The Strategy Unit.

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

An Independent Review for the Mayor of London of the NHSE Decision-Making Business Case

Phase 2 – July 2024

NHS
Midlands and Lancashire
Commissioning Support Unit

Introduction

This review builds on our Phase 1 Review and should be read in conjunction with it. Our task here has been to review the proposals in NHS England's Decision-Making Business Case (DMBC) against all six of the Mayor's tests. We were commissioned to complete this review ahead of the DMBC being approved but were unable to do this as the DMBC was not available until the day of the decision-making meeting. Consequently, this review and any subsequent position statement by the Mayor were completed after the final decision had been made.

Our review is again intended to be a constructive critical analysis of proposals as they relate to Londoners (who make up c.40% of the catchment population). In cases where we take the view that improvements could be made as proposals move towards implementation, we seek to offer practical suggestions as to how this might be done.

The approach we have taken in this review of DMBC proposals is twofold. We have examined:

- NHS England's responses to the key findings in our Phase 1 Review of the PCBC, against the evidence presented in the DMBC, noting both where the Mayor's tests have been more fully met and where some potential remains to improve the impact of proposals on Londoners;
- material changes made to proposals since the PCBC, especially in relation to the public consultation process and its impact.

In this review we have used a tabular format that brings together:

1. The key findings from our review of the PCBC;
2. The direct responses to our key findings that are set out in the DMBC (quoted in full in italics); and
3. Our new findings following analysis of the full DMBC and its appendices.

No further independent reviews are planned in relation to the Outline and Full Business Cases which the DMBC states that Guy's and St Thomas' NHS Foundation Trust (GSTT) will develop and approve by end December 2024, enabling implementation by October 2026.

Key Findings

1. Health and Healthcare Inequalities

We found extensive evidence of further work that had been undertaken in the Integrated Impact Assessment (IIA) and make the following further observations and suggestions:

- We suggest that NHSE implementation recommendations are further enhanced so that multiple patient/family representatives are included within the Travel and Access Group in addition to the provider and commissioner membership proposed so that the needs and experiences of families are better understood and directly inform decision-making.
- Noting the statistically significant difference in recorded incidence across the catchment, we suggest that NHSE sets out how it will seek to monitor, better understand and, where appropriate, address this difference as the service moves forward.
- Given the significant focus on future research in PTC proposals, and the constraints in meeting the expectations of the inequalities test to date, we suggest that NHSE ensures that the research priorities of the future provider explicitly address inequities in access, experience and outcomes (including structural racism), in line with the priority set out in 2024/25 NHS planning guidance to "continue to address health inequalities and deliver on the Core20PLUS5 approach for adults and children and young people" and the Trust's commitment to London Health and Care Partnership anti-racism strategic framework.
- After the publication of the DMBC, NHSE confirmed our understanding that the median journey to the Evelina will be cheaper than to the Royal Marsden and that the greater reduction in cost will accrue to those in the most deprived areas.
- We suggest that NHSE asks the preferred provider to confirm whether or not consultants transferring from the Royal Marsden or St George's will be required to live within 30 minutes or 10 miles by road from the Evelina, as is generally required under Schedule 12.2 of the consultant contract.
- We suggest that NHSE requires provider implementation plans to consider how the Trust will monitor wider access inequality issues, including where those issues may result from structural racism.
- We suggest that there is a clear NHSE expectation on the provider to monitor access, quality and outcomes in this service in a way which ensures these terms are broadly understood and that the data gathered are sufficiently granular to support ongoing research into disproportionate effects across social groups.

Key Findings

1. Health and Healthcare Inequalities

- We suggest that NHSE explicitly confirms that it does not view paediatric elective surgery and pathology services as fundamentally at risk on the St George's site, in a way that could affect patient access, experience or outcomes.
- We suggest that, as benefits realisation processes are advanced in Trust business cases, NHSE seeks assurance that data will be collected in a way that supports ongoing analysis of healthcare inequalities.
- We infer from the DMBC that the clinical risk associated with the new (and mostly planned) inter-site transfers that will be required after the change is made is of a lower order than that associated with existing emergency transfers to intensive care. We suggest that, in future Trust business cases and other communications relating to the PTC, this is made explicit, and that NHSE puts in place mechanisms for monitoring any adverse impact from the new transfers.

2. Hospital Beds

- We remain content that proposals reasonably reflect expected changes in population structure and morbidity.
- Whilst noting the NHSE recommendation that there should be ongoing review of capacity requirements, we suggest that this includes consideration to the circumstances (in isolation or combination) that could plausibly exceed the stated 20% capacity margin.

3. Financial Investment and Savings

The financial case appears to be robust but we suggest that:

- NHSE publish each Trust's economic evaluation of their change proposals and provide early assurance that the outcome of subsequent business case tests would not have switched the preferred option in the original PCBC appraisal;
- the relationship between private patient activity and NHS activity is made more explicit in subsequent Trust business cases and sensitivity analysis is undertaken on the impact on VfM and on affordability to the Trust of a potential total loss of private patient income in this service, in addition to other downside factors. We further suggest that, post business case approval, mechanisms are put in place to monitor waiting times for relevant services, especially given reported concerns that extended waiting times are one of the drivers of private patient activity.

Key Findings

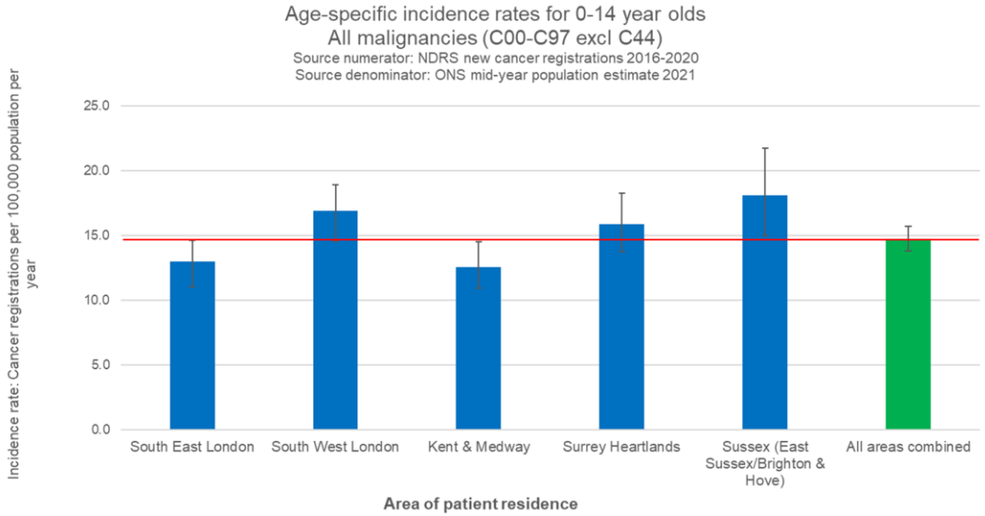
4. Social Care Impact
• We have no further observations or suggestions to make in relation to this test.
5. Clinical Support
• In our view, the DMBC clearly demonstrates strong clinical support for the case for change and the underlying service specification, with which the alternatives put forward in response to the consultation do not comply. • We have no further observations or suggestions to make in relation to this test.
6. Patient and Public Engagement
• In our view, proposers have continued and extended the seriousness and effectiveness of their engagement with the public and stakeholders through the process of public consultation. • The information received through consultation has led to various refinements of the proposer's implementation plans, including in response to the significant concerns received around travel impact, albeit no material changes to core proposals. There is good evidence that the proposers have listened and responded to information received from stakeholders, including transparently setting out objections to the proposals and why the change is still seen as necessary. • The Mayor may wish to consider seeking ongoing assurance about the effectiveness of the further engagement that is proposed and the extent to which the recommendations resulting from the consultation are being implemented.

1. Health and Healthcare Inequalities

1. Health and Healthcare Inequalities

Key Findings from our PCBC Review	DMBC Response to our Findings	New Findings from our DMBC Review
A. Significant work has been undertaken through the Integrated Impact Assessment (IIA), Equalities Profile Report, and associated engagement with patients, families, and carers to understand the impact of the proposed changes.	*The updated IIA includes:* • *An expanded executive summary* • *Acknowledgement of the impacts that structural racism can have on access to healthcare for certain population groups and confirmation of commitment of the potential future Principal Treatment Centres to address it* • *Mention of adjustments provided for learning disability* • *More detailed information on financial advice and support available through voluntary sector organisations* • *A summary of the wider inequalities work undertaken by the potential future Principal Treatment Centres* • *A summary of likely direction of travel for children's cancer shared care unit transformation* • *A summary of national patient experience survey results* • *Equity analysis of the current Principal Treatment Centre patient cohort* • *Future metrics for monitoring access, quality and outcomes of the new service specification* • *Incorporation of new travel time analysis by ethnicity* • *Incorporation of new travel cost analysis* • *Incorporation of feedback received through the public consultation, in relation to equity, travel and access* • *Updating of recommendations for mitigation* • *Updating of sustainability section* • *Updating of wider Impacts on other providers*	There is strong evidence here of a genuine attempt to build substantively on the already extensive IIA. Our observation is that this appears to demonstrate a serious intent to take action to reduce healthcare inequalities and that the Travel and Access Group proposed should provide an additional mechanism for ongoing stakeholder influence and assurance. There is also evidence in the recommendations proposed to decision-makers that proposers are seeking to ensure that the findings of the IIA are taken up in the implementation process. For example: • more timely and accessible support for travel, parking and accommodation costs; • ensuring that access arrangements meet the needs of equality groups and are monitored; • the establishment of a Travel and Access Group to monitor the implementation of IIA recommendations. **We suggest that NHSE implementation recommendations are further enhanced so that multiple patient/family representatives are included within the Travel and Access Group in addition to the provider and commissioner membership proposed so that the needs and experiences of families are better understood and directly inform decision-making.** In terms of specific goals for reducing healthcare inequalities, these are not yet defined but we note that mitigation 15 (IIA, p.69) proposes a plan for monitoring and evaluating equity for the future provider linked to the national Core20PLUS5 approach.

1.Health and Healthcare Inequalities

Key Findings from our PCBC Review	DMBC Response to our Findings	New Findings from our DMBC Review
B. Proposals could be further strengthened by: i. 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;	*The IIA has been strengthened with an analysis of the current patient cohort and compared this to both the Principal Treatment Centre catchment population and the cancer incident population. This reveals that the patient cohort is broadly representative of those diagnosed with cancer and the child population in general.*	We note and welcome this strengthened analysis. Where it is stated that "Childhood cancer incidence rates do not vary significantly between the different geographies within the catchment area" (IIA p.7) we cannot readily reconcile this with the visual representation replicated below (we have added the red line to indicate where confidence intervals do not coincide).  If the error bars in the chart are 95% confidence intervals (this is the usual convention and, although not explicitly stated in the DMBC, NHSE have subsequently confirmed this to us) then, for the period shown, incidence for Kent and Medway and SE London are at a statistically significant lower rate than for Sussex and perhaps SW London, too. Cancer Research UK data reveal an age-standardised incidence rate for children's cancer in England of 15.9/100,000 with 95% confidence intervals ranging from 15.5 to 16.4, albeit for a different time period. Whilst the catchment for this service as a whole falls within that range, most of the individual areas fall outside of it. We note from the IIA (as a correlation not with the suggestion of causation) that SE London and Kent and Medway populations also contain the highest levels of deprivation in the catchment, with SE London being the most ethnically diverse. **Noting the statistically significant difference in recorded incidence across the catchment, we suggest that NHSE sets out how it will seek to monitor, better understand and, where appropriate, address this difference as the service moves forward**.

1.Health and Healthcare Inequalities

Key Findings from our PCBC Review	DMBC Response to our Findings	New Findings from our DMBC Review
	The Under 16 Cancer Patient Experience Survey provides data at Trust level and is summarised in the IIA. *Much other data is available only at national level or without an age-breakdown, although data from the new Specialised Services Quality Dashboard is expected to provide a clinical outcomes baseline for the service from summer 2024.*	Where Under 16 Cancer Patient Experience Survey 2022 data is presented (IIA, p.19), an age breakdown is provided for the question "*please rate your child's cancer care*" but there is no breakdown for sex, socio-economic status and ethnicity. The reverse is the case for the question "*how well are you looked after for your cancer or tumour by the healthcare staff?*". No explanation for this differential treatment is provided in the DMBC but NHSE have subsequently confirmed to us that this is a constraint in the source data. A scan of that data, however, validated the summary that there is no statistically significant difference in the reported experience of care. We accept the constraints linked to national data noted by proposers, and that data collection related to the new service specification will provide a prospective baseline. Whilst the IIA was strengthened with an analysis of the current patient cohort, we did not see an explanation in the DMBC for why greater use of locally held data could not be made. **Given the significant focus on future research in PTC proposals, and the constraints in meeting the expectations of the inequalities test to date, we suggest that NHSE ensures that the research priorities of the future provider explicitly address inequities in access, experience and outcomes (including structural racism), in line with the priority set out in 2024/25 NHS planning guidance to "continue to address health inequalities and deliver on the Core20PLUS5 approach for adults and children and young people" and the Trust's commitment to London Health and Care Partnership anti-racism strategic framework** (IIA, p.72)**.**

1. Health and Healthcare Inequalities

Key Findings from our PCBC Review	DMBC Response to our Findings	New Findings from our DMBC Review
ii. further strengthening of travel time analysis and the addition of travel cost analysis, both reflecting the clear preference of families to travel by car;	*We have now included analysis of travel time by ethnic group.* *We have also asked the providers for further information on parking arrangements. Testing of mitigations for parking with families will take place during the implementation phase, through the travel and access working group that both providers have committed to setting up.* *Refreshed travel time analysis was undertaken for the IIA (extending to the impacts for different ethnic groups and analysis across the whole treatment pathway).* *The IIA also includes consideration of travel poverty through travel cost analysis for patients and staff (based on driving costs). We estimated the impact on travel costs for patients and staff travelling via public transport by analysing example journeys (due to the complexity of public transport fares, we were unable to conduct a systematic analysis, so these cost comparisons are illustrative only).*	Again, we note this significantly strengthened analysis, not least the inclusion of potential cost impacts. This includes a breakdown by London Borough (IIA, p.98ff) which shows the preferred option benefitting the more deprived population of SE London above other areas in terms of travel time. Our understanding from the detailed analysis (IIA, pp.48-53), although proposers do not explicitly state it, is that: • the median journey to the Evelina, whilst taking a longer time, is a shorter distance for many children and families living in the catchment area, and (given travel costs are based on mileage alone) is therefore cheaper, when compared to the journey to the Royal Marsden; • the median car travel costs to the Royal Marsden are currently higher for those from the most deprived areas but this gap would be reduced (but not eliminated) in the move to the Evelina. **After the publication of the DMBC, NHSE confirmed our understanding that the median journey to the Evelina will be cheaper than to the Royal Marsden and that the greater reduction in cost will accrue to those in the most deprived areas.** In terms of staff travel impact, the DMBC notes the availability for staff of transitional support for additional travel costs plus eligibility for the inner London high-cost area supplement to salaries. **We suggest that NHSE asks the preferred provider to confirm whether or not consultants transferring from the Royal Marsden or St George's will be required to live within 30 minutes or 10 miles by road from the Evelina, as is generally required under Schedule 12.2 of the consultant contract**. We believe that a limitation in the analysis still remains where systemic healthcare inequalities issues for access are largely reduced to travel-related issues. The King's Fund states that "Inequitable access might mean that a group faces particular barriers to getting the services that they need, such as real or anticipated discrimination or challenges around language. It can mean that information is not communicated in an easily understandable or culturally sensitive way." Through patient and family engagement, for example, proposers might have sought to understand whether such barriers are experienced around PTC services so they could be designed out of the future service. Although there is an acknowledgement of, for example, different types of racism operating at different levels of the health system - structural, institutional, discrimination and stigma (IIA, p.60) - and a comprehensive range of mitigations is proposed (IIA, p.63ff), **we suggest that NHSE requires provider implementation plans to consider how the Trust will monitor wider access inequality issues, including where those issues may result from structural racism**.

1. Health and Healthcare Inequalities

Key Findings from our PCBC Review	DMBC Response to our Findings	New Findings from our DMBC Review
		It is welcome that the IIA's proposed mitigations include the "Development of 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." Whilst, as above, initial indications (IIA, p.69) are that this could remain too focused on travel-related access, it helpfully also covers quality and outcomes domains. In the former, acknowledgement of experience unrelated to travel is limited to a few characteristics (ethnicity, religion, marriage, gender and sexual orientation, and language barriers); in the latter, there is reference to future use of the Specialised Services Quality Dashboard. **We suggest that there is a clear NHSE expectation on the provider to monitor access, quality and outcomes in this service in a way which ensures these terms are broadly understood and that the data gathered are sufficiently granular to support ongoing research into disproportionate effects across social groups.** We see this as a gap in the recommendations made to decision-makers in the DMBC (section 10.3).

1. Health and Healthcare Inequalities

Key Findings from our PCBC Review	DMBC Response to our Findings	New Findings from our DMBC Review
iii. 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;	*We have undertaken a range of work to better understand the impact on St George's and mitigations which could be required should the future Principal Treatment Centre be at Evelina London. These are described in detail in Section 8.6 of the decision-making business case. The potential impacts for St George's include:* • *Paediatric surgery* • *Pathology* • *Lost opportunities and other services.* *With implementation of the mitigations identified, we don't anticipate these to lead to additional/ different equity impacts.* *In the event the service transitioned to Evelina London, close working with St George's and other partners would be needed to identify risks/impacts before they become significant and to agree how these are best managed/mitigated so they do not have an impact on wider services.* *Representatives agreed to a set of principles that would underpin detailed work to be taken forward as part of the implementation phase if a decision to move the Principal Treatment Centre to Evelina London is made.* *NHS England (London and South East regions) are also committed, in principle, to working with trusts on stranded costs at the appropriate time.* *If there are any unanticipated impacts of the service change that could lead to changes in patient flows; subsequent options would be subject to a separate Equality and Inequalities Health Impact Assessment.*	We welcome the additional clarity that has been provided in the DMBC concerning potential knock-on impacts of the proposed changes. We note that, in addition to this response on impacts at St George's, the DMBC also helpfully sets out potential impacts on: • teenage and young adult services, radiotherapy services and mIBG therapy at the Royal Marsden if the preferred option is implemented; • opportunities linked to synergies between children's cancer services and other children's services at the Evelina, including a comprehensive care model for children with complex needs, if the preferred option is not implemented. Our concern at the PCBC stage was that, if it was considered likely that implementing the preferred option would lead to consequent changes, the impact of those changes on healthcare inequalities should be considered in final decision-making. The DMBC notes that PTC activity represents around 20% of total activity in St George's paediatric surgery and pathology services. In identifying risks and mitigations for affected services there is an implicit assumption in the DMBC that the continuance of those services at St George's is not fundamentally under threat. **We suggest that NHSE explicitly confirms that it does not view paediatric elective surgery and pathology services as fundamentally at risk on the St George's site, in a way that could affect patient access, experience or outcomes.** If this is not the case, then our original concern remains.

1. Health and Healthcare Inequalities

Key Findings from our PCBC Review	DMBC Response to our Findings	New Findings from our DMBC Review
iv. 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.	*The primary benefit of the reconfiguration is reduction in intensive care transfers, with the quantified impact being that all inter-site transfers for intensive care are eliminated in the future clinical model. There will also be other benefits, outlined in Section 2.4 of the decision-making business case.* *We expect quantification of further benefits to take place for the outline business case and full business case and recommend measuring the clinical outcomes within the new Children's Cancer Principal Treatment Centre service specification which will be monitored via the Specialised Services Quality Dashboard (SSQD), published on Model Hospital (see appendix H for details). This data is not currently available and will be published in summer 2024, enabling the establishment of a baseline for the current Principal Treatment Centre service.*	Our previous recommendation followed from our observation relating to the PCBC that the case for change appeared to rely heavily on the national service specification's requirement for collocated intensive care as a driver for change, without also setting out the specific measurable benefits sought (quantitative and/or qualitative) through the implementation of the proposals. We note and welcome the clear confirmation in the DMBC of the elimination of unplanned inter-site transfers for emergency care because of the otherwise irreducible risk involved (i.e. there is no other way to avoid the risk to [patients). Recognising that risk is the prime driver of change, we also note: • the additional proposed benefits of the model outlined in Section 2.4 (e.g. on-site access to a greater number of linked services, easier access to new treatments, more time spent in a familiar environment with the same staff); and • the commitment to further quantify expected benefits as Trust business cases are developed (which we recognise as standard procedure). Proposed metrics for benefits realisation are helpfully set out in section 11.2.2. **We suggest that, as benefits realisation processes are advanced in Trust business cases, NHSE seeks assurance that data will be collected in a way that supports ongoing analysis of healthcare inequalities.** We also welcome where there is transparency about the potential negative impacts of the change for patients including: • new transfers for conventional radiotherapy at University College London Hospitals NHS Foundation Trust (UCLH) which are quantified and include some very sick children who are often in a vulnerable clinical condition; • children reaching 16 (with case-by-case flexibility) having to be transferred back to the Royal Marsden to access its Teenager and Young Adult cancer service. Since not all risks can be avoided, decision-makers must determine acceptable trade-offs between clinical risks and benefits, which will not accord with the views of all families, as DMBC case studies illustrate (p.226ff.). **We infer from the DMBC that the clinical risk associated with the new (and mostly planned) inter-site transfers that will be required after the change is made is of a lower order than that associated with existing emergency transfers to intensive care. We suggest that, in future Trust business cases and other communications relating to the PTC, this is made explicit, and that NHSE puts in place mechanisms for monitoring any adverse impact from the new transfers.**

2. Hospital Beds

2. Hospital Beds

Key Findings from our PCBC Review	DMBC Response to our Findings	New Findings from our DMBC Review
A. Bed proposals appear to align with current demographic projections but	*As the child population of the Principal Treatment Centre catchment area is projected to decrease over the next decade (Office of National Statistics (ONS) sub-national projections 2018), we do not anticipate an increase in childhood cancer incidence or associated pressures on capacity. As a result, further to assurances received, we are confident that (within reason) either option would be able to meet the changing needs of the service, including any unexpected increases in demand.*	**We remain content that proposals reasonably reflect expected changes in population structure and morbidity.**
i. these warrant some sensitivity testing for assurance;	*We have completed sensitivity analysis on the population growth comparing population forecasts from ONS 2018-based to ONS 2021-based projections for England as a whole (as no further sub-national projections have been released since the 2018-based projections). This has shown the expected number of 0 to 14 year olds in England in 2040 is the same for both the 2018 and 2021 projections, although the growth profiles vary to get to this point. Both projections show a reduction in the child population of England over the next decade. Once sub-national projections are released by ONS, we recommend the provider update the demand and capacity analysis with a view to annual requirements.* *Activity levels for the service were reviewed to assess requirements for surges in activity using more recent data. This demonstrated that service requirements could be accommodated within 20 beds at 80% occupancy as per the original activity analysis from the data lake. To ensure that the service could respond to any increases in demand, we asked both providers to review their plans and let us know how they would meet increases in demand.* *Both providers described the provision for flexibility which would allow for a 20% increase in demand. This also includes changes to patient pathways that may require an increase in isolation rooms.*	We note and accept this assurance, including the argument that, in principle, the increased colocation of services and staff should enable earlier advice and intervention, potentially mitigating the demand for higher intensity care services. **Whilst noting the NHSE recommendation that there should be ongoing review of capacity requirements (DMBC p.351, no.21), we suggest that this includes consideration to the circumstances (in isolation or combination) that could plausibly exceed the stated 20% capacity margin**. Should such analysis identify areas of potential concern, appropriate 'early warning' monitoring mechanisms could be put in place. We were not clear whether the assurances provided explicitly cover CAR-T therapy and UCLH radiotherapy capacity but we are taking the view that the PTC represents only a small proportion of total activity and, therefore, that any capacity pressures arising from this service are unlikely to be material. Conversely, provision for PTC patients will be subject to wider demand pressures but this would be the case wherever the service is provided unless it was a discrete facility for children's cancer (for which there is unlikely to be an adequate volume of activity).

2. Hospital Beds

Key Findings from our PCBC Review	DMBC Response to our Findings	New Findings from our DMBC Review
ii. the change from current to future state bed numbers should be more explicit;	*The current service is provided across two sites with an inpatient bed base of 22 (18 beds are on the McElwain ward at The Royal Marsden and 4 beds are on the Pinckney Ward at St George's). St George's also has surgical beds in the children's surgical and neurosurgical ward as well as two on the intensive care unit.* *St George's current design is for 22 beds plus six adjacent rooms that could potentially be used for family suites. As 1,145 of these ward bed days are currently provided by St George's, the additional capacity required by St George's is only that relating to the activity provided by The Royal Marsden. As critical care is already provided by St George's, they would not require any additional capacity for this.* *Evelina London's base scenario design is for 20 beds (with an assumption that 0.3 beds are provided by University College Hospital as part of the radiotherapy service). Further to assurances provided before we launched consultation, Evelina London has since developed two additional ward designs that demonstrate flexibility in the overall bed base, including for 22 and 24 beds on the ward (compared to 20 beds within their base plans) within the proposed footprint for the service. The plan assumes absorbing critical care requirement (calculated as 2.2 beds) within its paediatric intensive care unit, which has a physical footprint of 30 beds. 25 of these beds are currently funded and open.*	We note and accept this helpful clarification. As noted on the previous point, PTC volumes are low so, in the event that activity exceeds expectations, planned mitigations are likely to be able to meet demand in the short to medium term. Over the long term, all developments face external changes that challenge historic assumptions and require further changes to be made. There is no robust way to mitigate these longer-term possibilities (as would be the case if no changes were currently proposed to the PTC service). A caveat to our view here relates to the impact of private patient activity which we address in relation to the Financial Investment and Savings test (see 3B, below).

2. Hospital Beds

Key Findings from our PCBC Review	DMBC Response to our Findings	New Findings from our DMBC Review
iii. the rationale for, and impact of, differing modelling assumptions should be made more transparent.	***Demand and capacity modelling:*** *The pre-consultation business case outlined the activity assumptions for the service transferring, the occupancy or other assumptions used, and the capacity required and included in each potential provider's proposal for how it would deliver the service, should it become the future Principal Treatment Centre (these assumptions remain consistent at this stage). We reviewed the activity assumptions of both Trusts in response to consultation feedback. Evelina London's bed days assumptions are higher than St George's as these include capacity for work transferring from St George's Hospital as well as from The Royal Marsden. There are some differing assumptions between the Trusts for opening hours for theatres and outpatient care based on the Trust's operational models; for example, St George's Hospital runs its day case theatre five days per week whereas Evelina London's runs six days per week. Both Trusts have provided adequate capacity for these resources. Theatre utilisation rates are 85% for both Trusts, as per national targets.* *St George's has modelled a higher occupancy rate (85%) than Evelina London and the current service at The Royal Marsden (80%) – however the physical capacity within its proposal is sufficient for 80% occupancy rates. There are some headline opportunities for synergies from delivering the Principal Treatment Centre as part of a much larger children's service. Opportunities for productivity/efficiency gains will be assessed by the future provider after the service has transferred.* ***Financial modelling:*** *Both Trusts have applied a consistent and reasonable set of financial assumptions in setting out their income and cost assumptions including both pay and non-pay. These are included in Section 8 of the decision-making business case.*	We note and welcome these helpful clarifications in the DMBC.

3. Financial Investment and Savings

3. Financial Investment and Savings

Key Findings from our PCBC Review	DMBC Response to our Findings	New Findings from our DMBC Review
A. 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 also noted (p.20) that "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".*	*Revenue affordability is assessed in Section 8.8.5 of the decision-making business case. Both options meet the hurdle criterion of demonstrating revenue affordability provided additional capital charges are funded either via the national depreciation and amortisation funding mechanism, time-limited and tapered commissioner funding, or a combination of both.*	In order for proposals to be affordable and to meet NHSE's hurdle criterion, the key assumptions being relied upon appear to be that: • an initial shortfall will be mitigated out over the medium to long term, and • in the shorter term, identified mechanisms will be employed by commissioners to mitigate the impact of capital charges on the provider. We see these as reasonable assumptions: • both providers seeking to deliver the service are large trusts for whom the required mitigation in marginal in the context of total turnover, and • the ability to deliver capital charge mitigation is within the control of parties to these proposals, although we note that the DMBC states that it is not giving any warranties or guarantees (p.273). Whilst it appears that the financial case is robust, subsequent Trust business cases (OBC and FBC) will be required to undertake an economic appraisal focused primarily on value for money (VfM), including the 'benefit cost ratio'. In that appraisal, HM Treasury Better Business Case guidance (p.59) expects the preferred option to be the one offering the greatest value for money, so long as it also passes the affordability test. The DMBC states (p.287) that both options would generate a VfM ratio of 1.5. This is based on separate economic evaluations conducted by each Trust which have not been published in full. Guidance in the Comprehensive Investment Appraisal Model, states that a VfM ratio of 4 is expected (p.25), although this is not a pass/fail test. It does reinforce the DMBC statement, however, that the VfM return for the proposed change is modest under either option. Given that the preferred option is the more costly option, the differential investment required has an opportunity cost that is not made plain. That is, from the published information it does not appear that decision-makers were able to consider whether another use of that differential investment could generate greater VfM (p.8) for children with cancer or for other groups. The capital costs at the Evelina are estimated to be £13m (43%) more than at St George's. **We suggest that NHSE publish each Trust's economic evaluation of their change proposals and provide early assurance that the outcome of subsequent business case tests would not have switched the preferred option in the original PCBC appraisal.**

3. Financial Investment and Savings

Key Findings from our PCBC Review	DMBC Response to our Findings	New Findings from our DMBC Review
B. Further assurance should be provided that additional private patient activity will not impact NHS patient access.	*Both Trusts have committed to the principle that growth in private patient income would not adversely impact access to services for NHS patients. Commissioners will ensure that is the case going forward, including to ensure adequate capacity and priority for NHS patients. This will be managed and monitored during implementation and beyond as part of the annual commissioning process for demand, planned activity and capacity. Both options have outlined sufficient capacity for physical space and workforce to meet NHS demand as per current demand and capacity analysis.*	We note and welcome this assurance from proposers and the associated commitments from each Trust. Without questioning those commitments, we note that the DMBC does not enable decision-makers or the public to readily understand the expected balance of NHS and private activity within relevant services. We assume it involves an alternate use of the same resources and note the expectation that capacity for private patients will be generated through efficiencies in NHS services. We understand from the DMBC that St George's have factored in a total private patient income of £489k p.a. (p.293), relating to this service, and GSTT an additional £1.3m (p.295). Should NHS demand exceed both the expected levels and the additional mitigation capacity identified, Trust commitments would lead to a reduction in total income for the service. In sensitivity analysis (DMBC, p.288), GSTT and St George's have modelled reductions in private patient income of 25% and 15%, respectively. There is a parallel modelled reduction in VfM to 1.1 and 1.25, respectively. **We suggest that the relationship between private patient activity and NHS activity is made more explicit in subsequent Trust business cases and sensitivity analysis is undertaken on the impact on VfM and on affordability to the Trust of a potential total loss of private patient income in this service, in addition to other downside factors.** Our rationale for this suggestion is to prompt further assurance for all stakeholders that, should demand increase and planned capacity mitigations be employed, the service remains affordable to the Trust without private patient income. **We further suggest that, post business case approval, mechanisms are put in place to monitor waiting times for relevant services, especially given reported concerns that extended waiting times are one of the drivers of private patient activity.**

4. Social Care Impact

4. Social Care Impact

Key Findings from our PCBC Review	DMBC Response to our Findings	New Findings from our DMBC Review
No impact on local authority social care is expected. We accept this conclusion. The in-hospital social care provision would transfer with the service.	*NHS England notes this feedback.*	**We have no further observations or suggestions to make in relation to this test.**

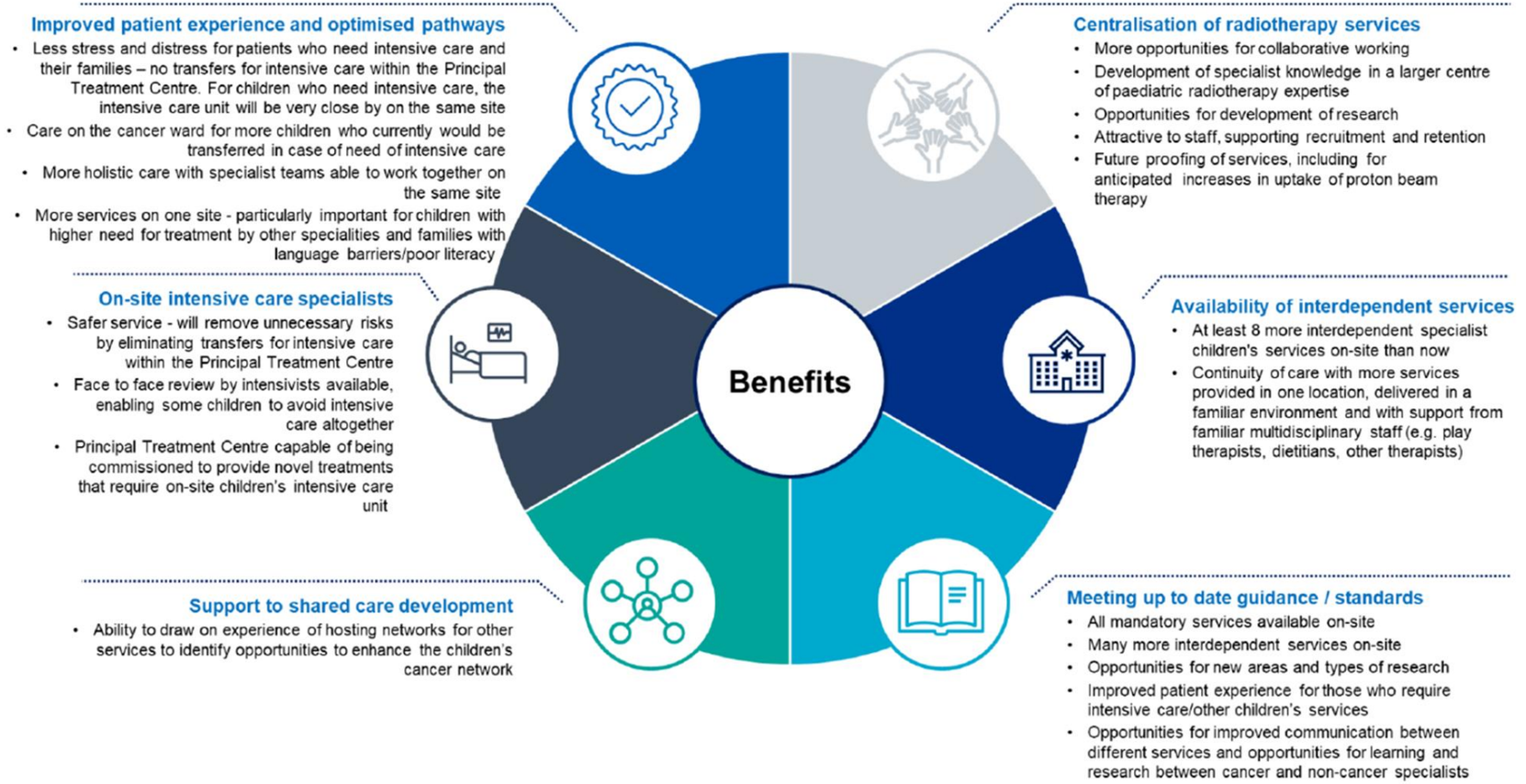
5. Clinical Support

5. Clinical Support

Key Findings from our PCBC Review	DMBC Response to our Findings	New Findings from our DMBC Review
A. 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.	*The intention to co-design and develop the future service with healthcare professionals from both future and current Principal Treatment Centre providers, as well as patients and their families, is described in the pre-consultation business case and decision-making business case and has been a feature of the pre-consultation evaluation of the options and other aspects of the programme so far.* *The consultation feedback showed there was strong support for the case for change from healthcare organisations, professional bodies, and clinicians. As well as firmly supporting the change, some clinicians and organisations urged NHS England to complete the reconfiguration quickly to secure the benefits for children it will bring as soon as possible.* *Some patients, families and others also supported it, including some families who had experience of their children being transferred for intensive care. A large number of families and some elected representatives and members of the public opposed it.* *In the decision-making business case, we have added more evidence on the compelling clinical evidence which underpins the case for change, demonstrating the period over which this evidence was published. We have also shared quotes from patients, parents, clinicians, and professional organisations gathered through the consultation, and updated the benefits that we expect from our clinical model. In addition, we have set out the case for change for conventional radiotherapy services in a way that mirrors the overall case for change, showing the evidence, case for change, and anticipated benefits.* *Further detail is in Sections 2 and 3.3 of the pre-consultation business case and Sections 1.4, 2.4 and 7.10 of the decision-making business case. Section 7.10 includes alternative suggestions made by the public, and our response to them.*	**In our view, the DMBC clearly demonstrates strong clinical support for the case for change and the underlying service specification, with which the alternatives put forward in response to the consultation do not comply.** Reinforcing this point, we did not find any evidence of clinicians affected by the proposed change - with whom there is an independent report of good engagement during the consultation – supporting the continuance of the current configuration. Proposers recognise the divergence in clinical and patient/family views, with a large number of families and advocates, and some members of the public continuing to oppose the case for change. We commend the transparency with which the variety of responses is described and addressed. We welcome the increased transparency in the DMBC about: • the shifting balance of risks associated with the proposed change, with proposals removing the risks associated with emergency transfers (c.35 p.a.) but introducing a risk to vulnerable children (c.10 p.a.) undertaking planned transfers for radiotherapy – a lower number and in more controlled circumstances; and • new (planned) transfers where access to cardiology, nephrology and neurosurgery expertise is required (depending on the option). As a minor point, we were confused by the apparent circularity of sections 1.4.3 and 6 in the DMBC.

5. Clinical Support

Key Findings from our PCBC Review	DMBC Response to our Findings	New Findings from our DMBC Review
		We note and welcome: • the addition of an enhanced case for change for the transfer of radiotherapy services to ULCH (DMBC, pp.36-40); and • the clearer setting out of the benefits of change (DMBC Figure 7, replicated below).



5. Clinical Support

Key Findings from our PCBC Review	DMBC Response to our Findings	New Findings from our DMBC Review
B. 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.	*The pre-consultation business case outlined the experience and expertise of both providers relevant to supporting children to transition to services for older children/young adults.* *We are aware of the wider developments relating to cancer care for teenage and young adults (TYA) and have committed to enhance children's and young adult's experience of health, continuity of care and outcomes, and transition between services. A framework is in development and aims to ensure experience of accessing and moving between services is safe and well planned and that children, teenagers and young adults feel empowered to make decisions about their health and social care needs.* *The Royal Marsden is undertaking a piece of work to understand the potential impact on its TYA services. This work will inform the development of an options analysis to identify the best way to do this. We are committed to supporting this ongoing piece of work which may include provision of stranded costs.*	The DMBC is also explicit about staff members and the Royal Marsden raising concerns about the disaggregation of services, namely its impact on patient experience and the impact on the current Royal Marsden TYA service. Given the very strong clinical support for the case for change, these impacts must be seen as unavoidable but mitigatable. We note and welcome the plans for ensuring the careful management of the transition between 0-15 and 16-25 services. We note that: • the consultation process has increased proposers' awareness of the risks that will need to be managed in implementation (including access to clinical trials); • the opportunity to learn for other centres is highlighted; and • there is a new national service specification for TYA cancer care that any provider would need to meet. **We have no further observations or suggestions to make in relation to this test.**

6. Patient and Public Engagement

In this section, we continue to make our observations on the proposer's response to the key findings in our previous review.

In addition, we more specifically address the Mayor's sub-tests under this heading which could not be done prior to public consultation.

6. Patient and Public Engagement

Key Findings from our PCBC Review	DMBC Response to our Findings	New Findings from our DMBC Review
A. Extensive pre-consultation activities have been undertaken and a consultation plan carefully planned and (partially) executed, as at the mid-point.		**In our view, proposers have continued and extended the seriousness and effectiveness of their engagement with the public and stakeholders through the process of public consultation.** We believe there has been a creative approach taken to consultation, using a variety of media and access options and multiple delivery partners, and strengthened by using an independent organisation to report on consultation activities. That report found that those engaged were broadly representative of the patient cohort. The DMBC clearly sets out: • the new information gleaned through consultation (p.6ff.); and • how proposers have responded to what they heard (see Table 65, p.325ff., for 'You said, we did'). We have reviewed the new information and do not believe this has further implications relating to the Mayor's 6 tests beyond the observations we have made above. We have also reviewed the 'you said, we did' table. Our observation here would be that **the information received through consultation has led to various refinements of the proposer's implementation plans, including in response to the significant concerns received around travel impact, albeit no material changes to core proposals. There is good evidence that the proposers have listened and responded to information received from stakeholders, including transparently setting out objections to the proposals and why the change is still seen as necessary.**
B. Identified gaps in engagement with priority groups are being addressed through a detailed action plan.	*The consultation feedback report highlights that there was good representation in feedback from potentially impacted children and families, and members of the public from marginalised communities and ethnic minorities, reflecting the demographic profile of the catchment area.*	We note and accept that the priority groups identified are appropriately represented in the number of responses received (consultation report, section 1.3.5). This follows the identification and implementation of targeted actions through the consultation mid-point review process (DMBC, p.76).

6. Patient and Public Engagement

Key Findings from our PCBC Review	DMBC Response to our Findings	New Findings from our DMBC Review
C. 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.	*We have outlined the benefits of the proposed change in Section 2.4 and 7.2.1 of the decision-making business case. These have been developed since pre-consultation business case, with input from subject matter experts in the leadership and management of clinical services.* *There is an existing quality governance infrastructure around the current service which is led by The Royal Marsden. Joint groups (comprising Royal Marsden and St George's staff) focus on clinical and operational quality and safety which feeds into internal Royal Marsden integrated governance structures. At a wider system level, governance includes the South West London Integrated Care Board (through the System Quality Group), the Children's Cancer Operational Delivery Network and NHS England. Regional governance includes the Clinical Quality Review Group and Regional Integrated Specialised Quality Committee which includes Integrated Care Board Quality Leads and provides oversight for the quality of services, ensuring action is taken to address any concerns and breaches.* *We also have highlighted the clinical compelling evidence which lies behind the case for change in Section 1.4 of the decision-making business case. In Section 7.10 we have given an overview of the support expressed for the case for change during the consultation by clinicians who currently provide the service, NHS and professional organisations, and some patients, parents, members of the public and other stakeholders. In Section 7.10 we have also given an overview of opposition to the case for change by a large number of families and some elected representatives and members of the public and have set out the alternative suggestions put forward by some during consultation, providing clarity on why these solutions would not be viable long-term.*	The observations we make under section 1B iv and 5A, above, are also relevant here. Proposers report and address the alternative options that were submitted to them by stakeholders through the consultation process. Whilst those stakeholders may not all be persuaded by the content of the DMBC, we cannot see how proposers could take a different position given the extent of clinical support for the case for change, reflecting and endorsing what is set out in the national service specification.

6. Patient and Public Engagement

D. Mayor's sub-tests	Strategy Unit Findings from our DMBC Review
i. Was the formal consultation well-publicised throughout the geographical and other communities in which affected people live, work and spend their time?	Yes, there was widespread publicity around the launch of the consultation and how to respond to it (see DMBC section 5.2. page 78)
ii. Were local networks used to promote engagement?	Yes, 'multi-layered, multi-targeted engagement' was undertaken (see DMBC section 5.1 p.73-75). Use was also made of local catchment area networks, whilst making the consultation available to all.
iii. Was the formal public consultation open for a sufficient period of time?	Yes, the consultation was open for 12 weeks (26/09/23 – 18/12/23) and a midpoint review was carried out to determine whether an extension was needed to allow for more responses. Independent consultation analysis determined that an extension was not required (see DMBC p.88-89).
iv. Was the consultation available via a range of mediums including online and hard copy?	Yes, a wide range of media were used, for different audiences, from a short animation to the full consultation document, including easy read formats (see DMBC section 5.2. p.78-79).
v. Was it possible to comment verbally via telephone and face to face meetings, as well as in writing?	Yes, multiple ways of responding were available including freephone, email or freepost (see DMBC section 5.2. p.80).
vi. Were proactive steps taken to engage patients and the public, especially harder-to-reach groups and communities, and those particularly affected by proposals – both directly and through representative groups?	Yes, multiple delivery partners were used and creative engagement approaches deployed, especially for younger patients (see DMBC section 5.1.1. p. 75)
vii. Did the consultation yield widespread, detailed public/patient feedback, especially from equalities and hard to reach groups, and those particularly affected by the changes?	Yes (see DMBC section 5.3 p.81-83). The consultation reached a broad range of stakeholders, particularly affected staff, and children and families including those with experience of cancer services. The children and families reached were broadly representative of the current patient cohort in terms of geography and demographics.

6. Patient and Public Engagement

Mayor's sub-tests	Strategy Unit Findings from our DMBC Review
viii. Have the final proposals been demonstrably modified following patient/public feedback?	Yes, there was a clear process around consideration of key themes emerging from consultation responses and good evidence of how this has affected implementation plans (see DMBC Table 65, p.325ff). For example, NHSE learning through consultation included: • the consequent loss on on-site neurosurgery, where the provider has now been asked to consider how to optimise the patient pathway; • risks around transition to Teenage and Young Adult services including clinical trials access, where close collaboration is now planned between the provider, the Royal Marsden and the wider network with monitoring by the Implementation Oversight Board; • the impact on miBG therapy at The Royal Marsden (one of only 2 providers nationally alongside UCLH) which may be unsustainable there, where there is now consideration of alternative treatment options and of consolidating the service at UCLH; • risks associated with radiotherapy services no longer being co-located with other PTC services, where mitigations have now been identified with UCLH; and • the availability and accessibility of family accommodation, where this is now identified as something the provider must manage and mitigate in implementation. The DMBC section that reviews further evidence received notes that consultation feedback demonstrated "a clear divide between the support for the case for change by NHS and professional organisations and clinicians, and the opposition to it from many parents, carers and members of the public" (DMBC, 7.2.1, p. 107). This opposition is described in more detail in Theme 9: Strength of case for change (7.10, p.228-233). The DMBC explicitly considers this opposition to the case for change, and the alternative suggestions, and concludes that there is compelling clinical evidence for the fundamental change proposed (as distinct from the preferred option). Given the strength of that clinical support, which we have considered in section 5 above, it is hard to imagine that an alternate case could be made which had the necessary clinical support.

6. Patient and Public Engagement

Mayor's sub-tests	Strategy Unit Findings from our DMBC Review
ix. Do the final proposals set out plans for ongoing dialogue with patients and the public as detailed delivery plans are developed and service changes are implemented?	Yes, the DMBC (see section 6.5 p.102-103) describes an ongoing engagement process that will, in future, be led by GSTT. Furthermore, the NHSE team will seek assurance from the Trust selected to be the PTC for their plans to continue engagement work with staff, families and wider stakeholders.
	The Mayor may wish to consider seeking ongoing assurance about the effectiveness of the further engagement that is proposed and the extent to which the recommendations resulting from the consultation are being implemented.

The Strategy Unit.

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