Proposed Changes to Adult Cancer Services in North West London - PCBC Review for the Mayor of London

Final Version - 20 March 2026

Contents

Executive Summary

The Mount Vernon Cancer Centre (MVCC) in currently located in Northwood within the London Borough of Hillingdon and serves a widespread and diverse catchment covering adults in Hertfordshire, Bedfordshire, North London, East Berkshire and parts of Buckinghamshire. It provides tertiary elements of the cancer pathway only.

An independent clinical review in 2019 highlighted that, because of the need for onsite surgical and comprehensive medical acute support services, the centre "must be on an acute DGH site". This led to the initiation of the MVCC Review and its supporting governance as a recognised programme across three NHS regions, including London. The proposals within the present Pre-Consultation Business Case (PCBC) seek to implement the 2019 clinical review recommendation and they involve:

a) Transferring the MVCC site and all the services it currently provides from Northwood to Watford General Hospital and the management of its services from East and North Herts Trust (ENHT) to University College London Hospitals NHS FT (UCLH).

b) Transferring haematology services from UCLH back to MVCC on the new site.

c) Increasing chemotherapy capacity at Hillingdon and Northwick Park Hospitals and radiotherapy capacity at Hammersmith Hospital to provide closer to home treatment for London patients, alongside increasing opportunities for chemotherapy at home.

d) Enabling blood tests and other diagnostic appointments to be accessed in a patient's local hospital.

e) Exploring a networked radiotherapy provision for non-London patients at either Luton or Stevenage.

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. Our subsequent review of the Decision-Making Business Case (DMBC) will address more recent developments.

We are grateful to colleagues in North West London and the East of England for the open and positive approach they have taken to engaging with the review.

In the sections that follow, we summarise where we believe the proposals already meet the Mayor's tests and where they could be enhanced to meet the tests more fully. Further detail can then be found in the sections addressing each test in turn.

In outline, the current MVCC proposals:

- are based on a strong case for change in which the strongest element is the clinical case – that is, the increasing need for specialist services to have ready on-site access to a wider range of clinical services than it is feasible to provide away from a comprehensive acute hospital
- strongly align with long-standing national policy drivers and frequently evidenced population appetite for services to be provided closer to home – something which, in relation to cancer treatments, carries extensive evidence of benefit, not least to deprived populations
- address defined specialist elements of the cancer pathway only - many key national cancer plan priorities such as faster diagnosis are out of scope, although proposals clearly need to take account of different levels of success being realised from those priorities
- evidence that a thorough approach has been taken – over an extended period, multiple NHS organisations and a wide-ranging geography that goes well beyond London – to identifying a preferred and feasible way forward for the services currently (and, in the case of haematology, historically) provided through MVCC
- in certain limited respects either do not set out the full range of considerations we would expect to find, mindful of the Mayor's tests and other guidance on the development of major service change proposals[1], and/or could more clearly narrate what has been considered and how it supports key elements of the proposals. Where we have made recommendations for further work, they generally address these issues rather than anything more substantive: that is, we believe greater assurance could be provided to stakeholders that the final proposals will appropriately meet the needs of the affected communities.

More specifically, our overall key findings are set out against each of the Mayor's first three tests in the table below.

Test One - On health and healthcare inequalities
1. On current systemic health inequalities issues, there is a clear description in the PCBC of the significant differential incidence of cancer nationally across groups with protected characteristics and deprived populations. The PCBC also notes links between deprivation and poorer health outcomes that are concentrated in London and provides an ethnic diversity breakdown across former CCG areas.

[1] See, for example, this Strategy Unit guidance developed for Clinical Senates nationally - Stage 2 Clinical Assurance Evidence Framework | The Strategy Unit

A more granular understanding of systemic health inequalities should be provided in the form of an explanatory narrative broken down to place-level that provides an understanding of how key demographic factors (such as those readily accessible in DHSC Fingertips data) relate to reported local outcomes, and the considerations that should therefore be built into plans for major service change.

2. On current systemic healthcare inequalities issues, much useful data is provided which makes clear the inequalities currently experienced by ethnic minority women and more deprived populations and the MVCC Review also sought the views of affected ICSs about the potential impact on their populations of moving MVCC.

Whilst the proposal to provide elements of care closer to home has the potential to reduce inequalities, as would local implementation of the national cancer plan around improved prevention and identification (outside the scope of these proposals), available data is not always turned into actionable intelligence that might more powerfully and directly have shaped the development of current proposals.

Proposers should explain the differences evident in the data between specific London populations and others in the MVCC catchment, and a clear narrative of how proposals respond to the underlying inequalities in a way that the national plan indicates they will need to.

In addition, information should be provided on the interaction between waiting times and deprived or protected groups.

3. On the potential impact of proposals, the Equality and Health Inequalities Impact Assessment (EHIA) identifies on-site access and environment benefits that could be realised through various aspects of building design and site planning processes. It also reports a mixed impact from proposals on protected groups, with an expected adverse impact for those on low incomes, living in deprived areas, or who are geographically remote, including from relevant public transport services.

In subsequent EHIA stages, proposers should clearly set out the key health and healthcare inequalities relating to each affected local population, and the protected and inclusion groups with them, and detail how final proposals are expected to improve, worsen, or have no effect on those inequalities.

4. On accessibility, proposals highlight the opportunity to reduce journey times through increased local provision of many services, not least the potential networked model of radiotherapy. An extensive drivetime analysis has been undertaken that appears to show

marginal change for London patients. This has generally been undertaken in a reasonable manner, though risks being too crude.

We were concerned that the impact analysis seems to focus on volumes and average travel times (i.e. the sites benefitting the greatest number of people), potentially prioritising the size of population over population need. We also note that the analysis is based on 2019 data, raising a question about whether that remains sufficiently accurate.

We recommend that:

- Proposers set out the impact of travel times and travel costs over a typical course of treatment, to enable a more realistic view to be formed of the actual impact on local populations, including where there is a real beneficial impact from closer to home provision.
- Further work is undertaken both on travel time analysis and on travel cost mitigation that reflects potential patient choice.
- Subsequent analysis should -
    - ensure that any aggregation of individual-level impacts does not lose significant richer insights that can be gained from patient-record level activity data, and clearly set out the expected net change in travel time and cost for all patients currently attending MVCC, regardless of their future treatment destinations
    - be undertaken at Lower (LSOA) rather than Middle Layer Super Output Area (MSOA) level which can readily be done with the same base data to avoid potential dampening of effects and to enable the identification and addressing of access issues for specific geographic or other communities.
- All results should be presented at place-level (e.g. Borough) so that there is a focus on the impact on defined populations within the catchment, not just site-based impact on the whole catchment.

5. On specific goals, we note the actions planned to address information gaps that should better enable the definition of appropriate goals going forward. We did not find specific goals relating to inequalities, and these should be provided at DMBC stage: for example, the expected increase in the uptake of radiotherapy by deprived populations, any associated reduction in surgical treatments, and the resultant changes expected in outcomes.

We were concerned about the different criteria used in the various option appraisals that have shaped proposals, finding those used in the radiotherapy appraisal to be clearer and

stronger than others. The Mayor may wish to consider seeking additional assurance that more clearly prioritising the reduction of health inequalities in all appraisals would not materially have affected the outcome. We note, for example, that in the acute site selection process, the essential criteria which led to the exclusion of Hillingdon and Northwick Park sites related to public transport and drive time access, respectively, assessed options on a whole catchment basis with no weighting for particular sub-populations.

6. On anchor institution impacts, we note that the PCBC addresses potential environmental improvements linked to the construction and configuration of a new site. The programme also advised the review that anchor opportunities are expected to be considered with the Outline Business Case that would follow DMBC approval. There is not yet an assessment of the workforce or wider local economic impact of proposals, though work is planned for the DMBC. The scope of that work should address whether any changes in direct local employment opportunities are expected and, if so, which communities or groups this would affect, and should also set out whether implementation would cause an indirect shift in local economic activity. We understand that the wider economic impact in Hillingdon of moving the MVCC from its current site depends on what plans emerge for the future on that site, and the Mayor may wish to be kept informed of that decision-making process.

Test Two - On hospital beds

1. Separate modelling exercises have been undertaken as follows:
    - Core MVCC site activity used 2019/20 then 2023/24 activity data and applied cancer incidence growth rates by tumour site and sex developed by the East of England Cancer Alliance. It was not clear to us how the latest ONS projections were factored into these assumptions or whether this was done in an appropriately granular way, reflecting specific local projections.
    - Demand modelling for radiotherapy at the MVCC site used a 2019 baseline of 2019 activity and applied a flat rate growth of 2%. Although we understand this to be the maximum growth supported within the national service specification, assurance should be provided that this rate would accommodate local demographic projections. A clear set of non-demographic assumptions relating to service changes was then applied to these growth assumptions.
    - For expansion capacity on existing sites, activity assumptions, although also lacking clear links to the latest demographic projections, appear to be reasonable, and there is flex capacity available across the catchment should it be required. There is an in-principle risk that current London activity, which is expected to be provided 'closer to home', continues to flow to the new MVCC site, causing a material capacity issue. We

accept the programme's view that this is unlikely given stated patient preferences and the fact that patient choice does not generally apply in specialist tertiary care. Nevertheless, we suggest that consideration is given to a simple modelling exercise which enables the programme to establish the tipping point in flows that needs to be avoided so that this risk can more readily be monitored and, if required, mitigated.

A collated overview should be provided that clearly links the full range of proposals to underlying demographic and non-demographic change.

2. Where some activity is expected to be re-provided on sites other than MVCC, plans for establishing that capacity appear to be well advanced, including additional chemotherapy capacity at Hillingdon and Northwick Park Hospitals, and extended radiotherapy capacity at Hammersmith Hospital.

3. Where known new treatments and therapies are likely to impact capacity, these appear to be clearly factored into plans. Actions related to the National Cancer Plan, beyond the scope of these proposals, also have clear potential to reduce overall demand.

4. Bed efficiency is unlikely to be a material issue given that inpatient bed use is a relatively small element of these proposals. We would observe, however, that the co-location of MVCC beds with a main acute site, adjacent to a much larger bed base, could enable efficiencies that have not been possible on the current MVCC site.

Test Three - On social care impact

1. We found no assessment of any potential social or community care impact from MVCC proposals within the PCBC. We have heard from the programme that there are no proposed changes to the role of Mount Vernon Cancer Centre staff in referring patients for social care and that, if the proposal is implemented, cancer centre staff would continue to work in partnership with community colleagues to initiate and coordinate social packages and support for cancer patients where required.

   Whilst we do not have any fundamental concerns with this position, we strongly recommend that the programme validates it with relevant social care functions so that no operational issues are inadvertently created for those functions, given the clear evidence base about the interactions between cancer and social care. This aligns with our recommendation to more clearly set out the expected impact of demographic change and cancer incidence on relevant services.

2. We also recommend that the programme seek similar assurance from established voluntary sector provision that it will not be adversely impacted (we note plans to transfer Macmillan facilities) and that opportunities to strengthen partnerships that assist the patient and carer

cancer journey are explored before implementation, especially for demographic groups that may especially need such support.

Background

The Mayor of London's Four Tests

The Mayor of London is committed to using his partnership with the NHS to support its work on behalf of Londoners. In particular, given the Mayor's statutory duties around inequalities in London, the Four Tests form a framework for assessing major health and care transformations in London as they enable the Mayor to take an evidence-based position on proposed changes to ensure that they are in Londoners' best interests. Recently revised from a broader set of six tests, the four tests cover:

- Health and healthcare inequalities
- Hospital beds
- Social care impact
- Patient and public engagement.

The Mayor has decided to apply the tests in the case of proposed changes to Adult Cancer Services in North West London linked to the Mount Vernon Cancer Centre. Although the affected services care for significant populations outside London, the tests and their associated reviews focus solely on the impact of proposals on Londoners.

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). The fourth test, patient and public engagement, is only addressed at the DMBC stage once public consultation processes have concluded and been factored into final decision-making.

At each stage, the Mayor writes a letter to proposers to share his recommendations on the proposals and any changes he would encourage the NHS to consider. Mayoral letters are informed by an independent review that is based on published proposals and supporting documentation.

Proposed Changes to Adult Cancer Services in Brent, Ealing, Harrow and Hillingdon

The Mount Vernon Cancer Centre (MVCC) is currently located in Northwood within the London Borough of Hillingdon. Its services, provided as part of East and North Hertfordshire NHS Trust (ENHT), cover a range of specialised non-surgical cancer services including radiotherapy, brachytherapy and Systemic Anti-Cancer Therapies (SACT) - mainly chemotherapy and immunotherapy. It does not provide any urgent two-week wait clinics but only sees patients who have already been diagnosed with cancer which usually takes place within the patient's local hospital before referral to MVCC if specialist input is required and cannot be delivered locally. The

centre also contains the Paul Strickland Scanner Centre and the Lynda Jackson Macmillan Centre. The centre serves a widespread and diverse catchment covering adults in Hertfordshire, Bedfordshire, North West London, East Berkshire and parts of Buckinghamshire.

There has been a series of reviews of MVCC over many years. More recently, concerns have increased around the lack of on-site access to necessary clinical support services such as emergency and critical care. An Independent Clinical Review in 2019 highlighted "The need for onsite surgical and comprehensive medical acute support services to quickly and safely manage treatment-related toxicities /complications, acute illness linked to patient comorbidities and frailty as well as disease-related sequelae".[2] The lack of such services has already led to the loss from the MVCC site of haematology provision and ongoing advancements in cancer treatments could lead to other services being similarly affected. The quality of buildings is also reported to be an increasing concern.

The 2019 review recommended that the centre "must be on an acute DGH site and in order to ensure the maximum integration of care must give consultant, nursing, radiographer, physics and oncology pharmacy staff who participate in networked clinics, chemotherapy or radiotherapy as many reasons as possible to spend significant time at the cancer centre on the acute DGH site". The proposals within the present Pre-Consultation Business Case (PCBC) seek to implement this recommendation. In outline, those proposals involve:

a) Transferring the MVCC site and all the services it currently provides from Northwood to Watford General Hospital and the management of its services from ENHT to University College London Hospitals NHS FT (UCLH).

b) Transferring haematology services from UCLH back to MVCC on the new site.

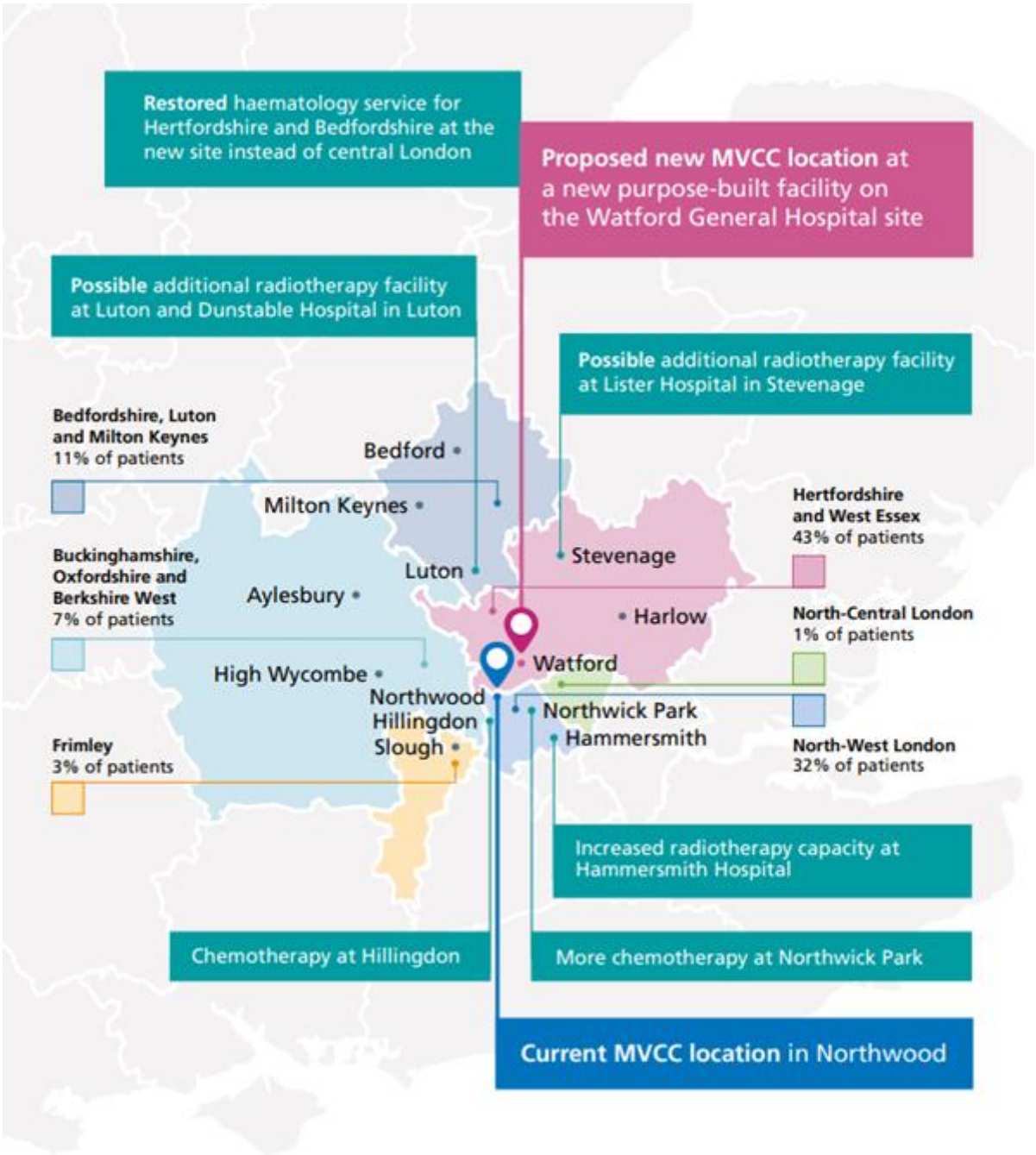
c) Increasing chemotherapy capacity at Hillingdon and Northwick Park Hospitals and radiotherapy capacity at Hammersmith Hospital to provide closer to home treatment for London patients, alongside increasing opportunities for chemotherapy at home.

d) Enabling blood tests and other diagnostic appointments to be accessed in a patient's local hospital.

e) Exploring a networked radiotherapy provision for non-London patients at either Luton or Stevenage.

[2] See Appendix 1 of the PCBC

The graphic below is the programme's summary representation of its proposals. The move to Watford, if agreed, would be achieved under the auspices and funding of the national New Hospital Programme.



The context in which these proposals are being brought forward is one marked in the NHS by its new 10 Year Plan, 'Fit for the Future'[3], and the supporting National Cancer Plan[4]. The cancer plan focuses on improving outcomes for cancer patients, noting that "Cancer mortality rates in the UK are much higher than in other, comparable countries, while survival is lower". It highlights the particular significance of this for patients from working-class or deprived communities: "There has been little improvement in tackling inequalities in cancer mortality over the last 15 years. This is a clear injustice, and the inverse care law in practice". Much in the national plan relates to how services are provided and continue to develop whereas MVCC proposals largely address where services will be provided. Three general points are worthy of note, however:

1. The relatively limited scope of MVCC services when seen in the context of the overall cancer pathway.
2. The clear focus within proposals to provide care closer to home, wherever possible, fully aligns with these most recent national plans.
3. The recognition in national plans of the disproportionate impact of poorer outcomes on more deprived communities will be of especial significance for much of the London population affected by the current MVCC proposals.

Our Review

The Strategy Unit is a specialist internal NHS consultancy that has previously conducted two independent reviews for the Mayor of London. Operating independently from NHS decision-making bodies, the Strategy Unit 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.

[3] 10 Year Health Plan for England: fit for the future - GOV.UK
[4] The National Cancer Plan for England: delivering world class cancer care

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 four tests. For this first phase of our independent review, we have individually examined the PCBC, its technical appendices, and other information provided by both NHSE and other stakeholders or independently accessed, including:

- East of England Cancer Alliances Mount Vernon Cancer Centre Radiotherapy Review: Estimated Radiotherapy Uptake and Cancer Analysis, May 2022
- NCL Cancer Inequalities Strategy 2024-2028
- RM Partners Cancer Alliance Strategy for North West and South West London: 2025–2030
- Improving Cancer Services Together - East of England Cancer Strategy, 2022
- NW London ICS Health and Care Strategy 2023
- Other documents underlying the PCBC –
    - MVCC Review - Our Integrated Care Systems; feedback on cancer strategic priorities and impact on the MVCC Review, December 2020
    - Travel Times analysis December 2020
    - Model Working File 5 Feb 2025 EC PCBC tables 120225
    - Mount Vernon Cancer Centre, NWL Preferred Option impacts, May 2023 (in confidence)
    - Reprovision of Mount Vernon Cancer Centre (MVCC) to Watford General Hospital site – impact on ambulance service provision
    - Letter from the London Ambulance Service.

We then compared and tested the lines of enquiry that each reviewer identified, and have summarised these in the following sections. Emerging findings were tested with the proposers, who were also invited to undertake a final fact-check.

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 four 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 recognise that the PCBC reflects a formative stage in the development of proposals and that some of the improvements we identify may already be planned for later stages of the work.

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 are asked to focus exclusively on the first three tests. In the second phase relating to the DMBC, we will review final proposals against all four tests, focusing on a review of the consultation process and the proposer's response to it.

Health and Healthcare Inequalities

Key Findings

1. On current systemic health inequalities issues, there is a clear description in the PCBC of the significant differential incidence of cancer nationally across groups with protected characteristics and deprived populations. The PCBC also notes links between deprivation and poorer health outcomes that are concentrated in London and provides an ethnic diversity breakdown across former CCG areas. A more granular understanding of systemic health inequalities should be provided in the form of an explanatory narrative broken down to place-level that provides an understanding of how key demographic factors (such as those readily accessible in DHSC Fingertips data) relate to reported local outcomes, and the considerations that should therefore be built into plans for major service change.

2. On current systemic healthcare inequalities issues, much useful data is provided which makes clear the inequalities currently experienced by ethnic minority women and more deprived populations and the MVCC Review also sought the views of affected ICSs about the potential impact on their populations of moving MVCC. Whilst the proposal to provide elements of care closer to home has the potential to reduce inequalities, as would local implementation of the national cancer plan around improved prevention and identification (outside the scope of these proposals), available data is not always turned into actionable intelligence that might more powerfully and directly have shaped the development of current proposals. Proposers should explain the differences evident in the data between specific London populations and others in the MVCC catchment, and a clear narrative of how proposals respond to the underlying inequalities in a way that the national plan indicates they will need to. In addition, information should be provided on the interaction between waiting times and deprived or protected groups.

3. On the potential impact of proposals, the EHIA identifies on-site access and environment benefits that could be realised through various aspects of building design and site planning processes. It also reports a mixed impact from proposals on protected groups, with an expected adverse impact for those on low incomes, living in deprived areas, or who are geographically remote (including from relevant public transport services). In subsequent EHIA stages, proposers should clearly set out the key health and healthcare inequalities relating to each affected local population, and the protected and inclusion groups with them, and detail how final proposals are expected to improve, worsen, or have no effect on those inequalities.

4. On accessibility, proposals highlight the opportunity to reduce journey times through increased local provision of many services, not least the potential networked model of radiotherapy. An extensive drivetime analysis has been undertaken that appears to show marginal change for

London patients. This has generally been undertaken in a reasonable manner, though risks being too crude. We were concerned that the impact analysis seems to focus on volumes and average travel times (i.e. the sites benefitting the greatest number of people), potentially prioritising the size of population over population need. We also note that the analysis is based on 2019 data, raising a question about whether that remains sufficiently accurate. We recommend that:

- Proposers set out the impact of travel times and travel costs over a typical course of treatment, to enable a more realistic view to be formed of the actual impact on local populations, including where there is a real beneficial impact from closer to home provision.
- Further work is undertaken both on travel time analysis and on travel cost mitigation that reflects potential patient choice.
- Subsequent analysis should -
    - ensure that any aggregation of individual-level impacts does not lose significant richer insights that can be gained from patient-record level activity data, and clearly set out the expected net change in travel time and cost for all patients currently attending MVCC, regardless of their future treatment destinations
    - be undertaken at Lower (LSOA) rather than Middle Layer Super Output Area (MSOA) level which can readily be done with the same base data to avoid potential dampening of effects and to enable the identification and addressing of access issues for specific geographic or other communities.
- All results should be presented at place-level (e.g. Borough) so that there is a focus on the impact on defined populations within the catchment, not just site-based impact on the whole catchment.

5. On specific goals, we note the actions planned to address information gaps that should better enable the definition of appropriate goals going forward. We did not find specific goals relating to inequalities, and these should be provided at DMBC stage: for example, the expected increase in the uptake of radiotherapy by deprived populations, any associated reduction in surgical treatments, and the resultant changes expected in outcomes. We were concerned about the different criteria used in the various option appraisals that have shaped proposals, finding those used in the radiotherapy appraisal to be clearer and stronger than others. The Mayor may wish to consider seeking additional assurance that more clearly prioritising the reduction of health inequalities in all appraisals would not materially have affected the outcome. We note, for example, that in the acute site selection process, the essential criteria

which led to the exclusion of Hillingdon and Northwick Park sites related to public transport and drive time access, respectively, assessed on a whole catchment basis with no weighting for particular sub-populations.

6. On anchor institution impacts, we note that the PCBC addresses potential environmental improvements linked to the construction and configuration of a new site. The programme also advised the review that anchor opportunities are expected to be considered with the Outline Business Case that would follow DMBC approval. There is not yet an assessment of the workforce or wider local economic impact of proposals, though work is planned for the DMBC. The scope of that work should address whether any changes in direct local employment opportunities are expected and, if so, which communities or groups this would affect, and should also set out whether implementation would cause an indirect shift in local economic activity. We understand that the wider economic impact in Hillingdon of moving the MVCC from its current site depends on what plans emerge for the future on that site, and the Mayor may wish to be kept informed of that decision-making process.

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 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:

a) **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 focuses on the extent to which proposals have considered the relevant underlying health inequalities faced by the local population ahead of any change.

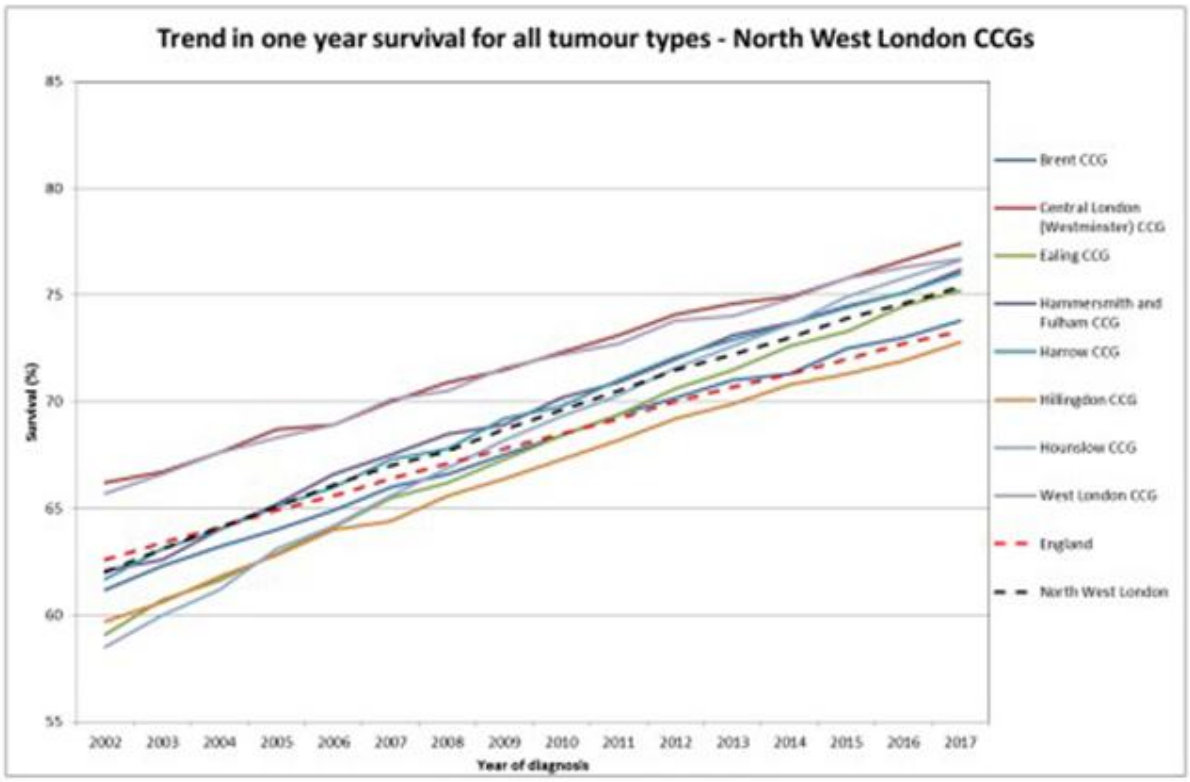
There is a clear description in the PCBC of the significant differential incidence of cancer nationally across groups with protected characteristics and deprived populations. This includes the following observations:

- the number of new cases is increasing year on year and affects the most deprived more than the least by around 16% in females and 19% in males

- incidence is 20-60% lower among ethnic minority groups (England), especially Asian, Chinese and Mixed groups, but this may be changing due to cultural assimilation (notably the South Asian population)
- female incidence, especially breast cancer, is higher for White women
- male incidence of prostate cancer is higher for Black men.

More specifically, in relation to the affected London populations, the PCBC also notes links between deprivation and poorer health outcomes and how this is concentrated in London and some surrounding towns. Of the 8 most deprived CCGs within Mount Vernon's extended catchment, only one (Luton) is outside of London. By contrast, Harrow is the only London CCG with lower levels of deprivation than the average for the catchment area. Further, the EHIA notes that the London population is generally more diverse than the wider MVCC catchment (especially in North West London as regards the Asian population) and also significantly more deprived.

We were also provided with other documents from the MVCC review process, and, beyond that, contain significant additional information about the health inequalities affecting the London populations within the MVCC catchment, and also where improvements have been evident. The graph below, taken from RM Partners data and reproduced in an MVCC review document, shows improving one-year survival across the former CCG populations of North West London.



In our view, a more granular understanding of systemic health inequalities might have been provided, such as an explanatory narrative broken down to place-level that provides an understanding of how key demographic factors relate to reported local outcomes, and the considerations that should therefore be built into plans for major service change.

The PCBC does provide an ethnic diversity breakdown across former CCG areas, but without relating this to the national-level observations referenced above. We noted the statement in the EHIA that "a full review of existing health inequalities across the cancer pathway (including patient access, experience and outcomes) was beyond the scope of this EHIA", but we were not fully persuaded of this view. Whilst we recognise that the PCBC proposals necessarily address limited elements of the cancer pathway, the planning of services needs to be rooted in a rich understanding of population health in specific communities that can readily be gained, for example, from DHSC Fingertips data[5].

b) 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 focuses on the extent to which proposals have examined the relevant inequities in healthcare experienced by the local population ahead of any change.

Our findings here are very similar to those above: that much useful data is provided (including in documents beyond the PCBC with which we were provided), but that the data are not turned into actionable intelligence that might more powerfully and directly have shaped the development of current proposals.

For example, the Clinical Model of Care for services at Mount Vernon Cancer Centre (appendix 2 of the PCBC) appends a Summary of Cancer Alliance Findings, including very pertinent data on cancer access and outcomes broken down to place level. A simple analysis of these tables evidences the general differences between the London catchment population of MVCC and the wider catchment population:

- The relevant London cancer population is proportionately smaller, receives a higher proportion of surgery and chemotherapy, but a lower proportion of radiotherapy (especially Enfield and Harrow). Except for surgery, where there is an average 5%

[5] Fingertips | Department of Health and Social Care

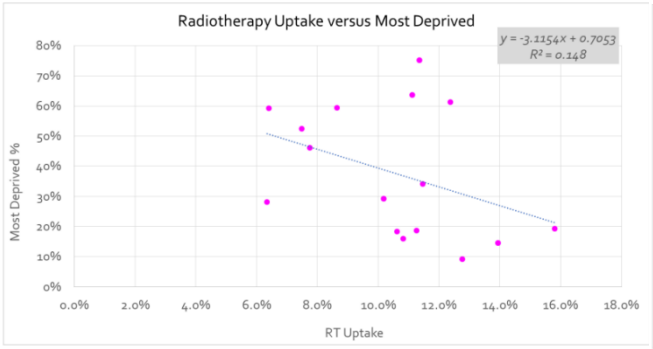
difference from the rest of the catchment, the gaps are small, but it is not made clear whether they are significant, what might underlie them, or how the proposals could mitigate them where appropriate.

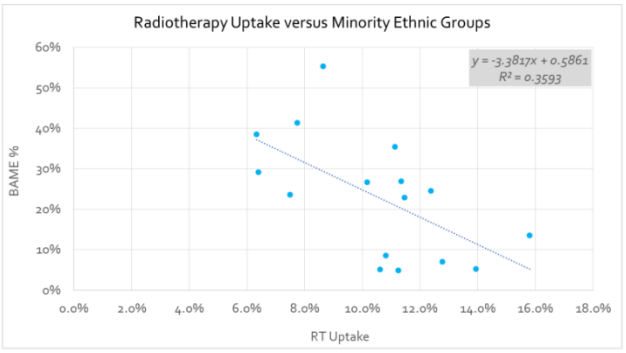
- Early stage diagnosis is generally lower in London, and emergency presentations are higher, but outcomes are a little better at 1 year and comparable at five years. Some of the evidence cited elsewhere rightly highlights the common linkage between later presentation and poorer outcomes. No explanation is offered as to why that might be the case here. The NHS Core20PLUS5 target for cancer is that 75% of patients are diagnosed at an early stage by 2028: affected London CCG performance reported in the PCBC (noting this was from 2018) averaged 55% (rest of MVCC catchment 57%) with a range from 52% in Brent and Ealing to 58% in Haringey.

The potential for any change to be as effective as it might be stems from a rich understanding of the current context and how proposed changes may interact with that context.

Nevertheless, we note the relevant data provided from which it is made clear that:

- Screening rates tend to be lower for ethnic minority women
- There is limited evidence of the impact of inequalities on diagnosis or staging
- 1-year cancer survival is higher in London than in England and the wider MVCC catchment
- There are some strong indications that longer travel distances can negatively impact patient uptake of non-surgical treatments such as chemotherapy and radiotherapy that require multiple journeys to be undertaken
- More deprived populations have lower access to cars, higher dependence on public transport and lower economic freedom to take the time off work that is required for a course of treatment
- Studies across Europe have shown that individuals living in more deprived areas have a lower uptake of non-surgical cancer treatment and higher mortality than those living in more affluent areas, reflected in more deprived CCGs having lower radiotherapy uptake relative to their cancer population in 2021. This is illustrated in the graphs below, taken from the Cancer Alliance reported in Appendix 2 of the Clinical Model of Care (Appendix 2 of the PCBC).





We did not find information provided on the interaction between waiting times and deprived or protected groups.

We also note that the MVCC Review sought the views of affected ICSs about relevant aspects of their strategies and the potential impact on their populations of moving MVCC. Although not included within the PCBC, the feedback gathered did enable the programme to distil relevant information from partner intelligence and plans. This is reflected in the first document described below, while the following documents reflect the related local information sources.

1. **Our Integrated Care Systems; feedback on cancer strategic priorities and impact on the MVCC Review** was a 2020 process run by proposers to enable programme proposals to reflect the cancer strategy of its key referring ICSs in the development of the clinical model, shortlisting of site options and business case for the future of the service. All ICSs refer to the health inequalities within their ICSs, and many were undertaking further work to try to understand and address these inequalities more fully. For example, North West London ICS stated that "we are addressing inequalities in key areas including deprivation, ethnicity and variation in service, particularly in areas where we are significantly worse than average", and it confirmed the following specific intentions:

    - Radiotherapy: They would expect a migration of patients for whom the journey time to one of their London radiotherapy centres was shorter than the MVCC site, such that they received their treatment at that closer location.
    - Chemotherapy: In line with the need to provide more care closer to home, they would expect the development of a local chemotherapy unit at Hillingdon, particularly if MVCC moved further away from this population.

2. **The North Central London Cancer Inequalities Strategy** looks at diagnosis, referral, survival, and quality of life by gender and ethnicity and provides a helpful summary

narrative of the kind we have indicated. This informs ten priorities under six themes, including:

- **Access**. Work with service leads to improve access to and design of hospital transport facilities, to help patients and carers attend all appointments.
- **Structure of the healthcare system**. Take an inclusive, user experience approach to quality improvement and service design to ensure barriers across the cancer pathway are considered and addressed

3. **The North West London Health and Care Strategy** has strong content on health and healthcare inequalities (including structural racism) and a section on cancer. It notes that "people from our more deprived populations, or from ethnic minorities, wait longer before presenting with symptoms of cancer, and then wait longer for referral for further investigation", and its actions include:

    - tackling why some groups take longer to come forward when they suspect cancer, and why they attend primary care more times before they are referred for further investigation
    - improving early diagnosis of cancer to 75% by reducing variation in screening rates, and improving willingness to present through education & outreach and standardising referrals

    Whilst these actions will largely sit outside the scope of MVCC proposals, the strategy does also identify a key challenge around treatment variation beyond screening and diagnosis – "Ensuring that access to treatment is local where possible and, where specialist, easy to access and resilient."

4. **RM Partners Cancer Alliance Strategy for North West and South West London: 2025–2030**. There is further relevant healthcare inequalities data here for the affected North West London population. The strategy recognises the need for interventions relating to care equity and co-design, including maintaining an inequity-first approach, raising awareness of deprivation as a clinical risk, reducing barriers to accessing diagnostic and treatment appointments through working in partnership with our communities, and monitoring equity in the secondary care pathway.

5. **The East of England Cancer Strategy** includes the MVCC proposals and states that its intended impacts include care closer to home, particularly a significant improvement in travel times for radiotherapy and a reduction in health inequalities.

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

This sub-test focuses on the extent to which proposals have considered how the options being explored may affect the health and healthcare inequalities to which the previous sub-tests point.

Impact analyses in the PCBC largely focus on access, reflecting reported public and patient concerns. This is addressed in the following section.

More broadly, the EHIA identifies on-site access and environment benefits that could be realised through various aspects of building design and site planning processes. It also reports a mixed impact from proposals on groups protected based on age, disability, or race/ethnicity, and the potential impact of changing travel costs (including parking at the new site) and the cost of time off work. These latter impacts are particularly noted in relation to those on low incomes, living in deprived areas, or who are geographically remote (including from relevant public transport services).

In subsequent EHIA stages linked to the DMBC, our view is that it would be helpful to clearly set out the key health and healthcare inequalities relating to each affected local population, and the protected and inclusion groups with them, and then to detail how final proposals are expected to improve, worsen, or have no effect on those inequalities.

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

From what we have already noted, it is evident that proposals will need to contribute to improving the situation for individuals living in more deprived areas who have a lower uptake of non-surgical cancer treatments.

Proposals highlight the opportunity to reduce journey times through increased local provision of many services, not least the potential networked model of radiotherapy.

An extensive drivetime analysis has been undertaken (see Appendix 3 of the PCBC) that compares travel to the current site with journeys to all others. It appears to show marginal change for London patients, and has generally been undertaken in a reasonable manner, though risks being too crude. It identifies the former CCG areas with the highest deprivation, but only shows the impact for those with the largest volumes. This shows, for example, additional journey times of 9-10 minutes by car for Ealing and Hillingdon residents and more so by public transport (by patients who may, through relative deprivation, be more likely to use it). Journeys for Brent (and Luton) are expected to improve a little by car. The table below provides

a summary of the impact on four of the most deprived areas in the catchment, although it was not clear why three other deprived London areas were not included.

	Episodes	Current site	Bedford	Harefield	Hillingdon	Luton	Northwick Park	Stevenage	Stoke Mandeville	Watford	Wexham Park
Brent CCG	3,928	32	61	31	29	40	13	47	54	29	37
Luton CCG	8,222	42	31	37	42	12	43	29	44	36	54
Ealing CCG	3,803	27	66	22	19	46	18	48	50	37	26
Hillingdon CCG	13,387	16	62	15	14	42	21	54	46	27	24

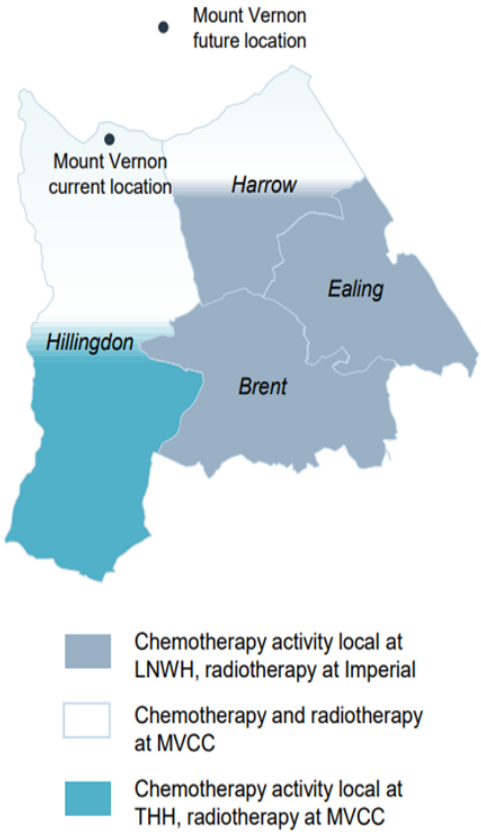
The PCBC notes that an additional exercise has carried out to estimate relative travel costs and that this showed that travel for London populations would only be cheaper for Barnet patients. For Harrow, costs were the same by car but greater by public transport.

Areas for potential mitigation are also identified, including patient choice, closer to home treatments, overnight facilities, and help with parking fees. A patient transport and access group has been established that will contribute to the full EHIA, and we would then expect to see confirmed plans at DMBC stage. Linked to this, we note the statement in the IIA that "Travel, transport and access have been the most frequently raised concerns by patients, carers and the public. In all areas, it has been agreed that a review of non-emergency patient transport should be undertaken to assess the opportunities for improving travel times."

Despite the extent of the travel analysis, we were concerned that the impact analysis seems to focus on volumes and average travel times (i.e. the sites benefitting the greatest number of people), potentially prioritising the size of population over population need. We also note that the analysis is based on 2019 data, raising a question about whether that remains sufficiently accurate.

Travel times are considered as either a single journey for an individual service user or a cumulative total for journeys by all service users. This might be more intelligible to service users and the wider public if some additional analysis were undertaken that shows the impact of travel times and travel costs over a typical course of treatment, using several examples as is done more generally in communicating the real effect of changes for patients. Without this, it is not possible to form a proper view of the actual impact on local populations, including where there is a real beneficial impact from the closer-to-home options that are planned outside of MVCC. We note, however, the additional work undertaken on the expected North West London impact of the preferred option, which concludes that "NWL patients for whom a longer travel

time results will be provisioned for in NWL". The graphic below illustrates this, although we have not been able to review the modelling on which this is based.



It is our view, then, that more work should be undertaken both on travel time analysis and on travel cost mitigation that reflects potential patient choice. Although proposals note that there is only 5.2 miles between MVCC and the Watford site, a review found that distance can affect patient decisions about treatment, potentially having an adverse impact on outcomes due to treatment options being declined. This impact is stated to not be measurable, but its significance appears to be reinforced by the reports of public and patient engagement, suggesting that all travel times are optimistic. There is therefore a risk of underestimating the impact and/or the need for effective mitigation.

In further analysis, we would strongly recommend that it is not only based directly on historic activity at patient-record level, suitably pseudonymised, but that any aggregation applied does not lose significant population insights. It should also clearly set out the expected net change in travel time and cost for all patients currently attending MVCC, regardless of their future treatment destinations (in analysis to date, activity expected to take place closer to home has been In the work to date, patient residences are estimated based on their registered GP, and in aggregating patient date to practice level, especially in a context where there can be material non-resident registrations (e.g. where it suits commuters to be registered nearer to work), that granularity is lost.

This is compounded by the analysis being undertaken at Middle rather than Lower Layer Super Output Area (LSOA) level, which can readily be done with the same base data. We did not find a rationale for this choice. Reporting at middle layer level (MSOA) can lead to the dampening of effects and impede the ability to identify and address any access issues for specific geographic or other communities. MSOAs are generally five times the size of LSOAs (c. 7,500 residents vs. 1,500), and the Index of Multiple Deprivation is calculated at LSOA level. Presenting all results at place-level (e.g. Borough) would also be beneficial. Current work is, in our view, too focused on the different sites and their impact on the overall catchment and not enough on defined populations within the catchment.

e) 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?

Benefits from the programme are expected in the following areas:

a. Better geographical access to services, particularly for deprived populations, will improve radiotherapy uptake in particular

b. Comprehensive range of treatment options. Some options not currently available at MVCC

c. Clear focus on research and innovation

d. Faster treatment (although noting that the existing service waiting times are best in class currently)

e. A collaborative programme with ICBs to work with communities to promote prevention and uptake, e.g. screening (partially in place, e.g. Luton Outcomes Project)

f. Reprovision will drive improved staff recruitment and retention.

We did not find specific goals linked to these benefits (notably a. and e. above, in this context) but recognise that the benefits realisation process is an evolving one and that further detail should be expected in the DMBC. Beyond formal PCBC documents, some related goals are evident in the other local strategies and plans referred to above. We would observe, however, that the ability to define the most relevant goals is directly related to the granularity of the underlying inequalities analysis. We note the actions planned to address information gaps that should better enable the definition of appropriate goals:

- the EHIA proposes monitoring the impact of implementation through demographic profile and uptake of services by protected characteristic/social inclusion groups - and similarly for outcomes - collating feedback by inequalities
- the IIA notes further work is required to gather data around protected characteristics (not specified) and mentions Luton, Slough and North Central London specifically due to deprivation and inequalities concerns.

We also recognise that the provision of closer to home treatment, which is a clear strand of the proposals, should reduce some aspects of health care inequalities in cancer treatment. In subsequent work, including the DMBC, proposers should consider defining measurable goals in relation to expected benefits: for example, the expected increase in the uptake of radiotherapy

by deprived populations, any associated reduction in surgical treatments, and the resultant changes expected in outcomes.

In making this recommendation, we are mindful of linked recommendations from the Clinical Senate Review:

- Recommendation 2: The MVCC Reprovision team should ensure that access to services and transport for all patients is carefully considered and made as convenient as possible. This includes changing referral pathways/centre catchments, where appropriate, plus dedicated transport.
- Recommendation 3: The MVCC Reprovision team should ensure that social and health inequalities are addressed thoroughly. This should include early recognition of symptoms, early presentation, and better take up of screening, diagnostic and treatment services.

Similarly, the Clinical Senate review of networked radiotherapy criteria recommended that improved health outcomes for all and a reduction in health inequalities should be elevated above all.

In terms of options appraisal processes we found a mixed picture. In the process appraisal, the delivery options (i.e. do minimum, re-provide the services on an acute site, and dispersal of services), there was no specific weighting for or mention of health and healthcare inequalities, although 'distance and time to access services' was included as a factor within the patient and carer experience criterion (overall 15% weighting). This reported an initial assessment that the preferred option's "Repatriation of work from other specialist centres, including from central London, would reduce the travel burden on patients. The reduced travel times would improve equality of access to services for deprived populations, particularly in the Luton and Watford areas". By contrast, it noted that the do minimum option would lead to "Reduced access to a comprehensive cancer centre for a number of deprived populations, potentially exacerbating health inequalities".

The appraisal panel included representatives from Healthwatch Hillingdon, Healthwatch Hertfordshire and the programme Patient Reference Group. The scoring of these representatives reflected the preferred option, and significantly so over the do nothing and do minimum options. The separate criteria used for appraising networked radiotherapy options took a clearer approach, including a discrete criterion for 'reducing health inequalities' that carried 30 out of 85 marks within the non-pass-fail criteria. This criterion is detailed in the table below.

Reducing health inequalities	The proposed site will **improve access** for service users in **deprived populations.**	**Assessment** of the change in the proportion of deprived population within 45 mins by car and public transport, compared to travel times if all radiotherapy were centralised in Watford. Defining deprived populations as the number of patients in the MVCC catchment living in the first quintile (LSOAs) (to note the consistency of the lowest quintile, the lowest 20% with CORE20)	Scoring out of 10: Car journeys: Score 5 if proportion for which a car journey of 45 minutes reduces to less than 10% Public transport: Score 5 if proportion for which public transport journey of 45 minutes reduces to less than 10%	**30**
	The proposed site will be located near to patient cohorts with low uptake of radiotherapy.	**Assessment** of the proportion of patients who could use the networked facility who would come from areas of low uptake of radiotherapy. We understand that this data exists but may be captured by previous clinical commissioning group boundaries.	Proposed site catchment population has levels of uptake significantly below average: score 5 Proposed site catchment population has levels of uptake moderately below average: score 10 It is noted advice to be sought from the Cancer Alliance to define significant and moderate variation thresholds.	
	The proposed site will be located near to patient cohorts with poor outcomes.	**Assessment** of the proportion of patients of patients who could use the networked facility who come from areas with poor cancer outcomes. We understand that this data exists but may be captured by previous clinical commissioning group boundaries.	Proposed site catchment population has survival outcomes significantly below average: score 5 Proposed site catchment population has survival outcomes moderately below average: score 10 It is noted advice to be sought from the Cancer Alliance to define significant and moderate variation thresholds.	

This sub-test would have been more fully met if the more specific criterion had been used across the option appraisal processes. The Mayor may wish to consider seeking additional assurance that more clearly prioritising the reduction of health inequalities in this way would not materially have affected the outcome. We note, for example, that in the acute site selection process, the essential criteria which led to the exclusion of Hillingdon and Northwick Park sites related to public transport and drive time access, respectively, were assessed on a whole catchment basis with no weighting for particular sub-populations. Outside of the PCBC, proposals have accepted that the consideration of inequalities and sub population impacts should be more explicitly articulated and strengthened at DMBC stage and they have provided assurance that there are specific plans in place for investment in London to improve services available to the London population, with further mitigations and opportunities under active discussion.

f) 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?

In terms of environmental impact, the IIA notes that:

- a detailed environmental and sustainability impact assessment will be completed

- the feasibility study undertaken by UCLH explores energy use and building efficiency to some degree, and this will be incorporated into future impact assessment in this area for outline and full business case stages.
- there are potential positive impacts from reduced and/or greener travel and better construction methods.

There is not yet an assessment of the workforce or wider local economic impact of proposals, though work is planned for the DMBC. The scope of that work might be expected to address whether any changes in direct local employment opportunities are expected and, if so, which communities or groups this would affect. It will also be helpful to develop an understanding of whether implementation would cause an indirect shift in local economic activity (e.g. local businesses as traffic flows change) and, again, how such impact might be felt.

The programme advised the review that anchor opportunities are expected to be considered with the Outline Business Case that would follow DMBC approval. It was also noted that the wider economic impact in Hillingdon of moving the MVCC from its current site depends on what plans emerge for the future on that site. The Mayor may wish to be kept informed of that decision-making process.

Hospital Beds

Key Findings

1. Separate modelling exercises have been undertaken as follows:
    - Core MVCC site activity used 2019/20 then 2023/24 activity data and applied cancer incidence growth rates by tumour site and sex developed by the East of England Cancer Alliance. It was not clear to us how the latest ONS projections were factored into these assumptions or whether this was done in an appropriately granular way, reflecting specific local projections.
    - Demand modelling for radiotherapy at the MVCC site used a 2019 baseline of 2019 activity and applied a flat rate growth of 2%. Although we understand this to be the maximum growth supported within the national service specification, assurance should be provided that this rate would accommodate local demographic projections. A clear set of non-demographic assumptions relating to service changes was then applied to these growth assumptions.
    - For expansion capacity on existing sites, activity assumptions, although also lacking clear links to the latest demographic projections, appear to be reasonable, and there is flex capacity available across the catchment should it be required. There is an in-principle risk that current London activity, which is expected to be provided 'closer to home', continues to flow to the new MVCC site, causing a material capacity issue. We accept the programme's view that this is unlikely given stated patient preferences and the fact that patient choice does not generally apply in specialist tertiary care. Nevertheless, we suggest that consideration is given to a simple modelling exercise which enables the programme to establish the tipping point in flows that needs to be avoided so that this risk can more readily be monitored and, if required, mitigated.

    A collated overview should be provided, which clearly links the full range of proposals to underlying demographic and non-demographic change.
2. Where some activity is expected to be re-provided on sites other than MVCC, plans for establishing that capacity appear to be well advanced, including additional chemotherapy capacity at Hillingdon and Northwick Park Hospitals, and extended radiotherapy capacity at Hammersmith Hospital.
3. Where known new treatments and therapies are likely to impact capacity, these appear to be clearly factored into plans. Actions related to the National Cancer Plan, beyond the scope of these proposals, also have clear potential to reduce overall demand.

4. Bed efficiency is unlikely to be a material issue given that inpatient bed use is a relatively small element of these proposals. We would observe, however, that the co-location of MVCC beds with a main acute site, adjacent to a much larger bed base, could enable efficiencies that have not been possible on the current MVCC site.

TEST 2: Hospital beds. The proposed bed capacity will need to be independently scrutinised in relation to the latest demographic projections. Any plans that 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).*

a) Do the proposals reflect the implications of the latest demographic projections?

Assessing activity plans is not simple in this context, given both the complexity of proposals (the dispersal of activity to multiple sites) and the multiple modelling exercises this has generated. A collated overview is lacking that clearly links the full set of proposals to underlying demographic and non-demographic change.

Separate processes appear to address the following areas of activity, so we summarise the related processes in the same way:

i. MVCC site activity (excluding radiotherapy)

For the activity plan agreed in 2021, baseline activity data were taken from 2019/20 Hospital Episode Statistics (HES), to which was applied a clear set of non-demographic

assumptions that are listed as strategic changes in Table 6.5 of the PCBC. Growth assumptions were then applied to this 'true baseline' which reflect cancer incidence growth rates by tumour site and sex developed by the East of England Cancer Alliance. It was not clear to us how the latest ONS projections were factored into these assumptions or whether this was done in an appropriately granular way, reflecting specific local projections.

This original activity plan was then tested as part of the final development of the PCBC. This included factoring in several known changes, such as the development of chemotherapy at home and the emergence of new chemotherapy treatments, which were judged not to be material in aggregate. At the same time, an updated 10-year forecast was produced, based on 2023/24 data and applying a similar process to the original. Amongst those assumptions were a 2% annual increase in radiotherapy fractions (noted to be the upper bound of national modelling scenarios) and a 7% annual increase in chemotherapy (in line with Royal College of Radiologists forecasts). Again, we see these as reasonable assumptions to draw on but note that they still lack an explicit grounding in the latest demographic projections relating to the affected local populations. That is to say, it is not possible to fully assess whether these apparently reasonable assumptions are sufficiently appropriate to potential local need.

The testing and refining of the activity plan also included inpatient beds, day case and outpatient capacity:

- Inpatient beds. Combined haematology and oncology bed capacity was recalculated using the same process as originally but using the updated 23/24 bed day baseline and assuming 90% bed occupancy. The latter is at the upper end of safe occupancy rates according to NICE guidance, which also notes the National Audit Office observation that hospitals with average bed occupancy levels above 85% can expect to have regular bed shortages, periodic bed crises and increased numbers of health care-acquired infections.[6] It should also be noted, however, that bed occupancy rates nationally have commonly exceeded 85% in recent years. The review led to no change in the proposal for 50 beds since the modelling produced a very similar result. We note that further review is planned, should the proposals be approved, to understand the impact of adjacencies on the Watford site. We had no concerns with this approach beyond

[6] https://www.nice.org.uk/guidance/ng94/evidence/39bed-occupancy-pdf-172397464704

wishing to better understand the source of the growth assumptions applied. It is noted that the modelling approach will subsequently adopt the principles used within the New Hospitals Programme, through which the development would be funded, and this may provide greater assurance.

- Day case and outpatient capacity. There has also been no change currently proposed to the originally identified chemotherapy chair capacity, despite activity projections shifting from 21,190 by 2030/31 to 46,138 by 2035/36. This reflects a 7% growth rate, the source of which is not stated. It is noted, however, that it is not clear if that rate will be sustained over ten years or how 'minutes in chair' or other developments may evolve over the period. We are broadly comfortable with the view of the PCBC that "given the uncertainty in both activity projections and chair time modelling – as well as the minimal impact on overall planned cancer centre capacity and capital costs of additional daycare chairs" this is a reasonable position to maintain for the time being. More general outpatient capacity can readily be flexed, so we have no concerns about current plans in this respect.

ii. Radiotherapy

Demand modelling for radiotherapy at the MVCC site (Appendix 1 of Appendix 18) takes a baseline of 2019 activity and applies a flat growth rate of 2%. It is not clear how this relates to demographic projections. A clear set of assumptions was then applied to these growth assumptions:

- Haematology activity transfer for UCLH
- Change in breast and prostate fractionation
- Local reprovision in North West London of 5,000 fractions
- A central and an upper bound scenario for the networked unit being either fully or minimally utilised.

The PCBC reports that this approach has been supported by the national lead for radiotherapy at NHSE. It also notes that further modelling in 2022 led to the proposed radiotherapy provision increasing from 6 to 7 linear accelerators (Linacs).

iii. Expansion capacity on existing sites.

Despite the absence of clear links to the latest demographic projections, the activity assumptions do not in themselves appear to be unreasonable, and there also appears to be flex capacity available across the catchment should it be required.

There is an in-principle risk that current London activity, which is expected to be provided 'closer to home', continues to flow to MVCC, causing a material capacity issue. The programme has advised the review that current public feedback indicates a strong desire to use 'closer to home' sites, that this will be further tested in consultation responses, and that standard patient choice does not apply in the same way for specialist tertiary care centres such as MVCC. We accept this view. We suggest that consideration is given to a simple modelling exercise which enables the programme to establish the tipping point in flows that needs to be avoided so that this risk can more readily be monitored and, if required, mitigated.

b) If not,

i. Is suitable alternative provision in place alongside or ahead of changes, with the required workforce?

The proposed capacity at MVCC assumes that patients will choose to attend closer to home facilities as these become available. Plans to enable this appear to be well advanced and are detailed in Appendix 7 of the PCBC. They include:

- New chemotherapy capacity at Hillingdon Hospital that is already factored into Trust plans
- Extended chemotherapy capacity at Northwick Park Hospital that is already in place and ready to open
- Extended radiotherapy capacity within Imperial College Healthcare NHS Trust, where an additional Linac is already in place.

ii. Are there new treatments and therapies which will reduce specific categories of admissions?

Where improvements are known, such as the potential to change fractionation, these are clearly factored into plans. The PCBC otherwise notes that, whilst other developments will undoubtedly continue to emerge, it is not possible at this stage to develop activity assumptions about them. We see this as an appropriate stance to take.

Actions related to the National Cancer Plan, beyond the scope of these proposals, also have clear potential to reduce overall demand.

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

Inpatient bed use is a relatively small element of these proposals as compared with capacity for chemotherapy, radiotherapy and other non-surgical treatments. It may also be that location on a main acute site, adjacent to a much larger bed base, could enable efficiencies that have not been possible on the current, more limited site.

Social Care Impact

Key Findings

1. We found no assessment of any potential social or community care impact from MVCC proposals within the PCBC. We have heard from the programme that there are no proposed changes to the role of Mount Vernon Cancer Centre staff in referring patients for social care and that, if the proposal is implemented, cancer centre staff would continue to work in partnership with community colleagues to initiate and coordinate social packages and support for cancer patients where required.

   Whilst we do not have any fundamental concerns with this position, we strongly recommend that the programme validates it with relevant social care functions so that no operational issues are inadvertently created for those functions, given the clear evidence base about the interactions between cancer and social care. This aligns with our recommendation to more clearly set out the expected impact of demographic change and cancer incidence on relevant services.

2. We also recommend that the programme seek similar assurance from established voluntary sector provision that it will not be adversely impacted (we note plans to transfer Macmillan facilities) and that opportunities to strengthen partnerships that assist the patient and carer cancer journey are explored before implementation, especially for demographic groups that may especially need such support.

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.

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

We found no assessment of any potential social or community care impact from MVCC proposals within the PCBC. In response to a query from the review, we were advised that "There are no proposed changes to the role of Mount Vernon Cancer Centre staff in referring patients for social care. If the proposal to move the cancer centre to a new building at the Watford site went ahead, cancer centre staff would continue to work in partnership with community colleagues to initiate and coordinate social packages and support for cancer patients where required." Whilst we do not have any fundamental concerns with this position, we strongly recommend that the programme engages with relevant social care functions – perhaps via

affected ICBs - to validate the position so that no operational issues are inadvertently created for social care functions.

Beyond social care, we note the very significant role played by national third sector organisations and local voluntary, community and faith groups in supporting cancer patients and their carers. We also recommend, therefore, that the programme seeks similar assurance from established voluntary sector provision that it will not be adversely impacted (we note plans to transfer Macmillan facilities) and that opportunities to strengthen partnerships that assist the patient and carer cancer journey are explored before implementation, especially for demographic groups that may especially need such support.

The programme advised that there should be a reduced demand for ambulance conveyances as a result of these proposals, due to the consolidation of some services and the 'closer to home' provision of others. We were also informed that they have been in conversation with the two affected ambulance Trusts and that the London Ambulance Service has confirmed proposers' planning assumptions.

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

We cannot comment on this currently, unless and until a relevant assessment is made.

We note, however, the wider evidence base about the interactions between cancer and social care:

i. A Macmillan report[7] found that 1 in 7 people with cancer (15%) have had to go to hospital for an unplanned or emergency visit because of a lack of support for their practical or personal needs, and that 1 in 20 (5%) are constantly or often having unplanned or emergency hospital visits because of a lack of support.

ii. Nuffield analysis[8] showed that there was evidence of a response by social services triggered by a cancer diagnosis, with a sharp rise in the number of people being assessed immediately after diagnosis, and that, overall, 10% of people diagnosed with cancer received a social care assessment within three months of diagnosis. It also noted that, for some people, receipt of social care is critical to their ability to retain independence and participate in society, and that social care can also have important

[7] https://www.macmillan.org.uk/dfsmedia/1a6f23537f7f4519bb0cf14c45b2a629/14735-10061/hidden-at-home-march-2015

[8] social-care-for-cancer-survivors-research-summary-web-final.pdf

financial implications for service users due to the means-tested funding system that currently exists in England.

It is accepted by the programme that increasing cancer incidence does have an impact on social care requirements. The programme view is that this is not driven by the relocation *per se*, but by the cancer incidence within the population. We accept this view but make two related observations:

- The scale of the effect, reported in the evidence, indicates that the interaction is significant, and this further strengthens the case for active engagement with relevant social care functions.
- The reference to cancer incidence reinforces our concerns raised in earlier sections around the lack of evidence that granular demographic projections have been appropriately factored into proposals.

c) 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?

We cannot comment on this currently, unless and until a relevant assessment is made.

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

This should be revisited following any engagement between the programme and relevant social care functions.

e) Do plans fit with local health and wellbeing board strategies?

We found no specific evidence to support this within the PCBC but acknowledge that the proposals cover a significant geographic catchment such that proposals cannot readily respond to local strategies. Improving cancer performance and outcomes is, of course, a widespread national goal and strongly set out in the National Cancer Plan.

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