Mount Vernon Cancer Centre Strategic Review

Clinical Advisory Panel Review and Recommendations

July 2019

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Mount Vernon Cancer Centre Strategic Review

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Foreword

NHS England commissioned an urgent review of Mount Vernon Cancer Centre (MVCC) in May 2019, led by the East of England Specialised Commissioning Team, due to increasing concern regarding the sustainability of a safe and high quality oncology service provided at the site.

MVCC has been subject to a long series of reviews over a period of at least 30 years. Due to the complexity of the large catchment area and patient flows, the number of organisations involved, the lack of capital funding, the continual change in oversight management, commissioning and network arrangements, these numerous reviews and recommendations have not resulted in any substantial change to the service. Moreover, the environment of oncology provision has changed enormously over this 30 year period with intensification of combined modality treatments, advent of immunotherapies with their unpredictable toxicities and increasing focus on managing comorbidities in an ageing cancer patient population. Acute support services have also been progressively depleted on the site over many years such that there is current and increasing concern regarding patient safety. All of this has inevitably led to low morale, frustration, loss of staff and difficulty in sustaining performance targets.

Services continue to be provided within very poor quality accommodation with much equipment reaching the end of its life without a replacement plan.

Undoubtedly the urgent challenges facing MVCC and those charged with their resolution are complex and will require a commitment from all the organisations involved to work collaboratively in reaching a sustainable solution for patients, their carers, the oncology staff and the oncology service. If appropriate, organisations must relinquish responsibility, and if required, associated funding in order to secure the optimal model of care.

Throughout the review, the Clinical Advisory Panel members were greatly impressed by the collegiality and determination of the MVCC team to continue to provide the best quality care they could under difficult circumstances. It should be noted that the feedback from patients has been consistently positive over a long period of time in spite of the significant challenges faced. It is a priority to maintain current patient confidence in services and to maintain local access, where appropriate.

Finally, we wanted to thank everyone we met and interviewed for their time, their candour, patience and their commitment to staying with the NHS England process. This review is focussed on expeditiously finding a practical and affordable solution for MVCC that will support their ambition to provide an integrated oncology service with the ability to deliver expert management using advanced techniques and latest treatments in a modern environment. It also aims to recommend the configuration that will continually drive improvements in clinical outcomes by significantly strengthening the focus on education, training, research and innovation.

Professor Nick Slevin
Clinical Advisory Panel Chair
July 2019

Executive Summary

1. The remit of the MVCC Clinical Advisory Panel was to undertake 3 specific actions:

   (i) Review the long list of options previously identified by key stakeholders

   (ii) Remove any non-clinically acceptable options

   (iii) Make recommendations to the MVCC Programme Board meeting held on 4th July 2019

2. The Clinical Advisory Panel undertook a series of interviews throughout June 2019 to inform their recommendations.

3. There is increasing concern as to whether high quality, safe and sustainable oncology services can continue to be delivered within the existing organisational framework and there is an urgent need to address this concern.

4. The review identified that in order to provide modern oncology care, comprehensive medical and surgical support services, including Intensive Treatment Unit (ITU), are needed. Acutely unwell patients require inpatient, multidisciplinary management including for multisystem toxicities from increasing use of immunotherapies. These support services are no longer available on the MVCC site requiring that some oncology services, at least, should relocate to an accessible District General Hospital (DGH) with comprehensive acute services integrated with oncology expertise on site.

5. Much of the existing estate used by MVCC is dilapidated and not fit for purpose. There is a need for considerable investment in buildings, equipment replacement and IT connectivity i.e. the basic physical infrastructure of the service.

6. Aligning with an experienced tertiary cancer service provider would facilitate new opportunities to attract and retain additional expert staff, not only for the provision of the clinical service but also to exploit research opportunities. Through the experience of the tertiary cancer centre and their critical mass of activity, robust clinical governance arrangements would be established.

7. The transition to a reconfigured service is challenging and requires dedicated clinical leadership at MVCC as well as support and goodwill from the many stakeholders in order to provide reassurance to patients.

8. The recommendation from the Clinical Advisory Panel review are:

   8.1 Identification of two supported options from the long list for further consideration:

      a. Option 5 in the long list – Ambulatory Hub (modified)
      b. Option 3 in the long list - Full replacement on an acute site

   8.2 Significant capital investment should be made be available to address build and equipment issues in the chosen option.

8.3 The estate used for cancer services should be owned by the service provider to strengthen their operational control.

8.4 Research should be supported as a priority in order that patients have access to clinical trials that are appropriate to their condition. Research should be embedded in the clinical service to promote clinical developments and best patient outcomes.

8.5 Any reconfiguration of service should not result in a significant redirection of patient pathways and patients should have local access to an integrated, networked, high quality service.

8.6 Any reconfiguration should retain the co-location with the Paul Strickland imaging unit.

9.0 Short Term Action Plan

The Clinical Advisory Panel identified a clear urgency for action in the short term to address the immediate concerns whilst a longer term solution is secured. The specific actions are as follows:

9.1 A MVCC clinical consultant lead is required to help manage the transition with the existing team, to be available on a daily basis and to ensure full MVCC participation and perspective in the partnership arrangement with the tertiary provider lead from London.

9.2 Under either of the two supported options, the leadership, governance, management and strategic development of the specialised oncology service at MVCC should transfer as soon as possible to an existing tertiary cancer service provider.

9.3 Appointment of additional staff to the Acute Oncology service.

9.4 Robust implementation of policies concerning admission criteria to MVCC, daily consultant ward rounds and MVCC staff reviewing patients who have been transferred to other DGHs. This will require job planning and additional medical staffing.

9.5 Urgent backlog maintenance of existing clinical facilities.

1. Introduction

The review of the Mount Vernon Cancer Centre (MVCC) has been commissioned by the East of England Specialised Commissioning Team to better understand the safety and sustainability of tertiary cancer services delivered by MVCC. MVCC is managed by East and North Hertfordshire NHS Trust (ENHT) who rent the hospital site from Hillingdon Hospital NHS Foundation Trust.

2. Scope of the Review

The review only considered oncology services provided by the MVCC team (adult oncology services and not those for paediatrics or teenage and young adults populations).

Its focus was on inpatient and outpatient services and staffing in the following service areas:

- Radiotherapy including brachytherapy and molecular radiotherapy (radioisotope treatment)
- Systemic Anti-Cancer Therapy (SACT) including cytotoxic chemotherapy, targeted therapies and immunotherapies
- Support services including imaging and inpatient care support
- Research and innovation
- Workforce

It did not include consideration of:

- Palliative care
- Oncology Surgery

It was recognised that whilst the principal focus was in the above areas, the non-surgical oncology provision at MVCC exists in a wider network of services and consideration of unintended consequences of any change with MVCC was needed.

3. Background and Key Drivers for Change

1. The particular challenges facing MVCC have been well documented and the Clinical Advisory Panel considered a comprehensive range of documentation in preparation for the review.

2. It is clear that over a period of at least 30 years, a number of different bodies have undertaken reviews of MVCC. Recommendations for action have been identified but with little evidence of the necessary investment required, resulting in no substantial change or service improvement.

3. The management of MVCC has changed several times over the years, both from a Trust perspective and also within the context of responsible cancer networks, STPs, cancer alliances and commissioning arrangements. This complexity of leadership and commissioning arrangements has contributed to the apparent lack of progress in addressing the challenges facing MVCC.

4. A consistent theme throughout the review was the value patients and carers place on the clinical team and services they experienced at MVCC. Despite the obvious issues of the capital stock, patients expressed deep appreciation regarding the care they received.

5. The ambition of the MVCC team to strengthen their focus on research and innovation in order to drive improvements in clinical outcomes is clearly evident and will be fundamental to the future success of reconfigured services.

6. The delivery model for care at MVCC has also been subject to review and the Clinical Advisory Panel considered this particular point when preparing its recommendations. The focus was on how best to consistently deliver high quality clinical care with appropriate numbers of skilled staff whilst enhancing patient experience through more local access to networked care.

7. There are a number of core clinical drivers for change in the current service configuration, recognising that standard oncological care has evolved substantially over recent years and the range of medical services required to safely deliver this has also changed. Any recommended model of care must address the following:

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

4. Mount Vernon Cancer Centre

1. MVCC is part of East and North Hertfordshire NHS Trust (ENHT) and provides a specialist non-surgical cancer tertiary service. It is situated in Hillingdon, Middlesex on a large site owned by Hillingdon NHS Trust and is 35 miles from East and North Hertfordshire Trust's main hospital, The Lister Hospital, in Stevenage. It serves a catchment population of 2 million people across a wide

area of Hertfordshire, Bedfordshire, Northwest London and parts of the Thames Valley (65% of its patients come from Hertfordshire and Bedfordshire, 30% from North London and 5% from East Berkshire and Buckinghamshire).

2. The MVCC clinical teams have, along with the East and North Hertfordshire NHS Trust, had concerns for some time about the clinical sustainability and longer-term future of MVCC and welcomed a commissioner review in order to create a momentum for strategic change.

3. At MVCC, there is a multi professional management team which includes a clinical director, divisional chair, a hospital director and a head of nursing.

4. The most recent CQC Inspection of the site in April 2018 rated MVCC as requiring improvement across 3 of the 5 domains, rating it Good for Effective and Caring domains (see appendix 5). Radiotherapy was rated as Good in every domain. The previous report following inspection in 2015 rated care as inadequate and raised concerns about safety and care of the acutely unwell patient. Since that report, a new management team has been in place and many of the concerns are being managed through mitigation e.g. the NEWS (National Early Warning Score) threshold for identification and subsequent escalation of a deteriorating patient is now lower than the recommended trigger point to ensure optimal management, stabilisation and transfer to the local DGH. In conjunction with this, there has been an increase in the acute oncology nursing team to proactively manage deteriorating patients and admission avoidance.

5. There is an academic and clinical collaboration in place with University College London Hospitals (UCLH) and a Memorandum of Understanding (MOU) was signed off by both Trust Boards in November 2017 to support the joint work.

6. East & North Hertfordshire NHS Trust and the Hertfordshire and West Essex STP have highlighted the poor quality of the MVCC estate within which services are provided and raised concerns about access to radiotherapy for some residents in the STP. They wish to see services re-provided in fit for purpose buildings replacing some of its oldest facilities; it is seen as an important part of delivering a healthier future for residents of Hertfordshire and West Essex.

7. Hillingdon Hospitals NHSFT as the landlord of the site has recently agreed to some estate investment. Much of the MVCC building stock is old and decrepit and recent adjustment to service provision have had to be made in some areas as a direct result of this e.g. leaking roofs.

8. The facilities at MVCC are as follows:

    - **Inpatient Facilities:** There are currently 33 medical inpatient beds (22 substantive beds and 11 beds relocated from the closure of the Michael Sobell Hospice), plus 4 escalation beds located on one ward in the oldest part of the building at MVCC. The physical structure of these facilities is poor. The ward cares for patients who require inpatient treatment because they (a) have complications of their cancers (b) are unwell during or following their

radiotherapy / chemotherapy treatment (c) are having radio-isotope treatments or brachytherapy (principally prostate and gynaecology cancers). In addition (d) some patients are admitted for their treatment if it is particularly arduous or (e) if the patient is frail. Since the relocation of the hospice inpatient service, there have been admissions for (f) symptom control and terminal care.

- There are limited support facilities onsite and, in particular, there are no onsite surgery and acute medical services and no ICU or High Dependency Unit (HDU) facilities. Patients requiring enhanced clinical support are transferred to non-specialised DGHs for acute medical care or surgery. A review of these patient transfers highlighted large numbers of patients who could not receive their inpatient care at MVCC.

- When acutely unwell patients are transferred out to local DGHs, there is a loss of line of sight to the MVCC responsible consultant, resulting in fragmentation of care. The de-skilling of inpatient staff to cope with acutely unwell patients will inevitably limit the deliverability of complex and innovative treatments and compound nursing and medical recruitment and retention issues.

- **Outpatient Facilities**: The Trust provides a chemotherapy / systemic therapy service at MVCC. Patients from all solid tumour groups, including those on clinical trials, are treated in the cancer centre's chemotherapy outpatient's suite where they receive cytotoxic drug regimens and targeted systemic therapies.

- The chemotherapy suite is open Monday to Friday, treating an average of between 50 and 70 patients per day. It has 20 treatment chairs and two beds. Side rooms are available for patients to be seen on a one-to-one basis by the unit's doctors or nurses. The current SLA with Baxter ends March 2020, and the production of long life, dose banded systemic therapy will be out to tender in the coming months. Staff raised concerns regarding the provision of short life therapies, if production could not be provided by an onsite facility.

- There are insufficient rooms for medical staff, specialist nurses, dietitians and speech and language therapists. Inadequate electronic systems and poor IT connectivity slow the clinic process. There is no direct real time connection of the x ray systems between MVCC and the hospitals in its catchment area which undermines effectiveness of clinical management.

- The 24 hour telephone service required for the MVCC chemotherapy service cannot access any more up to date information than that in the last clinic letter. Since the average time for clinic letters from MVCC clinical staff to be typed up is 2 weeks (but up to 6 weeks max), there is a risk that nurses manning the 24-hour telephone line will be acting on clinical information which has changed.

- There is an onsite MVCC acute oncology service and its main impact is on those patients who receive their treatment on the MVCC site. It works with the supportive care unit, which was opened in January 2018 to provide cancer treatments and adjuncts such as blood transfusions and any symptom management that can be managed on a day care basis in order to prevent deterioration and admission to an inpatient unit. There is also a central venous access devices (CVAD) and interventional radiology service on site.

- In addition, MVCC has a separate outpatient department with 16 clinic rooms and a small waiting room both of which are inadequate to meet current demand.

- Consultants provide a clinical outreach service for East and North Hertfordshire NHS Trust, West Hertfordshire Hospitals NHS Trust, Hillingdon Hospitals NHS Foundation Trust, Luton and Dunstable University Hospital NHS Foundation Trust, Frimley Health NHS Foundation Trust, Buckinghamshire Healthcare NHS Trust and London North West University Healthcare NHS Trust, including oversight of local delivery of chemotherapy in several of these sites.

- The radiotherapy centre has seven linear accelerators (linacs) and a cyber knife stereotactic platform covering a 5 day service 7am – 8pm. Four linacs are modern. Three of the linacs and the associated bunkers are leased. Two linacs will be over 10 years old in 2020 and in addition, one has had a temporary upgrade to prolong its useful life. There is currently a limit in treating patients with state of the art intensity modulated radiotherapy treatment (IMRT) due to a lack of treatment planning licences.

- The brachytherapy service at MVCC provides for both High Dose Rate (HDR) and Low Dose Rate (LDR) treatments but access to theatres is currently constrained. The brachytherapy service at MVCC is nationally recognised and accepts a significant number of referrals from outside its catchment area.

- Molecular radiotherapy (radioisotope therapy) includes radioiodine and radium (MVCC is one of 3 London providers of radium 223).

- MVCC has a private patient service which is currently limited but offers potential for future income generation.

5. Clinical Advisory Panel

The remit of the Clinical Advisory Panel was to undertake 3 specific actions:

- Review the long list of options previously identified by key stakeholders

- Remove any non-clinically acceptable options

- Make recommendations to the MVCC Programme Board meeting held on 4th July 2019

Panel Members:

- Professor Nick Slevin (Chair) – Former Chair of NHS England's National Radiotherapy Clinical Reference Group, The Christie NHS Foundation Trust, Manchester
- Professor Peter Clark – NHS England National Lead for the Cancer Drugs Fund and previously practiced at the Clatterbridge Cancer Centre, Merseyside
- Jenny Scott – Deputy Director of Business Development, The Christie NHS Foundation Trust, Manchester
- Julie Gray – Associate Chief Nurse and Deputy Director of Quality, The Christie NHS Foundation Trust, Manchester
- Steve Palmer – Chair, Hertfordshire Healthwatch
- Turkay Mahmoud – Interim Chief Executive Officer, Hillingdon Healthwatch

The Clinical Advisory Panel considered the current service model and its long term sustainability, referencing Key Lines of Enquiry (KLOE) with the aim of:

- ✓ Putting the needs of the patient and public first
- ✓ Developing recommendations for the MVCC Programme Board as an outcome of the clinical assessment to develop a sustainable model for the population to be served
- ✓ Providing evidence to support the outcome of the Clinical Advisory Panel assessment process.

The Clinical Advisory Panel was accountable to the Senior Responsible Officer for the Project and Chair of the Programme Board, Ruth Ashmore, Director of Specialised Commissioning and Health & Justice, NHS England and NHS Improvement, East of England.

The final Clinical Advisory Panel report outlining their assessment and recommendations will be presented to the MVCC Programme Board on 4th July 2019.

6. Key Lines of Enquiry (KLOE)

The purpose of the review was to undertake a strategic assessment of the Mount Vernon Cancer Centre with particular attention to 5 key lines of enquiry:

1. Quality of Care
2. Patient and Carer Experience
3. A Sustainable Workforce
4. Training and Education
5. Research and Innovation

KLOE	Factors under review
Quality of Care	The Clinical Advisory Panel will make an assessment and deliver a considered view regarding the Quality of Care in relation to: **Patient Safety:** reviewing safe care pathways, including patient transfer and shared care arrangements and the ability to meet the requirements for the co-location of critical services including specialist imaging. **Clinical Effectiveness**: review the ability to meet the required quality and regulatory standards, including the NHS England National Service Specifications, Cancer Waiting Time Standards and NICE guidelines. **Quality of the Patient Environment:** assess the specialist equipment required to deliver the clinical standards and patient experience. **Deliverability:** assess whether appropriate capacity is available to deliver a fast evolving service.
Patient and Carer Experience	The Clinical Advisory Panel will make an assessment and deliver a considered view of the experience of patient and carers, including access to services, taking into account: **Distance and Time to Access Services**: The Clinical Advisory Panel will review the distance and time required by patients to assess services at MVCC, including the impact on travel times (peak and off peak and non -emergency). **Patient and Carer Experience:** The Clinical Advisory Panel will establish a view on the impact on travel times on patient experience and the potential impact on patient decision making regarding treatment modality choice. **Service Availability**: The Clinical Advisory Panel will review the operating hours of the service, access to out of hours advice and care and the potential to access services to 7 days. **Continuity of Care and Survivorship**: Post treatment review arrangements and ability to address survivorship challenges
Sustainable Workforce	**Sustainability of the Workforce:** The Clinical Advisory Panel will make an assessment and deliver a considered view on the impact of the current environment in relation to the ability to recruit and retain staff across all of the multi-disciplinary team and the future sustainability of the teams to deliver the level of care required.

Training and Education	The Clinical Advisory Panel will make as assessment and deliver a considered view on the ability of MVCC to meet the training and educational requirements of the staff groups and any potential impact on opportunities for career development and progression.
Research and Innovation	The Clinical Advisory Panel will make as assessment regarding the ability of MVCC to engage in research programmes, including a broad range of research studies and the availability of academic research.

7. Activities Undertaken in the Review

A 2 day programme of meetings and interviews was held on 19th - 20th June 2019 (see appendix 2) which provided the opportunity for more detailed discussions and for triangulation of messages received from the different individuals and groups.

The Clinical Advisory Panel undertook a series of interviews, both face to face and by telephone (see appendices 3 and 4) in order to speak to as many key stakeholders as possible.

In addition to the interviews, previous review documents were referenced and 2 patient / carer listening events will be held on 3rd July.

The aim of the Clinical Advisory Panel was to be as fully informed as possible in making recommendations to the MVCC Programme Board.

A summary of the Clinical Advisory Panel's activities is outlined, with supporting evidence shown in the appendices.

7.1 Identification of Key Stakeholders

The Clinical Advisory Panel worked with East of England Specialised Commissioning Team to identify the individuals and organisations who had an interest in the future of MVCC.

These stakeholders came with a variety of perspectives and the intention was to speak to as many of them as possible in order that the review findings would have taken into account as diverse a range of comments as was possible.

Appendices 3, 4 and 7 list the stakeholders who were interviewed as part of Clinical Advisory Panel process.

7.2 Telephone Interviews

Clinical Advisory Panel members undertook a series of telephone interviews in advance of the 2 day assessment at MVCC. All interviewees were assured of the non-attributable nature of their conversation.

The Clinical Advisory Panel Chair, Professor Nick Slevin, was able to speak to almost all consultants identified on the stakeholder list and other telephone interviews included the Medical Directors at East and North Hertfordshire NHS Trust and Hillingdon Hospital NHS Trust as well as the Medical Directors at both The Royal Marsden and University College London Hospital (UCLH).

A summary of the themes to emerge from these telephone calls is shown:

Theme	Level of Support
Clinical Delivery	
Maintaining safety of patients cannot be guaranteed in the near future – status quo is not an option – there is a need for urgent action.	Consensus
To provide modern oncology care, comprehensive medical and surgical support services including ITU are needed – this is not now available at MVCC.	Consensus
Difficulty in redeveloping MVCC site to provide medical and surgical support services including ITU.	Majority
Deskilling of existing inpatient nursing staff as acutely unwell patients transferred out. Loss of ability to undertake practical interventions on site e.g. draining ascites.	Consensus
Need for an inpatient integrated service in order to manage acutely unwell patients (due to unpredictable toxicities of immunotherapies, intensive chemotherapy / radiotherapy regimens and comorbidities). Concern about the quality of integrated care for patients currently transferred out to non-specialist DGHs impacting upon patient management.	Consensus
Leadership and Oversight	
Specialist regional cancer services should not be led / provided / overseen by a DGH.	Consensus
Change of leadership for MVCC is a priority and a decision must be made urgently.	Consensus
New leadership should be an existing tertiary cancer service provider.	Majority
Service Configurations	
Radiotherapy satellite in the north of the catchment (Luton, Stevenage or St Albans) makes sense but is not the priority for now – core service must be addressed first.	Majority
Non acute sites could not provide a comprehensive acute support service.	Majority
Dividing up the existing catchment to surrounding providers would be unacceptable due to disrupted patient flows, insufficient capacity and access concerns, loss of workforce cohesion and commitment.	Consensus
Capital and Estate	
The estate should be owned by the service provider.	Consensus
Need for a robust capital replacement plan for the linacs.	Consensus
Current estate is not fit for purpose, particularly ward buildings for acutely unwell and end of life inpatients.	Consensus
Current heavy reliance on charity for capital developments.	Consensus
Poor IT / Picture Archiving and Communication System (PACS) / electronic patient record systems in place for networked activity – this is a clinical risk.	Consensus
Sustainable Workforce	
MVCC clinical staff are highly motivated, collegiate and work hard to deliver high quality clinical services.	Consensus
Urgent need for additional clinical and support staff due to the current excess workload.	Consensus
Inadequate levels of administrative support resulting in a backlog of clinical correspondence - this is a clinical risk.	Consensus
Research and Development	
Research and development is being lost as current oversight is not cancer specific, a lack of ownership of cancer trial income by cancer teams and a lack of investment in trials infrastructure.	Consensus
Development Opportunities	
Poor onsite provision for private patients which represents a missed opportunity for income generation.	Consensus

7.3 Face to Face Interviews

The Clinical Advisory Panel held a 2 day programme of interviews at MVCC on 19th / 20th June. Each group or individual were asked to outline from their perspective the key challenges facing MVCC and their views on potential solutions. The Clinical Advisory Panel also undertook a tour of the site so they could see for themselves the configuration and state of the site.

These assessment days provided the opportunity to meet with a large number of individuals and groups and to see more clearly where there was consensus in thinking and where there were divergent views on the challenges.

7.4 Patient and Carer Perspective

It was recognised that addressing issues of patient care experiences and access to service were paramount to any future service configurations. Patient safety at MVCC has been an increasing concern and the experience of patients and their carers has been undermined by basic service deficiencies and poor accommodation.

The large catchment area for MVCC and the predicted continued growth in patient numbers and treatments were clearly acknowledged.

Some geographical areas are more poorly served than others. For example, Slough and the northern parts of the catchment area suffer from poorer access to radiotherapy as a consequence of considerably longer travel times to receive treatment.

Clinical trials offer access to new treatments and should be embedded in the clinical service with equitable access for all patients – this is not currently the case at MVCC.

The impact on patients of poor IT infrastructure should not be underestimated. There are clinical risks as a consequence of duplicate paper records, lack of filing of clinical records, lack of access to complete scanning images out of hours and the inability to view a comprehensive patient record.

The Clinical Advisory Panel also reviewed previous feedback from patients and carers regarding MVCC. A set of issues of greatest importance to cancer patients had emerged from these which were used to structure the current review engagement process. Patients had identified 3 core issues:

- Assurance of quality of care
- Access to new treatments
- Ease of access to services / reduced travel time

Seeking an updated view from patients and carers at MVCC was considered fundamental to this review in order to maintain a patient focus for the recommendations. The Clinical Advisory Panel proposed holding 2 listening events to supplement the NHS England led engagement process.

These 2 events will be held on 3rd July in locations accessible to patients from either end of the MVCC catchment area.

7.5 Document Review

The Clinical Advisory Panel requested access to all previous reviews and supporting documents. They also received internal strategic documents from ENHT.

The documents reviewed by the panel can be seen in appendix 6.

8. Summary of emergent themes

From the review, the overarching theme that emerged related to the increasing concern regarding the effective clinical delivery of oncology care. For example, in relation to toxicities from systemic anti-cancer therapies, awareness of toxicities is high from traditional cytotoxic chemotherapy and these toxicities are predictable e.g. neutropenic sepsis. In contrast, there is increasing use of immunotherapies where toxicities are common (up to 90% for some therapies), awareness of toxicities is low and they are unpredictable such that there is a high potential for mismanagement. For immunotherapy toxicities, there is a need for education, awareness and expert management, supporting the requirement for comprehensive support services being readily accessible. The types of potential toxicities from immunotherapy treatment are as shown:

Organ	Examples of toxicity from immunotherapy
Heart	Myocarditis, pericarditis
Neurological	Neuropathy, Guillain Barré
Endocrine	Pituitary, thyroid, adrenal, diabetes
Kidney	Nephritis
Liver	Hepatitis
Bowel	Colitis (7% with ipilimumab)
Skin	Rashes, pemphigoid
Lung	Pneumonitis, granulomatosis
Eye	Uveitis, retinitis
Musculo skeletal	Arthritis, myositis

The Clinical Advisory Panel addressed each of the KLOE and their findings are as shown:

KLOE	Comments
Quality of care	• MVCC team to continue to provide the best quality care they can within the significant limitations of the current physical environment and clinical systems; this is not a sustainable situation.
	• There has been investment in clinical nursing leadership and this is evident in the quality of care provided to patients. However, there is still some resistance to developing nurse led services and initiatives.
	• Several elements expected within a modern healthcare system are not possible to implement due to the limitations of the environment and staff shortages e.g. daily consultant ward rounds, consultant review of patients admitted within the previous 14 hours, speedy access to simple tests and results, shortage of junior medical staff and nursing

	staff, failure to complete Do Not Attempt Resuscitation (DNAR) documentation in appropriate patients, patients self-management of medications, dementia care, non-medical prescribing and nurse and pharmacist led clinics
	• Not all patients have access to a disease specific clinical nurse specialist (CNS).
Patient and carer experience	• Feedback from patients has on the whole been positive over a long period of time in spite of the significant challenges faced.
	• Patients and carers may be unaware of the isolation of care at MVCC, the need to transfer patients if acutely unwell and the consequent dislocation of care.
Sustainable Workforce	• MVCC is still considered a good place to work. It should, however, be noted that staff stay because of their commitment to patients and the knowledge of the consequences of them leaving on patient care.
	• The team are, in the main, demoralised and frustrated with local management of the MVCC services due to an apparent lack of strategic direction over future provision.
	• Staff losses are impacting upon the service. There are additional clinical risks such as the backlog of patient letters and notes as a result of inadequate administrative support.
	• Recruitment and retention of expert staff is an increasing problem and is becoming critical.
	• Declining expertise for inpatient care – there are no onsite acute services and acutely unwell patients are transferred out, thus leading to deskilling of existing staff.
	• MVCC staff feel disempowered and disengaged from the executive management decision making.
	• MVCC is physically remote from ENHT executive team (30-35 miles away).
	• There appears to be a rapid turnover of MVCC divisional management and issues have not been resolved for many years.
Training and Education	• Poor service impacts upon training and education, measured by the following: ○ Unfilled CMT posts ○ Unfilled SpR posts ○ Difficulty in filling consultant posts ○ Difficulty in attracting nursing posts ○ From August 19, unfilled General Practice support posts
	• There has been investment in clinical nursing leadership and this is evident in the quality of care provided to patients. However, there is still some resistance to developing nurse led services and initiatives.

	• Several elements expected within a modern healthcare system are not possible to implement due to the limitations of the environment and staff shortages e.g. daily consultant ward rounds, consultant review of patients admitted within the previous 14 hours, speedy access to simple tests and results, shortage of junior medical staff and nursing staff, failure to complete DNAR documentation in appropriate patients, patients self-management of medications, dementia care, non-medical prescribing and nurse and pharmacist led clinics.
Research and Innovation	• There is general acceptance that research should be embedded in the clinical service of non-surgical oncology in order to: ○ deliver clinical developments ○ ensure equitable access to appropriate clinical trials for patients according to their particular condition
	• With increasing governance required to develop investigator led trials, there is need to continually invest in cancer research and development infrastructure which in turn necessitates the ring fencing of cancer research income.
	• Other areas of cancer research which require underpinning include: ○ Sponsorship function ○ Early phase clinical trials ○ Clinical trials pharmacy ○ Research accredited pathology laboratory accreditation ○ Appropriate clinical accommodation to support toxicity management for trials patients.
	• Research activity opportunities and profile is a particularly important driver for recruitment and retention of expert staff

9. Option Appraisal

The Clinical Advisory Panel's remit was to review the long list of options that had been identified by NHS England, informed by a number of stakeholders, and to make recommendations regarding any that would not be clinically acceptable.

9.1 Long list of options for service delivery

The long list of 6 options had been identified by the E&NH Trust Executive Team, MVCC Clinical and Management Team and wider stakeholders.

Option	Description	Potential Variants
1	**Do minimum.** Minimal investment to the buildings currently on site, and no change to the clinical delivery model.	
2	**Full replacement (non-acute site)** – replacement of existing facilities (including inpatient facilities, radio pharmacy and nuclear medicine) on the current (or alternative) site. Aseptic services provided on or off site. No change to the clinical delivery model.	• New build on existing site • New build on alternative (non-acute) site
3	**Full replacement (acute site)** – replacement of existing facilities (including inpatient facilities, radio pharmacy and nuclear medicine) on an acute hospital site, co-located with ITU facilities. Aseptic services provided on or off site.	• New build (or combination of new build/absorption) on acute hospital site • New build (or combination of new build/absorption) on existing acute tertiary cancer centre hospital site
4	**Majority replacement** – all non-inpatient services provided within a new build MVCC, including radio pharmacy and nuclear medicine. Inpatient ward and brachytherapy relocated to an existing acute tertiary cancer centre site/DGH acute site. Aseptic services provided on or off site. No satellite radiotherapy.	• New build on existing site • New build on alternative (non acute site)
5	**Ambulatory Hub:** ambulatory hub at MVCC providing radiotherapy, chemotherapy and outpatients. Onsite radio pharmacy and nuclear medicine. Aseptic services provided on or off site. Inpatient ward and brachytherapy relocated to acute tertiary site/DGH acute site. Development of new satellite radiotherapy in the north of the patch (e.g. Stevenage or Luton)	• Hub at MVCC • Hub at alternative location
6	**Distributed model, with satellite radiotherapy** – split all MVCC inpatient, outpatient and ambulatory activity across neighbouring tertiary cancer providers with satellite radiotherapy in the north of the patch (e.g. Stevenage or Luton).	• Redistribute across 2 providers • Redistribute across 3 providers • Radiotherapy at MVCC/Stevenage • Radiotherapy at MVCC/Luton • Radiotherapy at other location in the north of the patch.

9.2 Short list of options

The Clinical Advisory Panel considered all the evidence gathered during the review and matched this against the long options list.

A shorter list of options was identified, with some from the long list being disregarded due to their inability to address key drivers for change or deliver an acceptable clinical model.

In all the supported options, the Clinical Advisory Panel has recommended that the accountability and ownership of the MVCC services be transferred from East and North Hertfordshire NHS Trust to a current tertiary cancer centre (see appendix 8).

Option	Long List Description	Panel View	Rationale
1	Do minimum	This option is not considered clinically acceptable	The safety and sustainability of the MVCC services could not be achieved with this option. A number of high clinical risks have been identified if services do not change in major ways.
2	Full replacement on a non-acute site	This option is not considered clinically acceptable	This option does not address the need for comprehensive acute service support in the delivery of tertiary cancer care, a clearly identified clinical risk.
3	Full replacement on an acute site	This option is considered clinically acceptable	• This option would require the build of a new integrated cancer centre on an acute DGH site. • This should preferably be close to the existing MVCC site and central to the existing catchment area to maintain patient access. • Leadership for the centre should be through an existing London based tertiary cancer centre. • Services in the new build must include: ○ Oncology inpatient beds ○ All types of radiotherapy and appropriate radiotherapy planning facilities ○ Dedicated oncology teams of nursing staff and AHPs ○ Access to anaesthetics / theatres for brachytherapy services ○ Nuclear medicine and radio pharmacy services (preferably integrated with local isotope service) ○ Chemotherapy day case unit ○ Aseptic services for oncology pharmacy capable of manufacturing licence ○ Paul Strickland imaging centre ○ Linkages to existing hospital ○ Outpatient clinics ○ Medical physics hub ○ Consultant offices ○ Office for SpRs

			○ Clinical trials offices • Additional radiotherapy satellite provision in the north of the catchment area would be preferable. • A networked chemotherapy service run from the cancer centre on acute DGH sites would be preferable.
4	Majority replacement	This option is not considered clinically acceptable	The option of building up all but inpatient services on the existing MVCC site and relocating all acute inpatient services to a DGH would largely reproduce current clinical risks and result in lack of cohesion of service delivery.
5	Ambulatory Hub	This option is considered clinically acceptable	• This would comprise a new build on an acute site with an ambulatory service for radiotherapy (4 linacs) and chemotherapy remaining on the existing MVCC site. • Leadership for the centre should be through an existing London based tertiary cancer centre. • Services in the new build on an acute DGH site must include: ○ Oncology inpatient beds ○ Some radiotherapy especially for the most complex radiotherapy e.g. chemo radiotherapy for head and neck cancer. ○ Dedicated oncology teams of nursing staff and AHPs ○ Access to anaesthetics / theatres for brachytherapy services ○ Nuclear medicine and radio pharmacy services (preferably integrated with local isotope service) ○ Chemotherapy day case unit ○ Aseptic services for oncology pharmacy capable of manufacturing licence ○ Paul Strickland imaging centre ○ Linkages to existing hospital ○ Outpatient chemotherapy suite services ○ Outpatient clinics ○ Medical physics hub ○ Consultant offices ○ Office for SpRs ○ Clinical trials offices • Additional radiotherapy satellite provision in the north of the catchment area would be preferable as would networked chemotherapy with a single governance arrangement run from the cancer

			centre on the acute DGH site linked into acute DGHs and mobile chemotherapy if possible.
6	Distributed model, with satellite radiotherapy	This option is not acceptable	Based upon the review findings, this option would result in: • The loss of expert oncology workforce due to the further demoralisation of the workforce (as there was a clear consensus that this would not be acceptable). • Patient access may also be impacted with a proportion of existing patients having to travel further • The loss of a long established service, highly valued by patients

10. Recommendations

The Clinical Advisory Panel accept the capital investment challenges of the 2 recommended options with the ambulatory hub (option 5) perhaps more pragmatic than full replacement on an acute site (option 3). Nevertheless, the cancer centre still requires a full complement of services. It must be on an acute DGH site and in order to ensure the maximum integration of care must give consultant, nursing, radiographer, physics and oncology pharmacy staff who participate in networked clinics, chemotherapy or radiotherapy as many reasons as possible to spend significant time at the cancer centre on the acute DGH site. Under either of these options, the leadership, governance, management and strategic development of the specialised oncology service at MVCC should transfer to an existing tertiary cancer service provider.

Irrespective of which model of reconfiguration is recommended, there will inevitably be a significant period of transition to full implementation. Patient safety and confidence must be maintained during this transition by bolstering acute oncology provision, consultant ward rounds, and strict admission policies to existing MVCC site, MVCC staff reviewing patients who have been transferred out to local DGHs, maintaining linac capacity, ensuring the provision of oncology pharmacy services and recruiting additional staff.

APPENDICES

Appendix 1

Clinical Advisory Panel Biographies

Prof Nick Slevin.

Professor Slevin has been a consultant Clinical Oncologist since 1988 at the Christie Hospital in Manchester specialising in the non-surgical management of head and neck cancer.

He was Chair of NHSE Radiotherapy CRG 2012-19 and remains Chair of Radiotherapy Commissioning through Evaluation. He was Senior Responsible Owner for Manchester Proton Beam Therapy until the service opened in 2018.

Professor Slevin has previously been FRCR examiner, Regional Postgraduate Advisor for Clinical Oncology. He has over 100 peer reviewed publications and initiated much original research. He has recently been visiting Professor to Philadelphia and Dublin with the award of honorary Irish Fellowship.

At the Christie Professor Slevin was Director of non-surgical oncology services for many years, overseeing the chemotherapy strategy, Project Director for new chemo treatment centre, and purchase of mobile unit.

Professor Slevin as Clinical Director of Clinical Oncology initiated the Radiotherapy Related Research strategy and expansion of consultant staff complement as well as advising on establishing Radiotherapy satellite provision.

Most recently, he has been Clinical Director of Christie International, offering consultancy advice to providers in India, Ireland and Indonesia.

Professor Peter Clark

Professor Clark is a medical oncologist and practised in Liverpool and Merseyside for over 28 years. He has a passionate belief in the equity of access for patients to high quality evidence-based cancer care and the provision of the right chemotherapy to the right patient in the right place and at the right time and in the right way.

Professor Clark's roles have included being Medical Director of his Trust (1993-2000), Director of the Mersey & Cheshire Cancer Research Network (2001-2008), leading his specialty of medical oncology nationally (2000-2006), serving on the NICE Technology Appraisal Committee (2002-2009) and then chairing it (2009-2013) and then joining NHS England Specialised Commissioning in 2013 as chair of the Chemotherapy Clinical Reference Group (2013-2019)and National Clinical lead for the Cancer Drug Fund (2013-t0 date). His enthusiasm for evidence-based care and equity of access to the right clinically and cost-effective chemotherapy remains undimmed: the need for it is ever greater in a financially challenged NHS facing both the opportunities and threats of great drug discovery in cancer and an ageing population.

Julie Gray

Associate Chief Nurse and Deputy Director of Quality, The Christie NHS Foundation Trust

Julie qualified as a Registered General Nurse in 1993 gaining experience in a range of care environments including medical, surgical and intensive care. Julie went on to become a Clinical & Professional Skills Tutor, with a special interest in medicines management, at the University Hospitals of South Manchester which led onto a role with the Greater Manchester Strategic Health Authority as a clinical placement manager supporting student nurses in practice.

Julie joined The Christie NHS Foundation Trust as a specialist nurse in 2005, moving into a governance role in 2007. During this time Julie was instrumental in the Trust's achievement of NHSLA level 3 accreditation. She also participated in the comprehensive inspection programme as a Specialist Advisor for the Care Quality Commission and in 2016 she operationally led the Trust to a CQC Outstanding rating, repeated again in 2018.

In her current role as Associate Chief Nurse and Deputy Director of Quality Julie leads the patient safety, patient experience, clinical audit and improvement and non-medical prescribing services for the Trust.

Julie has an honours degree Health Service Management & Health Promotion, a Post Graduate Certificate in Education and a Master's degree in Leadership in Health & Social Care. In 2017 she also became a scholar of the Florence Nightingale Foundation.

Jenny Scott

Deputy Director of Business Development, The Christie Hospital

Jenny Scott is Deputy Director of Business Development at The Christie in Manchester and has extensive strategic and operational management experience in the NHS having held a number of senior positions both locally and nationally. These have included leading a North West England team commissioning specialised healthcare services, managing large scale service transformation programmes and most recently being the Programme Director for both the Manchester Proton Beam Therapy initiative and the National Cancer Vanguard in Greater Manchester. Jenny is now leading on a number of commercial initiatives and is the Programme Director of Christie International offering consultancy advice to providers in India, Ireland and Indonesia.

Jenny has an honours degree in Psychology, A diploma and a Master's Degree in Healthcare Management. She has gained qualifications in programme and project management and has trained as an Action Learning set facilitator.

Steve Palmer

Steve was elected Chair in May 2018 having previously been our Treasurer. Steve worked in social housing for many years, as Finance Director and Managing Director, and subsequently worked with tenants and others looking at the future of local authority housing. Steve has also served as a Councillor in Watford and has been a Board member of Housing Associations and various Charities.

Following a number of years of ill health, Steve has extensive practical experience of the NHS, and wants to ensure that the service we all rely on is the best it can be, and that people are fully involved in the care they receive.

Turkay Mahmoud

Turkay has lived in Hillingdon for over 32 years and has significant leadership experience in education at school, local authority, regional and national level having worked in education and the public sector for over 40 years. During his early career he taught in a number of schools in London and was a head teacher of a new school. He later worked in a senior leadership capacity in several local authorities with responsibility for school development and improvement, as an Ofsted inspector and for the National College for School Leadership.

He has worked on a number of national change programmes: school workforce reform and extended services for schools. He has worked for Inspiring Futures Foundation (a charitable organisation) providing careers advice to students and acted as a senior advisor to a charitable organisation in Bangladesh which has opened a new school with the aim of providing quality education in semi-rural Sylhet.

Turkay has been with Healthwatch Hillingdon since it was established (2013) and has been Chair, Vice Chair and is currently the interim Chief Executive Officer.

Turkay has a Certificate in Education, an honours degree in Education and Human Movement Studies and a Master's degree in Education in Urban Areas.

Appendix 2 **Clinical Advisory Panel Programme**

MVCC Clinical Advisory Panel Two Day Programme

19th and 20th June 2019

Seminar Room, Post Graduate Centre, Mount Vernon Cancer Centre (WD3 1PZ)

	18th June 2019
19.00	**Welcome and outline of the programme** Ruth Ashmore, Director of Specialised Commissioning and Health and Justice, NHS England and NHS Improvement

	19th June 2019
08.30-08.45	**Meet at Post Graduate Centre to begin Tour**
08.45-10.30	**Tour of the Mount Vernon Site** Clinical Advisory Panel with Dr Paul Mulholland and Kelly McGovern
10.30 – 11.00	**Return to Meeting Room - Coffee and Discussion**
11.00-12.00	**Divisional Chair, Cancer Division, MVCC** ○ Jagdeep Kudhail **Clinical Director, MVCC** ○ Dr Paul Mulholland
12.00-12.45	**Hospital Director** ○ Sarah James **Head of Nursing, Cancer Division, Cancer Division, MVCC** ○ Kelly McGovern
12.45-13.15	**Out Patient Department** ○ Neel Bhuva, Clinical Oncologist ○ Maggie Fitzgerald, Deputy Head of Nursing ○ Trisha Webbe, Associate Director, Cancer Division ○ Sarah Morgan, Matron Out-patients
13.15 - 14.00	**Lunch and Panel Discussion**
14.00-15.00	**In-patients and Palliative Care:** ○ Dean Weston, In-patient and Palliative Care Manager ○ Claire Dua, In-patient Matron ○ Humaira Jamal, Palliative Care Consultant ○ Suprotim Basu, Consultant, In-patient Lead ○ Zandie Chakunda, Acute Oncology, Lead Nurse
15.00-16.00	**Junior Medical Staff**: ○ Laura Morrison, Jyotsna Bhudia, Mohammed Abdul-Latif
16.00 – 16.30	**Coffee – Clinical Panel Discussion**
16.30-17.30	**Chemotherapy:** ○ Dr David Miles, Clinical Lead for Chemotherapy ○ Jo Demare, Chemo, AOS, OPD and Medical Records Service Manager ○ Michelle Orsmond, Chemo matron ○ Vikash Dodhia, Lead Pharmacist ○ Andrew Hood, Chief Pharmacist
17.30-18.30	**CNSs:** ○ Amanda Webb, Palliative Care Clinical Nurse Specialist, ○ Melanie Blyth, Lung CNS, ○ Helen Johnson, Haematology CNS ○ Maggie Fitzgerald, Deputy HON
18.30	**Close**

	20th June 2019
08.30-09.15	○ Cathy Cale, Medical Director, Hillingdon Hospital
09.15-10.00	**CCG Commissioners - Teleconference** ○ Beverley Flowers, Accountable Officer, East & North Herts CCG ○ Sharn Elton, Clinical Lead, Cancer Services, East & North Herts CCG ○ Lizzy Bovill – Director of Performance & NWL SRO for Cancer
10.00 – 10.30	**Coffee**
10.30-11.45	**Radiotherapy Modelling** ○ Edward Bramley-Harker and Kim Fell
11.45-12.45	**Consultants:** ○ Roberto Alonzi, Brachytherapy Consultant ○ Pete Ostler, Breast, Urology and Brachytherapy Consultant ○ Suzy Mawdsley, Head of School for Clinical Oncology, London
12.45 – 13.30	**Lunch and discussion**
13.30-14.30	**Radiation Services**: ○ Daniel Megias, Head of Radiotherapy ○ Karen Venables, Head of Radiotherapy Physics and Bioengineering ○ Claire Strickland, CEO Paul Strickland Scanner Centre ○ Professor Padhani
14.30-15.30	**Nuclear Medicine:** ○ Suzanne Douglas, Lead Clinical Scientist, Nuclear Medicine, ○ Andrew Shah, Head of Radiation Protection
15.30 – 16.00	**Coffee with Rachael Corser**
16.00 – 16.30	**Research & Development** ○ Philip Smith, Associate Director Research and Development ○ Paul Nathan, Medical Oncologist, Melanoma lead ○ Marcia Hall, Clinical Lead Research and Development ○ Anita Holmes, Trust Lead Research Nurse
16.30 – 17.15	**Panel Discussion**
17.15	Opportunity for additional questions to Jagdeep Kudhail, Dr Paul Mulholland, Sarah James and Kelly McGovern if required
17.45	**Close**

Appendix 3

Clinical Advisory Panel Programme Participants (19/20 June)

Name	Position
Jagdeep Kudhail	Divisional Chair, Cancer Division
Dr Paul Mulholland	Clinical Director, MVCC
Sarah James	Hospital Director, MVCC
Kelly McGovern	Head of Nursing, Cancer Division, MVCC
Neel Bhuva	Clinical Oncologist
Maggie Fitzgerald	Deputy Head of Nursing
Trisha Webbe	Associate Director, Cancer Division
Sarah Morgan	Matron, Out-patients
Dean Weston	In-patient and Palliative Care Manager
Claire Dua	In-patient Matron
Humaira Jamal	Palliative Care Consultant
Suprotim Basu	Consultant, in-patient lead
Zandie Chakunda	Acute Oncology, Lead Nurse
Laura Morrison	Junior Medical Staff
Jyotsna Bhudia	Junior Medical Staff
Mohammed Abdul-Latif	Junior Medical Staff
Dr David Miles	Clinical Lead for Chemotherapy
Jo Demare	Chemo, AOS, OPD and Medical records Service Manager
Michelle Orsmond	Chemotherapy Matron
Vikash Dodhia	Lead Pharmacist
Andrew Hood	Chief Pharmacist
Amanda Webb	Palliative Care CNS
Melanie Blyth	Lung CNS
Helen Blyth	Lung CNS
Helen Johnson	Haematology CNS
Cathy Cale	Medical Director, Hillingdon Hospital
Beverley Flower	Accountable Officer, ENH CCG
Sharn Elton	Clinical Lead, Cancer services, ENH CCG
Lizzy Bovill	Director of Performance, NWL SRO for Cancer
Edward Bramley-Harker	EDGE
Kim Fell	NHS E/I
Roberto Alonzi	Brachytherapy Consultant
Pete Ostler	Breast, Urology and Brachytherapy Consultant
Suzy Mawdsley	Head of School for Clinical Oncology, London
Daniel Megias	Head of Radiotherapy
Karen Venebles	Head of Radiotherapy, Physics and Bioengineering
Claire Strickland	CEO, Paul Strickland Scanner Centre
Professor Padhani	Consultant Radiologist, Paul Strickland Cancer Centre
Suzanne Douglas	Lead Clinical Scientist, Nuclear Medicine
Andrew Shah	Head of Radiations Protection
Rachael Corser	Director of Nursing, ENHT
Philip Smith	Associate Director, research and Development
Paul Nathan	Medical Oncologist
Marcia Hall	Clinical Lead, R & D
Anita Holmes	Trust Lead Research Nurse

Appendix 4

Clinical Advisory Panel Participants – telephone call interviews

Consultants	Clinical or Medical	Speciality
Dr Roberto Alonzi	Clinical Consultant	Urology
Dr Nicola Anyamene	Clinical Consultant	Upper and Lower GI
Dr Neel Bhuva	Clinical Consultant	Upper and lower GI
Dr Kevin Chiu	Clinical Consultant	Head and Neck
Dr Shirley D'Sa	Consultant Haemato-Oncologist	Haematology
Dr Jeanette Dickson	Clinical Consultant	Lung
Dr Rob Glynne-Jones	Clinical Consultant	GI
Dr Amy Guppy	Medical Consultant	Breast
Dr Marcia Hall	Medical Consultant	Gynae
Dr Mark Harrison	Clinical Consultant	Upper and lower GI
Prof Peter Hoskin	Clinical Consultant	Urology
Dr Humaira Jamal	Palliative Care consultant	Palliative Care
Dr Jonathan Lambert	Consultant Haemato-Oncologist	Haematology
Dr Catherine Lemon	Clinical Consultant	Head and Neck
Dr Alan Makepeace	Clinical Consultant	Breast
Dr Andreas Makris	Clinical Consultant	Breast
Dr Suzi Mawdsley	Clinical Consultant	Upper and lower GI
Dr David Miles	Medical Consultant	Breast
Dr Paul Mulholland	Medical Consultant	Neuro
Dr Paul Nathan	Medical Consultant	Melanoma
Dr Peter Ostler	Clinical Consultant	Breast
Dr Andreas Polychronis	Medical Consultant	Upper and lower GI
Dr Nihal Shah	Clinical Consultant	Breast
Dr Anand Sharma	Medical Consultant	Germ cell
Dr Heather Shaw	Medical Consultant	Melanoma
Dr Narottam Thanvi	Clinical Consultant	Breast
Dr Ignacio Vazquez	Medical Consultant	Breast
Dr Anup Vinayan	Clinical Consultant	Breast
Dr Charlotte Westbury	Medical Consultant	Breast
Dr Kee Wong	Clinical Consultant	Head and Neck
Dr Hannah Tharmalingham	Clinical Consultant	Gynaecology

Appendix 5

East and North Hertfordshire NHS Trust CQC Report

The most recent CQC Inspection of the Mount Vernon Cancer Centre Site in April 2018 rated the Hospital as requiring improvement across 3 of the 5 domains:

Domain	Rating
Safe	Requires improvement
Effective	Good
Caring	Good
Responsive	Requires improvement
Well led	Requires improvement

With specific services rating:

Service	Rating
Chemotherapy	Requires improvement
End of life care	Requires improvement
Medical care	Inadequate
Outpatient and diagnostic imaging	good
Radiotherapy	Good

Appendix 6

Clinical Advisory Panel Document Review

Title	Author	Date
Clinical Strategy 2019 – 2024	ENHT	2019
NHS England Radiotherapy Specification	NHSE	2019
Documents contained within MVCC Board Papers		02.05.19 13.06.19
ENHT CQC Report	CQC	July 2018
Mount Vernon Cancer Centre Strategy 2018 -2023	ENHT	March 2018
MVCC Clinical Strategy – Phase 1 Report	ENHT	Oct 2016
ENHT Research Strategy	ENHT	2016- 2019
NHS England Chemotherapy Specification	NHSE	2013
MVCC Reviews	MVCC	2002 2009 2013

Appendix 7

Stakeholder Interviewees

Caroline Blair	NHSE
Christine Moss	West Essex & Hertfordshire STP
Jane Brown	Healthwatch Hertfordshire
Turkay Mahmoud	Healthwatch Hillingdon
Jo Murfitt	NHSE
Michael Chilvers	E&NH (Executive Team)
Laura Churchward	UCLH
Cathy Cale	Hillingdon Hospitals FT
Sarah James	E&NH (MVCC)
Claire Strickland	Paul Strickland Scanner Centre
Jagdeep Kudhail	E&NH (MVCC)
Kelly McGovern	E&NH (MVCC)
Julie Smith	E&NH (Executive Team)
Sue Douglas	E&NH (MVCC)
Dan Megias	E&NH (MVCC)
Hannah Tharmalingam	E&NH (MVCC)
Paul Mulholland	E&NH (MVCC)
Prof Hoskin	E&NH (MVCC)
Harper Brown	West Essex & Hertfordshire STP/East & North Herts CCG
Nicky Bannister	Herts Valleys CCG
Rachael Corser	E&NH (Executive Team)
Sarah Brierley	E&NH (Executive Team)
Mandy Sanderson	NHSE and I
Nicola Hunt	RM Partners West London Cancer Alliance
Naser Turabi	North Central and East London Cancer Alliance/UCLH
Maggie Fitzgerald	E&NH (MVCC)
Mohammed Abdul-Latif	E&NH (MVCC)

Appendix 8

Advantages of tertiary cancer centre leadership for MVCC services

(Majority Consultant view)

	Advantages
1.	Ownership of MVCC by experienced provider of cancer services would establish strategic and operational priorities
2.	A change of management of the MVCC services would be established and restore confidence with clinical staff
3.	Academic links to a university would be secured with links to a large academic health science centre
4.	Protection of trials base
5.	Access to high quality clinical trials unit
6.	The radiotherapy network would preferably remain the same
7.	Enable MVCC to retain their brand – highly valued by patients and the public
8.	Geographical proximity if possible
9.	A tertiary cancer centre will have experience in managing other specialist services and satellite arrangements
10.	Tertiary centres are likely to have greater flexibility in negotiating with the host of the acute services
11.	Tertiary centres may have better access to capital funding
12.	Complex and uncommon cancer patients already flow to UCLH (e.g. paediatrics, sarcoma, CNS)
13.	A tertiary cancer centre will offer greater access to laboratory facilities
14.	Haematology oncology pathway needs to be in place
15.	A tertiary cancer centre should offer SpR rotation to MVCC
16.	Shared posts would be required
17.	A partnership agreement to describe the working between a tertiary cancer centre and MVCC should be a collaborative and mutually beneficial two way partnership
18.	Complementary with regard to tumour service with MVCC focussing on the 4 most common cancers and the tertiary centre on the less common ones
19.	The tertiary centre should be able to move quickly to establish leadership arrangements
20.	A tertiary centre would ensure critical mass exists to implement effective training / education and trials infrastructure which in turn would aid recruitment and retention of expert oncology staff.