

Proposed Changes to Children's Cancer Services in South London

Independent Review for the Mayor of London of the Pre-
Consultation Business Case

Phase 1 - December 2023

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1. Executive Summary

The pre-consultation proposals independently reviewed here concern potential changes to very specialist children's cancer services, as a consequence of the national service specification determined by NHS England.

The scope of the review is determined by the Mayor of London's Six Tests for major service changes in NHS services in London. These tests are designed to enable the Mayor to take a structured, evidenced and independent position on proposed changes and to ensure they are in Londoners' best interests.

Current Principal Treatment Centre (PTC) services for South London and other parts of South East England shared between the Royal Marsden NHS Foundation Trust at its Sutton site and St George's Hospital in Tooting (part of the St George's, Epsom and St Helier University Hospitals and Health Group) do not comply with that specification. This is because very specialist cancer services for children must now be provided on the same site as a Level 3 Paediatric Intensive Care Unit that provides "care for children requiring intensive care and monitoring, including medically unstable patients requiring intubation or ventilation, single or multi-organ support, and continuous or intensive medical or nursing supervision".¹ St George's has such a unit but the Sutton site does not and cannot.

Two options are under consideration for remedying the current position:

- under one, the majority of existing PTC services for children's cancer on the Sutton and St George's sites would be consolidated on the St George's site;
- under another, the majority of existing PTC services for children's cancer on the Sutton and St George's sites would be relocated to the Evelina Children's Hospital, provided by Guy's and St Thomas' NHS Foundation Trust; and
- under both, conventional radiotherapy services for children's cancer would transfer to University College Hospital, part of University College London Hospitals NHS Foundation Trust.

Our review is based predominantly on the published consultation proposals and the underlying Pre-Consultation Business Case. It reflects, therefore, the status of proposals at a certain moment in time, whilst further work will have continued to be undertaken that we cannot fully reflect here.

It is clear to us that a highly professional and diligent approach has been taken to the development of these proposals by the programme team and its various stakeholders, to bring services in line

¹ <https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2015/01/e07-sa-paed-inten-care.pdf>

with the national service specification and be better able to meet future challenges and opportunities.

In the sections that follow we highlight where we believe the proposals already meet the Mayor's tests and where they could be enhanced to meet the tests more fully.

Our key findings are that:

On health and healthcare inequalities

Significant work has been undertaken through the Integrated Impact Assessment, Equalities Profile Report, and associated engagement with patients, families, and carers to understand the impact of the proposed changes.

Proposals could be further strengthened by:

- greater analysis of routinely captured activity and performance data generated within the current PTC to understand any inequities in access to diagnosis and treatment in current services;
- further strengthening of travel time analysis and the addition of travel cost analysis, both reflecting the clear preference of families to travel by car;
- greater clarity on the potential for further directly consequent changes to linked services at St George's and, critically, an assessment of where any such changes may lead to additional and/or different equity impacts;
- some further quantification of the benefits expected as a result of the proposed change, to provide greater assurance to families as well as decision-makers.

On hospital beds

Bed proposals appear to align with current demographic projections but:

- these warrant some sensitivity testing for assurance;
- the change from current to future state bed numbers should be more explicit; and
- the rationale for, and impact of, differing modelling assumptions should be made more transparent.

On financial investment and savings

Capital funding is identified and appears affordable in the context of site consolidation and the efficiencies expected from this. Revenue affordability should be further detailed in the DMBC.

Further assurance should be provided that additional private patient activity will not impact NHS patient access.

<p>On social care impact</p>
<p>No impact on local authority social care is expected. We accept this conclusion. The in-hospital social care provision would transfer with the service.</p>
<p>On clinical support</p>
<p>There is evidence of clinical support for the case for change, alongside a desire for the benefits of change to be more clearly stated. Whilst the PCBC notes some strengthening of the case for change has been undertaken, we believe that the clinical case could be further refined, not least to provide greater clarity and assurance to families.</p> <p>There is a concern for the careful management of the transition between 0-15 and 16-25 services since the proposed change would result in these services no longer being on the same site, introducing a change in treatment location for affected young adults.</p>
<p>On patient and public engagement</p>
<p>Extensive pre-consultation activities have been undertaken and a consultation plan carefully planned and (partially) executed, as at the mid-point.</p> <p>Identified gaps in engagement with priority groups are being addressed through a detailed action plan.</p> <p>There remain opportunities to further clarify the benefits sought through the proposed change and to seek to assure those who are currently pressing for services to remain at the Royal Marsden.</p>

2. Background

The Mayor of London's Six Tests

The Mayor of London is committed to using his influence to champion, challenge and collaborate with the NHS on behalf of Londoners. The Six Tests are a framework for assessing major health and care transformations in London. They enable the Mayor to take an evidence-based position on proposed changes to ensure that they are in Londoners' best interests.

The Six Tests cover:

- Health and healthcare inequalities
- Hospital beds
- Financial investment and savings
- Social care impact
- Clinical support
- Patient and public engagement.

The Mayor has decided to apply the tests in the case of proposed changes to children's cancer services in South London. The proposals also affect other parts of South East England but the Mayor's concern is primarily with the potential impact on London residents. The tests are applied at two stages, linked to the publication by the proposing body of the pre-consultation business case (PCBC) and the subsequent decision-making business case (DMBC). At each stage, the Mayor writes a letter to proposers setting out his position on the proposals and any changes he would want to see. Mayoral letters are informed by an independent review that is based on published proposals and supporting documentation.

Proposed Changes to Very Specialist Children's Cancer Services in South London

The Principal Treatment Centre (PTC) for children's cancer in South London and much of the South East is currently based at the Royal Marsden's Sutton site and operates in partnership with St George's Hospital in Tooting. The latter provides specialist surgical, intensive care and other services that cannot be provided on the Sutton site. Due to the very specialist nature of children's cancer services, treatment commonly requires patients to visit additional sites.

In 2019, a public consultation was undertaken by NHS England (NHSE) on a new draft service specification for children's cancers. In evaluating responses to the consultation, NHSE commissioned Professor Sir Mike Richards to consider whether or not it should mandate the co-location of a PTC for children's cancer with a Level 3 Paediatric Intensive Care Unit (PICU). He

recommended that it should be co-located where there is a greater than 5% risk of PTC treatments requiring PICU care, noting that this is likely to affect an increasing number of treatments such as CAR-T therapy (which carries a risk of needing PICU of around 50%), bone marrow transplantation, and other complex new and intensive therapies. This recommendation was adopted by NHSE in its 2021 service specification for children's cancer PTCs which states that PICU must be on the same site as very specialist children's cancer services.

The NHS organisations involved agree that PTC arrangements across the Royal Marsden and St George's cannot meet the requirements of the new service specification because the Sutton site could not sustain a PICU service and that a service change is therefore required. NHSE is proposing that:

- PTC services excluding conventional radiotherapy should move from their current locations at The Royal Marsden and St George's to either the Evelina London Children's Hospital in Lambeth (run by Guy's and St Thomas' NHS Foundation Trust) or St George's Hospital in Tooting (run by St George's University Hospitals NHS Foundation Trust, part of the St George's, Epsom and St Helier Group);
- Conventional radiotherapy services should move to University College Hospital which is part of University College London Hospitals NHS Foundation Trust (UCLH) where other types of radiotherapy such as proton beam therapy are already provided to PTC patients. Proton beam therapy is currently delivered only at UCLH and The Christie in Manchester. It is expected to be an increasing proportion of the radiotherapy offered to children.

Our Review

The Strategy Unit is an internal NHS consultancy, operating independently from NHS decision-making bodies, that provides leading research, analysis and change from within the NHS. It exists to improve health outcomes and reduce health inequalities through:

- the application of critical thinking and structured analysis in high-quality processes, helping the health and care system to make better decisions, improve services and achieve practical benefits for population health and wellbeing. Clients trust us to provide impartial advice, based on clear thinking and rigorous analysis; and
- our work as a partner to systems to support the development of local competencies and to be a catalyst for, and coordinator of, collaborative decision-making processes.

Its core tenet is that better evidence leads to better decisions and better outcomes. Unit specialisms span complex analytics, data science, evidence analysis, strategic change, evaluation, and policy research.

The review team for this work has established expertise and experience relating to the areas covered by the Mayor's six tests. For this first phase of our independent review, we have individually examined the PCBC, its technical appendices and the findings of the mid-point review during the consultation period. We have also reviewed documents from:

- the South East London and South West London and Surrey Joint Health Overview and Scrutiny Committees;
- Healthwatch South West London (a response to NHSE questions regarding the planned paediatric oncology service change consultation);
- the "#HearTheMarsdenKids" campaign group;
- the Leader of Wandsworth Council, Councillor Simon Hogg;
- the Group Chief Executive of St George's, Epsom and St Helier University Hospitals and Health Group, Jacqueline Totterdell.

Having reviewed published materials, the review team then compared and tested the lines of enquiry that each reviewer identified, and we have summarised these in the following sections. Interim findings were tested with the proposers and conclusions were shared for fact-checking. We recognise that proposals will be continually evolving through PCBC and DMBC processes. Our comments reflect the information that has been shared with us at a certain point in time.

We were asked to:

- summarise positive evidence towards the test being met
- highlight areas where there is a lack of evidence (for example, if a proposal did not appear to consider demographic change)
- highlight areas where there is evidence of lack (for example if a proposal stated that demographic growth had not been considered)
- highlight areas where stakeholders are proposing to do further work (for example if a proposal stated that the NHS was undertaking further equalities impact work during the period of public consultation)
- critically assess key assumptions on which proposals are based – including but not limited to financial, demographic and supply/demand assumptions – and highlight any areas in need of further development and/or challenge.

In what follows we have sought to add value to the work of the proposers of this service change and, through this, to those who receive the services. We have taken a view on what may be of material impact.

Our review is intended to be a constructive critical analysis of proposals in the light of the six tests and aims both to highlight where the tests are met and where they might be met more fully. In cases where we take the view that improvements could be made, we seek to offer practical suggestions as to how this might be done.

We are explicitly asked not to take a view on the relative merits of the options under consideration. The purpose is, instead, to ensure that any changes are in the best interests of Londoners.

Each subsequent chapter addresses one of the tests and its structure reflects the detailed questions posed within those tests. For this first phase relating to the PCBC, we were initially asked to focus exclusively on the first four tests, with the expectation of adding the final two tests when reviewing the DMBC. This was subsequently varied such that the current review now also includes initial findings relating to tests five and six.

We are currently expecting to undertake the phase two review of all six tests during the latter part of March 2024 once the DMBC is available.

In all this, we have also been mindful of the unavoidably emotive nature of children's cancer care, for all concerned, and the profound anxieties and stresses faced by children, families and NHS staff alike.

3. Health and Healthcare Inequalities

Key Findings

Significant work has been undertaken through the Integrated Impact Assessment, Equalities Profile Report, and associated engagement with patients, families, and carers to understand the impact of the proposed changes.

With reference to the impact of the current service model, however, there should be greater analysis of routinely captured activity and performance data generated within the current PTC to test for any inequalities in access, experience, and outcomes across diverse social groups, ahead of any change. The lack of this results in a suboptimal baseline against which to assess the proposed change and monitor future progress.

We believe that proposals could be strengthened in the following ways:

- There appears to be an assumption of equitable access to diagnosis and treatment in current services. Given that the wider evidence base suggests that inequities do commonly arise in NHS services, we recommend that proposers test that assumption against data relating to the affected services. This may also enable them to meet the sub-test concerning structural racism.
- Travel time analysis could be further strengthened and, more significantly, a travel cost analysis should be undertaken as a priority. Proposers were responsive to feedback about modes of transport, and they remodelled travel analysis to reflect evidence that 81% of local patients travel by car. This is good practice for further analysis to build on.
- There is a reference (PCBC Section 6.2.3) to concerns about the proposals causing subsequent changes to linked services at St George's. Although the PCBC briefly discusses those concerns it does not form a definitive view on their validity. We see this as a gap in proposals that should be addressed in the DMBC. It is not currently possible to fully assess the potential equity impact of making the proposed change if there would be directly consequent service changes leading to additional and/or different equity impacts.
- There should be some further quantification of the benefits expected as a result of the proposed change, to provide greater assurance to families as well as decision-makers.

Detailed Analysis

TEST 1: The proposed changes have maximised the opportunities available to the health system to reduce health and healthcare inequalities, which have been set out transparently together with an evidenced plan for further action. The plans clearly set out proposed action to prevent ill-health,

including targeting action and resources to improve the healthy life expectancies of the most disadvantaged.

Do proposals:

Set out the current systemic health inequalities issues in their local population, including those driven by socio-economic deprivation and structural racism? Is the contribution of these inequalities to the Healthy Life Expectancy gap and other relevant measures of inequality considered?

This sub-test is concerned with underlying differences in health status across various social groups, ahead of the impact of either the current or the future service delivery model.

Those differences are summarised in the PCBC at a relatively high level but which is broadly appropriate to the scope of the proposals and the scale and diversity of the affected populations, although we did not find evidence that the impact of structural racism had been explicitly considered.

Further detail is provided in the Equalities Profile Report and the Integrated Impact Assessment (IIA) although the focus of that assessment is, appropriately, on the narrower question of the impact of the change proposed whereas this first sub-test concerns underlying inequalities which current services may or may not be mitigating.

Proposals set out that there is no clear relationship between inequalities and the incidence of childhood cancers in the published evidence base, and no significant variation across the catchment or in comparison with national patterns. It is noted in proposals, however, that there is:

- higher cancer incidence in 0-4 year olds with a Learning Disability, and of Leukaemia in children with Down's Syndrome;
- mixed evidence on ethnicity-related risk, some correlation between particular ethnicities and cancer types, and disproportionately high incidence for white children in London (55% of new registrations vs. 50% resident child population – the non-London catchment comparators are 85% vs. 83%);
- mixed evidence on income-related risk with some evidence of higher incidence and poorer survival for lower income groups but also of increased Leukaemia incidence amongst less deprived groups;
- some evidence of increased incidence in migrant populations from diverse areas, more deprived areas, and rural areas.

We recommend that further analysis is undertaken of routinely captured activity and performance data generated within the current PTC to test these against the broader (and limited) evidence. The relatively small number of cases annually suggests a need for caution in interpreting incidence data, but this can be mitigated by pooling data over multiple years. Assessment of the potential significance of small datasets should be made after they have been analysed rather than before.

Set out current systemic healthcare inequalities issues – in access, experience and outcomes – in their local populations and healthcare services, including those driven by socio-economic deprivation and structural racism? Is the contribution of these inequalities to the Healthy Life Expectancy gap and other relevant measures of inequality considered?

This sub-test is concerned with the differential impact of the current model of service provision on the health status of diverse social groups, ahead of the impact of the proposed future service delivery model.

There appears to be a broad assumption that there are no material inequities in access to diagnosis and treatment, in experience of care or in outcomes. As noted above, we believe this could be further tested against pooled local service data.

'Access' appears to be equated with travel time following the proposed change rather than the ease, timeliness, and equity with which different population cohorts are currently seen and treated by services.

We found limited evidence in the proposals of work to quantify whether the current service provision (as opposed to the proposed change) is equitable in relation to need. This potentially inhibits the ability of the future service model to address any inequities and, indeed, introduces a risk that they may inadvertently be compounded.

- In terms of new paediatric cancer diagnoses by deprivation quintile, it is reported that:
 - in South East London, 17% of diagnoses are from the most deprived quintile (covering 17% of the total population); and
 - in South West London, 10% of diagnoses are from that quintile (covering 7% of the population).
- Analysis by the National Disease Registration Service of five-year survival rates for paediatric cancer by deprivation suggests a trend towards worse survival for those children living in more deprived areas.
- There is again a lack of explicit evidence that the impact of structural racism has been considered. We note, however, that the Equalities Profile Report does compare the white and non-white proportions of cancer registrations for 0-15 year olds across

London. This reveals a higher incidence in the white population (55% vs 50%) and lower incidence across other groups (43% vs 50%) when compared with the general 0-15 London population. The report also notes that published evidence on prevalence and outcomes by ethnicity for childhood cancer is complicated, old, and inconclusive. Future engagement could seek proactively to understand the experience of diverse ethnic groups in accessing PTC services.

The crux of all this is that, in relation to this proposed major service change in the delivery model for children's cancer care, there is a risk that proposals do not adequately register or address any differentials in, for example, the time it takes for children to receive a diagnosis and access treatment, or in the specific treatments that are accessed. Whilst harnessing the benefits of research is evidently a key benefit sought from the proposed change, this may be too narrowly framed as relating to novel treatments but not also to a robust understanding of how well the pathway is functioning - and for whom. We would recommend that, in subsequent work for the DMBC, clear plans are included for monitoring and addressing any inequity in access or experience that emerges, whether or not it is associated with the specific change proposed here. In a similar vein, the Clinical Senates' review found that "From the evidence provided in the PCBC, it is not clear how the future providers have considered health inequalities in the preliminary design work, and it will be important for the future provider to consider how equality of opportunity can be built into the service as an aspect of the wider inequalities' strategy."

The Equalities Profile Report sets out patterns of incidence by geography and relevant demographic characteristics but there is also significant value to be derived from local service data on, for example, time to diagnosis and rates of access to specific diagnostic and treatment procedures. Without such a baseline analysis, there is a risk that the impact assessment gives an incomplete or misleading picture and that future monitoring and improvement efforts are impeded. Two pieces of evidence from previous Strategy Unit analyses highlight the inequities that can persist where differential access, experience and outcomes are not proactively considered:

- Having adjusted for age and sex in 2006 data, people living in the most deprived quintile were 2.36 (95% CI, 1.69 to 3.29) times more likely to need a hip replacement than those living in quintile 3, whereas those living in the least deprived quintile were 0.45 (95% CI, 0.39 to 0.69) as likely. Despite this, people living in the most deprived quintile were 0.81 (95% CI, 0.78 to 0.83) times as likely in England and 0.93 (95% CI, 0.84 to 1.04) as likely in Wales to receive an NHS-funded hip replacement than those living in quintile 3.²

² <https://www.strategyunitwm.nhs.uk/news/inequalities-access-healthcare-whats-our-next-move>

- In specialised services, including children’s cancer services, our analysis of access to specialised services across the Midlands found widespread geographic inequities, the reasons for which need local investigation and interpretation. This included inpatient admissions for children’s cancer (see Figure 1 below).³

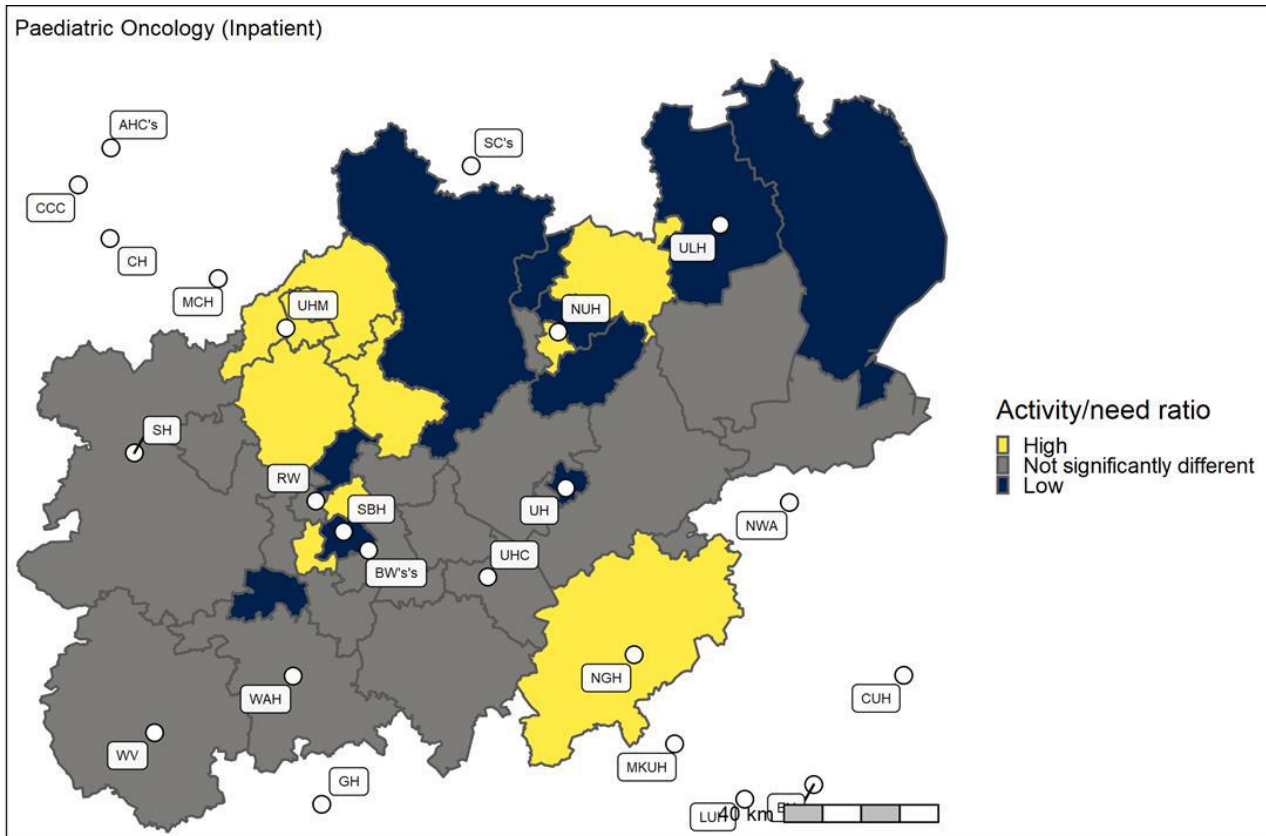


Figure 1 - Inequities in access to inpatient children's cancer services in the Midlands

Consider their impact on the health and healthcare inequalities identified in their baseline analyses in a systematic, documented way?

The extensive Integrated Impact Assessment (IIA) includes an interim Equality and Health Inequalities Impact Assessment (EHIA) that recommends mitigations in relation to the impacts identified and notes that these would benefit from patient, family, and carer engagement. If that engagement is not already underway, we would recommend that it is undertaken as part of the preparation of the DMBC and that the DMBC makes specific commitments about the recommended mitigations. We understand that both providers have committed, in principle, to the creation of a dedicated Travel and Access Working Group during the Implementation Phase to support this.

³ [Equity and Cost Growth in Specialised Services | The Strategy Unit \(strategyunitwm.nhs.uk\)](https://www.strategyunitwm.nhs.uk/equity-and-cost-growth-in-specialised-services)

Also included in the EHIA are qualitative insights derived from various pre-consultation engagement activities. What is reported focuses almost exclusively on travel times. It is not clear that other aspects of patient, family, and carer experience have been explored. Proposals are journey-centred rather than patient- and family-centred. This increases the likelihood that there are inequities related to the current delivery model that are not adequately understood and, therefore, that opportunities to address these through the proposed major service change are not fully identified for consideration by decision-makers and the public alike (and could even increase). It would also result in there being no baseline against which the changes that are finally made can be assessed over time. We believe that the local baseline analysis we have proposed above would address this.

Where travel-related impacts are considered, these are broken down by Local Authority area but are presented in terms of single journey times, an approach that risks understating the real-world impact (direct and indirect) of cumulative journeys experienced by patients and their families over, say, the course of a year. The effect is to suggest that impacts are more marginal (and affordable) than may be the case for some families.

An area in which we would particularly encourage further work relates to the treatment of travel poverty.

- **Travel cost analysis.** The IIA states that proposers have been unable to conduct a systematic analysis of travel-associated costs due to the complexity of the task (e.g. variety of potential journey types, variable ticket pricing for public transport). Our view is that these complexities can be simplified, based on what is known about current patient travel patterns through pre-consultation engagement and by using this to inform a transparent set of assumptions. The analysis could set out the total travel time and cost impact of the proposed changes relative to the current baseline (including the impact of moving radiotherapy services to University College London Hospitals). Modelling could be based on each Lower Super Output Area (LSOA) weighted for the local child population, rather than the 2019/20 cohort and the results could be tested for differential impact by geographic area and relevant protected characteristics, with consideration of intersectional effects. We suggest that such analysis is material to decision-making.
- **Impact on low-income families.** The costs – and the associated anxieties – of travelling with a sick child are likely to weigh even more heavily on families with lower incomes. In the EHIA (see Figure 2):
 - The description of the potential adverse drive-time impacts for low-income families risks being overshadowed, in the way the information is presented in the EHIA and wider PCBC, by the potential benefits of travel by public transport. This is significant in a context where 81% of patient journeys in the catchment are indicated to be

made by car. And, whereas the travel time may not be disproportional for low-income families, the travel cost will be.

- In terms of the ability to access the service, the EHIA sub-group found the impact of the proposed change to be disproportional for low-income families, reinforcing the case for assessing travel costs and their differential impacts.

As part of mitigation planning, mechanisms could be put in place to monitor the differential impact of travel costs and to enable on-the-day reimbursement (or even, as the EHIA suggests, prospective payments) for low-income families since take-up of the Healthcare Travel Costs Scheme is generally found to be low.

	Is there evidence of disproportional need for childhood cancer services (i.e. higher rates of incidence)?	Is there evidence of disproportional impact on travel times for this group?	Did the EHIA sub-group think there could be a disproportional impact in terms of ability to access the service (travel/onsite access), experience of change or the services being on site with intensive care?
Looked after and accommodated children and young people	No evidence found	Travel time analysis for this characteristic not possible.	Yes. Travel and experience of change may pose challenges for this group.
People or families on a low income/living in more deprived areas	The wider evidence on paediatric cancer and deprivation is mixed, with some evidence for a higher diagnosis rate among less deprived groups for some leukaemias and some evidence for poorer survival among more deprived groups. However, it is difficult to draw conclusions from the available evidence.	Yes. A positive impact on travel time by public transport for living in the most deprived areas. A negative impact was found for driving but this was not disproportional compared to the rest of the population.	Yes. Families experiencing financial difficulties may find these further compounded by any additional costs incurred due to a different journey to a future PTC. This would be in addition to the costs that family face already through caring for a child with cancer (Cancer costs - Young Lives vs Cancer). Conversely, families experiencing financial difficulties may benefit from co-location of service due to reduced requirement for travel to different locations.

Figure 2 - EHIA extract

Children’s cancer services touch families very deeply but, fortunately, they touch a very small proportion of families. Although there has been a modest upward trend in childhood cancer incidence rates⁴, ONS projections are for a 7% reduction in the PTC catchment 0-14 population over 20 years, most notably in South West London. So, the overall healthcare equity impact from these services will also be very small (however keenly felt).

The PCBC (p.177 ff.) reports concerns about potential knock-on effects on the sustainability of other services as a result of the changes presently proposed and, if these concerns prove valid, there could be a compounding of adverse equity impacts. We note that there are plans to further explore and mitigate the potential knock-on impacts once a decision is made, but this appears to be framed in terms of service sustainability rather than patient impact. Before a decision is made on current proposals, some assessment of the potential equity impact of any directly consequent effects should be made.

⁴ [Children’s cancers incidence statistics | Cancer Research UK](#)

Ensure that services become more accessible to vulnerable groups, including those identified as experiencing the worst health and healthcare inequalities?

The mitigation proposal in the EHIA to develop “key access, quality and outcome metrics by socio-demographic groups to enable monitoring and evaluation of progress towards improvements in equity i.e. taking a “Core20Plus5” approach to access” is a positive step that it would be good to see confirmed in the DMBC. Again, we believe that the local baseline analysis we have proposed above would be an important foundation for that planned future monitoring.

There is reference to the increased incidence for children with a learning disability or with Down’s Syndrome, but information is not currently provided on how the specific needs of these children and their families are identified and met, either now or in the future.

In terms of physical accessibility, the proposed changes involve longer travel times by car, the currently preferred travel model of 81% of patients, for those resident in rural areas or areas of higher deprivation. A set of mitigation proposals is described. Some further clarity on these is likely to provide greater reassurance to families who, proposals state, experience any change to treatment as a cause of anxiety. This could include a firming up of the parking offer in subsequent proposals and a thorough testing of proposed mitigations with families currently using the service. We note that the Clinical Senates’ review also found “that the additional costs of families (and staff) of travelling to London had not been given sufficient consideration and this is an area to be developed in the PCBC and subsequent implementation plan”.

Set out specific, measurable goals for narrowing health and healthcare inequalities and how health and healthcare equity is weighted in the options appraisal process? Are there plans to address information gaps on inequalities and population groups where such gaps exist?

We did not find specific goals within the currently published proposals. We recognise that the ability of the service in question to impact wider inequalities is severely limited and we note, again, the mitigation proposal in the EHIA to develop relevant metrics for the service going forward.

In the option appraisal process, the patient access sub-criterion included the impact of travel times on areas of greater deprivation. That sub-criterion, which was broader than the equity impact of travel, effectively carried a 3.9% weighting (15% of the patient and carer experience criterion that was weighted at 26%).

The Clinical Senates’ review recommends that “once a final decision has been made, the future provider develops and articulates a strategic approach to tackling health inequalities and improving inclusivity”, and that the scope of mitigating actions should not be limited to the PTC but also include linked services in POSCUs and in primary and community care. It also recommends that the “development of new systems and processes would be strengthened if coproduced with patients, their carers and the current providers to ensure all relevant learning is utilised.”

Set out plans to maximise the role of the NHS as an anchor institution by considering the following: widening access to quality employment and work, making local purchases for social benefit, using buildings and spaces to support communities, reducing environmental impact, and working with local partners to advance a collective ‘anchor institutions’ mission?

The appropriately narrow scope of these proposals provides few opportunities in isolation for new anchor-related initiatives given these are generally understood to require action at scale. Proposals set out the respective Trusts' broader approach in terms of the wider effect of the proposed decision and, especially, meeting their climate change duties (see, for example, IIA Section 4). It is stated that a further assessment of these areas will be provided as part of the subsequent decision-making process. In terms of estate plans and climate change impact, it is indicated that either option would work to minimise the carbon impact of construction activities, and both also cite their proximity to public transport (although, as we have noted above, the evidence is that families prefer to travel by car).

In terms of reducing environmental impact, proposals state that part of the future vision for children's cancer services is that travel overall will reduce as a wider range of care is provided at local POSCUs, however no sense of scale is given, and it is not modelled within the access analysis. Analysis of the additional carbon impact of the proposed change, should current patient travel preferences remain unchanged, or of the impact of additional staff travel (although it is stated that implementation planning will address green travel for staff), does not appear to have been considered at this stage. It may be that this future travel reduction is not directly linked to the present proposals, in which case it would be clearer not to refer to the potential associated benefits unless and until plans are clearer.

It is also stated that either option offers a better public transport solution compared to now, but the PCBC highlights that most families drive to the PTC (due, not least, to concerns around taking a sick child on public transport), so it is not clear to what extent proposers expect this notional benefit to be realised. It is not clear what the proposer's analysis is of the proportion of journeys that families might safely and feasibly make by public transport or what additional steps might be taken to encourage the use of public transport, where this is appropriate. Further clarity might be provided in the site-specific proposals expected in a DMBC.

Footnote on the case for change

This test seeks to ensure that the NHS has maximised the opportunities available to reduce health and healthcare inequalities. There is, therefore, an unavoidable cost-benefit question that is raised.

We recognise that the national service specification (with which it is agreed by all that the current service cannot comply) requires there to be a change and that the change is therefore “non-negotiable” (PCBC, p.27).

We do not seek to question in any way the content of the service specification but, in terms of this first test, the present case for change appears to rely heavily on that specification as a driver, without also setting out the specific measurable benefits sought (quantitative and/or qualitative) through the implementation of the proposals.

We understand that where, under current PTC arrangements, there need to be urgent transfers of very sick children, there is, in the words of the Richards Review, ‘an inherent geographical risk to patient safety [that] can only ever be partially mitigated’, as it is now through the use of specialist ambulances with expert teams on board. We also note the observations made in the Richards Review that there will still need to be transfers in specific, if reduced and less urgent, circumstances and that, without the proposed co-location, such risks would increase with the expected introduction over time of novel and more complex treatments).

We note that Clinical Senates’ review also recommended further work to “Develop the narrative on the case for change within the PCBC, to go beyond compliance with the technical aspects of the specification and demonstrating the improvements that the proposed change would bring for children across south east England and south London.” Whilst the response in the PCBC recounts that further work has been done on the case for change, we believe there is still further clarity that could be added, particularly in terms of the quantification of expected benefits.

Such additional clarity may also provide reassurance to families using the service about why there is a need to change the care on which they currently rely.

4. Hospital Beds

Key Findings

Bed proposals appear to align with current demographic projections but:

- these warrant some sensitivity testing for assurance;
- the change from current to future state bed numbers should be more explicit; and
- the rationale for, and impact of, differing modelling assumptions should be made more transparent.

Detailed Analysis

TEST 2: Hospital beds. The proposed bed capacity will need to be independently scrutinised in relation to the latest demographic projections. Any plans which involve a proposed bed capacity that is less than that implied by these projections should meet at least one of the following conditions (which are based on NHS England's 'common sense' conditions):

- *Demonstrate that sufficient alternative provision is being put in place alongside or ahead of the proposed changes and that the additional workforce required will be there to deliver it. The alternative provision might involve:*
 - *changes in care pathways in hospital (e.g. the introduction of the South West London Elective Orthopaedic Centre [SWLEOC] model).*
 - *changes in care pathways outside of hospital (e.g. increased GP or community services).*
 - *adapting to new technologies and innovations that lead to improved care (such as virtual wards, video consultations) whilst ensuring that these meet other tests and fully support those experiencing digital exclusion.*
 - *changes in patient flows (e.g. patients going to another hospital/service).*
- *Show that specific new treatments and therapies, such as new anti-coagulation drugs used to treat strokes, will reduce specific categories of admissions.*
- *Show, where a hospital has been using beds less efficiently than the national average, that the hospital has a credible plan to improve performance without affecting patient care (for example in line with the Getting it Right First-Time programme).*

Do the proposals reflect the implications of the latest demographic projections? If not,

- **Is suitable alternative provision in place alongside or ahead of changes, with the required workforce?**
- **Are there new treatments and therapies which will reduce specific categories of admissions?**

-
- **Are there credible plans to improve bed use efficiency where currently less than the national average, without affecting patient care?**

There is not expected to be any reduction in bed capacity through these proposals.

Proposals are based on existing demographic projections that predict a decline in the 0-15 population. Incidence, conversely, has been increasing, but the reasonable assumption of proposers is that activity will remain broadly flat. The advent of new, more complex and more intensive treatments could alter the pattern of demand over time, a prospect that might be subject to further sensitivity analysis.

NHSE and the current service providers agree that activity volumes would be inadequate for a PICU to be sustainable on the current Sutton site.

Population projections are due to be rebased and updated and, in anticipation of this, further sensitivity analyses might be undertaken in the DMBC to test plans against a range of variant projections.

Whilst this test appears broadly to have been met, we would also make the following observations:

- a) In the presentation of proposals, it is not easy to make a direct comparison between current and future bed requirements, both ward beds and PICU beds, as information is given primarily in terms of activity, not capacity. Both options propose a capacity that meets the modelled demand for 20 beds, either 20 at the Evelina or 22 at St George's, compared with the 18 beds currently in Sutton and 4 at St George's. Each Trust has confirmed that it has the flexibility on-site to provide additional beds if required, and the sensitivity analyses we propose could validate this for provider and public assurance.
- b) It is not entirely clear why the bed capacity plans for the two site options differ. There are different assumptions used by each Trust in terms of bed occupancy, and it should be made explicit why this is the case and whether it is related, for example, to risk appetite, productivity, or existing site configuration. There is no assessment of the relative efficiency of the two options, including what the differential impact on staffing requirements might be.

5. Financial Investment and Savings

Key Findings

Capital funding is identified and appears affordable in the context of site consolidation and the efficiencies expected from this. Revenue affordability should be further detailed in the DMBC.

We would recommend that further assurance is sought that additional private patient activity will not impact NHS patient access.

Detailed Analysis

TEST 3: Financial investment and savings. Sufficient funding is identified (both capital and revenue) and available to deliver all aspects of plans including moving resources from hospital to primary and community care and investing in prevention work. Proposals to close the projected funding gap, including planned efficiency savings, are credible.

Are plans to make efficiency savings sufficiently detailed and credible?

In assessing proposals, a financial hurdle criterion of capital and revenue affordability was applied. Both options reportedly demonstrate modest, positive value for money and do not appear to rely heavily on efficiency assumptions.

Using a hurdle criterion rather than a more detailed comparative economic assessment does mean, however, that the opportunity cost of the associated capital investment is not considered, including the proposed charitable contribution to the Evelina option which, although it is netted off in line with Green Book requirements, is still an investment with opportunity costs. This remains the case even where a particular type of change is seen as non-negotiable.

It is stated that, in either option, the impact of capital costs (estimated at c.£2m p.a.) would be fully mitigated within 5 years, through cost efficiencies. Proposals also state that the current £6.7m operating deficit for the service would be mitigated through overhead efficiencies, additional private patient activity, research and development activities and pay and non-pay efficiencies. These efficiencies are not currently specified but, although they are material in relation to the current operating income of c.£15m (and are set against a background of high-cost increases and broadly flat demand), they are marginal in the context of either Trust's total turnover.

Where there is a reliance on additional private patient income, it would be helpful to understand whether this is assumed to include new income from patients in the catchment area for assurance that there would be no adverse access impact for London patients, resulting from additional private activity. This might include setting out how increased private activity is to be accommodated without opportunity cost to NHS patients, and how it will be ensured that increasing private access to treatment will not increase inequity of outcomes for children with cancer.

Have plans secured capital and revenue investment to deliver in full, and are the sources of funding credible?

In terms of capital investment, proposals detail national funding of £20m, ICB and Trust funding of c.£11-14m, and varying levels of charitable support (£10m capital at the Evelina and £0.5m p.a. revenue at St. George's).

The revenue impact of capital charges is £1-2m annually (until mitigated out in 2030/31) and the PCBC notes that these charges and any additional stranded or transitional costs would represent a significant challenge for either Trust. It is stated that NHSE has agreed in principle to consider this impact on the Trusts, but that NHSE is not providing a warranty to cover those costs, although it has confirmed income assumptions and deemed capital charge assumptions to be reasonable. Whilst plans have not formally secured the full revenue investment required at this stage, we do not see this as problematic, and we would expect to see the position resolved in the DMBC process. As we noted above in relation to efficiency assumptions, it would be helpful to have some clear statement that a dependence on private patient income would not be allowed to arise that adversely impacted NHS patient access to these services.

Do plans include increased investment in primary and community care, including moving resources from acute care where appropriate?

Proposals indicate an ambition to provide more services locally, where appropriate, but the nature and scale of this ambition are not stated. Whilst we would expect that ambition to be welcomed by families, including the associated reduction in the burden of travel to treatment, the present proposals do not rely on a shift in activity and resources to other more local settings. From a purely financial perspective, then, the lack of greater detail is immaterial, but it might still be considered to provide further assurance to families.

Do plans include specific, increased investment in the prevention of ill health?

This is not evident in current plans but we would not expect it to be in relation to these proposals.

6. Social Care Impact

Key Findings

No impact on local authority social care is expected. We accept this conclusion. The in-hospital social care provision would transfer with the service.

Detailed Analysis

TEST 4: Social care impact. Proposals take into account a) the full financial impacts on local authority services (including social care) of new models of healthcare, and b) the funding challenges they are already facing. Sufficient investment is available from Government to support the added burden on local authorities and primary care.

Do plans include a full and credible assessment of the financial impact on social and community care?

They don't but this appears reasonable in the context of these proposals. It is expected that the current in-hospital social care service provided by Young Lives with Cancer will transfer with the rest of the service and that there should be no change in the impact on local social care services. There is an expectation of some increase in care closer to home, but this appears to be envisaged as being delivered in POSCUs rather than via community services.

Does this assessment take account of future demographic changes, especially an ageing population?

Yes, though we make an observation above about the merits of sensitivity analysis. Proposals accept the ONS projections that the child population will decline and, whilst there has been an upward trend in childhood cancer incidence rates, the demographic decline would more than offset this, leaving demand broadly flat. This is subject to any future changes in treatment modalities shifting the demand curve in either direction.

Does this assessment take account of the impact of new social care provision and funding models set out in the adult social care green paper?

No, but the social care provision linked to this service is bespoke and does not relate to adults.

Are there credible, funded, joint NHS/LA plans to meet any additional costs?

No additional social care costs are expected.

Do plans fit with local health and wellbeing board strategies?

Specialised services such as this are generally outside the scope of local strategies. In relation to the first test, however, we observe that greater consideration could be given to differential needs

and experience with this patient cohort, and there is a risk that these are not considered either in local strategies or in relation to specialised services.

7. Clinical Support

These are interim findings in advance of the publication of the DMBC based on our review of the PCBC, the report on PICU colocation by Professor Sir Mike Richards, and the London and South East Clinical Senates' Review of the proposals.

Key Findings

There is evidence of clinical support for the case for change, alongside a desire for the benefits of change to be more clearly stated. Whilst the PCBC notes some strengthening of the case for change has been undertaken, we believe that the clinical case could be further refined, not least to provide greater clarity and assurance to families.

There is a concern for the careful management of the transition between 0-15 and 16-25 services since the proposed change would result in these services no longer being on the same site, introducing a change in treatment location for affected young adults.

Detailed Analysis

TEST 5: Clinical support. Proposals demonstrate widespread clinical engagement and support, including from frontline staff.

Do proposals:

Include a demonstrable, robust clinical case for change, including an improvement in both quality of care and outcomes?

Proposals respond to a new national service specification that was informed by public consultation and a subsequent recommendation on PICU colocation by Professor Sir Mike Richards.

As noted in our footnote to the first test, however, we believe it would be helpful if published materials more clearly set out the specific nature and scale of the quality and outcomes benefits expected. This is made more difficult by a lack of baseline local data on quality and outcomes. The provision of greater detail in subsequent materials could enhance the intelligibility and acceptability of the case to change to the public and to affected families. This could also detail (with some indication of activity volumes) the known novel treatments that, it is suggested, may increase the demand for on-site intensive care.

It is not in the scope or competency of our review to assess the validity of the clinical case for change, but we would again suggest that further efforts are undertaken to communicate the specific benefits expected and why these cannot be achieved another way. For patients and families facing the uncertainties of a major service change, at an already vulnerable time, greater assurance about the need for change and the benefits they might experience could be provided. It is evident

from the mid-point review of the consultation process that there is a body of public opinion that is not yet persuaded about the clinical benefits of the proposed change.

Have the support of local primary and secondary care clinicians, including but not limited to those whose services/patients will be directly affected?

The PCBC reports that there has been clinical engagement through working groups and other means that have informed the development and appraisal of the proposals, as well as a workshop for Royal Marsden staff who were seeking assurance on maintaining current employment benefits (e.g. childcare, development support) and travel times.

We did not find specific evidence of support (or detailed concerns) from local clinicians at the PCBC stage, but would observe that:

- a) the PCBC states that all local NHS parties are agreed that it is not feasible to make the Sutton site compliant with the new service specification, and;
- b) local primary care clinicians will have very infrequent exposure to the affected services (and are, nonetheless, identified as stakeholders within the consultation plan).

No additional evidence was available from the consultation mid-point review in which it is noted that staff working in the current services is one of the groups proposers are currently hearing from least. This will be important and should include clinical staff in the 'readily available services' cited in the PCBC and those working in the linked services where concerns have been expressed about potential knock-on changes.

The PCBC does broadly describe some particular areas of concern for St George's, should services move to the Evelina. These include the risks that:

- the loss of the associated paediatric surgery adversely impacts the retention and recruitment of surgical staff, reducing the Trust's ability to maintain other non-cancer paediatric surgery activity;
- the loss of paediatric cancer services reduces the scale and variety of the Trust's pathology services, similarly affecting retention and recruitment; and
- the Trust loses the opportunity to provide new forms of treatments.

We note that some work has already been undertaken to explore these risks and that NHSE intends to further address these concerns, should the Evelina remain the preferred option, once a decision has been made. In the meanwhile, a set of principles has been agreed to inform such a process.

Have the support of pan-London clinical bodies – London-wide LMCs, London Clinical Senate?

A panel formed by the London and South East Clinical Senates has undertaken a joint review of the proposals and found that “the case for change was clear, with a sound evidence base”. Echoing the findings of the Richards’ review, the panel highlighted “an inherent geographical risk to patient safety that can only ever be partially mitigated, and that the safe delivery of complex and new intensive therapies will not be possible where there is separation”.

Amongst the recommendations made by the Senates’ review, two are of particular relevance to the Mayor’s tests. In line with our earlier observations concerning the first test:

- a) the panel asked that the case for change should “go beyond compliance with the technical aspects of the specification and demonstrate the improvements that the proposed change would bring for children across south east England and south London”.
- b) it is recommended that the interim EHIA is expanded and that, “once a final decision has been made, the future provider develops and articulates a strategic approach to tackling health inequalities and improving inclusivity”.

In addition, the Senates’ review team expressed some concern about the complexity of managing the transition from children’s to teenage and young adult cancer services, given that the latter would remain at the Royal Marsden. It noted “the risk that knowledge acquired by clinicians at either side of a patient’s 16th birthday could be diluted by the separation of the service” and highlighted the need for “effective working relationships and flexibility of both physical resources and staffing”. We note that the PCBC proposes mitigating this by flexing age boundaries in both children’s services and teenage and young adult services.

Have the support of local authority social care and other professionals?

Research and charity partners have been involved in the development of proposals.

Whilst local authority social care services do not appear to have been directly involved, this is perfectly reasonable given the in-house social care provision that will move with the wider service.

8. Patient and Public Engagement

These are interim findings in advance of the publication of the DMBC and do not address all of the specified sub-tests. Most of these relate to how the consultation was conducted so cannot be considered until a consultation report and DMBC are available for review.

Key Findings

Extensive pre-consultation activities have been undertaken and a consultation plan carefully planned and (partially) executed, as at the mid-point.

Identified gaps in engagement with priority groups are being addressed through a detailed action plan.

There remain opportunities to further clarify the benefits sought through the proposed change and to seek to assure those who are currently pressing for services to remain at the Royal Marsden.

Detailed Analysis

TEST 6: Patient and public engagement. Proposals demonstrate credible, widespread, ongoing, iterative patient and public engagement, including with marginalised groups, in line with Healthwatch recommendations.

Did patients/the public/the local Healthwatch influence proposals before they were published for formal public consultation?

We found evidence of significant and commendable pre-consultation engagement activity.

A stakeholder group, mostly formed of parents, was created early in the programme, although it was not clear how representative the group was or how members were enabled to speak up in a group chaired by a very senior nurse. There is sometimes a reticence for patients and carers in the presence of clinicians, and a different dynamic where there is a carer leading the group.

The Association for Young People's Health (AYPH) engaged with children, young people and their carers on behalf of NHS London in the early stages of proposal development. This work found the following issues to be important:

- Knowledge from specific cancer care specialists and access to the best treatments;
- Child and youth-friendly communication, care and environments;
- Continuity of care from clinical and non-clinical staff;
- Making travel to and from hospitals as quick, simple and stress-free as possible;
- Facilities which are clean with access to good food and other supports;

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- Access to a range of other services including mental health support.

Around 2,000 organisations and individuals were reportedly contacted in pre-consultation engagement, including specialist children and young people charities, others with protected characteristics, and Healthwatch organisations, and this appears to have informed both the format and the content of consultation materials.

This engagement included the involvement of stakeholder groups in the appraisal of proposals, where it was clear that proposers had listened to representations received and acted on them. An example of this is where travel analysis and its impact on option appraisal was sensitivity tested to reflect a greater proportion of travel by car. The PCBC also reports that:

“Several changes and additions were made to the patient experience domain criteria to reflect what was being heard. For instance, the requirement for the two Trusts to describe how families/carers will be supported through the different phases of illness, with particular focus on support during periods of extreme difficulty, including acute and rapidly evolving situations, was added by parents. This subsequently formed one of the evaluation criteria used to assess the proposals.”

Parents, as part of a group with representatives from national children’s cancer charities, and senior nurses, were subsequently involved in assessing options against this criterion.

What is less clear is where the fundamental shape of proposals or the options considered might have been materially influenced (or influenceable) by stakeholders, although it is noted that the Programme Board was expanded to include patient/public voice in May 2023 following advice from the Clinical Senate.

There is a public campaign that challenges various aspects of the case for change and proposes a ‘risk-adapted’ model as an alternative.

Did patients/the public/the local Healthwatch advise on the consultation plan?

NHSE posed a set of questions to Healthwatch organisations as part of its consultation planning and we have seen a submission from South West London Healthwatches and a response to this from NHSE.

The following groups were reportedly amongst those engaged in testing and refining the consultation plan:

- the stakeholder group that includes parents and charity/ voluntary and community organisations;
- children aged 15 and under and young people with cancer or who have experienced cancer (via The Royal Marsden and children’s cancer charities);

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- Overview and Scrutiny Committees across Kent, Medway, Surrey and Sussex and Joint Overview and Scrutiny Committees across South West London and Surrey and South East London;
 - Paediatric Oncology Shared Care Units within the PTC geographical area;
 - staff working at The Royal Marsden, St. Georges Hospital and Evelina London.

Observations on the public consultation mid-point review

In the consultation plan, and linked to the IIA, there is a clear intent to prioritise engagement with:

- children and young people with cancer or who have experienced cancer;
- people from ethnic minorities (including Gypsy, Roma and Traveller groups);
- families who are experiencing financial difficulties or who live in the most deprived areas;
- families with poor literacy and/ or language barriers;
- autistic people, those with physical disabilities and/ or learning disabilities or learning impairments;
- families with caring responsibilities (including young carers);
- looked after and accommodated children and young people;
- staff within the current services.

At the mid-point, independent analysts working for the programme note that consultation responses are coming least from these groups and that the programme has developed a detailed action plan to address this.

Amongst the key themes emerging at the mid-point of consultation are:

- objections to the case for change;
- the challenges of travelling to the candidate sites;
- conflicting perceptions about the quality of each Trust's specialist services and estate.

In relation to our previous observations concerning the clarity and detail of the case for change, we note that an element of the action plan is "reviewing opportunities to make the scope of the consultation even clearer, including the case for change, and to encourage more feedback on the options so that this can be captured and inform decision-making". We would suggest that enhancing communication around the case for change may be a key route to securing feedback on the options for change.

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