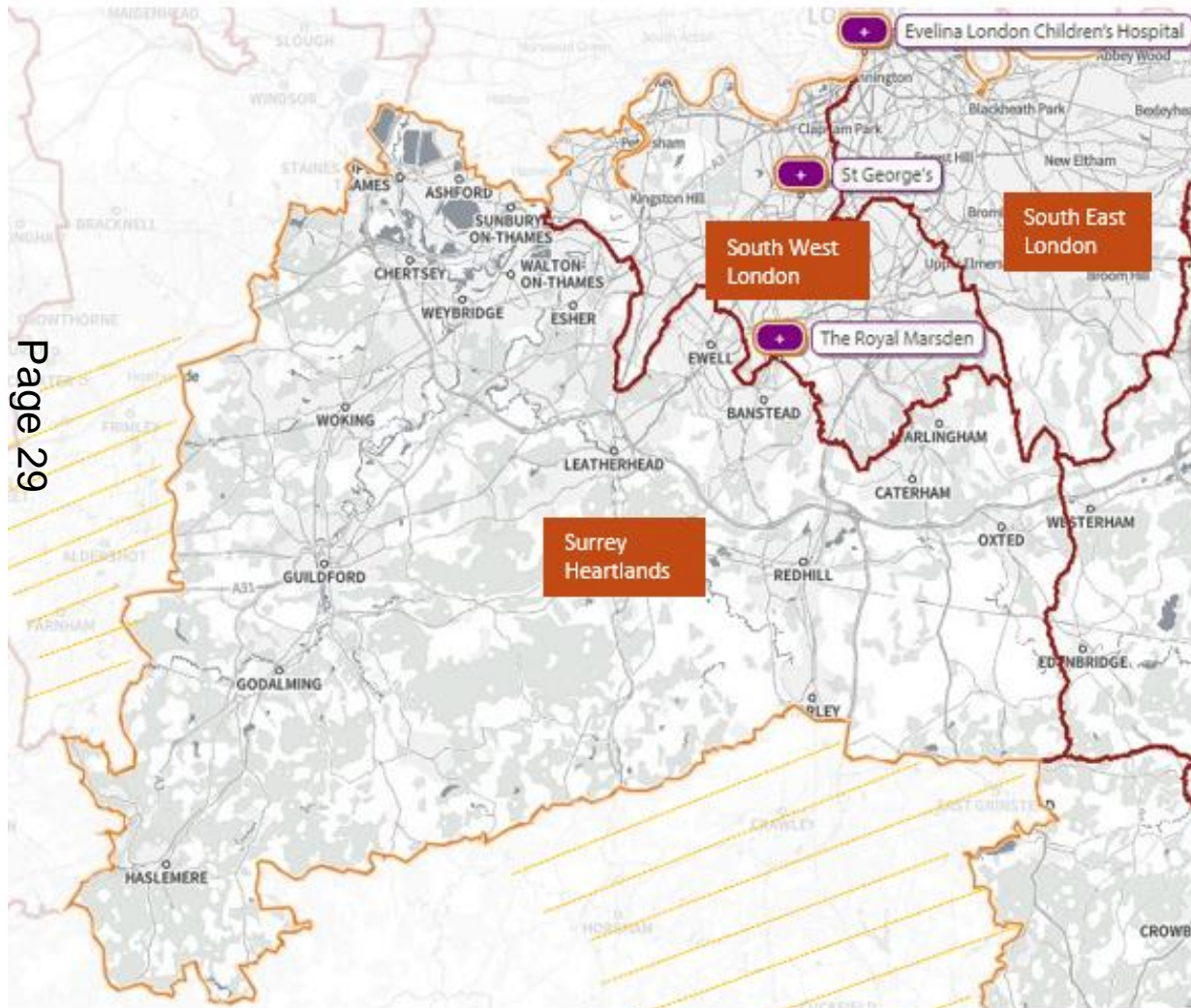
Principal Treatment Centres work in partnership with Paediatric Oncology Shared Care Units (POSCUs) at specified hospitals across their catchment areas, allowing care to be delivered closer to children's homes.

Many children with cancer also receive care in their homes. This can be from staff or 'outreach' services from the PTC, POSCU or staff from children's community nursing teams.

Principal Treatment Centres also coordinate children's care with cancer services that are provided at other specialist centres (if not provided by the Principal Treatment Centre), and with national services to ensure children receive the right care at the right time and in the right place.

The Principal Treatment Centre for south London, Kent, Medway, most of Surrey, East Sussex, Brighton and Hove

This Principal Treatment Centre is one of 13 across the country. It offers care to patients across a wide catchment area and some patients outside the catchment area who choose to access their care at this Principal Treatment Centre. The map below shows the locations of The Royal Marsden, St George's Hospital and Evelina London Children's Hospital.



There are also seven POSCUs within South West London and Surrey (with others across the wider region):

- St George's Hospital
- Kingston Hospital
- Croydon University Hospital
- St Peter's Hospital in Chertsey
- Epsom Hospital
- The Royal Surrey County Hospital in Guildford
- East Surrey Hospital in Redhill

The POSCU at Frimley Park Hospital has a formal referral pathway to the PTC at University Hospital Southampton

Childhood cancer in South West London and Surrey



Children newly diagnosed with cancer

While a diagnosis of cancer clearly has a huge impact on people's lives, it is relatively rare among children.

The rate of diagnosing new cancers among children in both South West London and Surrey is around **160 cases per million per year**. This means that around **1 child in every 6,200** are diagnosed with cancer each year.

On average, each year there are:

- 45 children diagnosed with cancer from South West London
- 35 children diagnosed with cancer from Surrey Heartlands

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South West London	Approximate number of new cancers diagnosed per year	Surrey Heartlands	Approximate number of new cancer diagnosed per year
Croydon	c.12	Elmbridge	c.5
Wandsworth	c.8	Epsom and Ewell	c.2
Kingston upon Thames	c.5	Guildford	c.4
Merton	c.6	Mole Valley	c.2
Richmond upon Thames	c.6	Reigate and Banstead	c.5
Sutton	c.7	Runnymede	c.2
		Spelthorne	c.3
		Tandridge	c.3
		Waverley	c.4
		Woking	c.3

Children receiving cancer treatment

In total, the PTC treats around 1,400 children per year. Of these, in 2019/20:

- 259 children (18%) came from South West London
- 233 children (17%) came from Surrey Heartlands

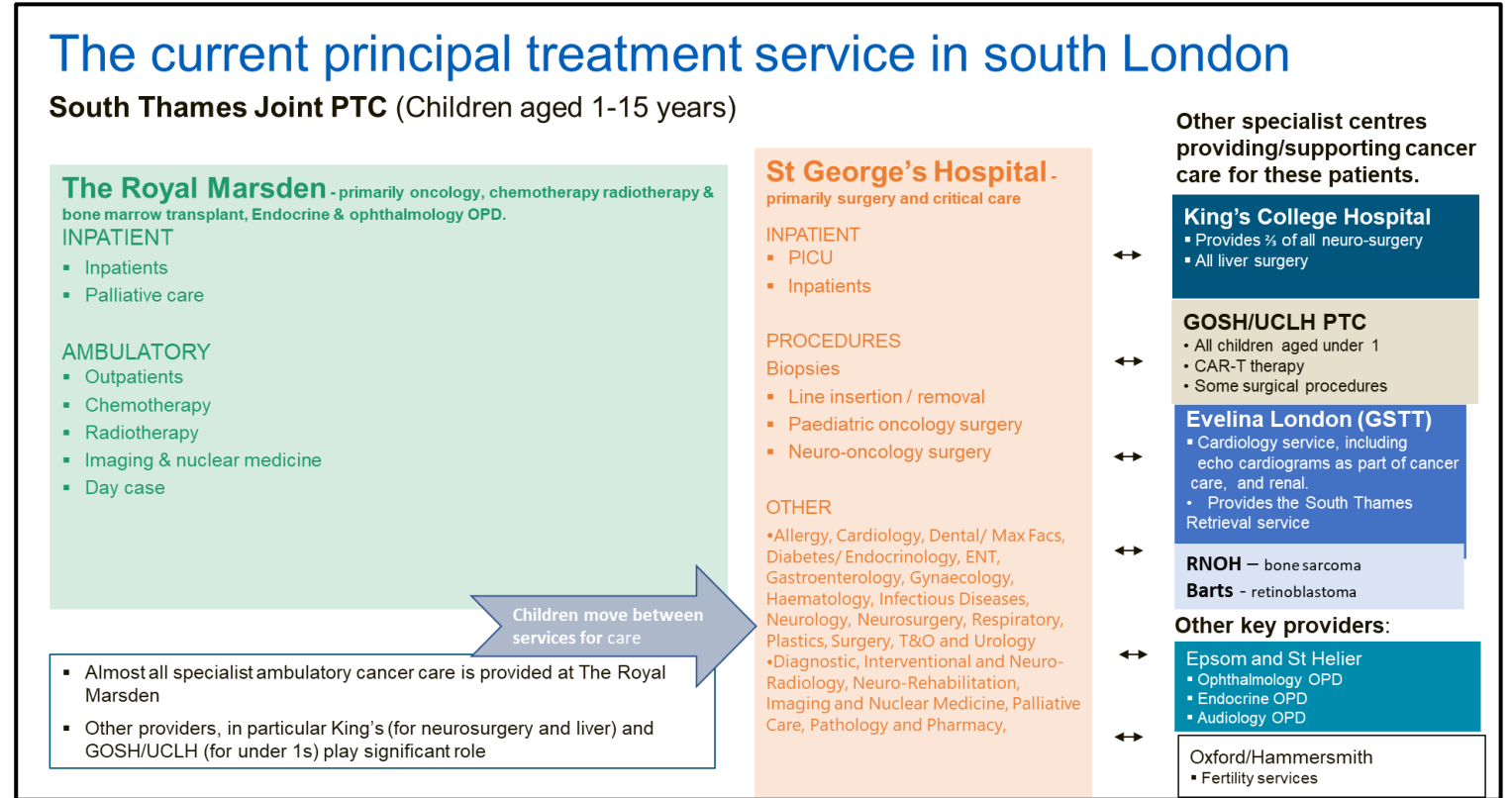
Across both areas, nearly all children are seen as an outpatient (98%); 23% also had an inpatient stay.

Due to data quality for patient postcodes, we are not able to show the actual split of all these patients between boroughs. However, below we indicate the likely distribution of patients, based on population size.

South West London	Approximate number of patients treated per year	Surrey Heartlands	Approximate number of patients treated per year
Croydon	c.70	Elmbridge	c.35
Wandsworth	c.45	Epsom and Ewell	c.20
Kingston upon Thames	c.30	Guildford	c.25
Merton	c.35	Mole Valley	c.15
Richmond upon Thames	c.35	Reigate and Banstead	c.35
Sutton	c.40	Runnymede	c.15
		Spelthorne	c.20
		Tandridge	c.20
		Waverley	c.25
		Woking	c.25

The current Principal Treatment Centre

- The Royal Marsden provides the majority of inpatient and outpatient care for children with cancer in the Principal Treatment Centre catchment area. Care is provided at its Sutton site.
- If children require surgery, critical care and some other specialist children's services they are treated at St George's Hospital in London.
- The Royal Marsden works closely with the Institute of Cancer Research, which is based on its Sutton site, on world leading research into children's cancer care.



Some children also travel to other London hospitals for care, this is because of the expertise these hospitals have in specialist areas. This will continue in the future too.

Case for change

All Principal Treatment Centres must now be on the **same site as a children's intensive care unit and other specialist children's services**. This follows the publication of the new [national specification](#) for children's cancer Principal Treatment Centres in November 2021 which includes this requirement for all Principal Treatment Centres in England.

Locating the Principal Treatment Centre on the **same site as paediatric intensive care** will:

- ✓ mean very sick children do not need to be transferred between hospitals, as some currently do, to receive intensive care.
- ✓ means some admissions to intensive care can be avoided if intensive care doctors are able to visit the child on the ward and keep a close eye on progress.

Placing the Principal Treatment Centre on the **same site as other specialist children's services** will:

- ✓ minimise the number of children who need to move between sites for advice and treatment by teams with expertise in other specialities such as gastroenterology
- ✓ improve patient experience as patients can get more of their care in a familiar place rather than having to find their way around different sites.

Other **benefits** of relocating the Principal Treatment Centre include:

- ✓ the ability to provide a future-facing service ensuring that children get world-leading care as new treatments become available
- ✓ the potential to further develop research by locating cancer researchers alongside researchers into other childhood illness and relevant adult treatments.

Transferring critically unwell patients is associated with a risk of physiological deterioration and adverse events⁽¹⁾ and the emotional and psychological stress for parents should not be underestimated⁽²⁾. Although specialist transport services have been shown to enhance safety and quality⁽³⁾, the 2008 "[Safe and Sustainable](#)" framework, produced by clinicians and endorsed by the relevant Medical Royal Colleges, states that paediatric oncology and paediatric intensive care have "absolute dependency, requiring co-location". It is this clinical advice, backed up by subsequent expert reviews⁽⁴⁾ that underpins the national service specification requirement.

See Appendix for references

There are two strong proposals for the relocated PTC

- Although the services which the **current Principal Treatment Centre** in south London provides are safe, by not having critical care services on site they can not provide the best quality care for children with cancer and they do not and cannot comply with the national service specification. The Royal Marsden is a specialist cancer hospital, not a children's hospital, and does not have a paediatric intensive care unit onsite or other specialist children's services required by the specification. Intensive care units are always on hospital sites that also provide many other specialist children's services. The Royal Marsden recognises that it cannot meet the national service specification and is supporting the reconfiguration process.
 - We are fortunate to have two strong options for relocating the Principal Treatment Centre:
 - Evelina London Children's Hospital, which is run by Guy's and St Thomas' NHS Foundation Trust and is based on the St Thomas' site by Westminster Bridge
 - St George's Hospital, which is run by St George's University Hospitals NHS Foundation Trust and is based in Tooting.
- NHS England London's consultation will seek views on the benefits and disadvantages of both options, along with enhancements and mitigations. Feedback will be part of the evidence considered when we take the decision.
- In combination with the new specification for Paediatric Oncology Shared Care Units (POSCUs) this will enable NHS England London to implement the national vision for children's cancer services, driving continued improvement across the network with enhanced levels of care closer to where children live.

We are ambitious for our PTC. In relocating the service, we believe there is the opportunity to go above and beyond the current specification by drawing upon the experience and expertise that exists within both providers who have submitted proposals, that preserves the strengths and expertise that is evident within the existing service at The Royal Marsden; and more widely, leverages opportunities that exist through collaboration between other parts of the NHS.

Things to note:

In setting its clinical model, the Programme Board overseeing this reconfiguration made a number of key decisions including:

- No matter which option is chosen, children will need travel to other London hospitals for the care listed below. This is because of the expertise these hospitals have in these specialist areas – these services are not going to move as part of the reconfiguration
 - Royal London Hospital (RLH), Whitechapel – eye cancer
 - Royal National Orthopaedic Hospital (RNOH), Stanmore - bone cancer
 - Great Ormond Street Hospital for Children (GOSH), Bloomsbury – care of babies aged 0 to 12 months with cancer of any type
 - King’s College Hospital (KCH), Denmark Hill – liver cancer
 - St George’s Hospital, Tooting and King’s College Hospital, Denmark Hill – neurosurgery for cancer of the brain and central nervous system. See table below →
 - University College London Hospitals’ Grafton Way building (UCL), near Euston - proton beam radiotherapy at one of only two proton beam machines in England.

- **Access** - the Principal Treatment Centre must be accessible for all service users in terms of journey time and should therefore be based within Greater London.
- **Timeliness** - once a decision has been made, the new service must ‘go live’ within a 2.5 year implementation timeline
- **Affordability** - so long as both options remain affordable, the cost will not influence the decision. Instead, the decision will focus how to create the best possible service for children with cancer.

2. Where are we now

Where we are in the formal reconfiguration process

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Programme timeline/expected milestones

Jan - April

- Evaluation of options concluded
- Planning for consultation (including preparing consultation materials and questions)
- Joint Clinical Senate panel
- **Meetings with OSCs/JOSCs**
- Engage with a number of stakeholder groups
- Drafting pre-consultation business case (PCBC) and supporting appendices
- Engage with Trusts involved

May - June

- Continue planning for consultation (including preparing consultation materials and questions)
- Commissioning of expert organisation(s) to support engagement
- Joint Clinical Senate report
- NHSE Stage 2 Assurance against the national 'Five Tests' in NHSE's 'Planning, Assuring and Delivering Service Change for Patients.'
- **Meetings with OSCs/JOSCs**
- Planning with Greater London Authority re Mayoral Tests
- Regular meetings with Trusts involved

To note:

Public Consultation currently spans the period July-end September which includes the summer holiday period. This has pros and cons in terms of the impact of engaging with key stakeholders. During July we will proactively target those groups we perceive may be challenging to reach to ensure initial contact is established and we can plan activities in before any significant periods of annual leave kick in. There will also be opportunities in September, once the summer holidays are over. A mid-point review will be conducted during which we will evaluate whether there an extension of the consultation may be required.

End of June/July - September

- Conclude NHSE Stage 2 Assurance
- **Expect to launch consultation** (expected duration 12 weeks)
- Conduct mid-point review
- **As part of public consultation, consult with J/OSCs that deem the change substantial; engage with OSCs so that they can provide a response if they wish**

End September - December

- Conclude consultation, subject to mid-point review
- Consultation feedback analysed and outcome report produced and shared
- **Consultation with J/OSCs**
- Programme Board/NHS England - London consideration of feedback ahead of decision making
- Decision Making Business Case prepared
- Decision made and communicated
- Establish Implementation Board
- Begin planning to implement decision

3. Equality and Health Inequality Impact Assessment

Equality and Health Inequality Impact Assessment: Process

Purpose of the EHIA

To support meeting legal duties including the Public Sector Equality Duty (Equality Act 2010) and the Health and Social Care Act (*to have regard to the need to reduce inequalities between persons in access to, and outcomes from healthcare services*)

What changes are we assessing the impact of?

A change in location of the current PTC and the implications of this change on patient travel arrangements including travel time, complexity of journey (including parking arrangements) and cost.

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Additional considerations:

- the prospect of the service change process itself
- the prospect of a new environment and aspects of onsite accessibility
- other potential benefits

The EHIA takes a non-comparative, population-based approach.



Which population groups were considered in terms of experiencing differential impacts?

Those with a protected characteristic as specified in the Equality Act 2010, or who typically face health inequalities, including those living in deprived areas or families on low incomes (EHIA document contains full list).

For each group, using the information referenced below, plus professional and personal experience, the sub-group assessed any potential differential impacts of the proposed changes in relation to both the Public Sector Equality Duty and inequalities in access to, and outcomes from the service.

Sources of information used:

1. An equalities profile for the PTC catchment population
2. A travel time analysis report
3. Qualitative insight collected through patient engagement activities



Impacts of travel time differences on health inequalities (access)

When comparing travel times to the current Principal Treatment Centre main site (The Royal Marsden) to either future PTC location, travel time analysis shows:

- there are differential positive impacts for children living in the most deprived areas and rural areas when travelling by public transport.
- there are differential negative impacts for children living outside London or in rural areas when driving.



Other impacts Several population groups (full list in EHIA) may experience a differential impact in terms of:

- complexity or cost of their journey
- uncertainty brought on by the prospect of the service change process itself
- on-site accessibility

For example, patients and/or families:

- where a family member is disabled (or has a spectrum disorder)
- who are on a low income/living in more deprived areas
- with poor literacy and/or language barriers
- who experience digital exclusion

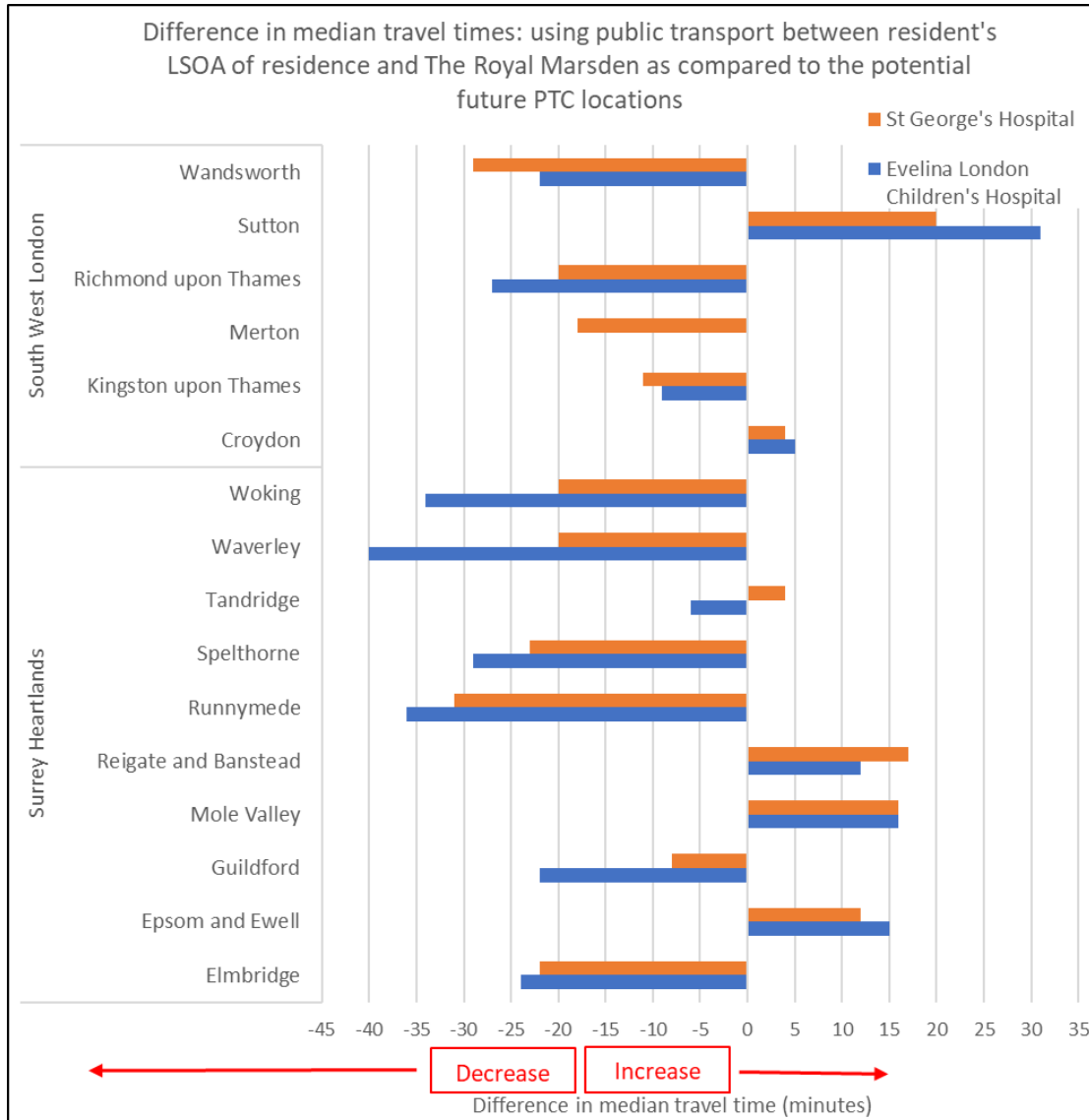
The Equalities profile document includes an estimated quantification of the size of each population group within the PTC catchment area.

Benefits for improving outcomes and reducing inequalities:

Compliance with the service specification will mean that healthcare related outcomes (in terms of patient experience and safety) are likely to be enhanced through receipt of co-ordinated, holistic care with a reduced requirement for treatment transfers at a time of crisis and the risk that certain types of transfers involve.

While this will benefit all children attending the PTC, the EHIA sub-group concluded that there may be a differential positive benefit for certain groups who may have a higher need for additional paediatric specialties (e.g. those with complex cancer care needs, co-morbidities, who are disabled or have or other conditions) or with communication difficulties (e.g. language barriers or poor literacy) where the reduced need for treatment transfers/multi-site appointments may be beneficial.

Equality and Health Inequality Impact Assessment: Public transport

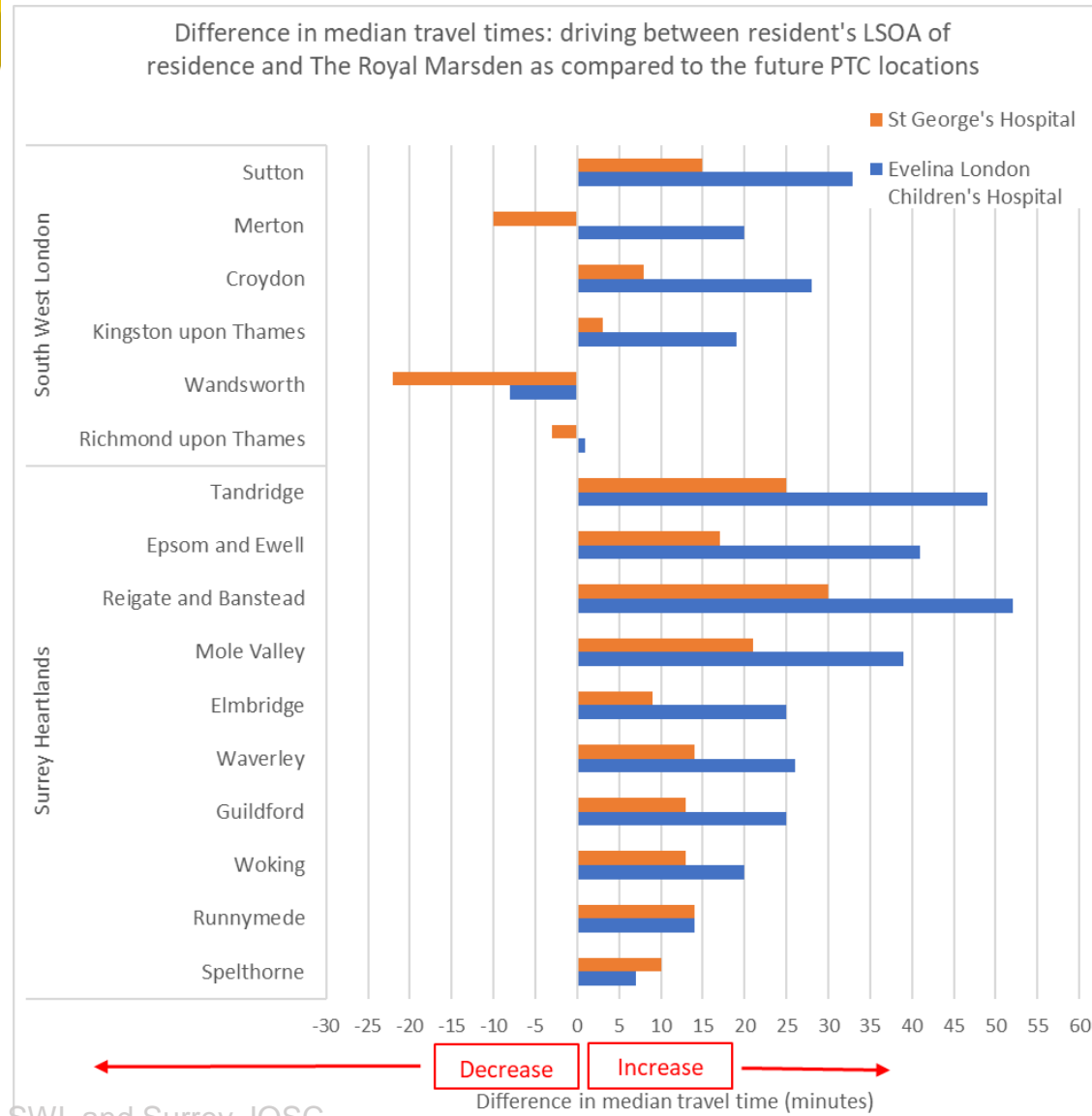


On average, the residents of most boroughs within South West London and Surrey would see a reduction in travel time to either Evelina London or St George's via public transport, compared to travelling to The Royal Marsden.

Due to their proximity to the current PTC, residents of Sutton, Reigate and Banstead, Mole Valley and Epsom and Ewell would see an increase in travel times in the region of an additional 15 to 30 minutes.

Residents of Croydon and Tandridge could also see small increases in journey time.

Equality and Health Inequality Impact Assessment: driving



On average, the residents of most boroughs within South West London and Surrey would see an increase in travel time for driving.

Residents of South West London would, on average, experience an increase in journey time of 18 minutes to Evelina and no change to St George's. However, this masks a difference between the boroughs where Sutton, Merton, Croydon and Kingston see increases of up to 30 minutes in driving time compared to decreases or no change for Wandsworth or Richmond.

Residents in Surrey would, on average, experience an increase in journey time of 30 minutes to Evelina and 17 minutes to St George's.

Residents of Mole Valley, Reigate and Banstead, Epsom and Ewell and Tandridge see the largest increases in journey time (20 to 45 minutes additional travel time on average), and the biggest differential between the two potential PTC locations.

The remaining boroughs in Surrey see smaller increases in travel time (12-20 minutes on average) with a negligible difference between the two potential PTC locations.

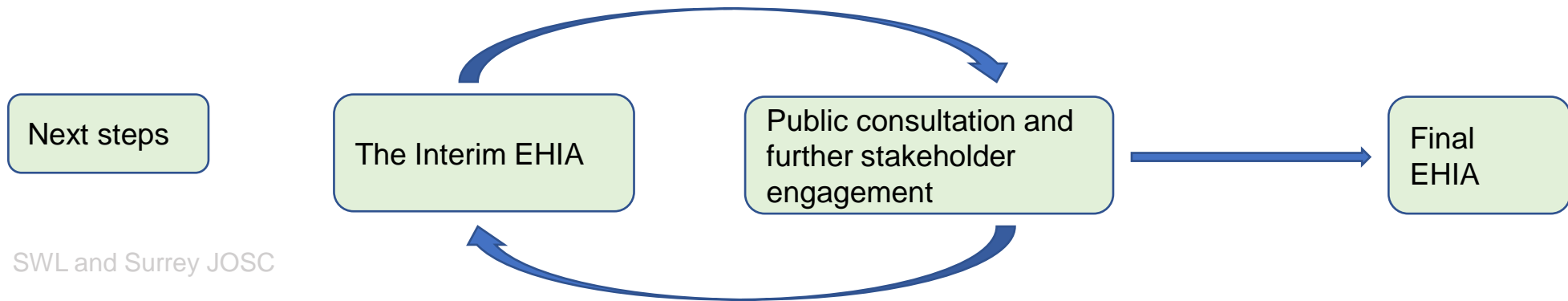
It is important to note that the travel analysis can only capture impacts in terms of travel time. It is not possible to systematically quantify impact in terms of complexity of journey, reliability of transport services and costs. **The most important aspect of the EHIA is the recommendations for mitigation.** The EHIA sub-group has put forward a range of potential systems, processes or programmes that could serve to mitigate the adverse impacts of a longer, more complex, more costly journey.

The main themes include:

1. Systems and processes aimed at helping patients and families plan their journeys to hospital, including provision of inclusive and accessible information and translation services.
2. Systems and processes aimed at reducing the financial impact of travel, such as reimbursement schemes for travel costs (including ULEZ charges) or supporting patients to access other financial support.
3. Transport services provided directly to patients and their families (with clear eligibility criteria) and family accommodation.
4. High quality onsite accessibility arrangements, including parking and drop-off facilities.
5. Other aspects of care planning including flexibility for appointment times, shared care closer to home, strong communication systems between different health and social care teams, and remote (non face to face) appointments (that take into account aspects of digital capability)
6. An excellent implementation plan for the service change process, to support patients through the transfer period, with high quality continuity of care. Implementation plans should consider meeting NHS duties around health inequalities and take a Core20Plus5 approach.

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Other impacts

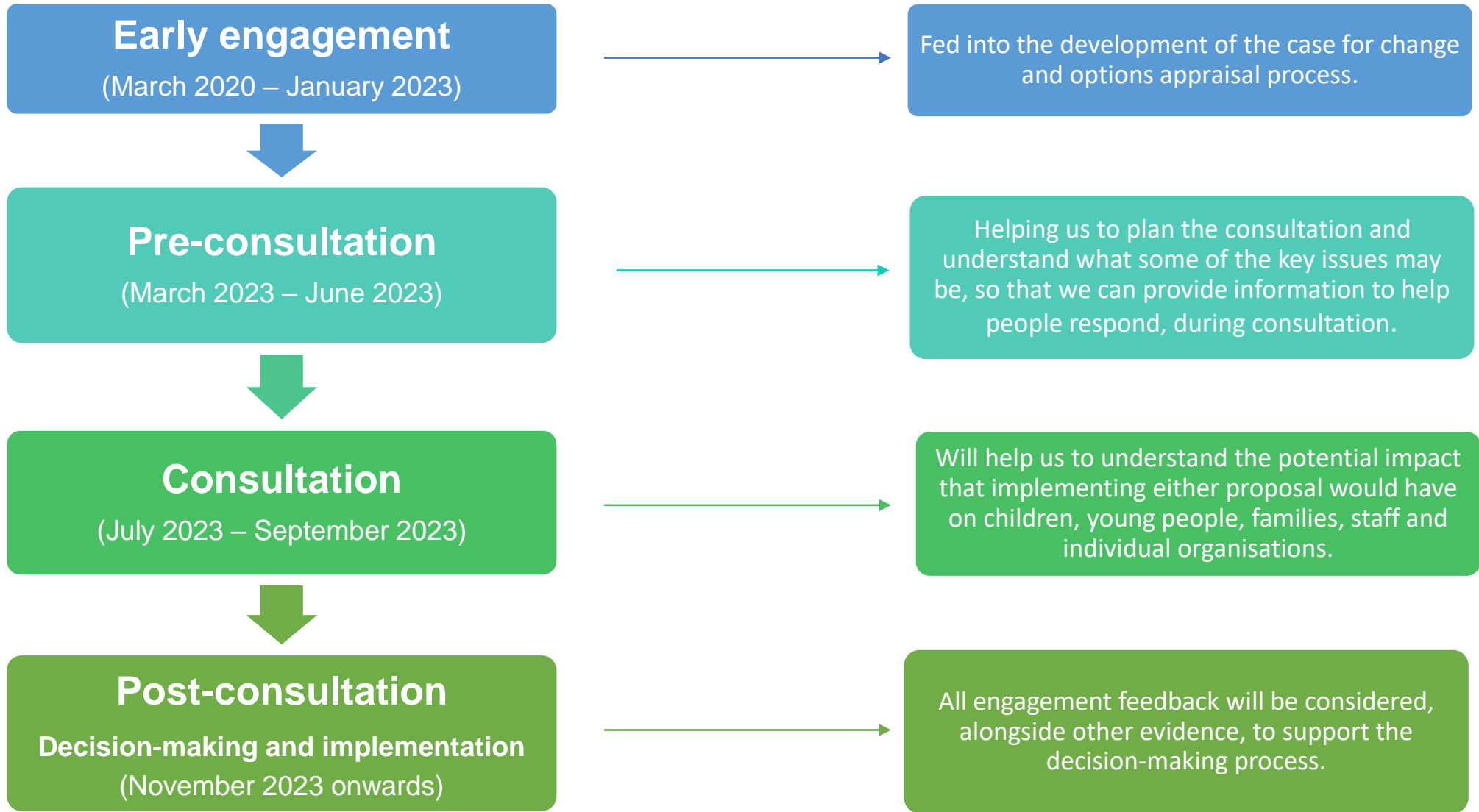
Alongside the duty to reduce inequalities of outcomes, NHS England – London, have, and will continue to give due regard to:

- The wider impact of the decision made
- The need to contribute towards compliance with the UK net zero emissions target (s. 13NC NHS Act)

5. Consultation plan and document, including stakeholder engagement

Overview of engagement to date

Feedback from our engagement work can be found in the appendices.



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These are indicative timescales and are subject to change.

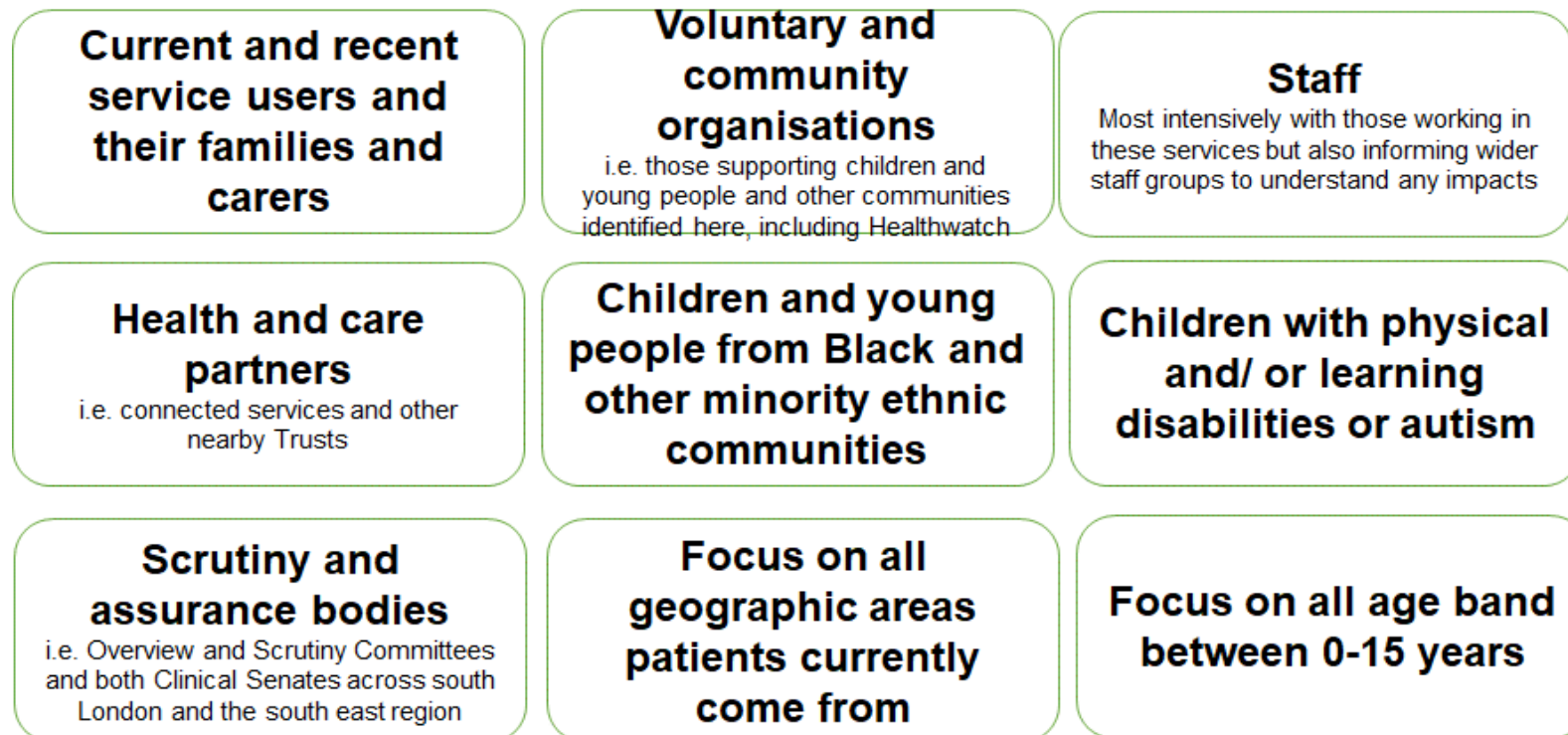
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We seek to ensure an inclusive engagement approach

- Working with **experts in the voluntary and community sector** to include a range of views.
- Commissioning specialist expert organisations to ensure we reach EIA groups and children and young people in an effective and appropriate way.
- Learning from Trust and ICB engagement colleagues to develop **relationships** with key stakeholders to be **inclusive of seldom heard, minority and deprived population groups**
- **Using intelligence** from the IIA to **inform engagement plans** to focus on those most affected and impacted groups
- Historic engagement (via both surveys undertaken) has reached a **range of ages, ethnicities and geographies**

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Planned engagement (during pre-consultation and consultation) will focus on reaching professionals and different groups:



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Aims of consultation, engagement methodology and key questions

Following the options appraisal, two proposals have been identified. We believe both would be able to deliver an excellent future service to children. The consultation aims to inform NHS England – London on which proposal adds the greatest value in providing a future facing service for children with cancer.

The **purpose of the consultation** is to:

- engage with as many people as possible in the geography affected by this service change and hear their views on the proposals for the future location of the children's cancer PTC
- understand the impact of implementing either proposal and any mitigations or enhancements that could be put in place
- ensure NHS England - London, as decision-maker, is made aware of any information which may help to inform the options and the decision-making process.

Public consultation is not a vote or referendum, and we are asking stakeholders to consider each proposal in its own right.

Consultation questions will focus on understanding:

- Understanding of the case for change
- Views on key aspects of both proposals such as travel, access and research
- Ideas around how to mitigate or enhance impacts
- Understanding how we could make implementing the change easier for those currently in the service

Engagement methodology

- Writing to current and recent service users and their families/carers
- Online events
- Targeted sessions with the stakeholder group and other charities/VCS organisations already closely involved with us
- Community outreach to children and young people and their families with specific characteristics identified in the equalities impact assessment
- Creative activities on existing sites with children and young people currently accessing services (through working with a play therapy organisation)
- 1:1 interviews/ survey completion on existing sites with parents/carers
- Attending existing meetings in the community
- Survey (including an easy read version)
- Wide use of simple animation to raise awareness and encourage feedback
- Sharing information through existing contacts and networks including Facebook group for RM parents
- Posters with QR codes linking to online materials
- Briefings
- Offering non-digital channels: completion of surveys by post, interviews by phone, printed documents in wards/given out by Royal Marsden volunteers/in flats used by long-stay parents

Pre-consultation activities – progress so far

Activity undertaken

- **Contacted over 300 organisations across south London, Kent, Medway, Surrey and Sussex, to let them know about the project and to encourage feedback, including:**
 - Specialist CYP cancer charities/groups (including parent-led organisations)
 - Youth Forums/Councils/ Parliaments
 - Healthwatch organisations
 - Maternity Voice Partnerships
 - Mental health umbrella organisations
 - Black and minority ethnic forums/ groups
 - Pan-geography organisations supporting; refugees or asylum seekers, addiction and/or substance misuse issues, people involved in the criminal justice system, people experiencing homelessness and gypsies or travellers)
 - Learning disability and autism groups
 - Groups supporting people with physical impairments
 - Carers (young and adult)
 - Community groups in the most deprived areas within the catchment
- **Attended the RMH teenage and young adult forum**
- **Session with POSCU staff**
- **Session with POSCU patient representatives**
- **Working with engagement leads from all three Trusts to reach their patient groups, forums and volunteers**

Upcoming activities

- **Visit to wards to directly engage with CYP and families**
- **Further work with Children with Cancer UK and Young Lives VS Cancer to reach a broader range of families**
- **Session with Overview and Scrutiny Committees to discuss the consultation plan and document**
- **Sessions for staff from all Trusts**
- **Follow up communications to all groups we originally contacted**

Stakeholder feedback is influencing our consultation plans and documents

How we engage

- Having a number of different ways to feedback will be important
- Attention span (as a result of treatment) can be an issue therefore keeping things concise is essential
- Being conscious of the pros and cons of engaging over the summer holidays

Opportunities include

- Possibly having access to newer equipment
- Increase in access to leisure activities

What information we need to provide during consultation

- How to travel to the service safely (i.e. if having to travel on public transport how they can be safe)
- Where to park
- Could there be videos of each environment to physically see what it's like there?
- All communications need to be jargon free with clear explanation and information. This is particularly important for specific groups such as Gypsy, Roma and Traveller families and asylum seeking families who need materials in their own languages
- Reassurance around how any move would be managed so that the impact on treatment is minimised
- How travel costs will be reimbursed and who is eligible
- How research will be impacted/ continue once a decision is made
- How any additional funding will be used to support either proposal

Consultation document: proposed content

- How people can get involved (including hard copy questionnaire)
- What the consultation is about
- Why a change is needed and benefits
- What matters to children, families and staff and how this has shaped the plans
- Information on both proposals (including travel and access implications)
- High level information about options appraisal process and outcome
- How the proposals could affect different communities in south London, Kent, Medway, most of Surrey, East Sussex, Brighton and Hove
- Next steps and making a decision
- What services won't change

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Appendices/ other supporting documents

- Factsheets on development, summary and evaluation of the proposals, transition to teenage and young adult service, assurance process, research at each Trust, getting to the two potential sites
- Initial Equalities Health Impact Assessment (EHIA)
- Early engagement feedback report
- Feedback from the Clinical Senate and programme actions.

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We are testing and refining this document with key stakeholders to ensure it is fit for purpose

We welcome your feedback

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Annex 1

Annex 1: Supporting slides

- Case for Change - references
- Options development and evaluation
- Engagement journey so far
- Travel time analysis - methodology

Transferring critically unwell patients is associated with a risk of physiological deterioration and adverse events⁽¹⁾ and the emotional and psychological stress for parents should not be underestimated⁽²⁾. Although specialist transport services have been shown to enhance safety and quality⁽³⁾, the 2008 “[Safe and Sustainable](#)” framework, produced by clinicians and endorsed by the relevant Medical Royal Colleges, states that paediatric oncology and paediatric intensive care have “absolute dependency, requiring co-location”. It is this clinical advice, backed up by subsequent expert reviews⁽⁴⁾ that underpins the national service specification requirement.

References:

1. Drogoh, J.M., Smit, M., Absalom, A.R. *et al.* Transferring the critically ill patient: are we there yet?. *Crit Care* **19**, 62 (2015). <https://doi.org/10.1186/s13054-015-0749-4>
2. Harvey, Edmunds, Ghose. Transporting critically ill children. *Anaesthesia & Intensive Care Medicine* Volume 21, Issue 12, December 2020, Pages 641-648
3. Gilpin Hancock. Referral and transfer of the critically ill child. *BJA Education*, 16 (8): 253–257 (2016)
4. NHS England [board-meeting-item-9-update-on-specialised-services-c-appendix-2.pdf](#) (england.nhs.uk)

Options development and Evaluation

Longlist to shortlist

In line with NHS formal reconfiguration guidance, 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).



Following this stage, two options remained: the Trusts running St George's and Evelina London Children's hospitals. Both were asked to complete a formal proposal document outlining how they would deliver the service using set criteria.

Evaluation Criteria

Evaluation criteria were developed with input from a range of stakeholders over 2020/2022, these reflect requirements of the service specification incorporating research, patient and carer experience, capacity and resilience. They also reflected our ambition for the PTC.



This resulted in **four domains for evaluation: clinical, research, enabling requirements, and patient and carer experience.** Measurable sub-criteria were developed for each domain, drawing on expertise from clinicians, parents, and managers from in London and outside London.

Weighting the evaluation criteria

Four expert panels comprised of **patient and carer representatives, charities, researchers** from outside London, **clinicians (medical and nursing)** from in and outside London, **managers**, and **experts in specific fields** (e.g. emergency preparedness, human resources) - over 30 people - were established to weight and score the criteria within each domain.



In September 2022, the Programme Board finalised the high-level weighting given to each of the domains. Between October and November 2022, the identified panels for each domain undertook a virtual, two-stage exercise to establish the sub-weights for the criteria within their domain.

Scoring the proposals

In November 2022 both Trusts submitted their proposals, aligned with the domains and sub-criteria. During December 2022, the topic-specific expert panels scored the submissions against each of the sub-criteria for their specific domain. Sensitivity analysis was also performed.



Final scores were calculated for each option using the pre-agreed weighting.

Engagement journey so far

Since 2020, we have been working with children, young people, parents/carers and professionals to help shape our work. A Stakeholder Group involving parents, carers, charities and wider voluntary organisations, and a Clinical Advisory Group have been key to testing and refining our plans.

Activity

- **Fourteen meetings** with the Stakeholder Group.
- Over **60 contacts** with parents/carers /caregivers - a combination of meetings, individual conversations with parents.
- **208** survey and interview responses to an externally commissioned survey.
- **50** survey responses from the Stakeholder Group and current inpatients.
- **Supported a panel of parents to participate in the options appraisal process** helping up to develop and score aspects of the patient experience domain.
- **Supported self-nominated parents** to feedback on the IIA and consultation plan and document.
- **Four meetings** of the children and young people’s sub-group with charities and Trust representatives.
- **A Clinical Advisory Group (CAG)** of clinicians from St George's, Evelina London, King's and The Royal Marsden considered and commented on the fixed points, hurdle and evaluation criteria.
- A group of senior managers from the same four Trusts **considered the impacts of the change on staff and the capacity and activity** needed to deliver it.
- **A joint workshop** was held with staff from The Royal Marsden, St George's and Evelina London. This led to more in-depth work with Royal Marsden staff.
- A senior professor and nurse director (independent advisers to the programme) **spoke with nurses and medics from the various services** to gain informal feedback.
- The independent chair of the CAG **spoke with senior researchers from each of the three Trusts** to gather their views on the key considerations for research.

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Case for change and options development	Understanding current experiences of services and what is most important about the current service.
Options appraisal process, including criteria development	Feedback around the sub-criteria scoring for the clinical, patient experience, enabling and research domains changed what was included.
Integrated Impact Assessment (IIA)	Feedback on the document and mitigations as well as challenges around transport and access that need to be considered.
Engagement plans	Supported; the development of FAQs, consultation plan , consultation document, early and pre-consultation questions.

Travel time analysis: methodology

Travel time modelling software was used to generate public transport and car journey travel times for all children (aged 15 and under) living in the PTC catchment to each of the three provider locations, from their “origin” (based on their Lower Super Output Area* (LSOA) of residence). There are 4,000 LSOAs within the PTC catchment area.

Travel times are for the fastest trip departing from resident origin for arrival at midday on a Wednesday. Metrics used in the analysis are median and longest travel times (minutes) and the proportion of the population within a 60 minute journey time of each provider, by public transport and driving.

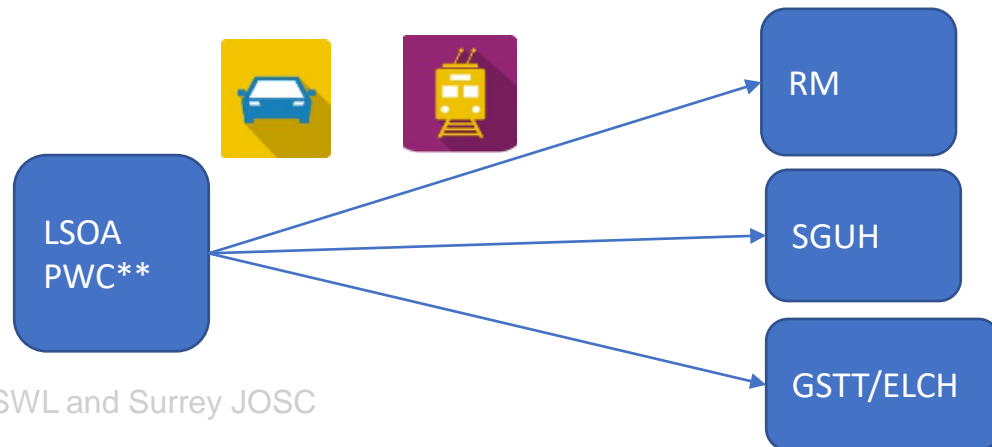
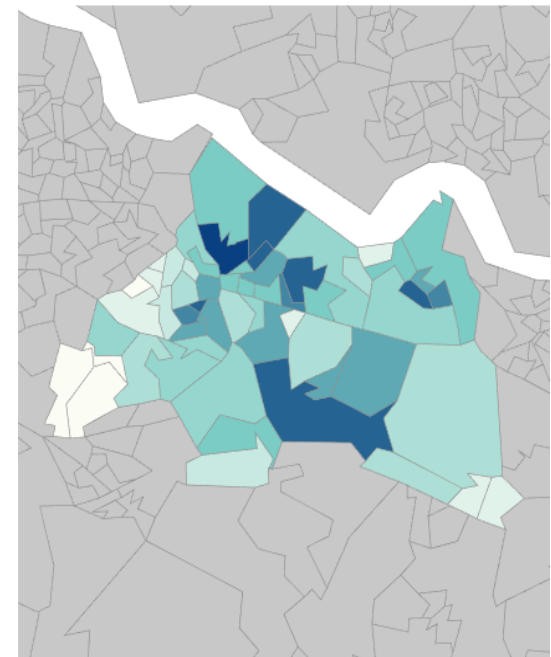
The modelling uses both road networks and timetabled transport networks. The potential combination of travel modes for each journey by public transport are national rail, tram, light rail, tube, bus, coach, ferry, and walking to and from stops and interchange, and walking alone if quicker. A public transport journey was only measured if a station or stop was reachable within an initial 20 minute walking time (only 0.2% of LSOAs did not meet this criteria).

The travel measures are intended to provide a typical indication of the quickest journey from origin to destination for people travelling with no additional requirements. Individual experiences may not completely align with the estimated times.

* **Note: Lower Super Output Areas (LSOAs)** are a small area geography averaging approximately 1,500 people. Each LSOA has a PWC (population weighted centroid) which represents the centre of the distribution of residents across the LSOA.

Population estimates are available at LSOA level and each LSOA is assigned an [Index of Multiple Deprivation \(IMD\)](#) score and an [urban/rural classification](#). This allows for travel time analysis by these classifications. More information on the IMD is in [Appendix B](#)

Illustration of Lower Super Output Areas (Dartford)



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