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# Proposals for the future location of very specialist cancer treatment services for children in south London and much of south east England

**Decision-making business case**



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## Glossary of terms

Acronym	Definition
AHP	Allied health professional
Ambulatory care	Ambulatory care means services provided as an outpatient, where you do not need to stay in hospital.
BAU	Business as usual
BCIS	Building Cost Information Service
BMT	Bone marrow transplant
Brachytherapy	Brachytherapy is a type of internal radiotherapy. A sealed radioactive source is placed in the body, inside or close to the cancer or where it used to be before surgery. The source delivers radiotherapy to the area, destroying the cancer cells while limiting the dose to surrounding healthy tissue.
CAP	Clinical Advisory Panel
CAR-T	Immunotherapy using Chimeric Antigen Receptor T-cells
CCLG	<u>Children's Cancer and Leukaemia Group</u>
Children's Cancer Network	Children's, Teenagers' and Young Adults' Cancer Operational Delivery Network
CDEL	Capital departmental expenditure limit
CEO	Chief executive officer
CIA	Comprehensive investment appraisal
CPD	Continuous professional development
CQC	Care Quality Commission (regulator of health and social care services)
CT	Computed tomography (CT scan) a test that takes detailed pictures of the inside of your body
CYP	Children and young people



Day case	A patient admitted electively during the course of a day with the intention of receiving care who does not require the use of a hospital bed overnight and who returns home as scheduled
DHSC	Department of Health and Social Care
DMBC	Decision Making Business Case
ECMC	Experimental Cancer Medicine Centre
EHIA	Equality and Health Inequalities Impact Assessment
Elective admission	A patient admitted electively with the expectation that they will remain in hospital for at least one night, including a patient admitted with this intention who leaves hospital for any reason without staying overnight
Epic	Electronic patient record system
EPRR	Emergency preparedness, resilience and response
ESA	Environmental Sustainability Assessment
Evelina London	Evelina London Children's Hospital, part of Guy's and St Thomas'
FBC	Full business case
GSTT	Guy's and St Thomas' NHS Foundation Trust (Guy's and St Thomas')
HBN	Health building notes
HDU	High dependency unit
HEA	Health equity audit
HEPA filter	High efficiency particulate air filter, used in isolation cubicles to protect patients with no or very little resistance to infection
HIAs	Health inequalities impact assessments
HMDS	Haematological Malignancy Diagnostic Service
HMT	His Majesty's Treasury
HOSC	Health Overview and Scrutiny Committee

HPCG	Healthcare Premises Costs Guides
HRG	Healthcare resource groups are the 'currency' of payment by results (PbR) for admitted patient care, outpatient procedures and A&E attendances
ICB	Integrated Care Board
ICR	Institute for Cancer Research
ICS	Integrated Care System
IIA	Integrated Impact Assessment
ITU	Intensive therapy unit – a synonym for intensive care unit
I&E	Income and Expenditure
JACIE	Joint Accreditation Committee ISCT-Europe & EBMT
JHOSC	Joint Health Overview and Scrutiny Committee
LA	Local authority
LINAC	Linear accelerator – machine that delivers radiotherapy
Mean	The sum of a collection of numbers divided by the number of numbers in the collection.
Median	The 'middle' value of a data set, which separates lower and higher values into two groups. For example, in the data set {1, 3, 3, 6, 7, 8, 9}, the median is 6, the fourth number in the sample.
MEP	Mechanical, electrical and plumbing
MDT	Multidisciplinary team
mIBG	meta-iodobenzylguanidine is a form of radioactive substance that can be given as an injection. The tumour recognises the mIBG and will absorb it – this makes the radiation stick to the tumour. It can be used in the treatment of children with neuroblastoma.
Molecular radiotherapy	Molecular radiotherapy is a form of radiotherapy which uses a radioactive medication. This can be administered orally (through the mouth) or intravenously (through the veins), directly targeting tumour tissue, wherever it is in the body.
MRI	Magnetic resonance imaging

MMC	Modern methods of construction
Neuro-oncology	Service for brain, spinal and central nervous system cancers
NHSE	NHS England
NICE	National Institute for Health and Care Excellence
NIHR	National Institute for Health and Care Research
Non-elective	Non-elective admissions are unplanned, emergency admissions
OBC	Outline business case
ODP	Operating department practitioner
ONS	Office of National Statistics
OPCS	The OPCS Classification of Interventions and Procedures (OPCS-4) is a statistical classification of interventions and procedures undertaken in the National Health Service (NHS) reflecting current clinical practice
OSC	Overview and Scrutiny Committee
OAWG	Options Appraisal Working Group
PA-DDU	Paediatric and Adolescent Oncology Drug Development Unit
PBT	Proton beam therapy enables a dose of high energy protons to be precisely targeted at a tumour, reducing the damage to surrounding healthy tissue and organs
PCBC	Pre-consultation business case
PDC	Public dividend capital
PFI	Private finance initiative
PICU	Paediatric intensive care unit (children's intensive care unit)
PLICS	Patient level information and costing systems
POSCU	Paediatric oncology shared care unit (also referred to as children's cancer shared care unit)

PPV	Patient and public voice
PSED	Public Sector Equality Duty
PTC	Principal Treatment Centre
PUBSEC Index	Public Sector Building Non-Housing Index
RCPCH	The Royal College of Paediatrics and Child Health
REF	Research Excellence Framework
RIBA	Royal Institute of British Architects
The Royal Marsden	The Royal Marsden NHS Foundation Trust
RNOH	Royal National Orthopaedic Hospital
SFBC	Short form business case
SLA	Service level agreement
SME	Subject matter expert
SOC	Strategic outline case
SOCNI	Statement of Comprehensive Net Income
Spell (admitted patient care)	A stay in hospital from admission to discharge is called a 'spell' and can be made up of one or more episodes of care.
Specialty code	Specialties are divisions of clinical work which may be defined by body systems.  Each consultant should be assigned a specialty by the organisation with which they are contracted
SGUH, SGH, or St George's	St George's University Hospitals NHS Foundation Trust, which St George's Hospital is part of
SRS/SRT	Stereotactic radiosurgery and stereotactic radiation therapy – forms of radiation that can precisely target high-dose radiation.
SSQD	Specialised Services Quality Dashboard

South Thames	South Thames is the name given by some NHS services to the area covered by the Children's Cancer Principal Treatment Centre: Brighton and Hove, East Sussex, Kent, Medway, south London, and most of Surrey.
STPN	South Thames Paediatric Network
STRS	South Thames Retrieval Service
Surgery case load	Inpatient activity which has required the use of theatre time
SUS	The Secondary Uses Service (SUS) is the single, comprehensive repository for healthcare data in England
TACRI	Translational and Clinical Research Institute
TFC	The Treatment Function Code (TFC) is the service under which the patient will be or is treated.
TUPE	Transfer of Undertakings (Protected Employment) regulations
TYA	Teenage and young adult
UKONS	UK Oncology Nursing Society
ULEZ	Ultra low emission zone
University College London Hospitals	University College London Hospitals NHS Foundation Trust, which runs University College Hospital
VAT	Value added tax
VfM	Value for money
WTE	Whole time equivalent

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## Note about this document

This decision-making business case has been written by the Joint NHS England London and South East Regional Principal Treatment Centre Programme team. Its purpose is to enable the leaders of NHS England (London and South East regions) to take an informed and evidence-based decision about the location of the proposed future Principal Treatment Centre for children with cancer who live, or use children's cancer shared care units, in its designated catchment area of Brighton and Hove, East Sussex, Kent, Medway, south London and most of Surrey, including the future location of conventional radiotherapy services for these children.

It is a technical and analytical document, written at a point in time, and its contents reflect information (including sources and references accessed) as of the date of publication.

When this document uses the term 'we', this is referring to the Joint NHS England London and South East Regional Principal Treatment Centre Programme team.

To make this document easier to follow, we have used an alphabetical approach to the presentation of both the list of places in the catchment area of the Principal Treatment Centre, and to information about the two options. We do not refer to the current service in alphabetical order. This reflects the approach taken in the pre-consultation business case. There is a glossary to assist with complex terminology.

When we refer to the future Principal Treatment Centre, we are referring to the future service that will be compliant with the national service specification for children's Principal Treatment Centres and will be either at Evelina London Children's Hospital (Evelina London) or at St George's Hospital. When we refer to the current Principal Treatment Centre, we are referring to the Children's Cancer Principal Treatment Centre services currently provided by The Royal Marsden and St George's Hospital working in partnership.

Teenage and young adult cancer services are also led by a Principal Treatment Centre. When we talk about these services, we distinguish between the Children's Cancer Principal Treatment Centre and the Teenage and Young Adult Cancer Principal Treatment Centre. All other references should be understood as referring to the Children's Cancer Principal Treatment Centre.

When we talk about transition in this document, we are mainly referring to service transition, which is the phase between the decision being made and the service beginning to move to its future location (at which point the implementation phase begins). Our governance also references programme transition, which will be when responsibility for delivery of the programme passes from commissioners to the future provider.

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When we talk about cancer surgery in this document, unless specified otherwise, we are not referring to bone, eye or liver cancer surgery or cancer-related neurosurgery which will continue to be provided at specific hospitals, as happens now.

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## Executive Summary

**Very specialist cancer treatment services – like those provided at The Royal Marsden - must be on the same site as level 3 children’s intensive care unit and other specialist children’s services. This is not currently the case.**

NHS England regions are responsible for commissioning specialised cancer services for children from Principal Treatment Centres in England, there are 13 across England. Principal Treatment Centres undertake the diagnosis of and direct the provision of treatment for children with cancer aged 0 to 15 years, working in partnership with children’s cancer shared care units, local specialist cancer services and other specialist services. The principle underpinning children’s cancer services is that care must be age-appropriate, safe, effective and delivered as locally as possible.

Several national standards and guidelines about the appropriate design of specialist children’s cancer services have been developed through clinically-led processes, approved and published. They state that very specialist cancer treatment services for children – like those at The Royal Marsden NHS Foundation Trust’s Sutton site – must be on the same site as a level 3 children’s intensive care unit and other specialist children’s services. In 2019, NHS England held a national consultation on a draft service specification for these services. In response to the feedback to this consultation and following a further review by the former National Cancer Director, the national service specification for children’s Principal Treatment Centres, which was published in 2021, made it a mandatory requirement for them to be on the same site as a level 3 intensive care unit.

The current Principal Treatment Centre cannot meet this requirement. The Royal Marsden in Sutton leads and coordinates systemic cancer treatment for children (chemotherapy, radiotherapy and bone marrow transplants), while level 3 intensive care services that can give life support, most cancer surgery and other specialist services needed by children with cancer are at St George’s Hospital, Tooting. Every year, a small number of very sick children who need intensive care are transferred eight miles from The Royal Marsden to St George’s Hospital’s children’s intensive care unit. Such transfers are done as safely as possible but, even in a special children’s ambulance with an expert team on board, add avoidable risks, and stress, to what is already a very difficult situation. While the current service arrangement continues, underlying risks remain and can only ever be mitigated. Our proposals remove these risks and deliver on-site access to more of the services that children with cancer need, enabling more holistic care. They will create a future children’s cancer centre which is capable of giving cutting-edge treatments that can only be offered if a children’s intensive care unit is on site.



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## **NHS England has undertaken a consultation on two options that are consistent with the national service specification**

NHS England London was tasked by the NHS England Board with identifying and commissioning a Principal Treatment Centre for children with cancer living in south London and much of south east England which is on the same site as a children's intensive care unit and other specialist children's services.

Between 26 September and 18 December 2023, following an extensive period of pre-consultation, we undertook a consultation on two options for the future Principal Treatment Centre, that it is either:

- at Evelina London, Lambeth, south London, with conventional radiotherapy services at University College Hospital
- or
- at St George's Hospital, Tooting, south London, with conventional radiotherapy services at University College Hospital.

**Evelina London** is a purpose-built specialist children's hospital. In 2019/20 it treated almost 120,000 young patients living in Kent, Medway, south London, Surrey and Sussex. All the staff are experts in children's care. They have very broad and in-depth expertise and experience in children's clinical care, including intensive care and surgery.

**St George's Hospital** is a large teaching hospital that provides specialist care for adults and children. In 2019/20 it treated almost 60,000 children, mainly living in south west London, Surrey and Sussex. All its children's service staff are experts in children's healthcare. It has 25 years experience of caring for children with cancer as part of the current Principal Treatment Centre.

Under both options, conventional radiotherapy is proposed to be delivered at University College Hospital, bringing together all radiotherapy services (conventional, as well as proton beam and other types) on one site, instead of two as now.

### **Based on the pre-consultation options evaluation, Evelina London was our preferred option for the future Principal Treatment Centre**

We undertook a rigorous process to evaluate the two options, looking at four high level domains or key areas for the future Principal Treatment Centre. Advisory and working groups and other experts advised us, including an independent Clinical Review Group. More than 30 experts sitting as four panels of up to 10 people – one for each of the domains – assessed and scored the options.

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The scoring was underpinned by a weighting process, in which the most important domains for the future service were weighted so they would get a higher percentage of the scores.

Both options scored highly in our pre-consultation evaluation, but overall, Guy's and St Thomas' NHS Foundation Trust's proposal on behalf of Evelina London scored higher than St George's University Hospital NHS Foundation Trust's proposal on behalf of St George's Hospital (80.5% compared to 75.3%).

Guy's and St Thomas' proposal scored higher on three of the four sub-criteria for clinical services area (Evelina London's network effectiveness, the number of interdependent services it has on site, and its support for children moving on to teenage and young adult services) and on all three sub-criteria for research (people, place, and capability and performance). St George's proposal scored higher on two of the five sub-criteria for patient and carer experience (the quality of facilities it would provide (specifically, privacy and dignity), and patient travel times, especially by road). Other scores were the same or very similar.

On this basis, going into the public consultation, Evelina London was our preferred option for the future Principal Treatment Centre. The consultation was undertaken with an open mind.

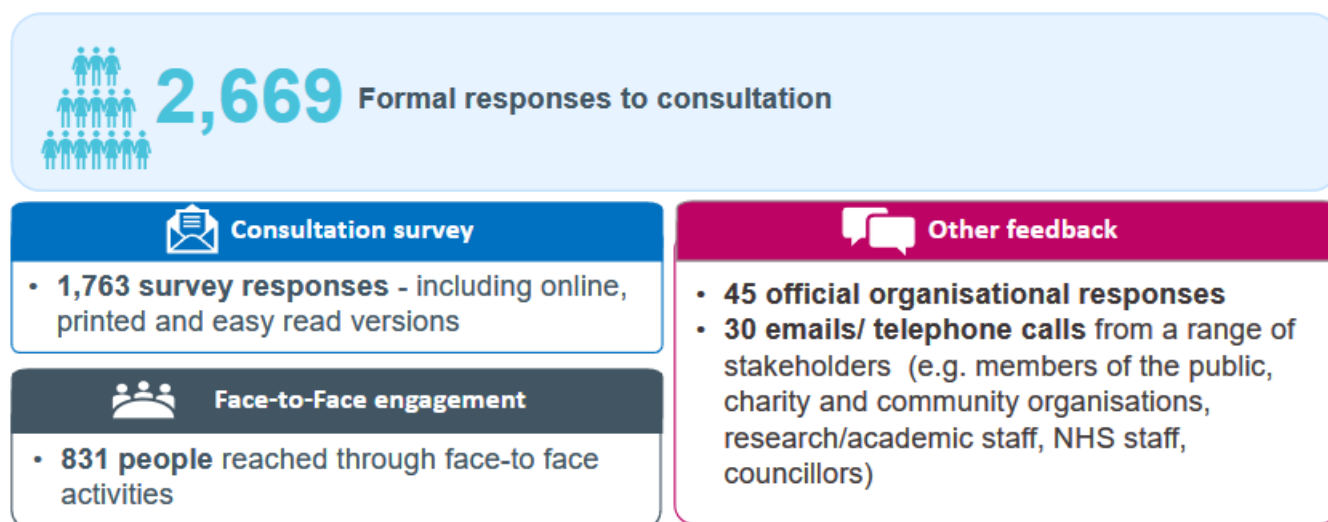
### **The consultation provided valuable feedback on considerations for the future Principal Treatment Centre**

The 12-week public consultation on the future location of very specialist cancer treatment services for children who live in south London and much of south east England, between 26 September 2023 and 18 December 2023, was open to all. However, in line with the consultation plan, we targeted specific stakeholder groups which were identified by the Integrated Impact Assessment as likely to be impacted by the proposed move of services. These included groups directly impacted such as children, young people and families with direct experience of cancer; affected NHS staff; other key stakeholders including other NHS staff, children and families with related experience, professional bodies, children's charities, research organisations and local government; and those with protected characteristics or living in the most deprived areas.

We worked closely with a range of partners to carry out the consultation activities and analyse the responses, providing independent analysis and support.

At least, 604,895 prompts were sent to organisations and individuals to raise awareness of the consultation and encourage people to share their views. We received 2,669 formal responses to the consultation, as highlighted in the figure below.

Figure 1: Consultation responses



Explain Market Research conducted an independent analysis of all feedback received during the consultation period and wrote the consultation feedback report, which was published on 31 January 2024 on our consultation website, and is included in Appendix 2.

The main purpose of the consultation was to understand what attributes matter most to people for the future Principal Treatment Centre, their views on the good points and potential challenges of both options and on our radiotherapy proposals including what would improve the challenges. We also asked for feedback on travel and access, and on information and support needs for patients and staff.

A number of themes emerged. Feedback across different stakeholder groups about the options was broadly consistent, highlighting similar strengths and potential challenges for both options. Concerns were voiced for both about travel and access, the recruitment and retention of staff, and the potential impact of the move on research and clinical trials. There were also concerns on some aspects of the proposed move of conventional radiotherapy services. Many of these themes are consistent with areas identified in pre-consultation public engagement and the interim Integrated Impact Assessment.

Although we did not specifically ask for feedback about the case for change, some people took the opportunity to voice their views. There was a notable divide between the views of clinicians and NHS and professional organisations, which strongly supported the need for the reconfiguration, and those of families with cancer and members of the public, many of whom argued for children's cancer services to stay at The Royal Marsden. The #HeartheMarsdenKids petition, which was set up by parents, argued for a risk-adapted solution, which would preserve the current services at The Royal Marsden and St George's but change which patients are seen where.

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Key findings of the independent consultation feedback report (Appendix 2) are quoted below.

- “The consultation successfully engaged stakeholders,” hearing from “a diverse range of people across stakeholder types, ages, ethnicities, socio-economic groups, and geographical areas in the catchment area for the future Principal Treatment Centre.”
- The most valued attributes for the future Principal Treatment Centre were “the provision of all or most specialisms and services needed for children’s cancer care on a single site, as well as having a specialist knowledge and experience of children’s cancer care.”
- “Overall, the feedback received on the proposals was mixed. There were strong views on the benefits and challenges of both options, including the proposal to move conventional radiotherapy to University College Hospital.”
- “Travel to and accessibility of the future Principal Treatment Centre was a very important topic for respondents across all stakeholder groups.”
- “Alternative proposals were put forward by a small number of respondents.”

Feedback was not specifically sought in relation to a preference on the options. Some respondents used the consultation as an opportunity to express a preference. However, the consultation feedback report does not conclude that there was consensus on a preference.

### **We have considered consultation feedback and other relevant information through the development of this decision-making business case**

To address the key consultation themes and additional evidence that has been identified since the options evaluation, we used this process, set out in our framework for review of information:

- Assess whether the information from consultation/other sources is new or has been previously considered.
- If it is not new, consider its impact on implementation.
- If it is new, assess whether it impacts our understanding of the differences between the options.
- If it impacts our understanding of the differences between the options, consider the nature of that impact, and whether further steps are required.

Among the information we looked at was evidence highlighting mitigations or enhancements for either option that would need to be managed through implementation. Within Section 7 of this decision-making business case, we have responded to concerns and feedback raised through consultation across 10 themes including 27 sub-themes. Table 65: Consultation themes and actions to address presents ‘You said, we did’ feedback for all 10 themes. This includes how we

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have listened to children and young people, their families and staff alongside other people and organisations who took the time to respond to our consultation. Feedback is reflected in our recommendations for implementation as well as our consideration of the options for the future location of the service.

### **Through the consultation and other sources, new information has arisen for the consideration of decision- makers**

Evidence that has been identified as 'new information' is summarised below for the consideration of decision-makers.

#### **Theme 1: Clinical model**

**Interdependent services:** New information has increased our understanding of mitigations for interdependent services that will not be on site, depending on the option that is chosen as the location of the future Principal Treatment Centre, particularly neurosurgery. Mitigations would be needed for neurosurgery if the future Principal Treatment Centre was at Evelina London, which does not provide neurosurgery. Interdependent services formed part of our pre-consultation options evaluation; the information does not differentiate further between our understanding of the options.

#### **Theme 2: Patient pathways**

**Transition from children's services to teenage and young adult services:** Consultation feedback has strengthened our awareness of the risks of the reconfiguration to the process to support children moving on to teenage and young adult services, emphasising the importance of managing this during implementation. Impacts on The Royal Marsden's Teenage and Young Adult Principal Treatment Centre are likely to be similar regardless of which provider is selected as the future Children's Cancer Principal Treatment Centre. Our evaluation of the options looked at how both options currently support children and young people to move on to teenage and young adult services. This does not differentiate further between our understanding of the options.

#### **Theme 3: Travel and access**

**Travel times and costs:** We understand that families are concerned about the costs of travel. We have analysed the costs of driving to both potential sites for the future Principal Treatment Centre and to University College Hospital. Travel costs analysis shows both options cost less to get to than The Royal Marsden by car, on average, with the average journey being £2-3 cheaper. Travel to University College Hospital is about the same. However, there is variation across patient journeys and some families would see travel costs increase, some substantially. The reduction in average driving costs is slightly greater for St George's Hospital. This does not

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impact on our understanding of the differences between the two options as we already understood from the pre-consultation options evaluation that travel by car was likely, on average, to be quicker to St George's Hospital and this finding is in line with that.

**Impact of reconfiguration on equality groups – travel times and costs:** We understand that people are concerned about the impact of travel and access on equality groups. New analysis has been undertaken of driving times and costs for socio-economic groups and ethnic groups. Analysis shows that although driving times increase on average for all groups for both options and to University College Hospital compared to current journeys, the increase is less on average for ethnic groups other than white than for white ethnic groups. Analysis of driving costs shows that although, like now, they remain higher for the most deprived population than the whole population, the reduction in cost to both options and University College Hospital is greater for people travelling from more deprived areas than for the area as a whole. This indicates that the change could improve ability to access services for these populations. The reduction in average driving costs for the most deprived population is slightly greater for St George's Hospital. This does not impact on our understanding of the differences between the two options as we already understood from the pre-consultation options evaluation that travel by car was likely, on average, to be quicker to St George's Hospital and this finding is in line with that.

**Sufficiency of on-site accommodation:** We understand that it is important for families to have access to accommodation close to the Principal Treatment Centre. We have received new information on the level of Ronald McDonald House provision at each site and arrangements for payment for family accommodation. While both options have Ronald McDonald capacity, St George's Hospital has a much smaller facility than Evelina London, although it is recognised that this benefit for Evelina London is likely to be offset by higher demand. Both potential providers have access to alternative accommodation which is used to support excess demand. This isn't differentiating on current information. Further consideration and development of accommodation plans and mitigations are reflected in our recommendations for implementation.

#### **Theme 4: Workforce sustainability**

No new information has been identified for workforce sustainability; however consultation reinforced our understanding that:

- There will be a time and cost impact of the changes on staff – while a systematic public transport cost analysis across the entire staff cohort is not possible, illustrative journeys indicate that the costs of travel are likely to be greater for the majority of staff than their current travel costs. Under TUPE protections, relocated staff will be eligible to receive

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support for excess costs for up to four years (claims will be reviewed by the future provider on a case by case basis) and will also receive inner London high cost area supplement.

- There will need to be robust retention, training and recruitment plans to ensure the wide range of skills and competencies required to provide high quality care for patients of the Principal Treatment Centre, both before and after service transition, are available.

We have detailed recommendations in place to address these, and other concerns regarding workforce sustainability during implementation. This does not differentiate further between our understanding of the options.

## Theme 5: Radiotherapy

**Arrangements for radiotherapy:** We considered potential risks of the proposed relocation of conventional radiotherapy services before the public consultation; concerns raised in public consultation have prompted us to gather extra information from University College London Hospitals NHS Foundation Trust (University College London Hospitals) to provide further assurances over how these would be managed. Both potential providers propose that conventional radiotherapy is provided at University College Hospital and this information does not differentiate between the options. We acknowledge that there are some important travel impacts associated with our proposal that will need to be managed through the service transition and implementation phases. University College London Hospitals already provides proton beam and superspecialist radiotherapy for the current Principal Treatment Centre and conventional radiotherapy for others, it would provide the full range of radiotherapy treatments for the future centre with a range of associated benefits.

## Theme 6: Impact on other services

**Impact on mIBG (meta-iodobenzylguanidine) therapy:** arrangements for provision of this therapy (currently provided at The Royal Marsden) for a small number of children with cancer from across the country were raised through consultation. Like radiotherapy, considerations for mIBG therapy are needed irrespective of the location of the future centre. Besides The Royal Marsden, the only other centre in England which provides this service is University College Hospital.

**Potential impact on Great Ormond Street Hospital:** Concerns were raised through consultation around recruitment and retention challenges at Great Ormond Street Hospital if the future Principal Treatment Centre is located closer, with a perception the impact could therefore be greater if the future centre was at Evelina London. Potential impacts on services at Great Ormond Street Hospital would be kept under review during the service transition and implementation phases. At this time the risk is not considered to be significant in the context of



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workforce mitigations identified. Great Ormond Street Hospital for Children NHS Foundation Trust is supportive of the case for change and of the development of a joined-up workforce strategy with the future Principal Treatment Centre. Given this risk is not significant, and clear mitigations are identified, this does not differentiate further between the options.

## Theme 7: Estates and facilities

**Ensuring appropriate physical capacity:** New information has been shared providing assurance that both potential providers could expand capacity should baseline assumptions change. Further work with University College London Hospitals has re-confirmed that there would be a range of options to meet demand arising from our proposals, which was a concern of the consultation. If a need is determined, we are assured that there would be a solution for additional LINAC capacity (LINACs are the machines that deliver radiotherapy). This would be agreed during the transition phase. This does not differentiate further between the options as both Evelina London and St George's Hospital have demonstrated adequate capacity, and in both options, radiotherapy will be provided at University College Hospital.

**Estates solution:** The proposed location for the Evelina London option was updated in April 2023, following the options evaluation, and was reflected in the pre-consultation business case. Evelina London's proposal is for the children's cancer ward to be on the third floor of the main children's hospital building. Benefits would be associated with the centre being within the Evelina London footprint. This space is currently being used by other clinical services with the impact that a series of four decants would be required. Guy's and St Thomas' has provided mitigations for this, including staggering of decants and construction work, alongside robust programme management. The capacity and facilities offered in the updated estates solution is the same as assessed at options evaluation. This information doesn't materially impact our understanding of the options.

St George's proposed option remains unchanged. In the future, St George's would have a new children's cancer centre in a converted wing of the hospital with its own entrance. The centre would include the inpatient ward, outpatient clinics and day case treatments. Consultation feedback highlighted benefits of these proposals and also considerations around the wider hospital environment.

In response to consultation feedback around the configuration of proposals for Evelina London's proposed cancer centre, the Trust has developed plans to demonstrate it has flexibility on the configuration of ward space and also for outpatients accommodation. The final configuration would be confirmed during the service transition phase if Evelina London was the future Principal Treatment Centre.



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## Theme 8: Research

**Research capability and capacity:** Concerns were raised about the potential impact of reconfiguration on research capacity and capability, echoing pre-consultation engagement. Both providers had previously set out their mitigations and we have also worked with The Royal Marden and the Institute of Cancer Research to consider these. New information about a potential merger between St George's, University of London and City, University of London was provided by St George's. We note this reflects potential opportunities for St George's to broaden its research platform (including in areas such as computer science and engineering, among others) but do not, at the moment, have evidence to suggest this would have a material impact on our understanding of the options.

There are no changes to the Evelina London research offer since pre-consultation evaluation of the options.

## Theme 9: Strength of case for change

No new information was identified. We have set out consultation feedback about the case for change and responded to alternative solutions that were raised in consultation.

## Theme 10: Deliverability

The financial impact assessment confirmed that both options remain affordable in terms of revenue and capital. Both potential providers propose to refurbish existing space within their hospitals to create dedicated areas for children with cancer to be cared for. Work to develop the future Principal Treatment Centre would use £20 million national capital contribution from NHS England plus a contribution from their local health commissioners, of circa £11 million to £14 million. The Evelina London option would also use £10 million of grant funding from the Trust charity.

Both proposals for the future location of the Principal Treatment Centre have been costed and remain subject to robust financial scrutiny. Recurrent capital and revenue affordability have been tested and assured at an appropriate level within the pre-consultation business case. Both Trusts have provided reasonable sensitivity analyses showing how downside income and cost scenarios would be managed. This business case outlines a commitment to fund non-recurrent stranded and transitional costs.

## Summary of information review

As we have noted above, any new information has been considered specifically in the light of whether this differentiates the options as compared to previous assessments. As summarised

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above and set out in Section 7, while some information is new, it has not materially differentiated the options further than at the pre-consultation options evaluation. All the information set out above is material to implementation and will be very useful for the provider of the future Principal Treatment Centre.

**The Integrated Impact Assessment has identified a number of potential impacts of the reconfiguration, these would need to be managed and mitigated during service transition and implementation phases**

As part of understanding the impact, we have conducted an Equality and Health Inequalities Impact Assessment (EHIA) to assess the potential impact of this programme on population groups with a protected characteristic, or who face health inequalities. This provides information about the potential positive and negative impacts of proposed changes to services particularly in regard to travel and access, alongside a set of potential mitigations that may help to address some of the areas identified. Post decision, a Travel and Access group will be established with representatives across providers and NHS England to implement the recommendations set out within the Integrated Impact Assessment.

Consultation reiterated the importance of considering impacts on other services, as such we have re-visited these as part of our work to prepare this business case. Other than information listed above, we have not identified any 'new' impacts on other services that were not considered pre-consultation.

We and our partners in Integrated Care Boards are committed to working with affected and potentially affected organisations to ensure impact is either avoided or minimised and/or mitigated through the transition and implementation phases. In addition, governance mechanisms to consider and agree stranded and transitional costs for impacted parties would be established.

In considering the proposals from both Guy's and St Thomas', and St George's, the environmental impact in relation to capital build and transport access has been initially assessed and summarised. Both Trusts have published environmental strategies which detail how they will support the national NHS commitment to delivering a 'net zero' health service.

**Appropriate assurance and guidance has been sought throughout the process**

At the pre-consultation stage, our proposals were scrutinised by:

- the London and South East Clinical Senates
- NHS England assurance

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- the South East London, and South West London and Surrey Joint Health Oversight and Scrutiny Committees which see our proposals as a substantial change for their residents and who latterly responded formally to our consultation.

We have undertaken further work since the consultation:

- updates to our Integrated Impact Assessment
- to re-visit the London and South East Clinical Senates' joint recommendations
- consideration of feedback from the Joint Health Overview and Scrutiny Committees (JHOSCs) and Health Overview and Scrutiny Committees (HOSCs)
- consideration of feedback provided by the London Mayor about potential impacts on Londoners.

Our Integrated Impact Assessment has been updated to include further analysis of different aspects of travel and costs including the impact on people of different ethnicities, largely set out above, and mitigating actions from consultation responses which had not previously been identified.

Responses to the London and South East Clinical Senates' 30 joint recommendations were included in the pre-consultation business case. Further updates (Appendix 3) have now been made to incorporate our consideration of consultation feedback and a further evidence review. These updates include:

- review of workforce plans to ensure a smooth transfer for staff
- review of plans for children moving on to teenage and young adult services
- further assurances and sensitivity testing for provider capacity

South East London JHOSC's formal response indicated that their conclusion was non-unanimous in terms of the two options presented but, by significant majority and based on the evidence presented and considered, the Committee's preferred option is for Guy's and St Thomas' NHS Foundation Trust's Evelina London Children's Hospital to be the future location of the Principal Treatment Centre.

The unanimous view of the South West London and Surrey JHOSC, and its Sub-Committee in their formal consultation responses was that, should the service be required to move, St George's Hospital would be their preferred option.

The committees for the other local authorities across the catchment area were engaged with and kept informed, as requested.

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The Mayor of London has developed six tests to apply to major health and care transformation and reconfiguration programmes. The Mayor provided feedback on proposals including whether the changes were equitable, transparent and in the best interest of all Londoners which we have considered. The Mayor's response has also informed our recommendations for implementation.

### **Considerations for Implementation**

We recognise that both options will require focus in a number of areas in order to enable a smooth transition; some of these areas have also been highlighted through the consultation and have informed our recommendations (set out below):

- planning and undertaking building work to refurbish existing space for the future centre
- developing and implementing detailed action plans to address concerns around travel and access,
- maintaining the current levels of research activity
- supporting as many staff as possible from the current service to move to the future centre
- developing clear patient and family information on the new services, how and when to access them as part of the implementation plan
- putting everything in place for a safe, smooth transfer of patient care.

### **Leaders for NHS England (London and South East regions) are asked to consider a number of resolutions**

The ambition of the decision-makers for this reconfiguration is to identify the option that gives them the greatest confidence that it will deliver the best quality care for children with cancer for decades to come. The process we have undertaken over the past three years has sought to gather the information that is most relevant to this decision.

The pre-consultation options evaluation identified that we have two viable options for the future location of the Principal Treatment Centre – both scored highly but the Evelina London option scored more highly. Both options would meet the national service specification and crucially would co-locate very specialist cancer treatment services with a level 3 children's intensive care unit, giving children with cancer on-site access to a greater range of specialist paediatric services.

As reflected in the evaluation scores, both options have strengths; and we are fortunate to have two good options to choose from.

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- As a specialist children’s hospital, Evelina London is the largest provider of specialist children’s services in south London, including tertiary heart and kidney services, and its staff have in-depth expertise and experience in children’s clinical care, including intensive care. Evelina London scored most in the clinical and research domains.
  - As part of the current Principal Treatment Centre, St George’s Hospital provides all the intensive care, most cancer surgery and other specialist children’s services for the current centre. It has 25 years experience of caring for children with cancer working with The Royal Marsden. Its children’s services staff are experts in children’s healthcare. St George’s Hospital scored most in the patient and carer experience domain.

During public consultation we had over 2,650 responses from families, staff, other stakeholders and organisations providing feedback on our proposals. This is valuable feedback and has informed the development of this decision-making business case.

As part of developing this decision-making business case, we have been through a defined process, underpinned by a clear framework for review of information that was agreed by the NHS England London and South East Region Executive Teams, to consider consultation feedback and additional evidence. Throughout our consideration of this information, the initial question has been whether the information is new and, if so, whether it has a material impact on our understanding of the options, and specifically the differences between them. ‘New’ information is information that emerged after completion of the pre-consultation evaluation of the options.

In the majority of cases, the consultation feedback and additional evidence has reinforced our knowledge of information previously considered or it has provided clarification or additional detail. It has also informed the identification of mitigations for the service transition phase and recommendations set out below. **Following consideration, new information provided, summarised above, is not considered to have had a material impact on our understanding of the options for the future location of the Principal Treatment Centre.**

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**On the balance of information reflected in this business case, decision-makers for NHS England London and South East regions are therefore asked to consider the following resolutions:**

1. To agree that, if chosen and implemented as the future Principal Treatment Centre, either option under consideration could meet the national service specification for Children's Cancer Principal Treatment Centres, issued by NHS England in November 2021.
2. To agree that the future location for the Principal Treatment Centre should be Evelina London Children's Hospital.
3. To agree that conventional (photon) radiotherapy services for the future Principal Treatment Centre will be delivered by University College London Hospitals NHS Foundation Trust at University College Hospital.
4. To agree and adopt the recommendations (set out below) that will support the smooth transfer of services, enable continuity of care for patients and deliver the benefits of the clinical model.
5. To establish a London and South East Implementation Oversight Board (including patient and public voices, and independent representation) to oversee the service transition and monitor the delivery of the recommendations throughout implementation.

**As part of decision-making, key recommendations for implementation have been developed.** These reflect the need for a number of risks to be mitigated during the service transition phase and will help ensure that services for children with cancer provided at the future centre build on the strengths of the current service, meet the national service specification with all the benefits that brings, and give best quality care to achieve world-class outcomes for decades to come.

Table 1: Recommendations

Theme	#	Subtheme	Recommendation
Clinical model	1	Benefits	Further development of plans for the future Principal Treatment Centre should focus on delivering and maximising benefits associated with the reconfiguration. Monitoring of benefits realisation and of clinical outcomes/service standards through resources such as the Specialised Services Quality Dashboard (SSQD) should form part of the oversight framework (described in Section 10.1). This should be owned by the future Principal Treatment Centre.
	2	Mandatory services	Future Principal Treatment Centre to ensure that, prior to the current services transferring, detailed planning and service development work is undertaken to deliver mandatory services to the standard set out in the National Service Specification as a minimum, with consideration for 'future proofing' services to meet changing demand. This is expected to be done in partnership with clinicians and experts currently providing these services as well as patients and families.
	3	Neurosurgery	Irrespective of the decision, further consideration of specific neurosurgery arrangements would be needed to optimise pathways for patients of the future Principal Treatment Centre and ensure good patient experience.
	4	Interdependent services - on site	Appropriate capacity and resilience needs to be in place for all aspects of care for interdependent services to support the delivery of care to future Principal Treatment Centre patients; more detailed service planning will need to be carried out by the future Principal Treatment Centre during the service transition phase.

Theme	#	Subtheme	Recommendation
	5	Interdependent services - off site	Clear patient pathways and targets for access to these services need to be set out prior to implementation, with appropriate mitigations in place for when patients need to be transferred. The future provider (supported by the wider system) should work collaboratively across the system to design patient pathways that minimise transfers.
	6	Networking	The future provider should focus on the development of effective networking arrangements with providers across the networks, most importantly paediatric oncology shared care units (POSCUs) across the Children's Cancer Operational Delivery Network. This will support continuity of care and the development of effective communication approaches as well as the transformation programme associated with the delivery of the national service specification for POSCUs. Where there are opportunities to align governance and deliver synergies through the two programmes of work, these should be explored.
Patient pathways	7	Teenage and Young Adult transition arrangements	Effective transition from the Children's Cancer Principal Treatment Centre to the Teenage and Young Adult Cancer Principal Treatment Centre must be considered during service planning. The future provider should work in close collaboration with The Royal Marsden and wider network, with input from patients, parents and carers, to agree how pathways can be optimised with a particular focus on the 16 to 18 age group. The Implementation Oversight Board should monitor progress and support any barriers to be addressed.
	8	Impact on Teenage and Young Adult services	NHS England and Integrated Care Boards to continue to work with The Royal Marsden and other stakeholders to support ongoing sustainability of the teenage and young adult service at Sutton, including through the provision of stranded costs.



Theme	#	Subtheme	Recommendation
Travel and access	9	Parking	Parking possibilities must be available for patients and carers at the future provider and University College London Hospitals, and they must be easily accessible from the hospital. Processes around payment must be easy to understand and accessible (catering for families experiencing digital exclusion and available in inclusive formats).
	10	Hospital transport	Alternative methods of patient transport to and from hospital should be provided and its performance monitored (e.g., reliability of timing) by the provider of the future Principal Treatment Centre and University College London Hospitals.
	11	Equity of access	The provider of the future Principal Treatment Centre and University College London Hospitals should ensure that accessibility arrangements meet the needs of equality groups (for example, cost reimbursement for those experiencing financial difficulties, translation and inclusive communications for those that require it or reasonable adjustments for those with disabilities) and are regularly monitored against equality frameworks.
	12	Children's cancer shared care units	The provider of the future Principal Treatment Centre should work with the Children's Cancer Network to support the development of plans and model of care within paediatric oncology shared care units so that all children and young people have the same experience of care, delivered close to home whenever this is possible.
	13	Travel and accommodation costs	The future provider and University College London Hospitals should further consider mechanisms to support families or staff who can't pay for travel costs or hotel accommodation, such as easier access to automatic reimbursement mechanisms or collaboration with local hotels if appropriate.

Theme	#	Subtheme	Recommendation
Workforce	14	Risks to current workforce	The Implementation Oversight Board should continue to develop mitigations and contingency plans for the potential changing profile of the existing workforce (for example, if fewer staff are retained than expected, fewer staff transfer or staff resign), monitoring resilience and support delivery of the current service. Where needed, identify mitigating actions to ensure that the services can continue to deliver high quality care.
	15	Supporting staff to transfer	As a high priority, the future provider should support retention of the current workforce, including through clear and timely communications, close engagement and providing assurance about future arrangements. Salary and benefits should also undergo a clear impact assessment, with financial mitigations provided where possible.
	16	Integration and organisational development	The future provider should work with The Royal Marsden (and St George's if applicable) to develop an organisational development strategy to preserve and support the transfer of organisational memory, key skills, and competencies and support integration of multiple teams. Ensure staff working in the future Principal Treatment Centre receive equivalent benefits, with appropriate onboarding processes, organisational culture and values integration, and buddying processes between staff.
	17	Workforce strategy	A workforce strategy should be co-developed between organisations and collaboratively with support from the wider network, aligned to regional workforce strategies. This should be developed through the workforce workstream, with staff and HR representation, and should include detailed training and education plans (including engagement with relevant leads for training posts in service), as well as recruitment and retention plans.

Theme	#	Subtheme	Recommendation
			The Royal Marsden to work with the future provider to consider value of @Marsden model as a vehicle for continuity, collaboration and making best use of available skills and expertise.
	18	Workforce planning	The future provider should develop a detailed workforce modelling baseline and plan, against competencies required to deliver the Principal Treatment Centre and recruitment and retention gaps. They should also carry out a mapping exercise to determine any gaps or new roles that will be required to deliver the services with the appropriate workforce as part of transition planning.
Radiotherapy	19	Radiotherapy	The future provider should work closely with University College London Hospitals, The Royal Marsden, commissioners, and other stakeholders to develop detailed patient pathways, capacity and resourcing plans for conventional radiotherapy services, drawing on the experience of providing care for patients from other Principal Treatment Centres.
Impact on other services	20	Working with organisations	The future provider, along with NHS England, Integrated Care Boards and other system partners should work with organisations/services which could be impacted by Principal Treatment Centre reconfiguration to ensure that risks are monitored so that mitigations can be identified in a timely way, including through collaborative working and existing networks.
Capacity	21	Sufficient capacity and resource	Sufficient capacity for beds, theatres, and clinical support services should be in place for Principal Treatment Centre, with potential for future capacity expansion should this be required. Ongoing review of capacity requirements for the future service should take place

Theme	#	Subtheme	Recommendation
			with associated demand/capacity planning and consideration of POSCU transformation, new treatments/therapies and other changes to models of care to enable this.
Estates	22	Estates solution	The estates solution for the future provider should continue to be developed during the service transition phase, with clinical, patient and carer input to the design.
	23	Accommodation and wider spaces	The future provider should develop detailed design work to ensure appropriate space is provided for accommodation, education, indoor and outdoor play space drawing on engagement with patients, carers, staff and wider stakeholders on their needs, in line with advice from the London and South East Clinical Senates.
Research	24	Research	<p>Work closely with the Institute of Cancer Research, The Royal Marsden and other key stakeholders to maintain and support the development of research and access to clinical trials for children and young people. We suggest that a dedicated work programme focused on enabling this through the management of risks is established with support from an Expert Advisory Board.</p> <p>The future provider should also work with The Royal Marsden to explore potential for a @Marsden model as a vehicle for supporting collaboration, continuity of research and clinical trials.</p>
Deliverability	25	Timely delivery to realise benefits	In order to realise benefits of the service change in a timely way it will be important that the future provider of the Principal Treatment Centre works proactively to enable the safe transition of the service in line with plans. Collaborative working with partners will be a key

Theme	#	Subtheme	Recommendation
			enabler to this and should support the development of more detailed plans and business cases informed by and co-designed with staff, patients, families and other stakeholders.
	26	Governance	Work with NHS England/Integrated Care Boards through the identified governance processes to ensure recommendations and mitigations are implemented with necessary support in place. This should include active management of risks including over the transition period and early implementation phase.
	27	Recommendations from the Integrated Impact Assessment	Establish a Travel and Access group with representatives across providers and commissioners to implement the recommendations set out within the Integrated Impact Assessment.
	28	Leadership	<p>Successful change requires strong clinical leadership. To enable successful implementation, clinical leaders from the current Principal Treatment Centre and future provider will need to be identified, developed and supported.</p> <p>Joint roles between organisations are also likely to be an important enabler to effective integration between teams and should be established to support the change process.</p>
	29	Support to families throughout transition	Consideration and plans developed to support families preserve memories and legacies, and support families throughout the transition and implementation period.

Theme	#	Subtheme	Recommendation
	30	Affordability	The future provider should demonstrate capital and revenue affordability of the scheme through development of the outline business case and full business case, with mitigations in place for associated risks.

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## **Arrangements for implementation should now begin to be put in place**

Following decision-making, time will be required to set up and agree governance arrangements and finalise plans to progress implementation. During this time, there will be a phased programme transition during which delivery of the programme will transfer from NHS England to the future provider. We, along with Integrated Care Boards which will have a key role in implementation, will remain involved in the programme in an advisory capacity, also providing assurance and scrutiny of plans and decision-making. A strong governance structure will be required to ensure joint decision-making and collaboration between NHS England/Integrated Care Boards, the future provider, The Royal Marsden and (if it is not the future provider) St George's, and wider stakeholders.

A programme plan has been developed incorporating the key implementation activities to progress plans towards the build stage with the expected service transfer of the Principal Treatment Centre in October 2026. Working in partnership, more detailed plans to enable a safe and sustainable service transition will need to be co-designed.

As with the transfer of any established service, the transfer of the Principal Treatment Centre and its staff brings risks which will need to be carefully managed throughout service transition and implementation phases.

Once the decision is made, we will work closely with staff in the current and future Principal Treatment Centre, patients and their families, all the Trusts involved, the Children's Cancer Network, the Institute of Cancer Research, and other partners to ensure that the move to the future site, wherever it is, is as smooth as possible. All staff involved in the service will have the opportunity to be part of this work. Patients and parents will also be able to help design the new service – the team running the future centre would make sure that people from different groups and communities have the chance to get involved.

Successful change requires strong clinical leadership. Leadership from both the future and current Principal Treatment Centre with support from the wider system will be particularly important during this next phase. With this, our ambition for the future Principal Treatment Centre is for it to build on all the strengths of the existing service, meet the national service specification with the benefits that brings, and give best quality care to achieve world-class outcomes for children with cancer for decades to come.

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## Context and clinical model





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## 1. Background and case for change

### 1.1 Purpose and scope of Decision-making Business Case

The purpose of this decision-making business case is to enable the leaders of NHS England (London and South East regions) to take an informed and evidence-based decision about the location of the proposed future Principal Treatment Centre for children with cancer who live, or use children's cancer shared care units, in its designated catchment area of Brighton and Hove, East Sussex, Kent, Medway, south London and most of Surrey, including the future location of conventional radiotherapy services for these children. The national NHS England Board has tasked NHS England London, working closely with NHS England South East, with ensuring the Principal Treatment Centre for children in this catchment area provides very specialist cancer treatment services for children on the same site as a children's intensive care unit and other specialist children's services. The current service does not do so.

This decision-making business case is based on the evidence compiled in the pre-consultation business case, feedback from the public consultation that was undertaken between 26 September and 18 December 2023, and other relevant information. It considers the feedback and information which came forward during the public consultation, including that from all relevant London boroughs and other local authorities, and which is covered in detail in the consultation feedback report (see Appendix 2). This document will enable decision-makers to ensure that decision-making and subsequent implementation is fully informed by detailed consideration of all relevant information, including the consultation feedback and suggestions for alternative solutions as well as the many different suggestions for making the transition go smoothly which were received through the consultation.

This decision-making business case includes:

- An overview of the feedback NHS England received from patients, parents/carers, NHS staff directly or potentially affected by the proposals and other staff, Health Overview and Scrutiny Committees, public representatives, NHS Trusts, research organisations and many other key stakeholders during our public consultation.
- Information about both options for the proposed future Principal Treatment Centre including our proposal for conventional radiotherapy services. This includes additional information gathered during and after consultation on the benefits and potential impacts on service users of both options and the radiotherapy proposals, along with mitigations for the impacts.

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- Information about the potential impacts on other services of our proposals, along with mitigation for the impacts. This includes additional information gathered during and after consultation.
  - Resolutions for service change for consideration by the decision makers, and associated recommendations for implementation based on all the information gathered during this process.

## 1.2 Intended audiences and their decision-making roles

This decision-making business case has been written by the Joint NHS England London and South East Regional Principal Treatment Centre Programme team. It is intended for:

- The leaders from NHS England (London and South East regions) who, on the basis of the evidence provided, will decide the location of the proposed future Principal Treatment Centre for children with cancer who live, or use children's cancer shared care units, in the catchment area, including the future location of conventional radiotherapy services for these children. NHS England is the statutory body responsible for making a decision on the location of the Principal Treatment Centre.

It may also be of interest to:

- The executive boards of Kent and Medway, South East London, South West London, Surrey Heartlands, and Sussex Integrated Care Boards who support the proposed reconfiguration to deliver compliance with national standards and are committed to supporting the delivery of high-quality cancer services for children and young people across the catchment area.
- The boards of The Royal Marsden NHS Foundation Trust (The Royal Marsden), St George's University Hospitals NHS Foundation Trust (St George's), Guy's and St Thomas' NHS Foundation Trust (Guy's and St Thomas'), and University College London Hospitals so they have full sight of the evidence on which NHS England's decision is based.
- South east London, and south west London and Surrey Joint Health Overview and Scrutiny Committees (JHOSCs), which have determined the proposed changes are substantial for their populations and are being formally consulted with, will scrutinise the final proposals in line with their responsibilities. It may also be of interest to Brighton & Hove Health Overview and Scrutiny Committee (HOSC), East Sussex HOSC, Kent HOSC, Medway HOSC and West Sussex HOSC, which we consulted informally.
- Public and patient stakeholders, including the Stakeholder Group for the programme.

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## 1.3 The process we are undertaking

### 1.3.1 Our responsibility

NHS England regional teams commission specialised services for children, such as the services for children with cancer under consideration in this business case. Although commissioning arrangements are changing, with the commissioning of many specialised services being delegated to Integrated Care Boards (ICBs), there will be no change in the London or South East regions before 1 April 2025. Regardless of delegation status, NHS England will remain the accountable commissioner for the entire portfolio of specialised services and will maintain responsibility for setting consistent national standards, service specifications, and clinical access policies.

### 1.3.2 Background

In November 2021, the new national service specification for Principal Treatment Centres for children's cancer<sup>1</sup> setting out all the different elements that every Principal Treatment Centre in England must provide, was published after being approved by NHS England, following a public consultation in 2019.

The service specification states that very specialist cancer treatment services must be on the same site as a level 3 children's intensive care unit, as well as other specified services needed by children with cancer.

There are clear reasons for this, which are set out in our case for change (Section 1.4 below).

The current Principal Treatment Centre for children with cancer who live in south London and much of the south east is provided by The Royal Marsden and St George's, working in partnership.

The teams leading and coordinating systemic cancer treatments for children, including chemotherapy, conventional radiotherapy and bone marrow transplants, are based at The Royal Marsden's site in Sutton. Life-saving intensive care, most children's cancer surgery, and other specialist services needed by children with cancer are led and coordinated by the teams at St George's Hospital eight miles away in Tooting.

The Royal Marsden's children's cancer consultants lead the overall care for children with cancer who are receiving treatment from the Principal Treatment Centre, even when they are on another site, such as at a shared care unit. If children with cancer are admitted to St George's Hospital (other than to its shared care unit), the children's intensive care unit team or surgical

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<sup>1</sup>[NHS England » Children's cancer services: Principal treatment centres service specification](#)

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team will lead those episodes of care with daily input from The Royal Marsden's children's cancer team.

It is our view, shared by The Royal Marsden, that it would not be clinically or financially sustainable for The Royal Marsden to establish a children's intensive care unit. The South Thames Paediatric Network agreed.

This is because children's intensive care units are always on sites used by tens of thousands of children every year because intensive care teams need to see high volumes of very sick children to maintain their specialist skills and expertise. This would not be possible at The Royal Marsden due to the smaller number of children who need treatment there. It is therefore not possible for The Royal Marsden's children's cancer treatment services to comply with the national service specification. In recognition of this, The Royal Marsden formally confirmed in July 2022 that it would not be bidding to provide the service longer term.

### **1.3.3 Pre-consultation business case**

To develop the pre-consultation business case, the South London and South East Principal Treatment Centre Programme, which was established by NHS England (London region) in partnership with NHS England (South East region), undertook these key processes:

- Development of the clinical model, which implements the national service specification, drawing on the existing expertise in south London (see Section 2 for details of the model).
- Development of the options for a compliant Principal Treatment Centre, by applying fixed points and hurdle criteria to a list of eight possible solutions – this resulted in one solution for a compliant centre, which can be delivered in two ways. These are the two options we consulted on. Full details of how we did this are on our consultation website<sup>2</sup>.
- Development of the evaluation framework through which the proposals submitted for the two options were assessed. The process we followed drew on the expert knowledge and experience of clinicians, managers, parents, charities, staff and research leads, and the views of children and families. Full details of the process and the criteria are on our consultation website<sup>3</sup>.

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<sup>2</sup> <https://www.transformationpartners.nhs.uk/childrenscancercentre/key-information/how-we-identified-options/>

<sup>3</sup> <https://www.transformationpartners.nhs.uk/childrenscancercentre/key-information/evaluation-criteria-development/>

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- Pre-consultation assessment and scoring of the options which was done by four expert panels, one for each of the key areas by which it was agreed the future service options should be assessed. Full details of how this worked are on our consultation website<sup>4</sup>.
  - Public and stakeholder engagement to support development of the pre-consultation business case (described below).

#### **1.4.4 Public and stakeholder engagement**

The Joint South London and South East England Principal Treatment Centre Programme has overseen the Programme which been inclusive, innovative, and constructive in engaging with our internal and external stakeholders. Over this period, we have worked closely with patients, parents/carers, staff, researchers, professionals and other experts. This included pre-consultation engagement which elicited more than 730 responses, and which was written up in a pre-consultation engagement report<sup>5</sup>.

Both early engagement and pre-consultation engagement enabled us to:

- Establish what patients, parents/carers, staff and researchers want from the future service and what their concerns are.
- Develop and weight evaluation criteria for an appraisal of the two options for the future Principal Treatment Centre covering four key areas (clinical services, patient and carer experience, enabling [non-clinical factors], and research).
- Assess and rigorously evaluate proposals for the future Principal Treatment Centre submitted respectively by Guy's and St Thomas' NHS Foundation Trust (Guy's and St Thomas'), on behalf of Evelina London, and St George's, on behalf of St George's Hospital. Each Trust's proposal set out responses to questions about their expertise, experience, skills and plans for the future Principal Treatment Centre, if it were to be at their hospital. As a result of this process, in which the Evelina London proposal scored more highly, Evelina London was the preferred option as we went into consultation.
- Develop the pre-consultation business case, with clinical advice from the London and South East Clinical Senates, and input from the Trusts involved; Integrated Care Boards in Kent and Medway, south London, Surrey and Sussex; Joint Health Overview and Scrutiny Committees and Health Overview and Scrutiny Committees; the Institute of Cancer Research and many other bodies.

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<sup>4</sup> <https://www.transformationpartners.nhs.uk/childrenscancercentre/key-information/how-the-options-were-assessed-and-scored/>

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- Design, test and refine our approach to consultation, including what we did and how we did it.
  - Undertake a comprehensive, wide-reaching public consultation about the options.

### **1.3.5 Consultation**

The consultation on the future location of very specialist cancer treatment services for children living in south London and much of south east England ran from 26 September to 18 December 2023.

Its purpose was to gather people's views on the good points and potential challenges of each option and of the proposals for conventional radiotherapy services, as well as their ideas for making the proposed changes go smoothly. It also welcomed views, questions and any additional information people thought we should know.

#### **Consultation approach**

Our approach to patient, public, and staff engagement for the consultation was multi-layered and targeted to different stakeholder groups to give the best chance of hearing from as many different perspectives as possible. Our communications were also multi-layered and targeted, to meet people's different needs. We received 2,669 responses to the consultation through questionnaire responses, face to face engagement, official organisational responses and emails/phone calls.

We held 115 face-to-face or online sessions. In total, 604,895 different prompts to different organisations and individuals to share their views were sent by post, social media, direct emails, newsletters and other communications channels.

All the feedback also informed the refresh of the Integrated Impact Assessment (IIA) (see Section 8.4 and Appendix 4).

Details about the consultation and more information on the findings are in Sections 5 and 6.

### **1.3.6 Decision-making business case**

This decision-making business case has been informed both by the feedback and evidence received through the consultation and by subsequent work covered in Sections 6, 7 and 9.

#### **Output of consultation**

We commissioned an external company to receive and analyse the consultation data. This was to ensure complete separation from the programme, to give decision-makers, stakeholders and others assurance about the independence and impartiality of the process.

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The independent consultation feedback report<sup>6</sup> [Appendix 2] explains that the consultation heard from a range of stakeholder and equality groups, with good coverage of representation across the geographical regions in the catchment area of the current Principal Treatment Centre.

### **Careful consideration of the consultation findings**

As part of the assurance process for developing the decision-making business case, we reviewed information from the consultation and other sources through a series of working groups. These working groups were made up of subject matter experts from London and South East regions and national teams with expertise in areas pertinent to the reconfiguration including management of clinical services, workforce, operations, data, and travel and access. Information was shared with these groups for consideration to support the development of mitigations and solutions.

The NHS England Region Executive Teams for London and the South East considered consultation feedback and other relevant evidence through a series of workshops, the outputs from which have informed the decision-making business case.

These other organisations/groups have provided us with additional information or other valuable inputs:

- Guy's and St Thomas' NHS Foundation Trust, St George's University Hospitals NHS Foundation Trust, The Royal Marsden NHS Foundation Trust and University College London Hospitals NHS Foundation Trust.
- Kent and Medway, South East London, South West London, Sussex and Surrey Heartlands Integrated Care Boards.
- The Stakeholder Group of parents and representatives of children's cancer charities for the programme
- The Programme Board for the reconfiguration.

Further information about this work is in Section 5 and 6.

### **1.3.7 Decision-making process**

We have used the feedback from consultation and this additional work to inform our final proposals and solutions, including the recommendations in this decision-making business case.

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<sup>6</sup> The independent consultation report, produced by Explain Market Research, is available at: <https://www.transformationpartners.nhs.uk/wp-content/uploads/2024/01/Consultation-feedback-report-Full-report.pdf>



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## 1.4 Case for change

### 1.4.1 Evidence for our case for change

Our case for change is based on clinical guidance and evidence developed by national bodies which emphasises the critical importance of Principal Treatment Centres for children with cancer having immediate access to children's intensive care services. This culminated in the publication of a national service specification for Children's Cancer Principal Treatment Centres in 2021. For completeness, the main milestones are set out below.

- National Institute for Health and Care Excellence (NICE) cancer service guideline (CSG7) [Improving Outcomes in Children and Young People with Cancer](#) (2005) states that at Principal Treatment Centres for children *“there should be immediate access to paediatric intensive care.”* It also said patients undergoing intensive treatments *“that predictably produce profound and prolonged neutropenia and carry a significant risk of requiring intensive support... should have... direct access to intensive care facilities.”* This guidance was developed through a formal process with representation from The Royal Marsden, Great Ormond Street Hospital, Kingston Hospital, Bristol Children's Hospital, Children's Hospital for Wales and others on the Guidance Development Group.
- [Commissioning Safe and Sustainable Specialised Paediatric Services](#) (2008) is a framework that shows which other services specialised paediatric services need to be located with to deliver safe, high quality and sustainable care. It states there is *“absolute dependency, requiring co-location”*, between children's cancer services and paediatric critical care, and also between bone marrow transplantation and paediatric critical care. It cites *“acute septic shock and multi-organ failure in patients with neutropenia on chemotherapy”* as an example of why children's cancer services need to be on the same site as a children's intensive care unit. It defines co-location as *“location on the same hospital site or location in other neighbouring hospitals if specialist opinion and intervention were available within the same parameters as if services were on the same site.”* The framework was produced by clinicians, supported by the Department of Health, and endorsed by the Royal College of Paediatrics and Child Health (and other medical colleges).
- [NICE guidance on Improving Outcomes for Haematological Cancers](#) (NG47, 2016) confirmed that the previous NICE guidance (Improving Outcomes in Children and Young People with Cancer) should be used to guide the facilities required for children undergoing chemotherapy.



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- After three further reports<sup>7</sup>, including one which looked at the service delivered by the current Principal Treatment Centre and one which suggested an approach to cancer care for London, a draft service specification for Children’s Cancer Principal Treatment Centres in England was drawn up.
  - The draft service specification did not mandate co-location for Principal Treatment Centres with a level 3 children’s intensive care unit, though it was clear that one should be on the same site. However, a public consultation in summer 2019 about the draft was subject to significant criticism from cancer specialists, children’s cancer charities and NHS Trusts. For example:
    - The Royal College of Paediatrics and Child Health’s (RCPCH) response said: “We would suggest that the Principal Treatment Centres where treatment risks must be at their highest, inherent both in the intensive oncology treatment and, potentially, new more exploratory regimens, must be co-located with NHS England level 3 units. If the service plans to give high intensity treatment to a child on a site, then that site should have a paediatric intensive care unit service in [sic] the same site that can be accessed without the need of a transport team or ambulance transfer.”
    - Children’s Cancer and Leukaemia Group<sup>8</sup>, (CCLG) an affiliated specialty group of the Royal College of Paediatrics and Child Health<sup>9</sup>, stated that the requirement for co-location of critical care level 3 and other defined services at all Principal Treatment Centre sites was “*strongly endorsed at all the engagement events, involving professionals working in children’s cancer service across the whole country*”. It added: “*The fundamental drive for this clarification was patient safety and survival but also patient experience...it is a widely held view in the profession...that providing services without critical co-dependencies in place is to compromise patient safety and experience.*”

As part of its work to consider responses to the public consultation on the draft service specification, NHS England commissioned the former National Cancer Director, Professor Sir Mike Richards, to complete an independent review on whether or not co-location of a Principal Treatment Centre for children’s cancer with a level 3 children’s intensive care unit should be a mandatory requirement for an NHS England commissioned Principal Treatment Centre. The review, which reported to the NHS England Board in January 2020, concurred with the large majority of other clinical experts and parents of children who had contributed to the process,

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<sup>7</sup> South London Paediatric Oncology: NCAT review (2011); London Paediatric Oncology Review (2015); On the Right Course? (2018)

<sup>8</sup> Children’s Cancer and Leukaemia Group response: <https://www.cclg.org.uk/news/consultation-on-the-future-of-childrens-cancer-services-our-response>

<sup>9</sup> CCLG brings together those working on children’s cancer in the UK and Ireland and is also a leading cancer charity.

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that a Principal Treatment Centre for children with cancer must be co-located with a paediatric intensive care unit.

In the review, Professor Sir Mike Richards stated: *“I believe that without co-location there is an avoidable geographical risk to patient safety and poor patient experience and potentially poor outcomes.”*

On the Principal Treatment Centre, which is the subject of this decision-making business case, he added: *“The main weight of clinical expertise and support is located at The Royal Marsden, while the sickest patients are largely at St George’s. This means that oncologists who are in charge of a patient’s care are not always readily available when difficult decisions and conversations are needed. A large number of patients and parents are required to ‘shuttle’ between the two sites, adversely impacting on their experience of care. I commend the staff who have worked tirelessly to mitigate safety risks, but the current arrangements should not continue longer than necessary. If the recommendations of this review are accepted the service specifications should be published with modifications as soon as possible. Other improvements to service delivery which were widely agreed to be beneficial for patient care can then start to be implemented.”*

The NHS England Board accepted the recommendations of the report in full, including the recommendation that the service specification should make co-location with a range of co-dependent services, including level 3 paediatric intensive care, a mandatory requirement for NHS England commissioned Principal Treatment Services (except in specific circumstances outlined in the report<sup>10</sup>). The new national service specification for Principal Treatment Centres, which was published in 2021, duly states that very specialist cancer treatment services must be co-located with (on the same site as) a level 3 paediatric intensive care unit and other specialist children’s services.

**To note:** as part of our assurance process, the London and South East Clinical Senates reviewed our proposals while they were in development. They said our case for change is strong and also highlighted the potential for a stronger local narrative to describe this. We took

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<sup>10</sup> In addition to this central recommendation, the Richards report noted: ‘Co-location with a paediatric intensive care unit (PICU) is of particular importance in relation to treatments which carry a significant risk (say >5%) of requiring intensive care. This applies to CAR-T therapy, bone marrow transplantation and several other patient groups.’ He added: ‘Some chemotherapy treatments and radiotherapy carry a risk significantly below 5% of requiring PICU. These can, in my view, be safely given on sites without PICU as long as clear arrangements are in place for transferring patients safely on the rare occasions when this is necessary.’ Management of children with cancer is done on a network wide basis, with low-risk activity and treatments given locally as far as possible in children’s cancer shared care units, without on-site level 3 intensive care. As per the national service specification, Principal Treatment Centres have a role overseeing this treatment (while delivering higher risk procedures in the Principal Treatment Centre with access to level 3 PICU and advice from other relevant specialists).

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this advice and further developed our case for change for our pre-consultation business case, and it has now been additionally informed by consultation feedback.

### **1.4.2 Our case for change**

Our case for change is below. We set out consultation responses to the case for change, including alternative suggestions that were made, at Section 7.10.

#### **The current Principal Treatment Centre does not meet the national service specification**

National clinical requirements for Principal Treatment Centres are set by NHS England and set out in the national service specification. They state that very specialist cancer treatment services for children – like those at The Royal Marsden – must be on the same site as a level 3 children’s intensive care unit and other specialist children’s services.

The current Principal Treatment Centre does not and cannot meet this mandatory requirement. Therefore, it must change.

*NHS providers that have a children’s intensive care unit on site will, by definition, provide many specialist services that children with cancer may need, and will deal with the most complex and rare conditions in children. They can provide holistic, multidisciplinary care on site to children who are very seriously ill because of their cancer or side effects of their treatment. The Royal Marsden cannot do this.*

*Service specifications for specialised services are produced nationally based on clinical evidence and set out the standards and requirements for delivery of these services.*

#### **Hospital transfers of very sick children with cancer for intensive care add clinical risks and stress to what is already a difficult situation**

Treatment for cancer in children is complex and can be high intensity. Children can become very seriously ill very quickly. A small number will require close monitoring or life-saving services provided by intensive care specialists.

Every year, a small number of very sick children who need intensive care are transferred eight miles from the specialist children’s unit at The Royal Marsden’s Sutton site to St George’s Hospital’s children’s intensive care unit at Tooting<sup>11</sup>.

While such transfers are done as safely as possible, urgent transfers of clinically high risk and very sick children to another hospital for level 3 intensive care services that can give life

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<sup>11</sup> Between 1 April 2019 and 31 March 2020, the data lake reflects that 35 children were taken by ambulance from The Royal Marsden to St George’s Hospital because they needed or might need intensive care. 15 children were treated in the intensive care unit. 23 children were treated on the ward (some had more than one type of care during different stays at St George’s Hospital after transfer).

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support, even in a special children’s ambulance with an expert team on board, add avoidable risks to what is already a very difficult situation. Although these risks are carefully managed, while the current service arrangement continues, underlying risks (that would be removed by our proposals) remain and can only ever be mitigated. Transfers of very sick children for intensive care also put added stress on patients, parents, and on the staff involved, who have to take the decisions.

The Children’s Cancer and Leukaemia Group’s response to the 2019 consultation was clear that while a “*reasonable interim solution*” can provide mitigations, “*the final status of a patient focused service*” must be for children’s cancer services to be on the same site as a children’s intensive care unit.

*Patient transfers from shared care units in local hospitals to the specialist children’s cancer centre, including emergency patient transfers, will continue to be necessary and would not be affected by our proposals.*

### **The intensive care team is not currently able to provide face-to-face advice on the care of children on the ward**

Currently, the Principal Treatment Centre’s intensive care specialists are at St George’s Hospital while most specialist care for children with cancer is at The Royal Marsden. Every year some children have to be transferred by ambulance from The Royal Marsden to the cancer ward at St George’s Hospital as a precaution, in case they deteriorate and need intensive care.

Intensive care specialists can’t work closely with specialist cancer teams to help children stay well enough to avoid intensive care if they are not all on the same site.

### **There is a need to improve children and families’ experience when patients require intensive care and other specialist children’s services.**

The diagnosis of cancer in a child causes extreme anxiety for both the child and the parents. Treatment often requires many hospital visits and admissions, including for treatment by other specialties for issues related to the child’s cancer or for other conditions they have.

Currently, children have to travel to other hospitals for these services named in the service specification: intensive care; emergency surgery, and most biopsies and central lines; specialist cardiology; children’s cancer surgery; other children’s surgery; infectious diseases; gastroenterology; specialist nephrology; neurosurgery; ophthalmology; and some types of radiotherapy (proton beam and superspecialist).

Parents and staff say having to get to know new members of staff at different locations, especially at a time of crisis, can increase families’ anxiety and distress. It is more difficult for

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different teams treating the same child to work together closely to coordinate their care when they are not on the same site.

*Children's cancer care is complex. Our proposals would not eliminate the need for children to get specific kinds of expert care at different hospitals.*

*Although, under our proposals, conventional radiotherapy would no longer be on the same site, requiring travel to a new site for some children, this would almost always be on a planned basis<sup>12</sup>.*

**Although it offers a wide range of innovative treatments, The Royal Marsden is excluded from giving a specific type of new treatment, and others expected in the future.**

Innovative cancer treatments are bringing new hope for children and families. Some have a greater risk of complications – such as a severe immune response – that could require urgent support from an on-site intensive care team and associated specialist children's services. As a result, they can only be given at children's cancer centres which are on the same site as a children's intensive care unit.

This is the case for ground-breaking CAR-T treatment, which uses a child's own, treated, cells to fight their cancer. At Great Ormond Street Hospital, even with pre-emptive treatment to reduce the reaction, 10 to 20% of children having CAR-T treatment currently need some form of intensive care. The most recent CAR-T trial treating children with acute myeloid leukaemia requires the CAR-T cells to be administered on the children's intensive care unit as a precaution because of how quickly these children can react to the treatment. Many more of these treatments are expected to become available in the next few years.

The Royal Marsden is excluded from giving CAR-T because it is not on the same site as a children's intensive care unit. There is a compelling case to move the service, so it has the same opportunity to provide innovative treatments which require an intensive care unit on site as other major centres worldwide.

### **1.4.3 Anticipated benefits**

The benefits we expect from delivery of the case for change and our clinical model are set out in Section 1.4.3 of this decision-making business case.

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<sup>12</sup>There would also be transfers required for cardiology and nephrology if St George's was the future Principal Treatment Centre, and for neurosurgery under both options, although there would be more transfers if Evelina London was the future Principal Treatment Centre.

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#### 1.4.4 Case for change for radiotherapy - background

Many children diagnosed with cancer receive external beam therapy – radiotherapy – as part of their treatment. There are two main types of radiotherapy:

- conventional radiotherapy which mostly uses high-energy x-rays (photon beams)
- proton beam therapy, an advanced form of radiotherapy, that uses beams of high-energy protons.

There are other superspecialist radiotherapy services for children too:

- brachytherapy (a form of internal radiation therapy providing localised treatment using sealed radioactive sources)
- stereotactic radiosurgery and stereotactic radiation therapy (forms of radiation therapy that can precisely target high-dose radiation)
- molecular radiotherapy treatments (a form of radiotherapy which involves the use of radioactive medication to target specific tumours within the body).

Clinical requirements for children’s conventional radiotherapy services are set by the national service specification for Paediatric Photon Radiotherapy Services<sup>13</sup>. This was published by NHS England in June 2023.

It specifies that each conventional radiotherapy service for children must serve a large enough population to support a big enough team with the knowledge, skills and equipment to deliver care to children with complex needs and maintain sub-specialist experience, given how wide-ranging cancer diagnoses can be in children.

In addition, the service specification details:

- how children must be referred to the service
- the membership and skills of the multidisciplinary team that must provide the service, which must have more than one consultant clinical oncologist with subspecialisation in paediatric radiotherapy.
- how the service will ensure children get the best form of radiotherapy for them, referring to proton beam and other specialist types of radiotherapy where appropriate.

The service specification also requires conventional radiotherapy services for children to be open 24 hours a day, 365 days a year.

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<sup>13</sup> <https://www.england.nhs.uk/publication/service-specification-paediatric-photon-radiotherapy-services/>



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The service specification was developed following completion of the national service review with wide stakeholder engagement undertaken as part of this process. Of particular significance is the expected increase in the use of proton beam therapy as a treatment for paediatric cancers in place of conventional photon radiotherapy.

Proton beam therapy has the advantage of limiting the dose of radiation to the surrounding normal tissues. It is suitable in certain types of cancer. It is only provided at two centres in England, The Christie NHS Foundation Trust in Manchester and University College Hospital in central London<sup>14</sup>.

In 2019/20, data shows that 41 children had conventional radiotherapy treatment at The Royal Marsden, delivered in 700 sessions, and 20 children from The Royal Marsden were referred for proton beam therapy. Modelling we have undertaken with clinical teams at The Royal Marsden expects that in the future the proportion of children who have proton beam therapy would increase to about 60% (equivalent to about 35 children). Fewer children are expected to have conventional radiotherapy in comparison. Demand will vary from year to year.

As a result of changes, including due to workforce shortages, there has been movement towards providing these services in a different way, including the consolidation of conventional radiotherapy services for children. A recent example of such consolidation is the transfer of conventional radiotherapy services for children from the Clatterbridge Cancer Centre NHS Foundation Trust in Liverpool to The Christie NHS Foundation Trust in Manchester (the other centre which provides proton beam therapy).

#### **1.4.5 Case for change for radiotherapy**

The Royal Marsden currently provides conventional radiotherapy services for children with cancer under the care of the current Principal Treatment Centre.

University College London Hospitals NHS Foundation Trust (which we mainly call University College London Hospitals)'s specialist teams provide the other types of radiotherapy, listed above (Section 1.4.4), for these children, as well as conventional radiotherapy for other children from other Principal Treatment Centres. Where they provide conventional photon radiotherapy for other Principal Treatment Centres, the paediatric clinical oncologists based at University College Hospital join relevant multidisciplinary teams hosted by those Principal Treatment Centres, in compliance with the service specification.

Evelina London and St George's Hospital have both proposed that, as part of the move of specialist children's cancer services to the future Principal Treatment Centre, alongside

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<sup>14</sup> For more information on proton beam therapy visit [NHS commissioning » Proton beam therapy \(england.nhs.uk\)](https://www.nhs.uk/commissioning/proton-beam-therapy/)

advances in radiotherapy treatment, conventional radiotherapy services for the future centre are provided by University College London Hospitals' specialist children's radiotherapy team.

This is because:

- It would be difficult to sustain the conventional radiotherapy service for children at The Royal Marsden without the staff and facilities of the Principal Treatment Centre available on site. The service at The Royal Marsden is delivered by highly skilled and specialist multidisciplinary teams including children's cancer play specialists, nurses, and therapists who will no longer be at The Royal Marsden once the service transfers. Funding and specialist workforce for current inpatient beds will also transfer to the provider of the future Principal Treatment Centre. The Royal Marsden does not have a wider paediatric service (being a specialist cancer hospital) that would offer this provision.
- We expect the number of children requiring conventional radiotherapy services in the future to fall, as more children have proton beam treatments instead, meaning a high-quality service would be even harder to sustain.
- Specialist staff needed to provide paediatric radiotherapy might not want to work for a standalone service at The Royal Marsden once the Principal Treatment Centre for children's cancer was no longer there. Given the reduced number of children expected to require conventional radiotherapy, it could also be more challenging for staff to maintain (and build) their skills and experience to a sufficient degree.

Alongside the reasons above, providing radiotherapy at two different sites, neither of them on the same site as the future Principal Treatment Centre, could create the need for additional journeys and add complexity for children undergoing both chemotherapy and radiotherapy. Under this scenario, clinical (radiation) oncologists at the future Principal Treatment Centre would need to work with both University College London Hospitals and The Royal Marsden to coordinate, make decisions, and provide care to children, as well as spending time at the future centre.

#### **1.4.6 Anticipated benefits of our radiotherapy proposal**

The benefits we expect from delivery of the case for change for radiotherapy are set out in Section 1.4.6 of this decision-making business case.



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## 2. Clinical vision for the future

Management of children with cancer is among the most complex paediatric services. These children require multiple complex interventions for best quality care. Complications are common and many different tertiary children's services are called upon during most patient journeys. A truly multidisciplinary team approach (where possible) provided from a single site is optimal for managing the complexities that clinicians encounter. Our clinical model addresses the challenges faced when treating the sickest cohort of children, those who require intensive care support, and will provide more holistic care for many children.

### 2.1 Our vision for the future Principal Treatment Centre

Our vision for the future centre is that it will:

- Comply with the national service specification with all the benefits that brings, including removing the avoidable underlying risks associated with the current service arrangement where, every year, a small number of very sick children are transferred from one hospital which is part of the Principal Treatment Centre to the other for level 3 intensive care services that can give life support.
- Build on all the strengths of the existing service – high quality care by expert staff, good access to clinical trials, a family-friendly centre for children and young people, and ground-breaking research working very closely with the Institute of Cancer Research (ICR). These things are very important to children, families and staff.
- Give best quality care to achieve world-class outcomes for children with cancer for decades to come.

Our vision for conventional radiotherapy services at University College Hospital is that they will become part of the largest radiotherapy service in the country, with significant potential benefits for children. This concentration of experts working together in a multidisciplinary way will provide the best treatments for children, share learning, and innovate, including through ongoing research and clinical trials. Children will have access to every type of radiotherapy in one place with clinicians working closely together to determine which form of treatment is best.

The proposed consolidation of radiotherapy services at University College Hospital is consistent with the national service specification for radiotherapy<sup>15</sup>. It will support increased uptake of

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<sup>15</sup> Aims set out in the [national service specification for paediatric photon radiotherapy](#) include to: improve outcomes from radiotherapy by delivering best practice external beam radiotherapy treatments and holistic support in a culturally appropriate way; to enable children with cancer to access high-quality care at the right time and in the right place; to reduce variation in clinical practice through standardisation, audit and rapid adoption of best practice; and to participate in clinical trials and research relating to children's cancer.

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proton beam therapy while ensuring that children who need it continue to receive high quality conventional (photon beam) radiotherapy. This service change has already been successfully made for children with cancer living in Dorset, Hampshire, the Channel Islands, the Isle of Wight, south Wiltshire and West Sussex, whose care is led by the Principal Treatment Centre at Southampton.

## 2.2 Delivering the national service specification

The future Principal Treatment Centre for children with cancer who live, or use children's cancer shared care units, in Brighton and Hove, East Sussex, Kent, Medway, south London, and most of Surrey will deliver the national service specification in full, including having all the required services on site and the staff, expertise, space and equipment to give children all the care that they need, 24 hours a day, 365 days a year.

- As part of this, it will work in close liaison with children's cancer shared care units which are known as POSCUs (paediatric oncology shared care units). Work on implementing the [service specification](#) for these units, which was also published in November 2021, is underway. It is led by the South Thames Children's, Teenagers' and Young Adults' Cancer Operational Delivery Network (which is currently hosted by The Royal Marsden and would move to the proposed future Principal Treatment Centre), working with their North Thames equivalents. The aim is to achieve an improved balance between the 'centre of excellence' (the Principal Treatment Centre) and a vibrant network of shared care units based in district general hospitals delivering care closer to home under the guidance of the specialist centre. Within this document we refer to this as the POSCU transformation programme.

### 2.2.1 Local application

In implementing the Principal Treatment Centre service specification, we will make the most of the existing expertise in south London in paediatric oncology care and other paediatric services that children with cancer may need, and build on the current services to create a Principal Treatment Centre for children with cancer living in south London and much of south east England that delivers our vision.

Network working is a very important element of cancer care because of how vital it is for children who have very complex patient journeys. Collaboration to coordinate and improve care for these children may be through network multidisciplinary teams, joint consultant contracts, consultants working on two sites or consultants travelling to the patient to give clinical review. Networking will help mitigate any loss of continuity and may reduce loss of historical knowledge. The Children's Cancer Network can and will support this. This is reflected in our recommendation in Section 7.2.5.

## 2.2.2 Mandatory services

The national service specification mandates that the following services are available on site at the Principal Treatment Centre. Our clinical model will adhere to the national service specification, including by delivering the following mandatory services:

Table 2: The specialist children's services that must be available on site at the Principal Treatment Centre

Mandatory services in the Principal Treatment Centre service specification	
Children's anaesthetics and pain management	Children's radiology services (such as CT and MRI scans)
Children's blood cancer (haematology) services, including bone marrow transplants	Children's surgery, including management of emergencies, central lines and biopsy services
Children's cancer services (oncology) including diagnosis, chemotherapy, ongoing monitoring and care	Level 3 critical care (for children who need life support)
Children's cancer pharmacy services	Therapy services such as psychology and physiotherapy

## 2.2.3 Interdependent services

The national service specification requires the services listed below to be readily available at all times for children at the Principal Treatment Centre<sup>16</sup>. However, they are not required to be on the same site.

Our clinical model will prioritise accessibility of these services.

Table 3: The specialist children's services that, if not on site, must be readily accessible at all times for children being treated at a Children's Cancer Principal Treatment Centre

Non-mandatory interdependent clinical services in the Principal Treatment Centre service specification		
Radiotherapy (uses radiation to kill cancer cells and treat symptoms)	Nephrology (for patients with kidney disorders)	Cardiology (for patients with defects and diseases of the heart and blood vessels)
Endocrinology (for patients with hormone-related disease)	Ophthalmology (for patients with eye and visual disorders)	Cancer surgery (to remove or reduce tumours and manage some cancer-

<sup>16</sup> The Clinical Advisory Panel of experienced clinicians, which helped us develop the options, defined 'readily available' as available on site within 30 minutes. The panel decided that genomic testing did not need to be available on site within 30 minutes, so genomic testing was excluded from our evaluation criteria.

## Non-mandatory interdependent clinical services in the Principal Treatment Centre service specification

		related symptoms) and other specialist children's surgery
Neurosurgery (for cancer-related problems affecting patients' brains, nervous systems or spines)	Gastroenterology (for patients with problems of the digestive system)	Pathology (investigates and identifies cancers)
Infectious disease services	Palliative care (for patients living with an illness that cannot be cured)	Genomic testing (finds changes in genes that are causing cancer)

### 2.2.4 Radiotherapy

For the reasons set out in our radiotherapy case for change (Sections 1.4.5 and 7.6) our clinical model proposes that conventional radiotherapy services currently provided at The Royal Marsden move to University College Hospital in central London under both options for the future Principal Treatment Centre.

This would consolidate conventional radiotherapy services for children and young people with proton beam and other superspecialist types of radiotherapy that University College London Hospitals already provides for the Principal Treatment Centre that is the subject of this decision-making business case.

## 2.3 Research

Research facilities and capability are a crucial aspect of the clinical model for the Principal Treatment Centre. Research plays an important role in supporting improvements and quality of life for children affected by cancer. Early clinical trials can be a way for children to access new or innovative treatments that might not otherwise be available.

Research is a significant strength of the existing service at The Royal Marsden, in partnership with the Institute of Cancer Research.

Together, both organisations form a National Institute for Health and Care Research (NIHR) Biomedical Research Centre, one of 20 in the UK. They jointly run a Paediatric and Adolescent Oncology Targeted Drug Development Programme which oversees early clinical trials.

The Drug Development Programme sits within the wider Royal Marsden Paediatric Clinical Research team which conducts clinical trials and research studies, including on cancer

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treatments, supportive care, alleviating symptoms, and palliative care, in collaboration with other teams.

The Royal Marsden and the Institute of Cancer Research jointly operate an Experimental Cancer Medicine Centre (ECMC) for children as well as one for adults. ECMCs have world-leading expertise in early phase clinical research. They work together in a UK-wide network to generate new treatments for cancer.

Even though we do not commission research (it is primarily commissioned by the National Institute for Health and Care Research and research grant funders), clinical research and NHS care are closely integrated in very specialist cancer treatment services for children.

Our clinical model for the future is for 'wet lab' (scientific) elements of research into children's cancers to remain at the Institute of Cancer Research in Sutton, with the team of researchers working closely and collaboratively with the clinical research team - clinicians who are active in both research and clinical care – at the future Principal Treatment Centre.

Much contemporary scientific research does not have co-located laboratories, not least because many of the studies are multicentre, recruiting children from across the UK or Europe with a lead centre undertaking the laboratory experiments. Hence, there are already procedures and facilities in place to allow the transport of blood samples and tissues from the site where the children receive their clinical care and are recruited and consented to the centre, such as the ICR, where these samples are used for research investigations.

Risks associated with the development of a new model for research will need to be carefully managed by the future Principal Treatment Centre provider, working closely and with assistance and guidance from The Royal Marsden, the ICR and other partners. NHS England will also play an important role in facilitating this.

## 2.4 Benefits of the clinical model

### 2.4.1 Benefits we expect from the proposed changes to the location of very specialist cancer treatment services for children

The future clinical model for the Principal Treatment Centre will:

- Be safer because all children with cancer receiving Principal Treatment Centre care as inpatients will be on the same site as a children's intensive care unit and many other specialist children's services. This will remove avoidable underlying risks associated with the current service arrangement because very sick children who need intensive care input will no longer be transferred for it from one part of the Principal Treatment Centre to

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the other. For children who need intensive care, the intensive care unit will be very close by on the same site.

- Enable children to get more of their care on the specialist cancer ward in a more familiar, comfortable environment, minimising the number of children admitted to intensive care, which can be frightening for children and families.
- Meet the national requirements and be capable of offering cutting-edge treatments such as ground-breaking CAR-T treatment that can only be delivered if a children's intensive care unit is on site.
- Provide on-site access to more of the services that children with cancer need. These include intensive care; emergency surgery, biopsies and central lines; specialist cardiology; children's cancer surgery; other children's surgery; gastroenterology; infectious diseases; specialist nephrology; neurosurgery; and ophthalmology<sup>17</sup>. At least eight of these services, which are not provided by The Royal Marsden, would be on site, whichever option is chosen for the future Principal Treatment Centre, providing a more holistic service for patients. This would reduce the number of transfers required (more information is in Section 7.3.1).

*Conventional radiotherapy would no longer be on the same site, but it would be co-located with proton beam and other superspecialist forms of radiotherapy, which would have benefits (see Section 1.4.3). It would also be accessed in a planned way, as would other services for which children still needed a transfer.*

- Reduce the need for many patients to travel to sites other than the Principal Treatment Centre for specialist care, improving their and their families' experience: this is likely to be particularly important for children with a higher need for treatment by other children's specialties (such as those with additional health needs and complex co-morbidities) and for families with language barriers or poor literacy who find attending several sites particularly difficult.
- Enable more children – particularly those who need surgery - to get support from the start from the team who will be leading their systemic cancer treatment and coordinating their care. Current arrangements mean that meeting that team can be delayed until a child is well enough to travel to The Royal Marsden.  
*Children with brain, spinal or central nervous system cancer would continue to typically start their treatment at one of the two neurosurgical centres for south London.*
- Improve opportunities for close multidisciplinary and multi-professional working between cancer specialists and many professionals in other specialties, as the teams will be on

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<sup>17</sup> This is looking only at the services that are named in the service specification. There are other specialist services that children with cancer may need which are not on The Royal Marsden's Sutton site.

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the same site. As well as medics and nurses, there could be significant benefits from cross-specialty working by dietitians, play specialists, physiotherapists, speech and language therapists, occupational therapists and others. Opportunities to work more closely together would improve communication and holistic care for children and could support new areas and types of research in children with cancer such as cardiac, neurological, anaesthetic and psychological research, as well as research on treating their malignancy.

- Make it easier for cancer and non-cancer specialists to learn from each other and share learning. As well as benefiting children's care, this would be likely to help the future centre keep and attract new staff.
- Make it possible for the future provider to leverage its experience of providing a range of specialist children's services and of leading other specialty networks to provide even stronger support to children's cancer shared care units, including developing their staff.

#### **2.4.2 Benefits we expect from the proposed changes to radiotherapy**

If conventional radiotherapy services for the proposed future Principal Treatment Centre are at University College Hospital, they will be part of a larger paediatric radiotherapy service offering the full range of radiotherapy treatments and supporting a larger number of patients.

Consolidating radiotherapy expertise and services in one location would offer significant opportunities to improve future care for children with cancer, including:

- More opportunities for doctors and other professionals delivering radiotherapy for children to work together in one place allowing them to develop greater expertise and specialist knowledge in treating children's cancers by sharing and growing their knowledge and skills. This offers the potential to improve the treatments provided and achieve even better patient outcomes.
- More opportunities to develop clinical and lab-based research (including opportunities for collection of real-world data) and deliver clinical trials that could help to improve care for children in years to come.
- Children will have access to a wider range of radiotherapy treatments in one place with their treatment overseen by a single team of clinicians incorporating both proton and photon specialists. This team will draw on their collective expertise to decide the type of radiotherapy most appropriate for individual patients.
- Jobs that are attractive to staff, supporting recruitment and retention of very skilled staff with all the benefits of service stability and resilience this would bring. This would be aided by having more staff working in the paediatric radiotherapy service than at The



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Royal Marsden, adding to resilience. Staff benefits are discussed in more detail in Section 7.5.2.

The proposed consolidation of radiotherapy services at University College Hospital is consistent with the national service specification for radiotherapy. It would support increased uptake of proton beam therapy while ensuring that children who need it continue to receive high quality conventional (photon beam) radiotherapy.

### **2.4.3 Realising these benefits**

As with all service changes, achieving these benefits will require careful planning throughout the implementation phase, taking full account of and managing risks in the transition. Among other things, this will involve monitoring metrics that capture improvements and changes, including in performance and outcomes, patient experience, workforce recruitment and retention. This monitoring will be aligned with that required as part of the national service specification.

It will require close working between the providers of the current Principal Treatment Centre and the provider of the future Principal Treatment Centre, to bring a full understanding of the requirements of a paediatric oncology service to the implementation of the future Principal Treatment Centre, as recommended by the London and South East Clinical Senates (Recommendation 4).

## **2.5 Potential negative impacts on patients of the proposed clinical model**

As well as the benefits for patients and families outlined above, there would be some negative impacts on patient pathways from the new clinical model:

- some inpatient transfers for conventional radiotherapy that are not part of the current model.
- patients moving from children's to teenage and young adult cancer services would change sites rather than remaining on one site, as now.
- there could be a reduction in access to clinical trials before and after the move to the future Principal Treatment Centre.

### **2.5.1 Inpatient transfers for conventional radiotherapy**

Bringing all radiotherapy services together on the same site at University College Hospital would create opportunities to improve care for children with cancer (outlined above). It would also have some other impacts. These would include some transfers that don't happen now and longer journeys for some children and their families compared to now (more information on this can be found in Section 7.6).



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- Up to 10 children a year<sup>18</sup> who have radiotherapy ahead of a bone marrow transplant (total body irradiation which often needs to be provided during a hospital stay) would have a planned transfer from the future Principal Treatment Centre to University College Hospital for this treatment. These are typically very unwell children who are often in a vulnerable clinical condition.
  - Children whose first experience of radiotherapy is as an inpatient would be transferred from the future Principal Treatment Centre to University College Hospital where they would meet new staff on a new site.
  - Around 25<sup>19</sup> other children with cancer every year would go to University College Hospital for conventional radiotherapy as outpatients or day cases, travelling from home and back, instead of going to The Royal Marsden (as now)<sup>20</sup>.
  - Around 35 other children would travel to University College Hospital (as some do now) for proton beam therapy and other types of radiotherapy.
  - The delivery of conventional radiotherapy services at University College Hospital would result in longer journeys for some children and their families.

Patients having ongoing treatment at University College Hospital may be offered family accommodation as part of their care plan or other types of support, such as patient transport. Recommendations on mitigating travel impacts that have been developed as part of the Integrated Impact Assessment for the service reconfiguration are in Appendix 4. We would learn from arrangements that are currently in place for patients who travel to University College Hospital from the catchment areas of the Principal Treatment Centres in Southampton and, some from Oxford. Information on plans for managing the relocation of conventional radiotherapy services to University College Hospital is in Section 7.6.

### **2.5.2 Moving on to teenage and young adult services**

Arrangements for teenagers and young adults distinguish between those who are aged 16 to 18, and those aged 19 to 24. Currently, most patients aged 16 to 18 with cancer in the catchment area receive all their care at the Teenage and Young Adult (TYA) Cancer Principal Treatment Centre at The Royal Marsden (a few remain under the care of children's cancer services for longer, on a case by case basis).

Young adults aged 19 to 24 with a suspected diagnosis of cancer may be referred to either the TYA Principal Treatment Centre or a TYA designated hospital, having been offered a choice of the two. For both age groups, their care must be discussed by the TYA Principal Treatment

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<sup>18</sup> In 2019/20, 7 children from the current Principal Treatment Centre had total body irradiation as part of their treatment. Numbers vary year on year.

<sup>19</sup> Numbers are estimates only and would vary from year to year.

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Centre multidisciplinary team meeting, to ensure they are offered the choice of participating in appropriate clinical trials and have their holistic needs identified and met. More information is in the service specifications for TYA services<sup>21</sup>.

Nine Trusts currently run TYA designated hospitals<sup>22</sup> in the Principal Treatment Centre's catchment area (sometimes at more than one of their sites). The designated hospitals are supported by Royal Marsden clinical nurse specialists in TYA services.

After the relocation of its children's cancer service under our proposals, The Royal Marsden will continue to provide cancer services for teenagers and young adults. This means that when children who have treatment for cancer in childhood reach their 16th birthday (with flexibility on a case-by-case basis) the management of their care will be transferred from the future Principal Treatment Centre to the TYA Principal Treatment Centre at The Royal Marsden.

This will need to be managed carefully to make sure children have an excellent experience of transitioning to the teenage and young adults' service. The London and South East Clinical Senates recognised that flexibility on the age at which young people move on (perhaps even extending to 18 or beyond), the geographical location of the patient and tumour site location will be important. They said it would be helpful to clarify current and future capacity to manage 16 to 18+ year old patients in appropriate facilities with appropriately trained workforce. Continuity of staffing (such as nurse specialists) supporting patients and their families through the move to teenage and young adult services may also help.

A new national framework, which highlights patient choice for young people with cancer moving on to teenage and young adult services, is due to be published in 2024.

### **2.5.3 Clinical trials**

There is a risk that access to research trials for children's cancer is impacted through the reconfiguration of the Children's Cancer Principal Treatment Centre. There is also a risk that companies will not want to open trials in an environment where significant change (and transfer of services) will be taking place.

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<sup>21</sup> Teenage and Young Adults Principal Treatment Centre service specification: <https://www.england.nhs.uk/wp-content/uploads/2023/05/service-spec-tya-ptc.pdf>, Teenage and Young Adults Designated Hospitals service specification: [https://www.engage.england.nhs.uk/consultation/teenager-and-young-adults-cancer-services/user\\_uploads/service-specification-tya-designated-hospitals.pdf](https://www.engage.england.nhs.uk/consultation/teenager-and-young-adults-cancer-services/user_uploads/service-specification-tya-designated-hospitals.pdf)

<sup>22</sup> Designated hospitals for teenage and young adult services in the catchment area are currently Conquest Hospital in Hastings, Eastbourne District General Hospital, Guy's Hospital in Southwark, King's College Hospital in Lambeth, Maidstone Hospital, Medway Maritime Hospital in Gillingham, Queen Elizabeth the Queen Mother Hospital in Margate, Royal Alexander Children's Hospital in Brighton (16 to 18 year olds), Royal Surrey County Hospital in Guildford, Royal Sussex County Hospital in Brighton (19 to 24), St George's Hospital in Tooting, Tunbridge Wells Hospital, William Harvey Hospital in Ashford. These may change.

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Both potential providers of the future Children's Cancer Principal Treatment Centre are committed to working with the Institute of Cancer Research and The Royal Marsden to build on and identify strategies to manage risks.

We will work with the Institute of Cancer Research and The Royal Marsden to meet with research funders (as appropriate) to discuss plans to encourage continued research funding, assuring them of the opportunities and giving them confidence in how the transition will be managed. Once a decision is made; the future provider would also join these discussions.

#### **2.5.4 Managing challenges**

Being aware of these things means that we can work together to manage them. The teams at the Trusts involved will make sure staff and families have the support they need through this time of change and that the service runs smoothly throughout, including for children moving on to teenage and young adult services. They will work with families on preserving memorials for children in line with families' wishes.

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## 3. The consultation proposals

### 3.1 Identifying options for delivering our clinical model

In line with NHS England best practice for reconfiguring services, the programme:

- Identified fixed points (things which would not be changed by the reconfiguration). For example:
  - The sites where bone sarcoma, retinoblastoma and liver cancer surgery for children, and children's neurosurgery are provided will not change (due to the specific expertise at the hospitals which provide these services).
  - The proposed options must deliver a Principal Treatment Centre on the same site as a children's intensive care unit.
- Identified hurdle criteria (criteria which potential options must meet to be evaluated further), such as being capable of providing a level 3 children's intensive care unit which complies with the [NHS England service specification](#) for such units, and meeting the financial capital and revenue affordability tests.
- Developed a long list of all the possible ways of providing a Principal Treatment Centre for children with cancer living in or using children's cancer shared care units in south London and much of the south east.
- Applied the fixed points and hurdle criteria to create a shortlist of possible solutions<sup>23</sup>.

This process resulted in one solution which met all the fixed points and hurdle criteria. It is that the future service must be based at an existing hospital in south London that provides specialist children's services and has a children's intensive care unit, and which wants to deliver the service. There are two ways this can be delivered.

They are for the future Principal Treatment Centre to be at either:

- Evelina London in Lambeth, south east London, with conventional radiotherapy at University College Hospital.

or

- St George's Hospital in Tooting, south west London, with conventional radiotherapy at University College Hospital.

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<sup>23</sup> More detail is available at <https://www.transformationpartners.nhs.uk/childrenscancercentre/key-information/how-we-identified-options/>

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These are the options that we consulted on.

### 3.2 Developing the options

Chapter 5 of the pre-consultation business case provided significant amounts of information about both options, taken from the proposals that Guy's and St Thomas' NHS Foundation Trust and St George's put forward for how Evelina London and St George's Hospital would meet the national service specification if they were to become the proposed future Principal Treatment Centre. The Trusts also provided outline implementation plans and financial information.

We are assured that if chosen as the future Principal Treatment Centre, both Evelina London and St George's Hospital would:

- End hospital transfers from the specialist centre for sick children with cancer who need or might need intensive care, removing avoidable underlying risks and stress associated with the current service arrangements, and could help other children avoid intensive care.
- Reduce distress and improve experience for children and families by providing more specialist services on site than now.
- Create a Principal Treatment Centre which is capable of giving cutting-edge treatments that need a children's intensive care unit to be on site.

We are assured that both options offer outstanding-rated children's services and outstanding-rated education, which is provided both at children's bedsides and in their hospital schools. Both set out proposals for good facilities for parents and children, including beds for parents to stay next to their children, close to the children's intensive care unit when needed, and in longer-stay accommodation nearby; play specialists to support children; quiet spaces, outdoor space and parents' rooms; a choice of cafés, self-catering options and a laundry for families' use. Both would offer staff rooms and staff benefits, including a nursery for childcare. Both hospitals care for many children moving on to teenage and young adult services every year.

We are assured that:

- Both have provision for sufficient age-appropriate ward, outpatient, day case, theatre, diagnostic, and pharmacy capacity to meet the requirements of the service specification and accommodate the transferring service. This is outlined in Section 7.8.
- Both have formally confirmed they would have the flexibility to provide the number of beds and isolation cubicles that could be needed for the future centre. Both say final capacity designs would be developed and agreed with key stakeholders, if they became the future Principal Treatment Centre. This is outlined in Section 7.8.

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- Both have given detailed consideration to supporting research following transfer of The Royal Marsden service. This is outlined in Section 7.9.

Neither of them currently delivers the specialist cancer services that are based at The Royal Marsden. Both would rely on staff transferring from The Royal Marsden, bringing their knowledge and expertise with them, if they became the future Principal Treatment Centre, in addition to direct recruitment and training.

Our travel analysis shows both of the potential Principal Treatment Centres would be faster to reach by public transport than the current Principal Treatment Centre at The Royal Marsden and St George's Hospital for the vast majority of families, but slower by car for most families travelling to Evelina London and many to St George's Hospital.

### **3.2.1 Evelina London – summary**

- Evelina London is a purpose-built specialist children's hospital which treats almost 120,000 young patients every year living in Kent, Medway, south London, Surrey and Sussex.
- All the staff are experts in children's care. Evelina London has very broad expertise and experience in complex non-cancer care, including intensive care, surgery and use of immunotherapies.
- Evelina London provides tertiary heart and kidney services for children and treats some children who have cancer for other (sometimes related) conditions.
- It runs four clinical networks for children's services, two of which (the Evelina London Congenital Heart Disease network and the South Thames Paediatric Network) include the same catchment area as the Principal Treatment Centre. It also provides the specialist ambulance service which transfers very sick children, including children with cancer, to specialist hospitals from across the catchment area, and trains hospital staff, including at The Royal Marsden, in the care of critically unwell children.
- Guy's Hospital, which is part of the same Trust, is a 'designated hospital' for teenage and young adult cancer services and provides cancer care to adults.
- Evelina London has more than 70 staff working on more than 180 national or international research projects in child health and has two dedicated children's research wards and dedicated children's imaging facilities for research. Guy's and St Thomas' attracted over £25 million to fund research staff in 2019/20.
- Researchers would have access to all the existing infrastructure and services, including sample storage, and to Guy's Cancer Centre for adults and adult Experimental Cancer Medicine Centre if Evelina London became the future Principal Treatment Centre.

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- Neurosurgery would not be on site if the future centre was at Evelina London – patients would go to King’s College Hospital or St George’s Hospital, although paediatric neurosurgeons from King’s College Hospital would visit Evelina London to review patients, as they do now, working closely with the paediatric neurologists at Evelina London.

### **What the future Principal Treatment Centre would have, if it was at Evelina London**

- A new children’s cancer inpatient ward in Evelina London’s main children’s hospital building. The latest design features 20 beds: four cubicles suitable for bone marrow transplant patients, 12 single ensuite rooms, and one bay of four beds. Evelina London has also developed plans that would provide more cubicles suitable for bone marrow transplant patients, if required to meet the needs of the service<sup>24</sup>.
- A dedicated day case unit with a procedure room in the new Children’s Day Treatment Centre. A dedicated outpatient space for children with cancer next to other facilities for children. Diagnostic services in the children’s hospital building.
- Beds for parents or carers to sleep next to their child on the ward and near the children’s intensive care unit. Extra accommodation in the Ronald MacDonald House and Gassiot House.
- Family friendly play areas, spaces for teenagers, and rooms for private conversations. Wi-Fi, with a 24/7 helpline to ensure families stay connected.
- Outdoor spaces on site and at a park directly opposite the hospital.

In addition, intensive care, cancer surgery and all other expert care would be on site, apart from radiotherapy and services provided elsewhere which are not changing including neurosurgery which would continue to be at King’s College Hospital and St George’s.

The electronic health record system is EPIC, which is shared with King’s College Hospital. Records could be linked to The Royal Marsden, University College London Hospitals and Great Ormond Street Hospital (which would continue to care for all babies under 12 months). There would be potential for access by shared care units in local hospitals, and a portal for patients and parents to use, including to communicate with clinical teams.

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<sup>24</sup> Evelina London submitted RIBA Stage 2 plans (January 2024) which include 12 single ensuite rooms and four cubicles suitable for bone marrow transplant patients. At PCBC its plans included 8 single ensuite rooms, four cubicles suitable for bone marrow transplant patients and 2 bays of four beds each. It has updated its plans to include more ensuite rooms in response to feedback that came through consultation. If Evelina London was chosen as the site for the future Principal Treatment Centre, the final design would be agreed after further engagement with staff and families of the current centre.



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Research staff would work alongside the teams treating children with cancer and on the two dedicated children's research wards, the children's intensive care unit and in dedicated children's imaging facilities.

Researchers would have access to on-site infrastructure and services including sample storage and office space at the scale and complexity essential for clinical trials. Access to Guy's Cancer Centre for adults, including the Experimental Cancer Medicine Centre and state-of-the-art biobanking.

In brief, should Evelina London become the future Principal Treatment Centre, to deliver the service specification it would be able to build on its existing scale as the largest provider of specialist children's services in south London and on its research partnerships including as part of King's Health Partners.

### **3.2.2 St George's Hospital – summary**

- St George's Hospital is a large teaching hospital that provides specialist care for adults and children. It treats almost 60,000 children every year, mainly living in south west London, Surrey and Sussex. All its children's service staff are experts in children's healthcare.
- St George's Hospital has 25 years' experience of caring for children with cancer: it provides all the intensive care, most cancer surgery and other specialist services for the current Principal Treatment Centre.
- In 2019/20 St George's Hospital neurosurgery service undertook around 20% of the operations needed by children with cancer for brain, nervous system and spinal tumours and emergencies. (The rest were undertaken by the other provider in south London, King's College Hospital<sup>25</sup>).
- St George's Hospital provides cancer services for adults and is a 'designated hospital' for teenage and young adult cancer services. It runs many clinical networks for adult NHS services, largely in south west London and Surrey.
- St George's Hospital has 25 children's researchers and a good track record in national and international research. In 2019/20 St George's attracted £8.2 million of funding for research staff. It would build research facilities, including for academic research staff, into its children's cancer centre if it became the future Principal Treatment Centre.
- Specialist cardiology and nephrology (heart and kidney services) would not be on site if the future centre was at St George's Hospital – patients would go to Evelina London.

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<sup>25</sup> Numbers of children having neurosurgery will vary year on year. The proportion of neurosurgery that both sites do is expected to remain similar.



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Neurosurgery patients would continue to go to King's College Hospital, in the same proportions as now.

### **What the future Principal Treatment Centre would have if it was at St George's Hospital**

- A new children's cancer centre in a converted wing of the hospital with its own entrance. The current design is for:
  - 22 single ensuite rooms for children with cancer. A further six ensuite rooms would be available for use as family suites as needed (each would interconnect to one other bedroom).
  - 10 of the 22 would be isolation rooms suitable for bone marrow transplant patients.
  - One would be a lead-lined room for specific types of treatment, if needed.
- Beds for parents or carers to sleep next to their child and near the children's intensive care unit, with extra family accommodation in the Ronald McDonald House and Pelican Hotel.
- Dedicated outpatient clinics and day case treatments including chemotherapy and minor operations in the cancer centre, with diagnostic services close by.
- Playrooms and TV, chill out, and gaming rooms for children of different ages.
- Dedicated garden space which could be closed off to other patients and visitors.
- In addition, intensive care, cancer surgery and all other expert care on site, other than services which are not changing (such as specific kinds of expert care at different hospitals), radiotherapy, and inpatient kidney and heart care, which would continue to be at Evelina London.

The electronic patient record system would be Infloflex cancer management. Patients can access appointment information on an app. Health Information Exchange system gives shared care units in local hospitals secure access to their patients' records at St George's Hospital. A portal for patients and families to use via the NHS App is being developed.

There would be dedicated research facilities in the children's cancer centre with a laboratory and offices for staff from the Institute of Cancer Research (ICR) and a clinical research unit with six clinical/consulting rooms, sample storage, a 'hot' laboratory and offices. Research staff would work alongside the teams treating children with cancer and on the children's intensive care unit.

Researchers would benefit from and be supported by the hospital's wider research infrastructure including its National Institute for Health and Care Research Clinical Research Facility and established biobank at St George's, University of London.

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In brief, should St George's Hospital become the future Principal Treatment Centre, it would be able to build on its cancer experience in critical care, complex and major paediatric surgery, other paediatric specialties and clinical support services, on its partnership with The Royal Marsden, and on its network of professional relationships with The Royal Marsden and the ICR, to deliver the service specification.

### 3.3 Evaluation of the options

The two proposals were evaluated in late 2022 against four high level domains or key areas for the future Principal Treatment Centre. These domains were agreed by the Programme Board along with their sub-criteria, which were developed by the programme through work with advisory groups, and lead researchers and clinicians (for the research domain).

Before the evaluation criteria were finalised, both providers reviewed them and provided feedback. In July 2022, a new independent Clinical Review Group was set up to help finalise the criteria. The members of the Clinical Review Group discussed each criterion and made recommendations on revisions, and the evaluation criteria were updated to reflect them. The Clinical Review Group confirmed that, with these revisions, the criteria were suitable, comprehensive and would allow us to differentiate between the options.

The domains and associated sub-criteria were:

#### Clinical domain

- Interdependencies: ensuring children have access to as many other specialties as possible on the same site.
- Transfers: reducing avoidable transfers of patients to other hospitals for care, particularly where a transfer would have an impact on patient experience and safety.
- Network effectiveness: experience of providing leadership for and working with a network of other hospitals (to provide care as close to home as possible).
- Transition: supporting children to make the move to teenage and young adult cancer services when they are ready.

#### Patient and carer experience domain

- Quality of facilities: patient environments are an important contributor to overall experience of care, with age-appropriate environments, play facilitation, patient privacy and dignity, space for parents/carers to remain with the child, and an education model for children and young people.

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- Patient navigation to services, including offsite care: patients and families want positive and connected experience of being guided through their treatments in a joined-up way, enabled by technology.
  - Family support during periods of extreme difficulty: the need for support and wrap around care, particularly during periods of difficulty.
  - Engagement: organisations that successfully engage patients and carers are most likely to be successful in delivering a service that meets the needs of users.
  - Service accessibility: measuring the impact of the location of the future Principal Treatment Centre on accessibility by car and public transport, with a focus on those who are less able to choose flexible arrangements.

### **Enabling (non-clinical factors) domain**

- Capacity: sufficient capacity to treat children from a wide geography for a condition that requires speedy access, including for bone marrow transplants.
- Resilience: patients who use the services must be able to access care when required, including surgery within reasonable timescales. There must be good plans for keeping services running smoothly, including in emergencies.
- Organisational support for staff: Staff must be supported through this period of change.
- Impact on staff: the service change must not have an unnecessary or significantly negative impact on the workforce who deliver the service.

### **Research domain**

- Performance and capability: assessed current research performance and capability, providers' ambition and future vision for research and innovation.
- People: research workforce; staff development programmes; income supporting research staffing; research networks and collaboration; previous impact on collaborating to advance international health policy.
- Place: current capacity and excellence - physical space for research, including infrastructure to support and enhance transferring research teams, capacity for (phase I, II, and III research) trials and tissue studies, ability to link with industry; plans to improve existing provision, and capacity to scale.

Before the scoring began, the different domains and sub-criteria were 'weighted', depending on their importance. This meant the more important the domains (and the sub-criteria within the

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domains) were for the future Principal Treatment Centre, the bigger percentage of the available scores they could get. These weights were applied to the scores post-panel evaluation.

The domain weights were determined by the Programme Board. The sub-criteria were then weighted by expert panels, each of which focused on one of the four domains. They went on to assess and score the proposals for that domain. The individual members of the panels were agreed by the Programme Board, including The Royal Marsden, St George's, and Guy's and St Thomas'. At the request of different Programme Board members, some people whose names had been put forward were not invited to be on the panels, and others were added. The Programme Board agreed these changes, ensuring there was full support for the membership of each panel.

The 10 members of the clinical panel included leading children's cancer specialists from across the country, and senior doctors and nurses who worked in Brighton, London, South East region and further afield.

The 10 members of the patient and carer engagement panel included parents from London, Surrey and Sussex whose children had been treated at The Royal Marsden, representatives from national children's cancer charities, and senior nurses from London, South East region and further afield.

The 10 members of the enabling panel included senior doctors who worked in London, Kent and Medway, and South East region, an expert in emergency preparedness, a human resources expert, senior managers from NHS England (London and South East regions), and independent clinical representatives.

The nine members of the research panel were leading children's cancer doctors from across the country and the Netherlands, research leads from The Royal Marsden and the Institute of Cancer Research, and a representative of Association of British Pharmaceutical Industry.

Seven people were on two of the panels. No one was on more than two. Thirty-two different people were involved in the panels.

### **How the options were scored**

After fact verification checks and assessment of aspects of the proposals which required pre analysis, (for instance, travel time analysis and vacancy rates) by NHS England, panel members scored the proposals.

- They used the pre-agreed evaluation criteria to mark against and gave a rationale for their chosen score, in relation to the evaluation criteria.

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- NHS England London collated all initial scores and shared these anonymously with members of the same panel for their review. A meeting was held with members of each panel to discuss the approach to scoring to allow members to hear the opinions of others and to identify whether panel members wanted any clarifications about what had been written in the proposals before they each finalised their scores. All scoring was anonymised.
  - Following the meeting, panel members were given the opportunity to revise their initial score, if they wanted to (there was no requirement to do so), based on new information obtained through the clarification information. Alternatively, members could simply confirm their initial score. Panel members were free to reflect and come to their own decisions. There was no encouragement to score in a particular way; the Director of Cancer Services for NHS England London was party to all panels to ensure that this was the case. This independent observer role was one supported by the Programme Board and all its members.
  - NHS England London took the median value for each sub criteria and processed them with the pre-agreed weights to calculate the final score for each proposal.

### 3.4 Scoring and preferred option

In the assessment the panels undertook for our pre-consultation options evaluation, Guy's and St Thomas' NHS Foundation Trust's proposal on behalf of Evelina London scored higher on three of the four sub-criteria for the clinical services domain (Evelina London's network effectiveness, the number of interdependent services it has on site, and its support for children moving on to teenage and young adult services) and on all three sub-criteria for research (people, place, and capability and performance). St George's University Hospitals NHS Foundation Trust's proposal on behalf of St George's Hospital scored higher on two of the five sub-criteria for patient and carer experience (the quality of facilities it would provide (specifically, privacy and dignity), and patient travel times, especially by road. Other scores were the same or very similar.

The overall scores and scores by domain from the pre-consultation options evaluation are set out below.

Table 4: Overall scores and scores by domain from the pre-consultation options evaluation

Domains	Evelina London	St George's Hospital
	80.51%	75.27%
1. Clinical	29.63%	27.01%
2. Patient and Carer Experience	20.59%	21.84%
3. Enabling	15.42%	15.27%
4. Research	14.88%	11.16%

### Preferred option

Both options scored highly but Evelina London scored higher. On this basis, going into the public consultation, Evelina London was our preferred option for the future Principal Treatment Centre. We were open about the outcome of scoring and the fact that Evelina London was our preferred option so that those with an interest in our plans including those responding to the consultation were fully apprised of this information, in the interests of transparency.

### 3.5 Radiotherapy proposals

Both Evelina London and St George's Hospital propose that conventional radiotherapy for the future Principal Treatment Centre is delivered at University College Hospital. This will be part of the overarching changes to specialist children's cancer services that this business case is about.

The proposal is that conventional radiotherapy for children moves from The Royal Marsden to University College Hospital, located on Euston Road in central London. This would mean that all radiotherapy (conventional radiotherapy as well as proton beam and other types) rather than some, as now, would then be provided at University College Hospital.

All forms of radiotherapy are already provided at University College Hospital for children who go to the Principal Treatment Centres at Great Ormond Street Hospital and University Hospital Southampton (UHS), and some patients from Oxford. The specific detail of how this would work in practice to give patients the best care and experience would be agreed by clinicians and managers. We would support the development of these plans, working with the future provider and University College Hospital. More information on transition and implementation planning is in Section 7.6.

*Our proposals do not affect radiotherapy services for 16 to 24-year-olds, or adult services provided at The Royal Marsden.*

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## 4. Previous assurance and advice

At the pre-consultation stage, our proposals were scrutinised by:

- The London and South East Clinical Senates, an expert group of senior clinicians who know the London and South East regions well and offered an independent view. At our request, they jointly tested our proposals and gave us helpful advice.
- NHS England: Any proposal for service change must satisfy the government's four tests, NHS England's test for proposed bed closures (where appropriate), best practice checks, and must be affordable in capital and revenue terms. The NHS England assurance process was conducted by a team of reconfiguration experts who are not involved in the programme.
- The South East London, and South West London and Surrey Joint Health Overview and Scrutiny Committees (JHOSCs) which see our proposals as a substantial change for their residents and responded formally to our consultation.

An interim Integrated Impact Assessment was also undertaken.

### 4.1 London and South East Clinical Senates

The role of Clinical Senates is to provide clinical advice and leadership to help statutory bodies make the best decisions about health for the populations they serve. The advice given by Clinical Senates is impartial and is informed by the best available evidence. The London and South East Clinical Senates jointly reviewed the documentation about our proposals and, in April 2023, convened a review panel of clinicians who are national cancer specialists, and research experts, co-chaired by the respective chairs of both Senates. The panel heard presentations from the NHS England programme team and then put questions to the team and representatives of the current Principal Treatment Centre and both potential future providers.

After due consideration, the London and South East Clinical Senates shared their views with the programme. They found that:

- The case for change is clear with a sound evidence base.
- The proposals are grounded in evidence and best practice as outlined by Professor Sir Mike Richards' report and the national service specification.
- Proposals did not raise concern about either provider meeting the Principal Treatment Centre service specification.

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- The interim Equality and Health Inequalities Impact Assessment undertaken (part of the Integrated Impact Assessment) was an important starting point. They recommended this work continue through and after consultation.

As well as giving this overview, the review panel made recommendations for the consultation and successful implementation of the proposals. These included that we should:

- Ensure the service reconfiguration plans maximise opportunities to reduce health inequalities in access, quality and outcomes, including by co-designing them with the communities served.
- Ensure staff, children and families are central to the co-design of the future service and involved throughout the implementation phase.
- Support organisational development with the current children's cancer workforce and the provider of the future Principal Treatment Centre to mitigate risks.
- Ensure strong clinical leadership, dedicated to the implementation, is in place, and is developed and supported.
- Explore how the reconfiguration plans can maximise environmental sustainability.
- Ensure robust risk management and assurance mechanisms are in place for the implementation phase.

The recommendations are part of the London and South East Clinical Senates' full report<sup>26</sup>, which is on the consultation website, and on the websites of both Senates.

We held a workshop with representatives from The Royal Marsden, St George's Hospital and Evelina London to discuss how to address the recommendations, particularly those for the implementation phase. Our full response to the Clinical Senates' recommendations<sup>27</sup>, setting out how we are taking account of their advice, is on the consultation website. A further update to our actions on the recommendations is in Section 9.2.

## 4.2 NHS England

All proposals for significant NHS service reconfiguration must be assured by NHS England against the national five tests in NHS England's guidance, 'Planning, Assuring and Delivering Service Change for Patients'.

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<sup>26</sup> <https://www.transformationpartners.nhs.uk/wp-content/uploads/2023/09/PCBC-Appendix-7-London-and-South-East-Clinical-Senates-Review-Final-Report.pdf>

<sup>27</sup> <https://www.transformationpartners.nhs.uk/wp-content/uploads/2023/09/PCBC-Appendix-8-NHS-England-rsponse-to-London-SE-senate-recommendations-Final.pdf>



NHS England convened a panel of reconfiguration experts who are not involved in the programme to scrutinise the proposals and our approach to engagement and consultation. The panel raised some items for further consideration and gave some advice about how best to improve aspects of our work, these were addressed by the programme team before go-ahead was given to us to go to public consultation.

In September 2023, NHS England’s assurance process confirmed to the programme that it was its considered view that our proposals and consultation materials were suitable to be taken to public consultation.

### 4.3 Health Overview and Scrutiny Committees

In line with our statutory duty to enable review and scrutiny from local authorities, we engaged with the Joint Health Overview and Scrutiny Committees (JHOSCs) and Health Overview and Scrutiny Committees (HOSCs) in the Principal Treatment Centre’s catchment area before and during the consultation.

Between August and December 2022, we liaised with scrutiny committee chairs and officers to familiarise them with the programme of work and to understand the most appropriate way for us to work with their committees. Some committees asked us to liaise with them because of their level of interest in the programme, even though they were also represented on other joint committees.

In early 2023, we held further conversations with the chairs and democratic service officers of the committees listed in the table below, and attended each area’s formal scrutiny committee meetings. At these meetings, we explained the background and context to the reconfiguration programme, detailed the case for change as well as potential impact on local populations, and highlighted the potential timelines for decision making. The committees told us whether they found the change to be substantial for their populations, and how they wanted to engage with us over the course of the change programme. The meetings were held on the dates set out in the table below.

Table 5: Engagement with Health Overview and Scrutiny Committees

Engagement	Date	Outcome
South West London and Surrey JHOSC	25 January 2023	South West London and Surrey determined the proposed reconfiguration to be substantial for their area.
Kent HOSC	31 January 2023	Kent determined the proposed reconfiguration to not be substantial for their area but, because of

Engagement	Date	Outcome
		the importance of the programme, asked to be kept updated.
Surrey Adults and Health Select Committee	14 February 2023	Surrey determined the proposed reconfiguration to be substantial for their area.
South East London JHOSC	22 February 2023	South East London determined the proposed reconfiguration to be substantial for their area.
Medway Children and Young People Overview and Scrutiny Committee	2 March 2023	Medway determined the proposed reconfiguration to not be substantial for their area but, because of the importance of the programme, asked to be kept updated.
East Sussex HOSC	2 March 2023	East Sussex determined the proposed reconfiguration to not be substantial for their area but, because of the importance of the programme, asked to be kept updated.
West Sussex HOSC	8 March 2023	West Sussex determined the proposed reconfiguration to not be substantial for their area but, because of the importance of the programme, asked to be kept updated.
Sutton Scrutiny Committee	8 March 2023	Sutton determined the proposed reconfiguration to be substantial for their area.
Brighton & Hove HOSC	15 March 2023	Brighton & Hove determined the proposed reconfiguration to be substantial for their area. After a meeting of the Committee on 12 July 2023 which NHS England attended, the Committee agreed that the plans did not after all constitute a substantial variation in services. Because of the importance of the programme, they asked to be kept updated.

Local authority democratic officers for the areas which considered the change a substantial variation explored the possibility of forming a single JHOSC, representing all three

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organisations. South West London and Surrey JHOSC, South East London JHOSC, and Brighton and Hove HOSC met to discuss this in May 2023. They agreed that forming a single JHOSC across the wide geography would be a challenging process and, to enable them to provide timely responses to the proposals, we should consult with each of them separately.

We held a meeting on 22 May 2023 with the chairs and democratic scrutiny officers of the committees listed in the table above to agree how we would engage with them, including with those which did not find the change substantial.

Before and during the consultation, we worked closely with South West London and Surrey JHOSC and South East London JHOSC to ensure we consulted them when our proposals were at a formative stage and feedback from pre-consultation could influence the way the consultation process was implemented. We sought their views on our draft plans for public consultation and our draft consultation document. We received and considered their feedback.

#### 4.4 Integrated Impact Assessment

The Integrated Impact Assessment (IIA) is a set of collated evidence that provides information about the potential positive and negative impacts of our proposed changes to services. Its purpose is not to determine any decision but to provide support to the decision-makers by giving them better information on potential impacts and how they can best promote and protect the wellbeing of patients, staff and communities and have regard to reducing health inequalities.

The IIA includes an Equality and Health Inequalities Impact Assessment (EHIA) which assessed the consequences for different groups in the population to whom the proposed service change would apply – including families which are struggling financially, do not speak English or have disabilities. It also lists a set of potential solutions (mitigations) that may help to address some of the areas identified as having a negative impact on a particular group, organisation or community.

An EHIA can be used to demonstrate compliance with the Public Sector Equality Duty and the duty to reduce inequalities of access and outcomes under the NHS Act 2006 (as amended by the Health and Social Care Act 2012). It also supports consideration of whether the first of the London Mayor's six tests has been met (see Section 4.6). The first test concerns health and healthcare inequalities.

The interim IIA has been revised, following feedback from the public consultation. The updated IIA is in Appendix 4.

#### 4.5 Five tests for service reconfiguration

The government has four tests for service reconfiguration, and we have an additional one. These are:

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- Strong public and patient engagement – for information on how we have achieved this, see Sections 5 and 6.
  - Consistency with current and prospective need for patient choice – our proposals would maintain the current position, of there being 13 Principal Treatment Centres in England, each delivered by different providers. The fixed points applied for this reconfiguration mean the service will still be delivered in south London which, because of public transport and road links, means it will be accessible from across the wider catchment area. Furthermore, this change will mean that the Principal Treatment Centre for children with cancer living in Brighton and Hove, East Sussex, Kent, Medway, south London and Surrey Heartlands will be compliant with the national service specification.
  - Clear, clinical evidence base – the national service specification is based on clinical evidence, set out in Section 1.4.1. Clinicians and professional organisations affirmed their support for it during the 2019 consultation on the draft specification, as described in Section 1.4.1, and during the consultation, as described in Section 7.10.
  - Support for proposals from commissioners - this is a specialised service commissioned by NHS England. The two regions (London and South East) have worked together as members of the Programme Board, and the programme has benefited from significant clinical leadership from within the commissioning team.
  - The Integrated Care Boards (which commission most health services) for Kent and Medway, South East London, South West London, Surrey Heartlands, Sussex and North Central London<sup>28</sup> have all sent formal letters of support for this reconfiguration.
  - Hospital bed closures - the proposed service change is not about reducing hospital bed numbers and has no recommendations to do so. It is about supporting patients of the Principal Treatment Centre to access very specialist cancer treatment services for children in a location that is compliant with the national service specification. More information on our assessment of the proposals' capacity is in Section 7.8.1.

## 4.6 London Mayor's six tests

The Mayor of London has developed his own six tests which he applies when giving a view of any substantial health service change in London. They apply only to impacts on Londoners. We engaged with the Mayor's Office and had their advice in mind as we developed the pre-consultation business case and this decision-making business case. The Mayor's six tests are:

1. Health and healthcare inequalities

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<sup>28</sup> The reconfiguration is relevant to North Central London Integrated Care Board because University College Hospital is located in its area and University College London Hospitals NHS Foundation Trust is part of the North Central London Integrated Care System.

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2. Hospital beds
  3. Financial investment and savings
  4. Social care impact
  5. Clinical support
  6. Patient and public engagement.

See Section 9.1 for more information about the Mayor's response to the public consultation. This will be followed by a further letter setting out his position on the proposals and his tests after publication of the independent consultation feedback report (which happened on 31 January 2024) and of this decision-making business case.

The Mayor will not provide a position on which of the two potential sites is their preferred option. They will apply his six tests to both options and set out any further information or changes they would like to see in each case.

#### 4.7 Financial assurance

The key financial test, set out in our guidance, 'Planning, Assuring and Delivering Service Change for Patients', is that any proposal is affordable in capital and revenue terms ahead of public consultation. The financial test is therefore a hurdle criterion and was treated as such by the Programme Board.

As part of their proposals for the future Principal Treatment Centre, both Trusts submitted, as required, short form 5-case narrative business cases, a value for money financial model, statement of comprehensive net income and summary financial tables. Supporting schedules including maps and drawings were also supplied.

Both options deliver a modest but positive value for money outcome. So long as our work shows that both options remain affordable, financial considerations will not impact which option is selected. The driver for change is clinical quality and patient experience; the need to meet the national service specification for Children's Cancer Principal Treatment Centres.

In May 2022, it was confirmed that £20 million of national capital departmental expenditure limit (CDEL) funding would be made available as a contribution towards the capital costs of the proposals. Both Trusts have demonstrated the affordability of the capital costs of their proposals and also the revenue affordability of their clinical and workforce models.

#### 4.8 Additional considerations

Under the Health and Care Act 2022, new duties were introduced which require us to have regard to the wider effect of decisions we make (s.13NA NHS Act), generally referred to as the triple aim duty, and to have regard to the need to contribute towards compliance with the UK net

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zero emissions target (s.13NC NHS Act). These are in addition to our general and other duties (s.13 NHS Act) and the public sector equality duty (s.149 Equality Act 2010). The IIA (Appendix 4) includes an Environmental Sustainability Assessment (ESA) for both options.

#### **4.8.1 Climate Change Duty (s.13NC of NHS Act 2006)**

We have considered the potential environmental impacts of Principal Treatment Centre reconfiguration, looking at the potential environmental impacts in relation to capital build and transport access for the proposals put forward by both Guy's and St Thomas' and St George's. This supports meeting the duties of the Health and Social Care Act 2022 which places a duty on NHS bodies to have regard to wider effect of decisions on the sustainable and efficient use of resources.

More detail is in Section 8.7.

#### **4.8.2 Wider Effects of Decisions Duty (s.13NA NHS Act 2006)**

Under Section 13NA of the National Health Service Act 2006<sup>29</sup> we have a duty to ensure that the organisation has regard to all the likely effects of our decision-making, specifically the effects on:

- The health and wellbeing of the people of England (including inequalities in that health and wellbeing).
- The quality of services provided or arranged by both us and other relevant bodies (including inequalities in benefits from those services).
- The sustainable and efficient use of resources by both us and other relevant bodies.

We have done this through:

- Our Integrated Impact Assessment (see Section 8 and Appendix 4) which includes an equalities profile of the Principal Treatment Centre population, Health Equality and Inequalities Impact Assessment, and which reviews impacts on environmental sustainability, and on other organisations.
- Patient and public engagement, including the public consultation, and wider stakeholder engagement, which assesses the impact of the proposed service change on people with protected characteristics.
- Our work with clinicians and other experts, including before, during and following consultation.

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<sup>29</sup> [National Health Service Act 2006 \(legislation.gov.uk\)](https://www.legislation.gov.uk)

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- Our due diligence regarding the financial, environmental and other aspects of the proposals set out in this decision-making business case.

A key consideration through this process has been how implementation of the national service specification will lead to positive changes for children with cancer, in line with our vision for the future service to give best quality care and achieve world-class outcomes for children with cancer for decades to come.

Furthermore, as set out above, we have engaged with all involved providers to better understand the potential impacts that could arise on service delivery from whichever option becomes the proposed future Principal Treatment Centre.

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## 5. Consultation and engagement process

The public consultation on the options for the proposed future Principal Treatment Centre, including the proposal for conventional radiotherapy services, was launched on 26 September 2023, and closed 12 weeks later, on 18 December 2023.

The independent consultation feedback report found that the consultation successfully engaged stakeholders and key audiences. It heard from a range of stakeholder and equality groups, with good coverage of representation across the geographical regions in the catchment area of the current Principal Treatment Centre. The largest numbers of responses were from NHS staff; then children, young people and families; members of the public; and organisations and public representatives. There was good representation in the feedback from potentially impacted children and families, and members of public from marginalised communities and ethnic minorities, reflecting the demographic profile of the catchment area.

The work undertaken for the consultation and the findings of the consultation are summarised in this decision-making business case. The independent consultation feedback report is included in Appendix 2.

### 5.1 Summary of consultation approach

Our consultation approach was shaped by the IIA for the programme, our pre-consultation engagement<sup>30</sup> and feedback from key stakeholders. These stakeholders included the Stakeholder Group of parents and local and national charities, affected Trusts, Integrated Care Board communications and engagement colleagues and Joint Health and Overview Scrutiny Committees within the service catchment area, as well as children and young people themselves. The Consultation Institute also provided advice on our plan.

All of this helped shape the multi-layered, multi-targeted engagement we undertook, supported by a wide range of communications to raise awareness of the public consultation and enable people to respond to it. The Principal Treatment Centre provides a specialised service, used by around 1,400 children a year across the catchment area covering half of London, the parts or whole of three counties and two unitary authorities. Given the wide geography and the impact of a diagnosis of cancer on children and their families, we ensured our engagement activities were proportionate, as recommended by best practice guidance, and tailored to differing audiences.

The consultation was open to all, however, in line with the consultation plan, we prioritised hearing from those directly impacted (see below) from across the entire catchment area; those

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<sup>30</sup> Pre-consultation engagement activity and stakeholder feedback 'You said, We did' report (October 2023) [https://www.transformationpartners.nhs.uk/wp-content/uploads/2023/10/Final\\_Pre-Consultation-Engagement-Report\\_V1.0.pdf](https://www.transformationpartners.nhs.uk/wp-content/uploads/2023/10/Final_Pre-Consultation-Engagement-Report_V1.0.pdf)



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who were identified in the Integrated Impact Assessment (IIA) as being disproportionately impacted compared to other groups; other key stakeholders; and those with protected characteristics.

Groups directly impacted:

- children and young people with cancer or who have experienced cancer and their families
- affected clinical and non-clinical NHS staff (defined as staff at the hospitals where the Principal Treatment Centre is currently, or could be in the future - The Royal Marsden, St George's Hospital and Evelina London).

Other key stakeholder groups:

- other clinical and non-clinical NHS staff with an interest in the service, including staff of children's cancer shared care units
- professional bodies, specialist children's cancer charities and research organisations
- children, young people, and their families with related experience
- members of the public
- local government, including Joint Health Overview and Scrutiny Committees and MPs.

Communities with specific protected characteristics identified in the interim IIA as potentially differentially impacted by the proposed move of service:

- people from ethnic minorities
- families with poor literacy skills and/or language barriers
- people with autism
- people with physical disabilities
- people with learning disabilities or learning impairments
- people with mental health issues
- families with caring responsibilities
- looked after children and young people.

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While not a group protected by equality legislation, families experiencing financial difficulties or who live in the most deprived areas were identified by the interim IIA as potentially experiencing a greater impact, and so were also included as a priority group.

### 5.1.1 Delivery partners

In line with the consultation plan, we worked closely with a wide range of partners to carry out the consultation activities and analyse the responses. The programme team led these activities, supported by:

- Starlight play specialists, who gently explored the views of children with cancer, and sometimes their parents and siblings, during play sessions at The Royal Marsden and St George's Hospital and online.
- Participation People, which specialises in youth participation and ran focus groups in more deprived parts of the catchment area with families and children (who did not have cancer) with specific characteristics set out in the interim IIA to understand their perspectives on a service move like this.
- Transformation Partners in Health and Care, a consultancy by the NHS for the NHS, which supported us with communications and engagement expertise, including with the development and delivery of our consultation plan.
- Hood & Woolf, an external consultancy, which led sessions for parents/carers of children being treated at The Royal Marsden and St George's, and for staff working in children's cancer services at the two hospitals.
- Explain Market Research, which reviewed and analysed the responses to the consultation, including the online and printed questionnaires, emails, letters, reports of what people said at meetings, and one to one interviews, and pulled together all this material into the consultation feedback report.
- Colleagues at The Royal Marsden, St George's, and children's cancer shared care units, who shared materials with patients, families and staff and encouraged responses to the consultation, including by sending out letters to individual families, putting up posters, and sharing printed materials for the consultation.
- Colleagues at Evelina London, the five ICBs in the catchment area, NHS England regions and other partners, such as Healthwatch organisations, who promoted the consultation through their varied communications channels to encourage people to respond.

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### 5.1.2 Mid-point review

In line with best practice, a mid-point review was commissioned from Explain Market Research halfway through the consultation. Explain Market Research reviewed the consultation activity that had happened so far and the profile of respondents who had given feedback. This was to identify any gaps in feedback at that point and assess whether planned activities would fully fill those gaps. The review also provided details of emerging themes from the analysis of consultation feedback to date.

Details of the review and of our plan to address gaps in feedback were shared with the Stakeholder Group, Programme Board, and JHOSCs. As a result of this mid-point review, some additional activities were undertaken, including:

- sessions with specific equalities groups that were being heard from less
- adding site visits to the engagement plan to hear directly from families and children and young people in waiting rooms at The Royal Marsden and children's cancer shared care units across the catchment area
- running a paid-for social media campaign
- commissioning an independent organisation to facilitate feedback sessions with staff and parents
- commissioning online play specialist sessions to increase uptake for those who are no longer in active treatment
- asking the external expert play specialist organisation to review their approach to ensure they were capturing the most useful feedback from children and young people
- follow-up phone calls to voluntary and community organisations to support promotion of the consultation
- adding videos to the online questionnaire to help people learn more about both options as they completed the questions, and using these videos in face-to-face sessions
- working with University College London Hospitals to raise awareness of the consultation with current proton beam patients.

## 5.2 Summary of consultation activities

In line with our consultation plan, we made available a wide variety of ways for people to respond to the consultation. The team provided the same information, and opportunities to engage through digital events, to all stakeholders no matter where they lived in the catchment area. Specific engagement activities that were commissioned in the community engaged with people who were representative of different characteristics, for example those who lived in more

rural locations rather than towns, and in inner rather than outer London, as well as other demographic characteristics.

Information, taken from the independent consultation feedback report, outlines a summary of consultation activities.

The table below summarises activity and the number of people engaged, or responses received.

**Table 6: Engagement activity and associated consultation responses**

Activity	Number of sessions/events	Number of people engaged/responses received
The consultation questionnaire, available to complete online and by paper copy, including an Easy Read version. Paper copies, along with freepost envelopes, were left at key locations in the catchment area	N/A	1,763 responses
Play specialist sessions (with children with cancer in hospital settings and online - facilitated by an external expert organisation)	11 sessions	28
Parent focus groups (facilitated by an external organisation)	7 sessions	27
Site visits to the Principal Treatment Centre outpatient waiting area at The Royal Marsden and some children's shared care units to speak to children with cancer and their families	13 visits	91
Public listening events during the day and evening which accommodated additional needs where appropriate	3 events	31
Staff sessions: with the three Trusts directly involved in the consultation (facilitated by us and an external expert organisation)	5 sessions	63
Staff sessions: across the wider clinical community	11 meetings	156

Activity	Number of sessions/events	Number of people engaged/responses received
Community meetings and equalities groups (facilitated by us and an external expert organisation)	25 meetings	271
One-to-one interviews (with staff/parents/research staff for example)	22 interviews	22
Q&A sessions (with councillors, MPs and voluntary and community organisations such as Healthwatch - facilitated by us)	18 sessions	93
Emails, letters, and telephone calls	N/A	29 responses
Formal responses received from organisations	N/A	45 responses
Information giving (facilitated by us via briefings or promotional opportunities to raise awareness of the consultation)	5 sessions	49

Our engagement was supported by communications activity to raise awareness of the consultation and encourage people to have their say. This included:

- Widespread publicity around the launch of the consultation and afterwards – encouraging people to find out more about the consultation and respond to it.
- A wide range of information about the consultation to cover different levels of interest and desire for detail, from a short animation to our consultation document, pre-consultation business case and supporting documents about key topics identified in pre-consultation engagement.

Figure 2: Communications used to promote the consultation

<p><b>Website</b></p>  <p>Including child friendly section</p>	<p><b>Animation</b></p> 	<p><b>Posters and printed documents</b></p>  <p>at the Principal Treatment Centre and Paediatric Oncology Shared Care Units</p>
<p><b>Facebook campaign</b></p>  <p>Widespread and paid-for</p>	<p><b>Proactive media releases</b></p>  <p>and responses to media enquiries</p>	<p><b>Social media</b></p>  <p>messaging by: NHS England (London and SE) and partners and others</p>
<p><b>Phone calls and offers of meetings</b></p>  <p>to groups working with communities identified by the Integrated Impact Assessment</p>	<p><b>Letters</b></p>  <p>to current and recent patients of the Principal Treatment Centre</p>	<p><b>Email briefings</b></p>  <p>to all stakeholder groups</p>

We developed a wide range of materials for the consultation including:

- full consultation document
- summary consultation document, and Easy Read summary
- consultation questionnaire and Easy Read questionnaire
- animation – subtitled in English and the most commonly spoken languages by people who don't speak English
- poster and flyer
- social media assets
- detailed factsheets about specific aspects of the process and proposals
- briefing information for staff to answer families' questions
- slide decks for meetings

- 
- frequently asked questions.

These materials were supplemented by age-appropriate materials developed by Starlight and Participation People for their work with children, young people and families with and without experience of cancer, and by Hood & Woolf for the focus groups they ran for families of children with cancer, and for staff at The Royal Marsden and St George's Hospital.

The main documents were available in a range of formats, including as accessibly presented html pages, on the consultation website. We offered British Sign Language and language interpreters for meetings to ensure accessibility. People could raise questions with us via freephone, email or freepost, as well as by joining meetings.

We designed the questionnaire with the Programme Board, Trust senior management leads, and our Stakeholder Group (of parents and local and national charities), with input from The Consultation Institute. Explain Market Research also provided comments on the questionnaire design. The questionnaire itself focused on key questions that would help inform decision-making. Many of the questions were qualitative in nature, leading to significant levels of detail in these responses. It included questions on:

- basic demographics (dropdown lists for people to choose from)
- history of treatment for families with experience of children's cancer services
- what people would value most in a future Principal Treatment Centre
- the importance of different aspects of travel and access
- the importance of different aspects of support and information (for current staff and patients)
- the good points, potential challenges and suggestions for potential challenges for both options
- the proposed move of conventional radiotherapy services
- other thoughts or ideas
- detailed demographics.

Printed copies of the summary consultation document, easy read summary, easy read questionnaire and posters were shared with The Royal Marsden, St George's Hospital and Evelina London and all children's cancer shared care units in the catchment area, with a request for them to encourage patients, families and staff to respond to the consultation.

## 5.3 Reach of consultation

### 5.3.1 Effectiveness of the consultation

Overall, given the size and specialism of the service, we are pleased with the reach and response rate to the consultation. Explain Market Research concluded that the consultation reached a good range of stakeholders – particularly affected staff, and children and families including those with experience of cancer services – supported by the additional steps taken after the mid-point review. It was noted that children and families reached were broadly representative of the current patient cohort in terms of geography and demographics.

Responses to our consultation tended to be from older consultees, those from higher socio-economic groups and from females. These trends were expected, given the profile of the clinical workforce responding and the precedent for higher response rates to surveys, in general, by females<sup>31</sup>. In spite of the challenges with engaging children and young people, we feel confident that we have heard sufficiently from younger respondents and their representatives through face to face engagement work. We offered a range of opportunities for children and young people to participate using creative methods. There was also a mix of consultees from deprived areas across the geographies.

### 5.3.2 Responses to the consultation

In total, 2,669 formal responses to the consultation were received. They came in via different engagement channels, shown below.

Figure 3: How people gave their feedback to the consultation



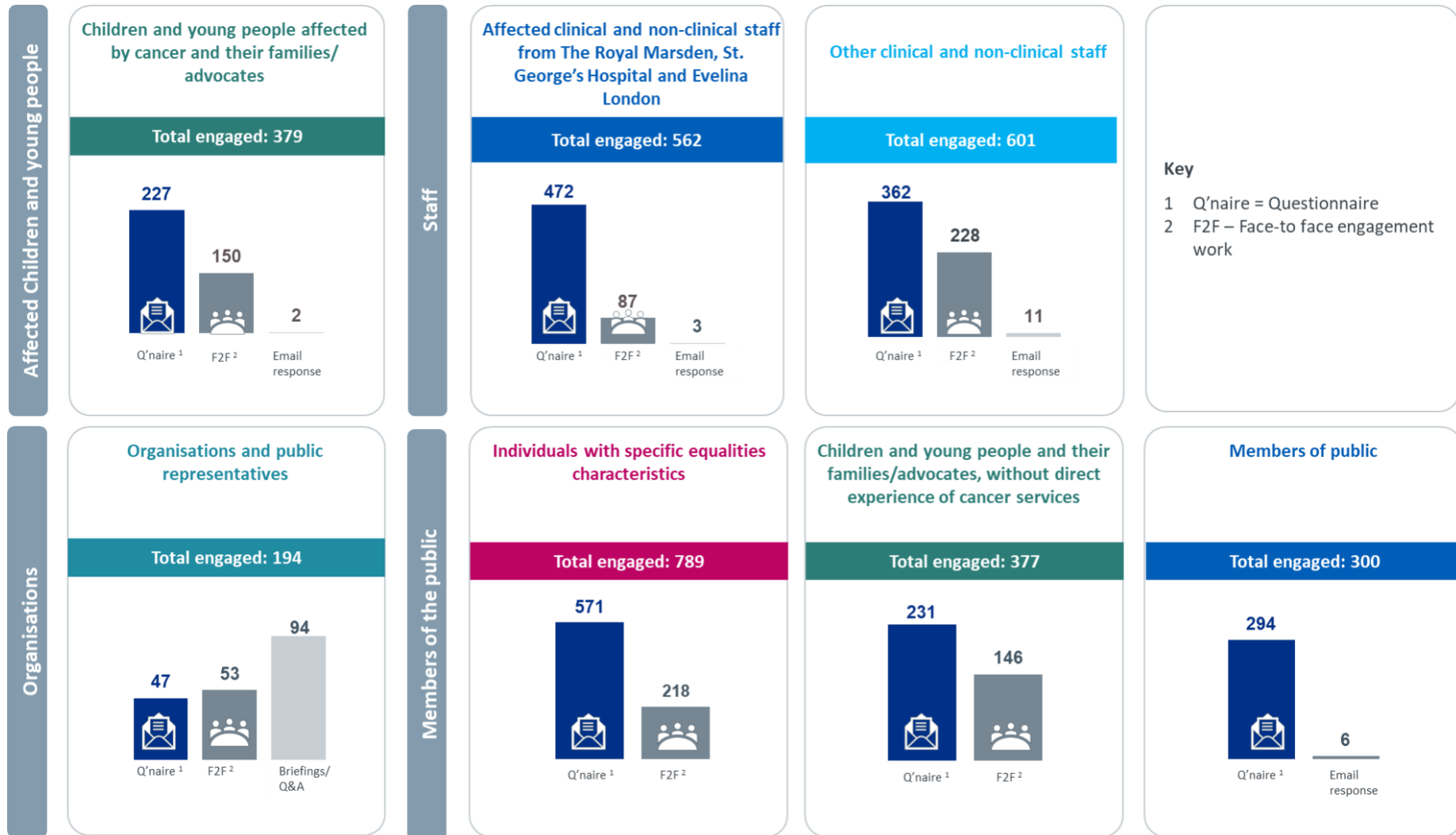
<sup>31</sup> In general, more educated and more affluent people are more likely to participate in surveys than less educated and less affluent people (Curtin, Presser, and Singer, 2000; Goyder, Warriner, & Miller, 2002; Singer, van Hoewyk, & Maher, 2000), **women are more likely to participate than men** (Curtin et al 2000; Moore & Tarnai, 2002; Singer et al 2000)



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The charts below show the reach of the consultation to our key audiences, by all engagement methods. Please note – not everyone shared their stakeholder type or demographic information and those in equalities groups were also included in other stakeholder types. However, this gives an indicative picture of the reach of our engagement.

Figure 4: Overview of the reach to different stakeholder types



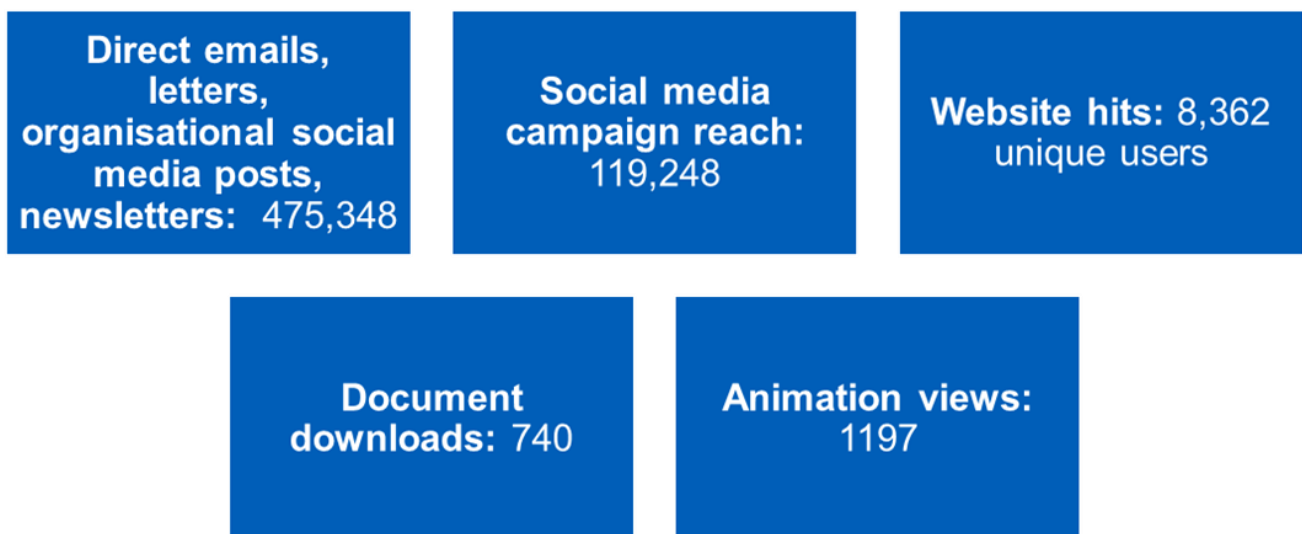
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### 5.3.3 Reach of communications

In total, 604,895 prompts were sent to organisations and individuals to raise awareness of the consultation and encourage people to share their views. These came directly from us and our colleagues at NHS England (London and South regions) and via NHS partners and voluntary and community organisations, such as Healthwatch.

The diagram below summarises the reach of our different communications.

Figure 5: Reach of communications to promote the consultation



There was proactive and reactive media coverage of the consultation by these outlets in the catchment area:

- BBC online
- BBC Radio Surrey
- Evening Standard
- The Independent
- ITV Meridian
- London Live
- London News Online
- London Post
- Metro

- 
- MyLondon
  - Putneysw15.com
  - South London Press & Mercury
  - South West Londoner
  - Sussex Express
  - SussexWorld
  - This is Local London
  - Your Local Guardian.

It is not possible to provide an overall figure for media reach as a dedicated media monitoring service for the consultation was not used. However, media coverage was monitored using online alerts and was tracked to ensure a breadth of coverage across the catchment area.

#### 5.4 Consultation feedback report

We commissioned Explain Market Research to conduct independent thematic analysis of all feedback received during the consultation period and to prepare a report.

People could take part in the consultation using more than one of the engagement methods. For instance, people may have attended a public meeting and also submitted a response to the questionnaire. Feedback numbers show responses, not unique individuals. This is not a matter of concern as the purpose of the consultation was to gather and gain rich insights into a wide range of different perspectives on our proposals; it was not, and was not intended to be, a 'vote'.

Many of the questions in the questionnaire were open questions with no word limit<sup>32</sup> and many of the responses were varied, detailed, and long. Sometimes people did not directly answer the question; they took the opportunity to state what mattered most to them. When analysing this qualitative data thematically, Explain Market Research used different codes for different aspects of the same topic to capture the richness of feedback<sup>33</sup>. As such, it is not possible to add up the number of responses (such as on travel) to understand how many

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<sup>32</sup> An example of an open question from the questionnaire is: 'Please tell us what you think the good things are about this option.'

<sup>33</sup> For example, feedback relating to travel covered many different aspects, including travel by car, parking availability, distance of parking from the hospital, travel by public transport, accessibility of public transport, travel costs, congestion and Ultra Low Emission Zone charges, accessibility specifically for sick children, practicalities of attending hospital with a sick child and siblings, and practicalities of attending hospital as a single parent with no support person.

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people raised an issue, because there may be overlap between those who gave those comments.

All other qualitative feedback was analysed thematically. Given the qualitative methods of engagement used (such as focus groups, interviews, and meetings), it was not possible to 'quantify' this qualitative data. This is because these engagement methods were not structured in the same way, they sometimes involved the dynamics of a group setting, and the presence of a facilitator meant they could probe further for meaning by asking follow-up questions.

The quantitative and qualitative data was analysed in triangulation to inform and validate each other, to improve understanding of how and why respondents were feeling the way they did about the proposals.

Some feedback included complex clinical and technical statements. Explain Market Research shared anonymised details of statements with our Programme Team for clarification and verification with subject matter experts. Some feedback also included misinterpretation of the proposals or factual inaccuracies. These were noted and analysed alongside all other feedback.

The independent consultation feedback report was published on 31 January 2024 on the consultation website and is included in Appendix 2. Upon publication, the link to the report was shared with a range of stakeholders including affected staff and those who have registered an interest in future involvement in the implementation of the change, once a decision is made.

## 5.5 Petitions

On 10 October 2023, a petition #HearTheMarsdenKids was launched calling on the NHS to reconsider the move. The parents who set up the petition do not agree with the need for the move of very specialist cancer treatment services from The Royal Marsden. Instead, they propose a solution which would maintain services on two sites, with children at highest risk of needing intensive care as part of their treatment identified at diagnosis so they could receive all their care at St George's Hospital. The petition was submitted to NHS England at the close of the consultation having received 10,394 signatures. It was analysed separately within the independent consultation report. The petition can be found at [Petition · #HearTheMarsdenKids campaign · Change.org](#).

In addition to this petition, we are aware of three other petitions that have some relation to this reconfiguration programme. We are not aware that these have been submitted to NHS England but they are recorded here for completeness.

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- A pre-existing petition #MustBeMarsden which was started on 4 February 2020 and focuses on retaining services at The Royal Marsden. The petition has over 35,000 signatures; the majority of comments appear to be historical, with 11 added during our public consultation.
  - A petition launched by Dr Rosena Allin-Khan MP, seeking support to keep the children's cancer centre at St George's Hospital and also one launched by Eleanor Stringer (Wimbledon Labour Party) seeking to keep services at St George's Hospital, closer to Wimbledon.

## 5.6 Meeting the Gunning Principles

The Gunning Principles are a set of legal principles designed to ensure consultation is conducted fairly and lawfully. This section sets out evidence to demonstrate these principles have been met through the consultation process. Some Healthwatch colleagues specifically cited issues with the process meeting Gunning Principles 1, 2 and 4. We have responded formally to these organisations (see Appendix 10).

### 1. **Proposals are still at a formative stage.**

*A final decision has not yet been made, or predetermined, by the decision makers.*

We entered into the public consultation with an open mind. For transparency reasons, following a robust options evaluation process, a preferred option formed part of the information shared – the preferred option directly reflected the scores awarded based on information available when the options evaluation was conducted. There is clear precedent in consultation processes for stating a preferred option, or even consulting on a single proposal – neither approach indicates that a decision has been made<sup>34</sup>. Instead, it provides transparency and sufficient information to those being consulted. Having a preferred option does not impact on our ability to maintain an open mind as to the right final decision for the benefit of patients.

The consultation itself sought to gather new and more detailed information and verify what we'd heard in earlier phases of engagement work, from a wide range of stakeholders, including from the Trusts which submitted proposals. The consultation highlighted a number of important issues for consideration which have been included in the decision-making business case – either in terms of feedback to strengthen the proposals or around implementation planning. Without the consultation, we would not have had the opportunity to take into consideration information shared by the public through this process as part of its decision-making.

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<sup>34</sup> Moseley v Haringey LBC [2014] 1 WLR 394, (Supreme Court)

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Care was taken to develop consultation questions which would collect information that would help inform our decision. This included asking questions about the strengths and challenges of the options, impacts on important areas such as travel and access, support and information people would find helpful during the service move, and gathering mitigating actions. The draft questions were developed and tested with The Consultation Institute, Explain Market Research (which prepared our independent consultation feedback report), Overview and Scrutiny Committees, Trust colleagues and our Stakeholder Group. Although the questions did not seek to gather preferences between the options, and we were clear from the outset that a public consultation is not a referendum, many consultees still took the opportunity to express a preference. Explain Market Research concluded that the feedback received on the proposals was mixed when looking across feedback and respondent types.

## **2. There is sufficient information to give ‘intelligent consideration’**

*The information provided must relate to the consultation and must be available, accessible, and easily interpretable for consultees to provide an informed response.*

During the pre-consultation phase of our work, we tested, with a broad range of stakeholders, our approach to providing information. Learning from what we heard, we produced a range of information in different formats to help consultation respondents give intelligent consideration to the materials. These are set out at Section 5.2 above.

Going further, during our mid-point review, our independent consultation analysts suggested changes to our approach to make information even more accessible, such as embedding information about both options into the online survey – which we actioned as a priority. Consultees were also able to request further information or ask clarification questions to support their understanding of the material. Where consultees stated they did not have the time to complete the full consultation questionnaire, we emphasised our offer of one to one interviews and/or highlighted the easy read questionnaire to them.

What is clear, through reading the independent consultation feedback report, is that many hundreds of stakeholders were able to give detailed feedback in response to the consultation questions and make sense of the information provided. Furthermore, across a range of different stakeholder groups of varying abilities, feedback continued to return the same themes – demonstrating a general consensus and understanding of the material provided.

## **3. There is adequate time for consideration and response**

*There must be sufficient opportunity for consultees to participate in the consultation. There is no set timeframe for consultation, despite the widely accepted 12-week consultation period, as the length of time given for consultees to respond can vary depending on the subject and extent of impact of the consultation.*

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We discussed and sought feedback on the duration of the consultation from external experts such as The Consultation Institute, legal advice and Overview and Scrutiny Committees. Although the consultation was set for 12 weeks, at the mid-point review we took stock of responses to date to consider whether an extension was needed. The independent consultation analysts felt that an extension was not needed and plans for the remainder of the consultation would ensure adequate time for consideration and response.

Earlier in the consultation, we received feedback from some families that they did not have the time or emotional capacity to respond to the full consultation questionnaire – in these cases it was made clear that they were welcome to speak with us one to one at a time convenient for them or to provide responses by email, which several parents did.

The programme also delayed the start of the public consultation, to allow more time to listen and respond to pre-consultation feedback, and to avoid consulting over the school summer holidays. Instead, the consultation got underway in September 2023.

#### **4. ‘Conscientious consideration’ must be given to the consultation responses before a decision is made**

*Decision-makers should be able to provide evidence that they took consultation responses into account.*

Prior to and upon publication of the independent consultation feedback report on 31 January 2024, decision-makers were engaged to consider and discuss findings of the consultation. This happened during Joint Executive meetings between January and March 2024 which involved key leads from NHS England (London and South East regions). They were also given the full report for review and given the opportunity to ask questions/seek clarity on any feedback within the report.

Additionally, information from the consultation and other sources has been reviewed by NHS England through a series of working groups. These working groups were made up of subject matter experts from London and South East regions and national teams with expertise in areas pertinent to the proposed reconfiguration, including management of clinical services, workforce, operations, data, and travel and access – the latter also included representation from the voluntary and community sector. Information was shared with these groups for consideration to support the development of mitigations and solutions.

Feedback from the consultation has been embedded within this decision-making business case. Each feedback theme has been assessed, using the process set out in our framework for review of information, as to the best way to take the feedback on board, including how any issues can be mitigated, opportunities enhanced and to determine whether or not feedback is relevant to this phase of work or to the implementation phase. Using a ‘you said,



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we did' format, we have demonstrated how individual themes have been considered and influenced our thinking. Decision-makers read and considered this document and the independent consultation feedback report before the decision-making meeting.

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## Consultation analysis



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## 6. Feedback from public consultation

### 6.1 Key findings

During the consultation, people were asked to give their feedback on what attributes mattered most to them for the future Principal Treatment Centre, on the strengths and challenges of both options (Evelina London and St George's Hospital) and on the proposal under both options to move conventional radiotherapy to University College Hospital. People were asked to make suggestions to address any challenges they had identified. They were also asked to reflect on what aspects of travel would be most important, while staff, patients and families connected to the current Principal Treatment Centre service were asked how important different types of information and support would be to make the move easier.

The consultation findings presented in this Section summarise feedback from all qualitative and quantitative engagement methods, from different stakeholder groups, across the catchment area. The independent consultation feedback report produced by Explain Market Research identified them as key findings because many people talked about them, there was a strength of feeling evident across engagement types, and they relate to the future service.

Significant feedback was received from affected staff. This Section also specifically spotlights feedback from clinical colleagues with specific and relevant insight into the current service. This aims to give a deeper understanding of the clinical challenges raised in the report.

The key findings were:

- The consultation successfully engaged stakeholders, hearing from a range of stakeholders and equality groups, with good coverage of representation across the geographical regions in the catchment area of the current Principal Treatment Centre.
- The most valued attributes for the future Principal Treatment Centre were the provision of all or most specialisms and services needed for children's cancer care on a single site, as well as having a specialist knowledge and experience of children's cancer care.
- Overall, the feedback received on the proposals was mixed. There were strong views on the benefits and challenges of both options, including the proposal to move conventional radiotherapy to University College Hospital.
- Travel to and accessibility of the future Principal Treatment Centre was a very important topic for respondents across all stakeholder groups.
- Alternative proposals were put forward by a small number of respondents.

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Although it falls outside the scope of the consultation, strong views were also received about the case for change. These views were mixed. There was strong clinical support for the case for change, largely found in responses from clinical NHS staff and in the formal responses submitted by organisations. Some family members and advocates also gave their support for the case for change; these were typically individuals who had lived experience of children's intensive care unit transfers involving their child or close relative. Other children, young people, family members and members of the public opposed the case for change. Many of those who did so argued for services to remain at The Royal Marsden.

Some criticism was received about the consultation. This centred on several key points 1) a feeling that the consultation should not have gone ahead because of perceived opposition to the case for change, 2) that the consultation was biased due to the preferred option identified by the pre-consultation evaluation being revealed and 3) a feeling that feedback could not affect the decision-making process.

Although these comments were made by a relatively small number of respondents compared to the total number of responses received, we recognise it is essential that the decision-making process provides assurances about the ways it has listened to and taken into account feedback given.

This document:

- uses a 'you said, we did' approach to demonstrate what we have done in response to consultation feedback
- sets out in detail in Section 7.10 the responses we received on the case for change, including alternative solutions suggested; and
- includes detailed responses to key organisational feedback (Appendices 3, 5, 6, 8, 9, 11), including individual comments raised by the NHS Trusts and professional organisations which are most closely involved in the Principal Treatment Centre reconfiguration, and some Healthwatch colleagues who believe our consultation failed to meet the Gunning Principles (which are explained at Section 5.6).
- We received positive feedback from some Health Overview and Scrutiny Committees about the way we engaged with them, and the efforts we have made to keep them informed.

## 6.2 The future Principal Treatment Centre

In responses to the questionnaire, the most valued attributes for the future Principal Treatment Centre were:

- 
- The provision of all or most specialisms and services needed for children’s cancer care on a single site, such as surgery, neurosurgery, radiotherapy, children’s intensive care unit, and health and kidney care (20% of questionnaire comments to the relevant question).
  - Specialist knowledge of and experience in children’s cancer care (20% of questionnaire comments to the relevant question).
  - A convenient location (18% of comments), particularly in terms of access by car (16% of questionnaire comments to the relevant question).
  - Strong research facilities and track record (16% of questionnaire comments to the relevant question)<sup>35</sup>.

For respondents answering the Easy Read questionnaire, the most important attribute for a future Principal Treatment Centre was the ability to travel to the site easily (41%) whether this be the site having good public transport links nearby or having good parking availability on site for patients, families and staff. Related to this, some left more general comments about accessibility (18%). Another key theme included the new site having a good level of knowledge and experience in treating children with cancer (20%).

Feedback from qualitative engagement activities validated these attributes as important ones.

Other key suggestions included:

- Child-friendly hospital, with bright and colourful spaces and spacious facilities that cater to children’s needs (such as age-appropriate play and education spaces, only for children with cancer).
- Preservation of the welcoming, family-friendly and homely environment of The Royal Marsden.
- Personalised care for the child.
- Ensuite accommodation, with space for at least one parent to stay overnight.
- If there are wards, there is no mixing of different ages of children.
- Spaces to accept visitors, especially siblings and other family members.
- Good hospital food, catering for the child’s needs, preferences, and tastes.
- Family accommodation nearby.

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<sup>35</sup> Data here given for the main questionnaire, after 23 October 2023 when the change was made to the question scales.

- 
- Private facilities for parents, such as working showers and comfortable beds. Kitchen facilities, including space to store food and cook meals were also important.
  - Access to outdoor spaces that are dedicated to children with cancer.
  - Cancer charities have their own spaces and rooms in the ward to provide family support.
  - Lifts instead of stairs, with priority given to sick children.
  - Good signage.
  - Staff to help you to navigate hospital spaces, make introductions, make you feel welcome, explain what is happening and when; staff knowing your name; people who make an effort to listen.
  - Plenty of free parking spaces close to the hospital.
  - Good communication between the Principal Treatment Centre, children's cancer shared care units, community nursing teams, and GPs.
  - Good communication of key information when a child first becomes a patient of the Principal Treatment Centre, easily digestible information and guidance.
  - Good communication with the Principal Treatment Centre, so they answer your call first time you ring.

These suggestions and recommendations will be shared with the provider of the future Principal Treatment Centre, to help shape implementation.

### 6.3 Overview of feedback on the options

This Section, and the Sections that follow detailing the feedback received on the options, presents a summary of key findings across all stakeholder groups, from all regions of the catchment area. Importantly, these are findings from all forms of feedback when considered together, including the questionnaire and qualitative engagement activities. This gives us a robust understanding of what people think about the options, which has been validated across different engagement types, with different groups.

#### 6.3.1 Feedback on options: Principal Treatment Centre at Evelina London

##### Strengths

Feedback on the strengths of the Evelina London option included the fact it is a dedicated children's hospital with many specialisms, such as heart and kidney care, and has a strong research proposition.

Across feedback, there was agreement across stakeholder groups that the strengths of the Evelina London option included:

- 
- It is a purpose-built children’s hospital, which is child-focused, with good facilities.

*“The main advantage about Evelina is that it is a children hospital. They understand the need of the child and the parents. The journey of the child affects the whole family not just one person. They already have the background of dealing with the other aspects of the family, transport, accommodation. The hospital infrastructure is excellent to accommodate an oncology department beside the other specialities. The team seemed friendly and willing to offer the best care.” (Member of NHS staff working at the Principal Treatment Centre at The Royal Marsden Hospital, questionnaire response.)*

- It provides other important specialisms that children with cancer need, including specialist heart and kidney care.

*“It has a large number of paediatric specialists with a lot of expertise. Not all patients follow the textbook: it would be good to have access to extra services, not just those that are specified [in the service specification].” (Member of staff, site visit to The Royal Marsden, December 2023.)*

- It has a large children’s intensive care unit with the perception that this would mean that there would be capacity for intensive care for children with cancer, if needed.
- The perception that it has excellent research infrastructure and expertise, with a strong track record of research.
- It has a good research proposition, in virtue of its membership of Guy’s and St Thomas’ NHS Foundation Trust and links to King’s College London.
- It has good public transport links given its location in central London for both families and staff.
- It is well-located for access to local amenities, such as shops and recreational spaces.
- It is located close to University College Hospital if a child or young person needed to travel for radiotherapy.
- There is family accommodation nearby.

Affected and other clinical and non-clinical staff highlighted these additional strengths of Evelina London’s proposal:

- Staff at Evelina London already work with some children with cancer and children’s cancer services through their existing work.
- It has existing links with many different healthcare providers in the catchment area, including King’s College Hospital and hospitals which also provide children’s cancer shared care units.

- 
- It has links to adult cancer services through the Trust it is part of - Guy's Hospital has an adult cancer centre and an Experimental Centre for Cancer Medicine
  - It uses the same IT system for patient records as The Royal Marsden, which could help with a smooth transition of the Principal Treatment Centre
  - It is considered by some staff to be a good place to work.

## Challenges

Feedback on the challenges of the Evelina London option included that it lacks experience and expertise in treating children's cancer and it would be challenging for families to access.

*"Lack of experience of the team at Evelina, as they have NEVER managed cancer, we are talking about radiology, infectious diseases, gastroenterology, surgery." (Currently works for the Principal Treatment Centre at St George's Hospital, questionnaire response.)*

*"No existing skills in oncology is a big risk. This extends to all different workforce groups, not just nurses." (Meeting with nurse at The Royal Marsden, December 2023.)*

Other challenges included:

- It does not provide neurosurgery.
- While it conducts a wide range of other paediatric research, it does not conduct research in paediatric cancer, which leads to concerns about the continued provision of children's clinical cancer trials.
- It is perceived that it may face significant recruitment issues as it would be heavily reliant on retaining experienced staff from The Royal Marsden.
- There is the possibility that staff would not want to work in and travel to central London, given the lack of financial incentive and the potential detrimental impact on family life.
- It would be difficult for families to access Evelina London by car, which is a preferred method of transport for parent and carers travelling with a child with cancer.
- It would be costly and time consuming for families to travel to Evelina London, acknowledging schemes to reimburse congestion charges and Ultra Low Emission Zone.
- Family accommodation at Evelina London considered not being close to the hospital.
- Eligibility for and the availability of accommodation may not be guaranteed and has not been confirmed at this stage.



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Affected and other clinical and non-clinical staff highlighted these additional challenges of Evelina London’s proposal:

- There was a concern that staff could be asked to work in other specialities, resulting in a loss of their oncology expertise, and having a detrimental impact on patients who need dedicated care.
- Recruitment to Evelina London could have a potential negative impact on the recruitment and retention of staff for other nearby NHS services (for example, at Great Ormond Street Hospital), due to competing demand.
- Due to the proposed layout of the service (inpatient ward in main children’s hospital building with link to outpatients area but not to day cases which would be in another building), staff would be working in different areas across the hospital, which could compromise communication between team members and care for some patients.
- There is a perception that Evelina London lacks space to take on the service - this was largely mentioned in relation to dedicated recreational, educational, and therapy spaces for children with cancer, to keep them separate from other non-oncology patients.

### **6.3.2 Feedback on options: Principal Treatment Centre at St George’s Hospital**

#### **Strengths**

Feedback on the strengths of the St George’s Hospital option focused on it already being part of a well-established Principal Treatment Centre, its 25 years of experience and expertise in aspects of children’s cancer care, and its existing strong links with The Royal Marsden. This was seen as a strength across all stakeholder groups.

*“I would like to highlight the outstanding quality of the professionals working at St George’s Hospital that I have the pleasure of working with (nurses, pharmacists, paediatricians, surgeons, anaesthetists, radiologists, etc). Every single one of them give their very best for the patients and are always prepared to walk the extra mile for them. I only have words of praise for what I consider top-notch personnel.” (Member of staff who currently works for the Principal Treatment Centre at The Royal Marsden and St George’s Hospital, email correspondence, December 2023.)*

Other strengths included:

- It is part of a well-established Principal Treatment Centre with The Royal Marsden, with services and pathways already in place, which were viewed as beneficial for transitioning the Principal Treatment Centre.

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*“The teams already work together with well-established MDTs [multidisciplinary teams]. The key inpatient specialties already deliver this work, so no transfers of personnel or expertise is needed. There is no need to move surgeons, or their teams. Most of the existing pathways can continue unchanged or with greater simplicity. There is neurosurgery on site properly, not just an acceptable compromise as Evelina option has.”*

- Some neurosurgery for children with cancer is undertaken on site and it has a well-established children's cancer surgery service.
- It would offer a separate unit, which was considered important to make it more child-friendly and minimise infection risk when mixing with other patients and visitors.
- Easy to access by car.
- Lots of private rooms with ensuite facilities.
- Family accommodation nearby.
- It is already known and familiar to some families, meaning the continuity of care would be maintained for those families when the transition happens.

There were no additional strengths identified by clinical and non-clinical NHS staff; feedback was consistent across all stakeholder groups.

## **Challenges**

Challenges of the St George's Hospital option focused largely on the fact it is not a dedicated children's hospital.

Feedback on its challenges included:

- Reflections on the current estate, which was described in some feedback as being outdated, with facilities considered to be poor, which was perceived by some as a cause for concern when thinking about the ability of St George's Hospital to accommodate the future Principal Treatment Centre.

*“Limited space for current services expanding with need to consider where a purpose-built cancer service could be provided. Need for ongoing support from other tertiary services (i.e. cardiology/renal) for oncology patients. Need to expand some imaging services such as echocardiography to support diagnostic treatment and management of oncology patients.” (Member of NHS staff currently working for the Principal Treatment Centre at St George's Hospital, questionnaire response.)*

- There is perceived to be a lack of privacy on the ward and in other parts of the hospital where adults are also being cared for.

- It feels busy and chaotic, particularly given the delivery of adult healthcare services there; and there is a perception that this poses an infection risk.
- Some key specialisms are missing, such as specialist heart and kidney care and, it was suggested, palliative care.
- They do not have experience of managing paediatric networks, or other networks across the catchment area for the Principal Treatment Centre.
- There is a perception that children would not be prioritised on surgery lists, because of treatment of trauma patients.
- There is a perception that the research proposition is not strong, with lack of experience in running clinical trials for children with cancer.

*“St George’s Hospital has a poor track record in paediatric cancer trial research... failed to open several key paediatric oncology therapeutic studies they had committed to opening... This meant that patients receiving initial treatment at SGH [St George’s Hospital] could not be enrolled on these trials.” (Member of staff who currently works for the Principal Treatment Centre at The Royal Marsden Hospital, questionnaire response)*

- It would be difficult for families to access, including by car.
- It would be costly and time consuming for families to travel.
- There is not enough family accommodation.
- There is a perceived lack of recreational facilities and activities, both indoor and outdoor, suitable children and young people receiving treatment for cancer.

Affected and other clinical and non-clinical staff highlighted these additional challenges of St George’s Hospital proposal:

- There are perceived financial constraints at St George’s Hospital, which could make the transition to the Principal Treatment Centre a risk for its future.
- Disentangling existing relationships to set up the future Principal Treatment Centre at St George’s Hospital could be challenging, for example, if key people had different views on what should be done.
- It does not use the same IT system for patient records as The Royal Marsden, which could have a negative effect on the transition of the Principal Treatment Centre.

### **6.3.3 Feedback on options: Challenges of both options**

Challenges affecting both options related to:

- 
- Neither option could offer a ‘single-site’ solution, including where all neurosurgery, specialist heart and kidney services, and radiotherapy could be co-located at the Principal Treatment Centre.
  - Concern that the quality of personalised care and specialist skills and services of The Royal Marsden could be lost, including the dedicated spaces of the Oak Centre for Children and Young People. This related to both staff expertise and experience and the attributes of the healthcare spaces at The Royal Marsden (Oak Centre for Children and Young People, Maggie’s Centre).
  - Concern that the excellent research infrastructure and expertise of The Royal Marsden could be lost, including the loss of access to children’s cancer clinical trials (which could be a temporary loss as the move happens, or a longer-term loss if the move has a detrimental impact on the ability of the Principal Treatment Centre to secure future research funding).
  - Both options could be costly, at a time when financial resource is perceived to be stretched in NHS England.
  - Both would need more parking spaces and more parent accommodation. The suggestion that children receiving cancer treatment should use public transport to travel to Evelina London and St George’s Hospital was considered at odds with advice that parents and family advocates have received in the past.
  - Staff recruitment and retention, given the wider issue of staff recruitment in the NHS, as well as the London-based locations of both Evelina London and St George’s Hospital.
  - Potential detrimental effect on the resilience of the current service at The Royal Marsden due the potential for staffing losses, such as early retirement.
  - Potential negative impact on The Royal Marsden’s teenage and young adults (TYA) service.

#### **6.3.4 Feedback on the proposal to move conventional radiotherapy services to University College Hospital**

Feedback on this proposal was mixed.

- Some respondents talked about the strengths of this proposal, particularly in terms of benefits associated with consolidating radiotherapy expertise and services in one location, including existing knowledge and experience of staff there. References were made to proton beam therapy and how this is available at University College Hospital.
- Many others, including family members, advocates and clinicians, expressed concerns that, under this proposal, conventional radiotherapy could not be offered on

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the same site as the Principal Treatment Centre. They talked about the potential negative impact this would have on the patient experience, especially in relation to travel and access, raising concerns specifically about:

- The transport of sick children into central London, to receive treatment.
- Longer journey times for some families to University College Hospital to receive radiotherapy treatment, particularly when compared to The Royal Marsden.
- The capacity and resourcing of University College Hospital to take on the service on behalf of the Principal Treatment Centre.
- Potential consequences from having a single radiotherapy site across London and much of the south east, such as loss of resilience.
- The potential negative experience of disjointed care, with the need to travel to a different hospital to receive radiotherapy treatment.

#### 6.4 Themes arising from consultation

The key themes arising from the independent consultation feedback report are explored in Section 7, including our consideration of the feedback and evidence of how these themes have influenced thinking. This follows a 'you said, we did' format.

#### 6.5 Continued public and stakeholder engagement

The consultation has been a part of an ongoing engagement process, with many stakeholders having worked with us over several years. Many new stakeholders, through the consultation process, have also expressed an interest in ongoing involvement in this programme. We are grateful for all of the participation to date, which is helping shape the decision-making process and outcome.

As part of our commitment to the feedback loop, a response to the consultation feedback report is included in this decision-making business case in Section 5.4. All stakeholders who asked to be kept up to date, including about the publication of the consultation feedback report, will be given the opportunity to receive updates from the Trust which is chosen to be the future Principal Treatment Centre so that their involvement can continue if they wish.

In the time between the close of the consultation and the decision-making meeting, we have been working with Trust colleagues to keep staff up to date at key milestones and continue to keep an offer open of further engagement/ briefings for staff if this is felt to be helpful, to answer questions and concerns.

Making the decision will mark the start of a new phase of engagement work to support implementation planning and involvement in the design of the building/ repurposing of Trust estate to accommodate the future Principal Treatment Centre. It will also signal a shift in

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responsibility for engagement from us to the relevant Trust (working collaboratively with stakeholders) as it begins to operationalise the change. We will work closely with the relevant Trust, in the early stages of this process, to seek assurances around plans for its own engagement work with staff, families and wider stakeholders.

The consultation website, which includes a record of all the engagement work to date, will remain active after the decision for a period.

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## 7. Addressing themes from consultation

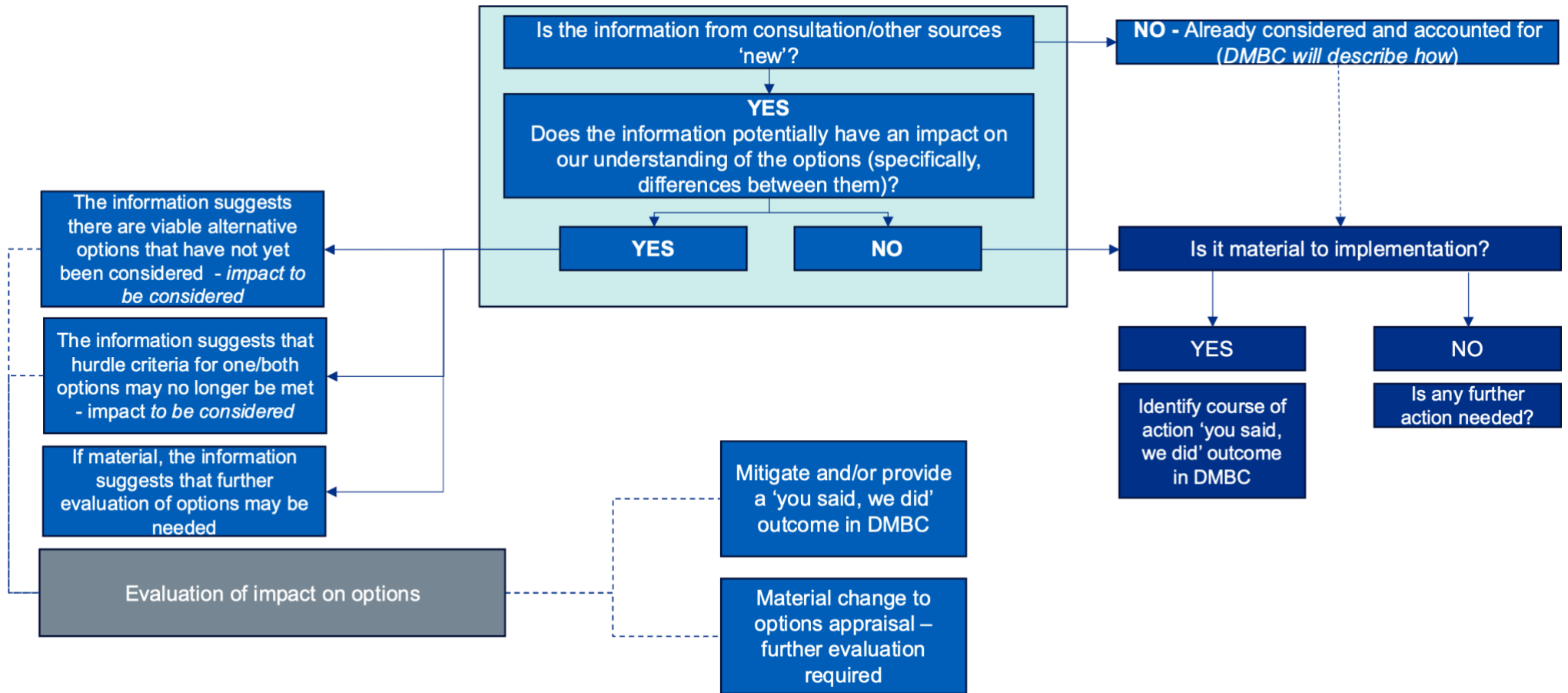
### 7.1 Process for addressing themes

As part of the assurance process for developing the decision-making business case, further information from consultation and other sources was reviewed by NHS England and other leaders or experts through a series of working groups. These working groups were made up of NHS England staff from London and South East regions and national teams with expertise in areas pertinent to the proposed reconfiguration, including management of clinical services, workforce, operations, data, and travel and access. Information was shared with these groups for consideration. Further to this work, a range of small group conversations took place to consider discrete areas of feedback. NHS England Executive Teams from London and South East regions considered consultation feedback and other relevant information through a series of workshops, the outputs of which have informed the decision-making business case.

To address the key consultation themes and additional evidence that has been identified since the pre-consultation options evaluation, we used this process, set out in our framework for review of information below in Figure 6:

- Assess whether the information from consultation/other sources is new or has been previously considered.
- If it is not new, consider its impact on implementation.
- If it is new, assess whether it impacts our understanding of the differences between the options
- If it impacts our understanding of the differences between the options, consider the nature of that impact, and whether further steps are required.

Figure 6: Framework for review of information





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We have categorised the consultation feedback and evidence from other sources, such as updated analysis or provider responses, into 10 overarching themes within this Section, which between them cover 27 sub-themes. These are:

1. Clinical model
2. Patient pathways
3. Travel and access
4. Workforce sustainability
5. Radiotherapy
6. Impact on other services
7. Estates and facilities
8. Research
9. Strength of the case for change
10. Deliverability.

Our specific responses to the organisations which are likely to be most impacted by the Principal Treatment Centre reconfiguration, as well as responses to local authorities, are included in Appendix 5, to supplement the thematic analysis in this chapter.

In reviewing feedback, the focus has been on assessing whether there is any new evidence, and to understand how this evidence has affected our understanding of the options. For each sub-theme, we outline:

- evidence previously considered
- our review of further evidence
- the impact of evidence on decision-making
- how we have listened to feedback.

For each sub-theme we have included a 'you said, we did' element, and recommendation(s) about things that will be important in the future including during the implementation and service transition phases.

## 7.2 Theme 1: Clinical model

### 7.2.1 Evidence and benefits

This sub-theme addresses the benefits articulated for the reconfiguration and the evidence base provided. It should be considered in conjunction with Section 1.4, Section 2.4, and Section 7.10.

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## **Evidence previously considered**

The pre-consultation business case set out the benefits of Principal Treatment Centre reconfiguration, including the benefits of having an on-site intensive care unit, centralisation of radiotherapy services, multidisciplinary working and improved opportunities for learning and development. These are set out at Section 2.4 above.

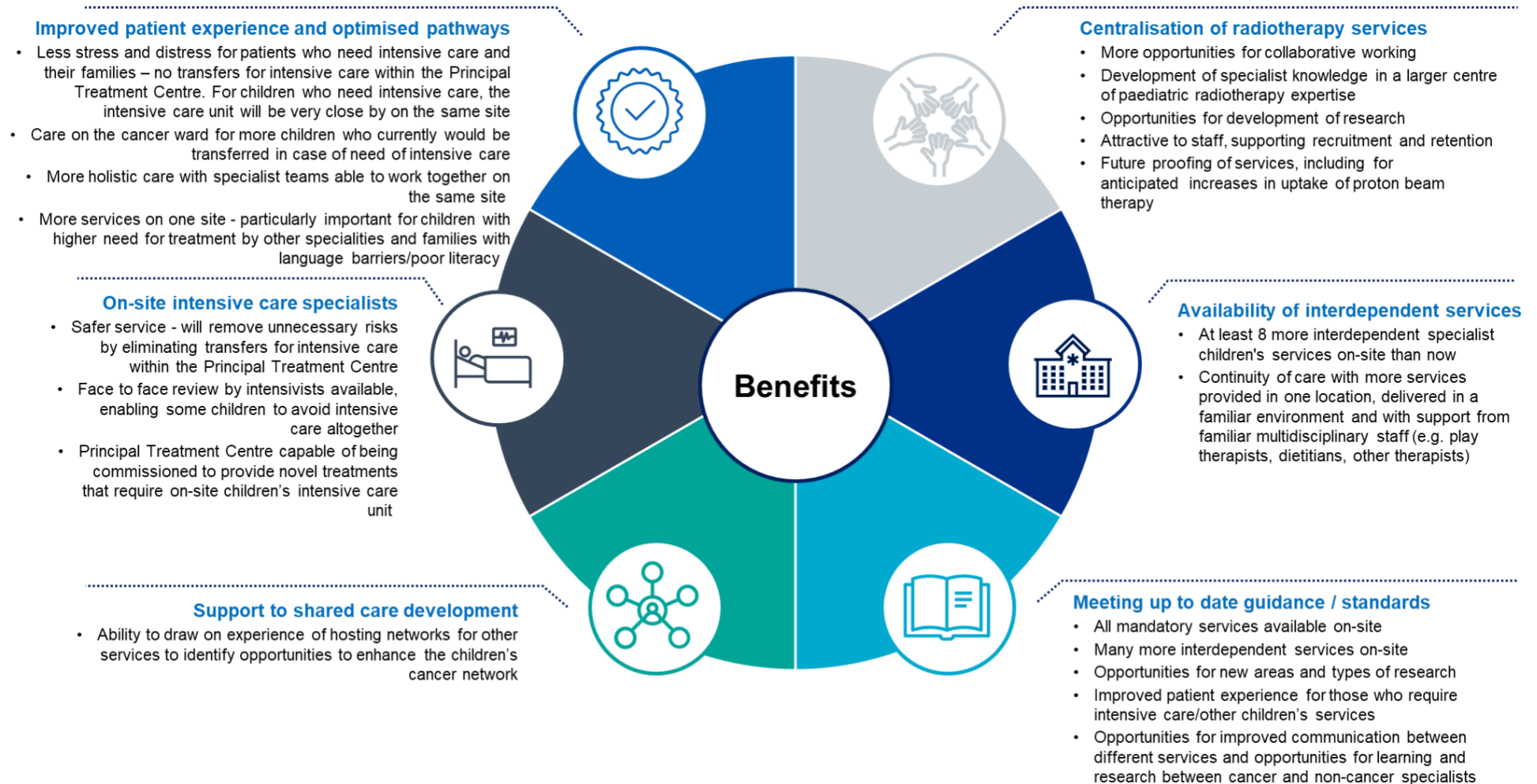
## **Review of further evidence**

During the public consultation, support for the benefits of co-locating the specialist children's cancer centre with a level 3 intensive care unit and other interdependent services was supported by a range of professional bodies, national and regional organisations. There was also support from NHS staff, set out in Section 7.10.

The London Mayor asked for more detail on the expected benefits that the changes will generate for patients and families. We have therefore reviewed new evidence from the consultation and developed the benefit areas further. The main benefit areas are summarised in Figure 7. We have also strengthened the articulation of the benefits of the clinical model, set out at Section 2.4.

Consultation feedback also 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. A summary of the evidence that underpins the case for change is provided in Section 1.4.1 with consultation feedback in Section 7.10.

Figure 7: Benefits of Principal Treatment Centre reconfiguration



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## Monitoring the delivery of expected benefits alongside outcomes

In line with existing plans, consultation feedback reflected the need to ensure benefits are realised and outcomes are monitored.

Benefits associated with the reconfiguration proposals are set out in the diagram above and at Section 2.4. The primary benefit is that the service change will remove the need for very sick children to be transferred from one part of the Principal Treatment Centre to the other for level 3 intensive care. Although these transfers are done as safely as possible, this will remove the avoidable underlying risks they bring that, under the current service arrangement, can only ever be mitigated, and the service will be safer as a result. It will also comply with the national service specification. This benefit will be realised when the service transfers. In parallel, compliance with other aspects of the national service specification and realisation of benefits will be monitored through a benefits realisation framework (Section 11.2.2).

There is an existing quality governance infrastructure around the current joint children's cancer 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<sup>36</sup>.

In the future, organisational and system governance arrangements will ensure that robust monitoring of services provided by the Principal Treatment Centre continues to be in place, both during the service transition phase and after it moves to the future centre. Patient safety incident review will also continue to be a core element of service monitoring<sup>37</sup>.

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<sup>36</sup> These meetings enable any quality concerns from The Royal Marsden and St George's to be discussed and escalated to the wider system. The Integrated Specialised Quality Committee reports into the London Joint Strategic Oversight Group and Specialist Commissioning Senior Management Team.

<sup>37</sup> To support arrangements for the current service this includes The Royal Marsden Patient Safety Incident Response Framework (March 2024) which sets out how the Trust will respond to patient safety incidents providing a framework for investigating incidents and identifying opportunities to support the continual improvement of quality and safety.

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To ensure maintained or improved outcomes, a baseline is needed, against which the provider of the future service can be held to account. Additional information around the monitoring of benefits realisation is included in Section 11.2.2. The following sources are available at present and include metrics that could be used to provide assurance around outcomes:

- Cancer Registry data on the incidence of childhood cancer across the Principal Treatment Centre catchment and how this relates to the patient cohort
- The Under 16 Cancer Patient Experience Survey.

Further information on childhood cancer incidence rates and patient experience data is within the Integrated Impact Assessment. However, in summary;

- Equity analysis reveals that the patient cohort is broadly representative of those diagnosed with cancer and the child population in general, indicating that there is equity of access to the service.
- In the latest Under 16 Cancer Patient Experience Survey (2022), results for the current Principal Treatment Centre, bar one metric<sup>38</sup>, were not significantly different from the overall national result on any area. There is no significant difference in responses to these questions between the demographic groups. It should be noted that the results are based on 100 responses to the survey. This is a response rate of 25% which is the same as the national response rate. Due to the small number of patients completing this survey, findings should be interpreted with caution.
- While the national cancer waiting times apply to children, data is not published by age due to small numbers.

Clinical outcomes within the new Children's Principal Treatment Centre service specification will be monitored via the Specialised Service Quality Dashboard (SSQD). The IIA (Appendix 4) contains the full details of metrics within the proposed dashboard, examples include one and five year survival, progression and relapse rates and admission rates to intensive care units. This data, produced by the national NHS England team, is not currently available but will be published in the summer of 2024, enabling the establishment of a baseline for the current Principal Treatment Centre service. This will be monitored by Integrated Care Boards and NHS England.

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<sup>38</sup> Parents were asked whether it was very or quite easy to contact the main person in the team looking after their child. The current Principal Treatment Centre score was lower than the national average.

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## Impact of evidence on decision-making

*Source of evidence:* This evidence has been provided through consultation responses and review by us (NHS England).

*Is this information new?* We have developed the detail and evidence base around the benefits; however no new information has emerged.

*Does the information potentially have a material impact on our understanding of the options (specifically, differences between them)?* No. The benefits reflect those which this reconfiguration process is expected to realise, regardless of the chosen location.

*Is the information material to implementation?* Yes. The identification of benefits and our review of available metrics ensures there is a framework for how outcomes will be monitored. Mechanisms for outcomes monitoring should be developed further as part of implementation – see recommendation below.

## How we have listened to feedback

Our response to the feedback received and actions taken to address the feedback are summarised in the ‘you said, we did’ table below.

Table 7: Evidence and benefits - You said, we did

You said	We did
Benefits should be articulated more clearly, with provision of metrics to monitor Principal Treatment Centre outcomes.	<p>Consultation feedback validated benefits reflected in consultation documentation and provided further evidence, allowing us to strengthen articulation of these, as summarised in Section 2.4.</p> <p>National metrics to monitor Principal Treatment Centre outcomes and performance will be in place from summer 2024 and these will provide a benchmark for future monitoring. Monitoring these metrics will sit alongside processes for ensuring patient safety (such as Serious Incident Review), evaluating equity of access to the service and other travel and access monitoring mechanisms. More detail is included in the IIA.</p>

Noting this feedback, we have also made the following recommendation:

**Recommendation #1: Further development of plans for the future Principal Treatment Centre should focus on delivering and maximising benefits associated with the reconfiguration. Monitoring of benefits realisation and of clinical outcomes/service standards through resources such as the Specialised Services Quality Dashboard (SSQD) should form part of the oversight framework (described in Section 10.1). This should be owned by the future Principal Treatment Centre.**

## 7.2.2 Mandatory services

Mandatory services are clinical services that must be provided on site alongside the Principal Treatment Centre. These are mandated by the National Service Specification.

### Evidence previously considered

The provision of mandatory services at both providers was considered within the pre-consultation evaluation and set out in the pre-consultation business case. Both options would provide all the services mandated by the national service specification once The Royal Marsden services transfer. These include anaesthetics and pain management, haematology and children’s cancer services including diagnosis, chemotherapy, bone marrow transplants<sup>39</sup>, ongoing monitoring and care; cancer pharmacy services; radiology services; children’s surgery (including management of emergencies, central lines and biopsy services<sup>40</sup>); level 3 intensive care; therapy services such as physiotherapy and psychology. Table 8 shows the current and proposed future provision of mandatory services.

Table 8: Provision of mandatory services

Mandatory services	On site for current service at The Royal Marsden	Would be on site if the future Principal Treatment Centre was at Evelina London	Would be on site if the future Principal Treatment Centre was at St George’s Hospital
Children’s anaesthetics and pain management	Yes	Yes	Yes
Children’s blood cancer (haematology) services, including bone marrow transplants	Yes	Yes	Yes

<sup>39</sup> Ability to deliver bone marrow transplants would be subject to training and achieving the relevant accreditation for both future providers.

<sup>40</sup> Paediatric oncology surgery other than management of emergencies, central lines and biopsy services is identified as an interdependent service which must be readily available at all times.



<b>Mandatory services</b>	<b>On site for current service at The Royal Marsden</b>	<b>Would be on site if the future Principal Treatment Centre was at Evelina London</b>	<b>Would be on site if the future Principal Treatment Centre was at St George's Hospital</b>
Children's cancer (children's cancer service) services including diagnosis, chemotherapy, ongoing monitoring and care	Yes	Yes	Yes
Children's cancer pharmacy services	Yes	Yes	Yes
Children's radiology services (such as CT and MRI scans)	Yes	Yes	Yes
Children's surgery, including management of emergencies, central lines and biopsy services	Partially – most surgery is at St George's Hospital	Yes	Yes
Level 3 critical care (can provide life support)	No - patients go to St George's Hospital	Yes	Yes
Therapy services such as physiotherapy. Psychology	Yes	Yes	Yes

### Review of further evidence

In their review (May 2023)<sup>41</sup>, the London and South East Clinical Senates did not raise concerns about the ability of either future provider to meet the national Principal Treatment Centre service specification.

<sup>41</sup> London and South East Clinical Senates Review – 19 July 2023; available on the website [London and South East Clinical Senates Review \(transformationpartners.nhs.uk\)](https://www.transformationpartners.nhs.uk)



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Feedback from the public consultation highlighted concerns related to the perceived experience of both providers in providing these mandatory services. In the following table we have summarised consideration of feedback, drawing on information provided pre-consultation by Guy's and St Thomas' on behalf of Evelina London, and by St George's on behalf of St George's Hospital, and, where needed, requesting additional information.

Table 9: Mandatory services feedback

Feedback from consultation	Response
<p>Lack of experience of treating children for cancer at Evelina London, including in mandatory specialties (for example anaesthetics, radiology, cancer pharmacy, and intensive care), and across workforce groups.</p>	<p>If Evelina London becomes the future Principal Treatment Centre, by the time services transfer from The Royal Marsden and St George’s at the end of the transition period, Evelina London would be expected to have put arrangements in place to meet the mandatory requirements. Evelina London does not currently provide the Principal Treatment Centre. Evelina London has a range of other relevant paediatric expertise on which it would draw to deliver the service. The strengths of the Evelina London option were reflected in the pre-consultation options evaluation.</p> <p>While some of the Evelina London workforce have experience of working with children with cancer and some are involved in the treatment of children with cancer, for example, through provision of specialist cardiology and nephrology services, Evelina London (like St George’s Hospital) would rely, in part, on staff from The Royal Marsden transferring across (approximately 170 staff would transfer to either Evelina London or St George’s Hospital from The Royal Marsden).</p> <p>In the event that fewer staff transfer than anticipated, Evelina London has developed mitigations, including for recruitment. It has also set out plans for training and skills development. These are outlined in Section 7.5.1.</p> <p>The service transition phase would be used to ensure that the necessary planning work had been done to support a safe and sustainable transfer of services. This would be supported through bringing the skills and experience of respective workforces together, and detailed planning to ensure underpinning systems and processes are in place.</p>

Feedback from consultation	Response
<p>St George's Hospital is not a dedicated children's hospital.</p> <p>Some concerns highlighted that St George's Hospital also looks after adults with a perception around it feeling 'busy' and 'chaotic'.</p> <p>Some concerns raised about children's cancer surgery being 'bumped' because of the Trust's trauma work.</p>	<p>If St George's Hospital becomes the future Principal Treatment Centre, by the time services transfer from The Royal Marsden at the end of the transition period, St George's Hospital would be expected to have put arrangements in place to meet the mandatory requirements.</p> <p>St George's Hospital treats 60,000 patients/year providing a range of services and specialisms for children mainly living in south west London, Surrey and Sussex. Like other hospitals, St George's Hospital also works in partnership with other hospitals for some specialist paediatric services.</p> <p>In the future, St George's Hospital would have a dedicated, specially designed children's cancer centre within an area of the estate – children would receive the majority of their care here.</p> <p>In the past, the hospital has provided less urgent cancer work on the same theatre list as trauma. To protect these procedures, St George's Hospital has advised it now has a procedure room in its existing theatre suite, something which would be replicated in the future Principal Treatment Centre, further increasing 'protected' capacity. <i>Estates and facilities are considered further in Section 7.8.</i></p>
<p>Some consultation feedback suggested a lack of confidence in St George's Hospital haematology services.</p>	<p>We asked St George's Hospital about these concerns. They have confirmed that they are experiencing some short-term issues relating to benign haematology work which they are currently mitigating. These would not impact on future Principal Treatment Centre provision.</p>
<p>Consultation feedback reflected the time that would be required to gain JACIE accreditation.</p>	<p>We are aware of the extensive nature of the JACIE accreditation process; both potential providers were therefore asked to set out details in their proposals of their plans to achieve compliance with the Haematopoietic Stem Cell Transplantation (children) specification, and specifically plans for JACIE accreditation. These were summarised in</p>

Feedback from consultation	Response
	the pre-consultation business case. Progress towards securing this would need to be monitored with planning beginning after a decision is taken (including with the current service).
Some consultation feedback advised that further review of both potential providers' diagnostic services was required.	We reviewed the diagnostic services available at both providers which were outlined in the pre-consultation business case. While there is variation, both organisations indicated that, should they become the future Principal Treatment Centre, the imaging and diagnostic demand would be met from within current facilities (including additional capacity created as part of Trusts' wider strategies). St George's Hospital already provides a proportion of this activity. Planning for this would take place during service transition.

### Impact of evidence on decision-making

*Source of evidence:* Additional feedback has been provided through consultation response and additional responses from providers. For some areas of feedback, we have drawn out or referred to the detail of plans set out in pre-consultation business case including plans to mitigate concerns raised.

*Is this information new?* No. Mandatory services were examined during the options evaluation, the feedback provided reflects the comparative strengths of the options considered at options evaluation; it also reflects areas where further planning will be needed during the service transition period.

*Does the information potentially have a material impact on our understanding of the options (specifically, differences between them)?* No, this information is not new and therefore doesn't change our understanding of the options.

*Is the information material to implementation?* Yes. Consultation feedback and provider responses have highlighted mandatory services that will require further planning and development during implementation phase, to meet the national service specification.

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## How we have listened to feedback

Development of the mandatory services will be key to successful implementation. Our response to feedback regarding this, and our recommendations to the provider of the future Principal Treatment Centre can be found below.

Table 10: Mandatory services - You said, we did

You said	We did
Can the Trusts provide all the mandatory services, and associated interdependencies?	Both Trusts would meet the national specification mandatory requirements and could deliver the associated critical infrastructure. Planning and preparation will be needed to support this (including working in partnership with clinicians currently providing relevant oncology services). The adherence of the future Principal Treatment Centre to the national specification will be monitored through ongoing quality assurance.

***Recommendation #2: Future Principal Treatment Centre to ensure that, prior to the current services transferring, detailed planning and service development work is undertaken to deliver mandatory services to the standard set out in the national service specification as a minimum, with consideration for ‘future proofing’ services to meet changing demand. This is expected to be done in partnership with clinicians and experts currently providing these services as well as patients and families.***

### 7.2.3 Clinical interdependencies

There are a number of independent services for the Principal Treatment Centre, which, if not on site, must be ‘readily available’.

#### Evidence previously considered

The provision of interdependent services at both potential providers was considered in the pre-consultation options evaluation. They both provide the majority of interdependent services which, if not on site, must be ‘readily available’<sup>42</sup> (as described by the service specification).

Interdependent services at each site were assessed as part of the evaluation of the proposals in pre-consultation phase. Evelina London scored 9 compared to 8.5 for St

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<sup>42</sup> The Clinical Advisory Panel of experienced clinicians, which helped us develop the options, defined ‘readily available’ as available on site within 30 minutes. The panel decided that genomic testing did not need to be available on site within 30 minutes, so genomic testing was excluded from our evaluation criteria.

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George's Hospital. Evelina London scored higher because it would have all but two of these services (neurosurgery and radiotherapy), while St George's Hospital would have all but three (cardiology, nephrology and radiotherapy).

Table 11 outlines the current services provided at The Royal Marsden as well as the services that would be on site for each potential provider and the arrangements in place for services that would not be on site.

Table 11: Interdependent service provision

Interdependent services	On site for current service at The Royal Marsden	Would be on site if the future Principal Treatment Centre at Evelina London	Would be on site if the future Principal Treatment Centre was at St George's Hospital
Tertiary cardiology (for patients with defects and diseases of the heart and blood vessels)	No – patients go to Evelina London	Yes	No – patients would go to Evelina London for specialist care
Children's cancer surgery (to remove or reduce tumours and manage some cancer-related symptoms. Does not include management of emergencies, central lines and biopsy services which must be on site)	No – patients go to St George's Hospital	Yes	Yes
Children's infectious disease services	No – patients go to St George's Hospital	Yes	Yes
Children's pathology (investigates and identifies cancers)	Yes	Yes	Yes
Endocrinology (for patients with hormone-related disease)	Yes	Yes	Yes
Gastroenterology (for patients with diseases of the digestive system)	No – patients go to St George's Hospital	Yes	Yes

Genomic testing* (finds changes in genes causing cancer)	Yes	Yes	Yes
Tertiary nephrology (for patients with kidney disorders)	No – patients go to Evelina London	Yes	No – patients would go to Evelina London for specialist care
Neurosurgery (for cancer-related problems affecting patients' brains, nervous systems or spines)	No – patients go to King's College Hospital or St George's Hospital	No – as now, patients would go to King's College Hospital or St George's Hospital	Yes - as now, patients would go to King's College Hospital or St George's Hospital
Ophthalmology (for patients with eye and visual disorders)	No – patients go to St George's Hospital	Yes	Yes
Other specialist children's surgery	No – patients go to St George's Hospital	Yes	Yes
Palliative care (aims to give a good quality of life for patients living with an illness that cannot be cured)	Yes	Yes	Yes
Radiotherapy (treatment using radiation to kill cancer cells)	Partially – patients have conventional radiotherapy on site but go to University College Hospital for proton beam and other types of specialist radiotherapy	No – patients would go to University College Hospital for all radiotherapy services	No – patients would go to University College Hospital for all radiotherapy services



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## Review of further evidence

The consultation provided feedback about some of the differences between the options in terms of interdependent service provision.

### Neurosurgery

Consultation feedback expressed views about the benefits of having neurosurgery on the same site as the future Principal Treatment Centre, highlighting the fact that up to 25% of children have some form of brain, nervous system or spinal cancer. Some feedback also reflected a limited understanding of current arrangements for providing neurosurgery. For clarity, we have therefore set out information about neurosurgery below (this reflects content in the pre-consultation business case).

Brain, nervous system or spinal cancer is the second most common type of cancer that children get, comprising around 25% of cancer diagnoses. Most children with those kinds of cancer, and some children experiencing side effects of treatment (such as complications from a shunt, swelling after radiotherapy or bleeding in the brain) need neurosurgery. Usually, this surgery is planned but occasionally it is needed urgently (for example, when a child comes to A&E with symptoms that need urgent attention).

In August 2023, St George's shared with us data on emergency neurosurgery procedures for children already on-site at the Principal Treatment Centre in the previous 12 months who had either needed emergency neurosurgery (one patient) or 24/7 monitoring with a view to potential emergency surgery (two patients). Although this number is relatively small, this re-confirmed the importance of having arrangements in place to care for patients who need urgent (rather than planned) neurosurgical intervention, including when they are being cared for at the Principal Treatment Centre.

In our proposals, neurosurgery is a fixed point – this means that the current arrangement for providing neurosurgery remains unchanged with King's College Hospital and St George's Hospital continuing to provide this service. Approximately 20% of activity is undertaken at St George's Hospital<sup>43</sup> with the majority at King's College Hospital.

Some consultation respondents expressed concerns that Evelina London doesn't have neurosurgery on-site meaning that children requiring this would need to be transferred between sites, *“despite the PTC [Principal Treatment Centre] moving from The Royal*

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<sup>43</sup> In 2019/20, 86 children had cancer-related neurosurgery. Around 20% of children had neurosurgery at St George's Hospital. Although numbers vary year on year, the proportion of neurosurgery that both sites do is expected to remain similar.

Marsden some patients would still need to be retrieved by STRS [South Thames Retrieval Service] from Evelina to KCH [King’s College Hospital or SGH [St George’s Hospital] which makes the whole process a bit pointless for neuro-oncology patients”. Some expressed a view that neurosurgery should be on the same site as the Principal Treatment Centre and that due to the configuration of paediatric neurosurgery services (with the majority of neurosurgery provided by King’s College Hospital) neither option would achieve this fully.

The table below sets out arrangements identified with providers pre-consultation.

Table 12: Neurosurgery arrangements for both potential providers

Option	Bed-based provision on site	24/7 cover	Current service model*
St George's Hospital	Yes	Yes	<p>Provides neurosurgery for the Principal Treatment Centre along with King’s College Hospital. Provides specialist neuro-radiology.</p> <p>Complex paediatric spinal surgery is delivered by three spinal surgeons from the wider spinal surgical team.</p> <p><i>In 2019/20, 86 children had cancer-related neurosurgery. 20% had their neurosurgery at St George’s Hospital, with the other 80% at King’s College Hospital.</i></p>
Evelina London	No	Yes	<p>One consultant neurosurgeon at King’s College Hospital is funded by Evelina London.</p> <p>Neurosurgery for the Principal Treatment Centre is provided by King’s College Hospital and St George's Hospital.</p> <p>The neurology service at Evelina London works closely with the neurosurgical team at King’s College Hospital for non-cancer neurosurgery patients. Evelina London provides out-of-hours neurology across both sites.</p>

			Pathways will be in place for Principal Treatment Centre patients who require specialist treatment and emergency surgery.
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\*Consultant workforce has been provided to give an indication of size and scale of the service. Where WTE is used, this refers to Whole Time Equivalent working.

In the context of feedback around Evelina London's not providing neurosurgery, further information is set out below.

If the future Principal Treatment Centre were to be at Evelina London, children would continue to go to King's College Hospital or St George's Hospital, as now, for planned neurosurgery. Evelina London confirmed that the existing relationship it has with King's College Hospital is particularly strong in neurosurgery/neurology. There is a shared out-of-hours acute neurology service provided at Evelina London covering both sites, shared neurosurgical pathways, and a King's College Hospital neurosurgeon funded by Evelina London. Their shared arrangements mean that, where required, neurosurgical consultants from King's College Hospital will attend Evelina London to discuss the requirement for surgery and on a monthly basis undertake elective work. In most cases, where a child presents in need of neurosurgery at Evelina London, they will be transferred (by South Thames Retrieval Service) to King's College Hospital following direct discussion with the neurosurgical team. However, in rare cases where patient transfer is inadvisable, emergency surgery can be undertaken by the King's College Hospital neurosurgeons in the Evelina London theatres. Evelina London has advised that there would be a clinical nurse specialist familiar with the relevant sites coordinating care and ensuring communication is effective.

King's College Hospital NHS Foundation Trust has confirmed that it has reviewed both potential providers' proposals and believes partnership working would be possible with whichever site is chosen for the future Principal Treatment Centre.

Further information about King's College Hospital's service is set out below:

- King's College Hospital has a formal paediatric neurosurgery on-call rota in addition to the subspecialisation.
- It has jointly appointed a paediatric neuro-oncologist on site, who delivers paediatric and teenage and young adult neuro-oncology care jointly with The Royal Marsden
- King's College Hospital has a very low threshold for transfer and any patient at risk is brought across as quickly as possible.

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- Transfer of patients for neurosurgery has worked well in the past from referring hospitals (from Brighton to Ashford and further).
  - King's College Hospital is working towards the requirements for enhanced level B POSCU care (to become a children's cancer shared care unit which can provide inpatient chemotherapy). This will enable children with cancer who live locally and need neurosurgery at King's College Hospital and also require chemotherapy to remain at the hospital for the vast majority of their treatment rather than be transferred to The Royal Marsden now, or the future Principal Treatment Centre in the future, (though they would still be transferred to University College Hospital for radiotherapy if necessary).

Consultation feedback showed that respondents valued the on-site neurosurgery provided by St George's Hospital highlighting it as a benefit of this option, *"St George's provide neurosurgery, this would be a missed opportunity to bring the PTC [Principal Treatment Centre] and neurosurgery together."*

If the future Principal Treatment Centre were to be at St George's Hospital, children would continue to have their neurosurgery at St George's or at King's College Hospital as now. St George's neurosurgical staff attend the Paediatric/Teenage and Young Adult Neuro-Oncology multidisciplinary team meeting with colleagues from King's College Hospital and The Royal Marsden.

In either scenario, as neurosurgery remains a 'fixed point', we recognise that it would not be possible to co-locate all neurosurgery for patients of the future Principal Treatment Centre. One of the mitigations for this would be the possible development of enhanced level B paediatric oncology shared care units at King's College Hospital and St George's Hospital (if it did not become the Principal Treatment Centre). This would mean children with brain tumours living close to either hospital who needed neurosurgery and inpatient chemotherapy would be able to receive it on site, reducing the number of transfers required and improving patient experience.

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## Cardiology and nephrology

Children with cancer will require heart and kidney tests to see if different types of treatment will work for them or to assess the side effects of cancer treatments on them, including as part of long-term follow-up. Some will require treatment for heart and kidney conditions which may or may not be related to their cancer.

Consultation feedback showed that staff and patients were concerned about the potential implications for children with cancer at St George's Hospital who need cardiology and nephrology services. While St George's Hospital provides aspects of these services, tertiary cardiology and nephrology services will continue to be provided at Evelina London rather than St George's Hospital. Further information (reflected in the pre-consultation business case) is set out below.

In 2019/20, 31 children with cancer who were treated at The Royal Marsden (as an inpatient or outpatient) also received inpatient care (including as day cases) at Evelina London for heart and kidney care (25 cardiology, six nephrology), and 30 for other specialties. Of the heart and kidney patients, 28 were seen as day cases, mostly for diagnostic tests, one for a planned inpatient stay and three for an unplanned stay (some children had more than one type of care).

The cardiology and nephrology inpatient service at St George's Hospital are outlined in Table 13 below, demonstrating that, while St George's doesn't provide these inpatient services, 24/7 cover is provided and there are established pathways for onwards referral to Evelina London for specialist input, if required. The pathways are expected to remain in place should the Principal Treatment Centre move to St George's Hospital.

If St George's Hospital were to be the site of the proposed future centre, it could deliver some heart diagnostics and kidney care that patients need on site. Children who needed tertiary inpatient, day case and outpatient cardiology and nephrology would be referred and then transferred to Evelina London, as they are at present. The exact arrangements for this would be agreed following detailed conversations between clinicians after a decision was made.

Table 13: Cardiology and nephrology services at St George's Hospital

Clinical service	Bed-based provision on site	24/7 cover	St George's Hospital current service model*
Paediatric cardiology	No	Yes	<p>Urgent and routine echocardiography and diagnostic cardiology provided on site. Acute cardio assessment on acute ward/ children's intensive care unit available 7 days a week.</p> <p>Interventional cardiology provided by Evelina London. 4 paediatricians with an expertise in cardiology. 3 external paediatric cardiologists support the service via service level agreement.</p> <p><i>Where further specialist diagnostics, advice or intervention are needed, St George's Hospital draws on the advice of specialists from Evelina London. It also runs clinics on site with specialist input from clinicians from The Royal Brompton, part of Guy's and St Thomas'.</i></p>
Paediatric nephrology	No	Yes	<p>Children's intensive care unit at St George's Hospital provides inpatient acute renal replacement.</p> <p>Paediatric nephrology clinics and input into late effects follow-up are in place through existing links with the regional nephrology service run by Evelina London.</p> <p>Specialist service is provided by and at Evelina London. Referral pathways are in place for patients who require specialist treatment.</p>

\*Consultant workforce has been provided to give an indication of size and scale of the service. Where WTE is used, this refers to Whole Time Equivalent working.

### Paediatric oncology surgery

Paediatric oncology surgery is currently provided by St George's Hospital but, unlike neurosurgery, cardiology and nephrology services, it will be on site wherever the future

Principal Treatment Centre is. This means that if the future centre is at Evelina London, the service will move there too.

Consultation feedback from a number of sources emphasised the strengths of the current service at St George’s Hospital, including the surgeons’, anaesthetists’, and specialist nurses’ experience and expertise in delivering paediatric oncology surgery for complex cases, such as mediastinal cancers, where the child has to be anaesthetised sitting up.

The importance of experience for effective surgical decision-making and planning children’s care as part of the multidisciplinary team was also stressed.

Consultation feedback from a number of sources also expressed concern about the complexity of establishing paediatric oncology surgery at Evelina London.

If the future centre is at Evelina London, Evelina London will need to expand its existing surgical experience to develop oncology expertise – its proposed plans setting out how it would do this are summarised below and at Section 7.5.1.

Table 14: Paediatric oncology service, if the future Principal Treatment Centre was at Evelina London

Clinical service	Evelina London Children’s Hospital
Paediatric oncology surgery (to reduce or remove tumours and manage some cancer-	<p>Although Evelina London has existing surgical strength in a range of other specialities<sup>44</sup> it does not currently provide paediatric oncology surgery. If Evelina London were successful, there would need to be a range of actions taken to ensure it could provide a high-quality oncology surgical service to children. Evelina London has set out plans to provide this service, these were set out in the pre-consultation business case and include:</p> <ul style="list-style-type: none"> <li>• Building cancer-specific expertise in its paediatric surgical team through training, recruitment or a mixture of both. It would explore options for support from St George’s and potentially other London Trusts such as Great Ormond Street. Surgeons from these</li> </ul>

<sup>44</sup> Evelina London illustrated this with reference to 10 children’s operating theatres: 54 individual paediatric surgical consultations across nine paediatric specialities and over 30 anaesthetists with experience across paediatric surgical specialities including cancer.

related symptoms)	<p>organisations could split their time, working at more than one hospital where their expertise was needed.</p> <ul style="list-style-type: none"> <li>• Recruitment (both nationally and internationally).</li> </ul> <p>Since consultation we have reviewed these plans.</p> <p>Detailed work would take place during the 2.5 year service transition phase. Arrangements for the transfer of this service would need to be planned in detail and closely overseen until the service became well-established. See further information at Section 7.2.4 and 7.5.1.</p>
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## Other services

Consultation feedback also showed that there were some concerns related to radiotherapy being delivered off-site at University College Hospital. We worked with University College London Hospitals to develop the mitigations in place in response to consultation feedback. Section 7.6 outlines the benefits of and mitigations for radiotherapy at University College Hospital.

### Impact of evidence on decision-making

*Source of evidence:* Feedback raised through consultation and information confirmed through NHS England’s review of evidence in response to feedback and information gathered from trusts.

#### *Is this information new?*

Yes – new information has increased our understanding of mitigations for interdependent services which will not be on site, depending on the option that is chosen as the location of the future Principal Treatment Centre, particularly neurosurgery. Mitigations would be needed for neurosurgery if the future Principal Treatment Centre was at Evelina London, which does not provide neurosurgery.

The information on paediatric oncology surgery is not new but it reflects an important part of the service which St George’s currently provides, and has provided for a number of years, as part of the current Principal Treatment Centre.

*Does the information potentially have a material impact on our understanding of the options (specifically, differences between them)?* No. Interdependent services were assessed as part of our pre-consultation evaluation of the options.



*Is the information material to implementation?* Yes. The plans and mitigations for radiotherapy, neurosurgery and paediatric oncology surgery (should the future Principal Treatment Centre be at Evelina London), and radiotherapy, cardiology and nephrology (should the future centre be at St George’s Hospital) are all important to consider during implementation.

### How we have listened to feedback

Consideration of mitigations for off-site provision of interdependent services has highlighted the need for providers to develop these mitigations as part of implementation to reduce transfers for interdependent services not available on site and to optimise patient pathways. Irrespective of the decision, further consideration of specific neurosurgery arrangements within the context of the POSCU Transformation Programme would also be beneficial to streamline pathways and optimise patient experience. This has informed our ‘you said, we did’ and recommendations below:

Table 15: Interdependent services - You said, we did

You said	We did
<p>The two potential providers provide different interdependent services. Evelina London provides specialist cardiology and nephrology services on site. It does not provide neurosurgery. St George’s provides neurosurgery but does not provide specialist cardiology or nephrology.</p>	<p>Both providers have different strengths in particular service areas. We have reviewed these strengths as compared to the understanding in the pre-consultation business case. This process has confirmed that it will be important that robust plans are put in place by the future provider (working with partners) to develop their mitigations for those services which are not on site so that patients receive excellent care.</p>

***Recommendation #3: Irrespective of the decision, further consideration of specific neurosurgery arrangements would be needed to optimise pathways for patients of the future Principal Treatment Centre and ensure good patient experience.***

***Recommendation #4: Appropriate capacity and resilience needs to be in place for all aspects of care for interdependent services to support the delivery of care to future Principal Treatment Centre patients; more detailed service planning will need to be carried out by the future Principal Treatment Centre during the service transition phase.***

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***Recommendation #5: Clear patient pathways and targets for access to these services need to be set out prior to implementation, with appropriate mitigations in place for when patients need to be transferred. The future provider (supported by the wider system) should work collaboratively across the system to design patient pathways that minimise transfers.***

#### **7.2.4 Clinical expertise**

This sub-theme explores how the relevant expertise of both potential providers was considered at pre-consultation evaluation of the options. It provides a summary of the expertise that respective organisations have, as described in further detail within the pre-consultation business case (PCBC).

#### **Evidence previously considered.**

The expertise of each potential provider was considered during pre-consultation evaluation against the national service specification including with respect to mandatory and interdependent services for the Principal Treatment Centre. Detail was included in the PCBC including a description of their current service models. An overview of this is included in Section 7.2.3 and Section 7.2.2 of this document. A more detailed description of how services would be provided that are not available on site was also included in the PCBC, as well as a description of training plans to account for how experience could be built in certain areas.

As published in the PCBC, St George's Hospital indicated that 50 of their staff<sup>45</sup> currently contribute to the Principal Treatment Centre patient pathways. Patients include children who are being treated for cancer and are transferred to St George's Hospital because they need/or may need intensive care, as well those who require surgery and other services. Within this workforce it was identified that four staff who work as part of the Principal Treatment centre pathway spend more than 50% of their time working on children's cancer services and would therefore be in scope for transfer to the future Principal Treatment Centre if it were at Evelina London.

As set out at Section 3.3, evaluation criteria were developed for the pre-consultation evaluation of the options, looking at what expertise would be required to deliver best quality care for children at the future Principal Treatment Centre. Before the evaluation criteria were finalised, the Trusts, Guy's and St Thomas' and St George's, were both given the opportunity

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<sup>45</sup> Around 50 WTE posts are funded to provide care to children as part of the Principal Treatment Centre. Headcount of staff is higher. Staffing groups include medical, nursing, allied health professional and support staff for the children's intensive care unit, surgical, theatres and ward teams. They can draw on wider teams who can support in the delivery of care for children who have not been included in the funded baseline for this service.

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to provide feedback on them and raise any questions. St George's highlighted its current expertise in delivering the current Principal Treatment Centre in partnership with The Royal Marsden and asked us to take into account that they had 25 years experience of providing important elements of care for children with cancer.

To help finalise the criteria, in July 2022, an independent transfer was set up including clinical directors from children's cancer and strategic paediatric networks, clinicians and medical directors from inside and outside London, and nursing specialists. The Group provided their expert view on the criteria, including the points raised by St George's. In response to this, they recommended amendments to two of the sub-criteria for the clinical services domain to reinforce the opportunity for scoring high marks by giving answers drawing on experience of delivering care for children with cancer (the sub-criteria on network effectiveness and transition to teenage and young adult services).<sup>46</sup>

However, the Clinical Review Group also considered that, although St George's Hospital's experience in children's cancer care is important, it is not more important than experience in delivering very complex non-cancer children's services and the organisational and clinical skills that this requires. This was particularly so as neither St George's Hospital nor Evelina London has experience in the very specialist cancer treatment services for children that The Royal Marsden currently provides and in which the 170+ staff who would be eligible to move to the future Principal Treatment Centre are experts.

The Clinical Review Group felt that the changes they made and the consideration they gave provided the right balance. It was their collective view that the most important thing is that the specialist children's cancer services currently at The Royal Marsden go to a hospital expert in children's care that can welcome and work with them to provide a Principal Treatment Centre for children with cancer that will be able to build on the strengths of the existing service and provide best quality care for children with cancer for decades to come.

Information on how the evaluation criteria were developed and how options were assessed and scored were published as part of the pre-consultation business case with Section 4.5.2.

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<sup>46</sup>The Programme Board largely agreed on the proposed updates to the criteria, but as there was not full consensus, the issue was escalated to the NHS England London Region Executive Team who subsequently supported the recommendations of the Clinical Review Group on the evaluation criteria as presented to the Programme Board on 28 July 2022.

Evaluation sub-criteria within the Patient and Carer Domain also included specific reference to experience of delivering care for children with cancer supporting confidence in responses provided; namely 'Quality of Facilities', 'Engagement and Collaboration', 'Patient Navigation' and 'Family Support.'

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## Review of further evidence

Consultation responses highlighted the comparative expertise and experience of both providers.

The Royal Marsden's multidisciplinary team provides systemic cancer diagnosis and treatment. While both potential providers highlighted benefits of their experience within their proposals, they do not replicate the skills or experience of The Royal Marsden's teams who lead and coordinate care in specialist paediatric oncology. Both options will require staff with this knowledge and expertise, we anticipate much of this would be delivered by staff transferring from The Royal Marsden, other strategies are set out above.

For example, the nursing expertise required is set out by the Standards for Children's Nursing including in Appendix 3 of the national service specification<sup>47</sup>, this details the requirement for training and competency as well as minimum staffing levels per shift. The Royal Marsden works to these standards.

The table below illustrates the split of activity between The Royal Marsden and St George's Hospital.

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<sup>47</sup> Available here: [1746-principal-treatment-centres-service-specification-.pdf \(england.nhs.uk\)](#)

Table 16: Summary of activity and income relating to The Royal Marsden/St George's Principal Treatment Centre<sup>48</sup>

19/20 PTC summary	The Royal Marsden		St George's Hospital		Total	
	Patients*	Activity	Patients*	Activity	Patients*	Activity
<b>Inpatient</b>	456	4,599	208	313	536	4,912
<i>Elective</i>	147	412	72	90	191	502
<i>Day case</i>	398	1,774	96	108	454	1,882
<i>Regular day</i>	283	2,363	-	-	283	2,363
<i>Non-elective</i>	44	50	93	115	136	165
<b>Outpatient</b>	1,354	7,943	72	275	1,367	8,218
<b>Critical Care</b>			84	1,451	84	1,451
<b>Radiotherapy</b>	41	700			41	700
<b>Drugs</b>	398				398	
<b>Total</b>	<b>1,356</b>		<b>210</b>		<b>1,373</b>	

<sup>48</sup> \*The total number of patients is likely to be lower than the total you would get from adding up rows as an individual patient can be in more than one row. Outpatient care includes attendances for imaging, ward attenders and other non-admitted ambulatory activity as well as outpatient appointments. The income column will not include all the income related to paediatric oncology at The Royal Marsden. Of the 1,451 critical care days, 819 were undertaken in a high dependency bed rather than in the intensive care unit.

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There is variation in the other relevant skills and expertise of both potential future providers. Further detail can be found in the pre-consultation business case Chapter 5. A summary is provided below.

Key benefits of the Evelina London option identified in the pre-consultation business case:

- Evelina London is a purpose-built specialist children's hospital which treats almost 120,000 young patients every year living in Kent, Medway, south London, Surrey and Sussex, it was designed for, and with input from, children and teenagers.
- All the staff are experts in children's care. Evelina London has very broad expertise and experience in non-cancer care, including intensive care and surgery.
- It provides the retrieval service which transfers ill children, including those with cancer
- It provides tertiary (specialist) heart and kidney services giving inpatient care (mainly diagnostic tests) to 31 children in 2019/20 who were also seen at The Royal Marsden.
- It would be able to offer children with cancer the benefits of its experience of delivering complex care in non-cancer settings. One example is immunotherapies, Evelina London is one of only four providers nationally commissioned to deliver zolgensma gene therapy for spinal muscular atrophy.
- Guy's and St Thomas' provides cancer care for adults and Guy's is a 'designated hospital' for teenage and young adult cancer services. Guy's provides one of five Adult Experimental Medicine Centres in London which Evelina London could draw upon.
- Evelina London has more than 70 staff working on more than 180 national or international research projects in child health.
- Guy's and St Thomas' attracted more than £25 million of funding for research staff in 2019/20.

St George's key benefits identified in the pre-consultation business case:

- St George's Hospital is a large teaching hospital that provides specialist care for adults and treats almost 60,000 children every year, mainly living in south west London, Surrey and Sussex.
- All its children's services staff are experts in children's healthcare.
- St George's Hospital has 25 years' experience caring for children with cancer, in particular intensive care, most cancer surgery and other specialist services for the current Principal Treatment Centre.

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- St George's Hospital provides neurosurgery alongside King's College Hospital. Around 20% of children who required cancer-related neurosurgery in 2019/20 had it at St George's Hospital. Although numbers vary year on year, the proportion of neurosurgery that both sites do is expected to remain similar.
  - It also has a children's cancer shared care unit where children living locally can receive supportive care.
  - St George's Hospital provides cancer services for adults and is a 'designated hospital' for teenage and young adult cancer services.
  - It has 25 children's researchers and a good track record in national and international research.
  - St George's attracted £8.2 million of funding for research staff in 2019/20.

### **Impact of evidence on decision-making**

*Source of evidence:* This feedback was raised by staff and providers through consultation.

*Is this information new?* No. This aligns to how expertise of both potential providers was considered within the scoring criteria at evaluation of the options and presented in the pre-consultation business case.

*Does the information potentially have a material impact on our understanding of the options (specifically, differences between them)?* No, this information is not new. Our pre-consultation evaluation took the respective expertise of both options into account. Consultation feedback reflected some of the differences between the options, information relevant to this has been summarised here.

*Is the information material to implementation?* Yes. As highlighted, there are differences in expertise between the providers, some mitigations will be required whichever option is chosen to ensure that the future provider is ready to take on the service at the point it transfers and to ensure ongoing provision of high quality sustainable care.

### **How we have listened to feedback**

Feedback from consultation reflects that there are differences in the experience of both potential providers in some key areas.

Table 17: Clinical expertise - You said, we did

You said	We did
<p>There are differences in the respective expertise and experience of the potential providers in some key areas, and this should be clearly laid out and taken into account for decision making.</p>	<p>The experience of providers was considered as part of the pre-consultation evaluation of the options. Information about the experience of both providers was included in the pre-consultation business case and is in this document.</p>

### 7.2.5 Networked care provision

Network effectiveness is an important part of the future Principal Treatment Centre model and is emphasised in the service specification: “The Principal Treatment Centre is responsible for ensuring the provision of high-quality care through the effective coordination of integrated, disease specific pathways across different providers, most importantly ‘paediatric shared care units’, but also with super-specialist providers, such as Barts provider of retinoblastoma services; these hospitals are known collectively as the Children’s Cancer Network.”

#### Evidence previously considered

The pre-consultation business case outlined the network management capabilities of both potential providers and confirmed that the Principal Treatment Centre reconfiguration is not expected to disrupt existing network relationships. ‘Network effectiveness and system benefits’ was also assessed as part of the clinical domain in the evaluation of the options. Evelina London scored 8 compared to 6 for St George's Hospital. Experience of delivering care for children with cancer formed part of the information providers could share to inform the assessment of responses.

The panel scored Evelina London 8 out of 10 on its demonstrated ability to drive change through clinical networks, due to the greater experience demonstrated by Evelina London in hosting complex paediatric networks, including networks that cover the geography of the Principal Treatment Centre: Kent, south London, Surrey and Sussex.

For this criterion St George’s Hospital provided evidence which primarily focused on the management of adult networks such as the London Kidney Network, hosted by St George's. In terms of geography, networks referenced in St George’s Hospital proposal predominantly cover south west London and Surrey. St George’s Hospital is also a member of the network as part of the current Principal Treatment Centre and the provider of a paediatric oncology shared care unit (POSCU).



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## Review of further evidence

Some consultation feedback identified that Evelina London had good links to other hospitals and other children's networks; potentially strengthened by its hosting of the South Thames Paediatric Network. A few others noted St George's Hospital may not have the same links across the catchment area. Others queried how St George's Hospital's experience of being part of the existing Children's Cancer Network had been factored in.

NHS England reviewed the description of networked care arrangements for both potential providers and discussed these with the Clinical Working Group to clarify their relative experience. The experience of both providers is included in Section 5.2.3 of the pre-consultation business case.

## Impact of evidence on decision-making

*Source of evidence:* Provider responses and NHS England review in response to consultation feedback.

*Is this information new?* No. Feedback reflected information that was taken into account as part of the options evaluation.

*Does the information potentially have a material impact on our understanding of the options (specifically, differences between them)?* No, as this information is not new.

*Is the information material to implementation?* The information reflects that the future Principal Treatment Centre will have an important role in leading the Children's Cancer Network to support the delivery of care across the catchment area (as set out in the national service specification). This will be important in the context of the POSCU Transformation Programme.

## How we have listened to feedback

Both providers have experience in leading network development. In the pre-consultation evaluation of the options, Evelina London was considered to have more experience leading specialist commissioned paediatric care networks, however St George's Hospital is an existing member of the Children's Cancer Network. Both have committed to driving further improvements and developments as the host of the Children's Cancer Network should they be chosen as the future provider. This has informed our 'you said, we did' and recommendation below:

Table 18: Networked care provision - You said, we did

You said	We did
The future Principal Treatment Centre should have experience of networked care provision, managing care across the system.	We reviewed the networked care experience and arrangements for both providers noting that the future Principal Treatment Centre will have an important role ensuring the delivery of high-quality care across the Children’s Cancer Operational Delivery Network.

***Recommendation #6: The future provider should focus on the development of effective networking arrangements with providers across the networks, most importantly paediatric oncology shared care units (POSCUs) across the Children’s Cancer Operational Delivery Network. This will support continuity of care and the development of effective communication approaches as well as the transformation programme associated with the delivery of the national service specification for POSCUs. Where there are opportunities to align governance and deliver synergies through the two programmes of work, these should be explored.***

## 7.3 Theme 2: Patient pathways

### 7.3.1 Patient transfers

The elimination of transfers of very sick children from one part of the Principal Treatment Centre to the other for intensive care is the primary driver for this service change. However, it is recognised that transfers for other services take place currently and will continue to do so in the future model. For some services like radiotherapy, new transfers would be required.

#### **Evidence previously considered**

Data from the shared data lake (a single data set established between Guy’s and St Thomas’, The Royal Marsden and St George’s with NHS England London) shows that in 2019/20 35 children, including those being transferred as a precaution, were transferred from The Royal Marsden to St George’s Hospital for critical care. Fifteen of these children were treated on the children’s intensive care unit and 23 on the ward (some had different kinds of care on different occasions).

Further to this, patients are also transferred for other types of care. Typically, many of these transfers are on a planned basis. Treatment transfers were assessed as part of the options evaluation which took place pre-consultation. The expert clinical panel reviewing this element of both submissions was confident that treatment transfers would reduce significantly and both options scored 80%. The panel did not assess either proposal as being able to eliminate transfers completely given London’s configuration of services, therefore neither option was awarded full marks.

Table 19 shows whether transfers may be required for each mandatory/interdependent service and whether they would be required under each future provider. This shows that in the future, **more services** will be provided on the same site as the Principal Treatment Centre than now.

Table 19: Transfers required

Are transfers for these services required?			
Mandatory/ interdependent services	The Royal Marsden (current)	Evelina London (future)	St George's Hospital (future)
Tertiary cardiology	✓	x	✓
Children's cancer surgery (to reduce or remove tumours and manage some cancer-related symptoms)	✓	x	x
Children's infectious disease services	✓	x	x
Children's pathology	x	x	x
Endocrinology	x	x	x
Gastroenterology	✓	x	x
Genomic testing	x	x	x
Tertiary nephrology	✓	x	✓
Neurosurgery	✓	✓	x
Ophthalmology	✓	x	x
Other specialist children's surgery	✓	x	x
Palliative care	x	x	x
Radiotherapy	x	✓	✓
Children's anaesthetics and pain management	x	x	x
Children's blood cancer (haematology) services	x	x	x
Children's cancer services	x	x	x
Children's cancer pharmacy services	x	x	x
Children's radiology services	x	x	x

<b>Are transfers for these services required?</b>			
<b>Mandatory/ interdependent services</b>	<b>The Royal Marsden (current)</b>	<b>Evelina London (future)</b>	<b>St George's Hospital (future)</b>
Children's cancer surgery, including management of emergencies, biopsies and central lines	Most	x	x
Level 3 critical care	✓	x	x
Therapy services such as psychology and physiotherapy	x	x	x

*This helps to demonstrate the benefits that will be delivered by the service reconfiguration.* As previously noted, the move will not eliminate all transfers. It will be important that the future service provider works with partners to design pathways so that transfers are minimised and/or ensure that these are well-managed to ensure continuation of high-quality care.

### **Review of further evidence**

Consultation feedback was concerned that the Principal Treatment Centre reconfiguration didn't solve the issue of transfers as, although the transfers between the specialist cancer centre and the children's intensive care unit would be eliminated, transfers for off-site services such as radiotherapy would still be required. Note - intensive care transfers are addressed within the case for change in Section 1.4 and Section 7.10.

#### *Evelina London option:*

- Transfers for neurosurgery to either King's College Hospital or St George's Hospital - the plans and mitigations for this are covered in Section 7.2.3.
- Transfers for radiotherapy – the plans and mitigations for this are covered in Section 7.6.

#### *St George's Hospital option:*

- Some transfers for inpatient cardiology and nephrology would be needed alongside potential requirement for patients to travel to Evelina London for outpatient/day case diagnostic tests/procedures - the plans and mitigations for this are covered in Section 7.2.3.

- 
- Transfers for radiotherapy – the plans and mitigations for this are covered in Section 7.6.

Radiotherapy transfers would typically be on a planned basis as part of a treatment plan, rather than as an emergency. It is acknowledged that a number of total body irradiation patients will need to be transferred to University College Hospital as part of their inpatient treatment and that their care will need to be carefully managed due to their vulnerability. Section 7.6 includes further information related to transfers for radiotherapy.

Bringing all radiotherapy services together on the same site at University College Hospital would create a range of opportunities to improve care for children with cancer (outlined above in case for change and benefits). It would also have some other impacts. These would include some transfers that don't happen now and longer journeys for some children and their families compared to now (this is set out in Section 2.4) but for completeness:

- Up to 10 children a year<sup>49</sup> who have radiotherapy ahead of a bone marrow transplant (total body irradiation which often needs to be provided during a hospital stay) would have a planned transfer from the future Principal Treatment Centre to University College Hospital for this treatment. These are typically very unwell children who are often in a vulnerable clinical situation.
- Children whose first experience of radiotherapy is as an inpatient would be transferred from the future Principal Treatment Centre to University College Hospital where they would meet new staff on a new site.
- Around 25<sup>50</sup> other children with cancer every year would go to University College Hospital for conventional radiotherapy as outpatients or day cases, travelling from home and back, instead of going to The Royal Marsden (as now)<sup>51</sup>.
- Around 35 other children would travel to University College Hospital (as now) for proton beam therapy and other types of radiotherapy<sup>52</sup>.
- The delivery of conventional radiotherapy services at University College Hospital would result in longer journeys for some children and their families.

As part of the service transition phase, work will take place with University College London Hospitals and the future provider to ensure that radiotherapy pathways are well-managed;

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<sup>49</sup>

In 2019/20, 7 children from the current Principal Treatment Centre had total body irradiation as part of their treatment. Numbers vary year on year.

<sup>50</sup> Numbers are estimates only and would vary from year to year.

<sup>52</sup> Numbers reflect estimate based on future projections for proton beam usage.

building on University College London Hospitals' experience of working with other Principal Treatment Centres to provide care to their patients.

Mitigations for these remaining transfers are outlined in 7.2.3 and will be developed further during implementation.

### Impact of evidence on decision-making

*Source of evidence:* The evidence came from consultation feedback, with concerns particularly raised from children, young people and their families. Concerns related to radiotherapy were also raised by The Royal Marsden, NHS staff and other stakeholders.

*Is this information new?* No, there have been no changes in which services would require patient transfers in each option subsequent to the pre-consultation evaluation. Further detail around radiotherapy transfers has been gathered which has informed our understanding of the service and some of the mitigations that would be required.

*Does the information potentially have a material impact on our understanding of the options (specifically, differences between them)?* No. No further information has been provided that suggests there would be transfers further to those considered at the options evaluation.

*Is the information material to implementation?* As identified in the pre-consultation options evaluation, it will be important that the future provider works with partners to minimise transfers and/or ensure that these are well-managed to ensure continuation of high-quality care. We have developed a recommendation outlined below to address this.

### How we have listened to feedback

The feedback we received, and actions taken to address the feedback are summarised in the 'you said, we did' table below.

Table 20: Patient transfers - You said, we did

You said	We did
Principal Treatment Centre reconfiguration doesn't solve the problem of patients requiring transfer.	Either option will result in more services being on the same site than now. However, movements of patients cannot be eliminated due to the configuration of services across London. While there will continue to be some transfers in the future, no children will be avoidably transferred for intensive care. University College London Hospitals clinicians have shared further detail on pathways for bone marrow transplant

	patients who need treatment at University College Hospital, including detail on transport arrangements.
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We recognise the importance of further work in this area during the implementation phase, with the below recommendation to be taken forward by the preferred provider and monitored by NHS England through the Implementation Oversight Board.

***Recommendation #5: Clear patient pathways and targets for access to these services need to be set out prior to implementation, with appropriate mitigations in place for when patients need to be transferred. The future provider (supported by the wider system) should work collaboratively across the system to design patient pathways that minimise transfers.***

**7.3.2 Moving on from children’s services to teenage and young adult services**

At 16, patients move from children and young people’s services to teenage and young adult (TYA) services, for patients aged 16 up to their 25<sup>th</sup> birthday. The Principal Treatment Centre for the TYA service will remain at The Royal Marsden which means that, in future, patients aged 16 to 18 continuing in cancer treatment will move from the future Principal Treatment Centre, to have their TYA care at The Royal Marsden<sup>53</sup>, changing providers. Pathways will need to be established to ensure the arrangements are as seamless as possible.

**Evidence previously considered**

The impact of the Principal Treatment Centre reconfiguration on TYA services was outlined in the pre-consultation business case (PCBC) and considered as part of the pre-consultation options evaluation in which both providers set out relevant experience<sup>54</sup>.

The PCBC outlined the experience and expertise of both potential providers relevant to supporting children to transition to services for older children/young adults. A summary of both providers’ proposals is included in Table 21 below.

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<sup>53</sup> Both Guy’s and St Thomas’ and St George’s have designated hospitals for the TYA services; this means that local patients may choose (if it is clinically appropriate to do so) to have their treatment there once they turn 19. Prior to that, patients are typically treated at the TYA Principal Treatment Centre at The Royal Marsden. There are other designated hospitals across the catchment area too.

<sup>54</sup> The Evaluation Criteria set out that experience of delivering care for children with cancer shared by providers would support confidence in responses provided.



Table 21: Proposals for transition to TYA services – summary from the PCBC

Guy's and St Thomas'	St George's
<ul style="list-style-type: none"> <li>• Clinical guidance on transition and transfer of care is compliant with and exceeds NICE Transition Quality Standards.</li> <li>• Will employ an accountable clinical lead for transition.</li> <li>• Will co-develop transition plans with children and young people's (CYP) and TYA teams to maximise continuity – starting conversations at around 13 depending on the needs of the person.</li> <li>• The transition process will start at least six months before transfer.</li> <li>• Support from CYP services will be available for at least 6 months after transfer.</li> <li>• Each young person will have a written summary, follow up care plan, and transition tailored to their physical, mental and social needs to optimise health outcomes.</li> <li>• Will continue to work with the Children's Cancer Network to co-design a transition policy with patients and families and a strategy for the Principal Treatment Centre and children's cancer shared care unit.</li> </ul>	<ul style="list-style-type: none"> <li>• Fully compliant with and would continue to work in line with NICE guidance using the 'Ready, Steady, Go' model already in use.</li> <li>• Will support a longer transition for young people with complex learning difficulties, including care within paediatrics beyond the age of 18 if this better meets their needs.</li> <li>• Will consider individual needs and preference, including where patients live and cancer type, when deciding when to begin the transition process.</li> <li>• Will work in partnership with the child, family, and clinicians to identify the service that best meets the clinical and emotional needs of the patient.</li> <li>• Will ensure close liaison with the clinical nurse specialist to prepare the patient and their families / carers for transition.</li> <li>• Will maintain contact following transition to support young people who move to adult services to engage with their first appointments.</li> </ul>

Arrangements for transition to TYA services were considered as part of the pre-consultation evaluation of the options, in the transition sub-criterion of the clinical domain. Both options scored well: Evelina London scored 9 and St George's Hospital scored 8.



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One of the strengths of Evelina London's proposal was the transition model that it set out for other disease groups, including for its specialist renal service, which was an example of the transition planning model it would deploy if it were to be the site of the future Principal Treatment Centre.

### **Review of further evidence**

We are also aware of wider developments relating to cancer care for teenage and young adults set out below.

In 2023, prior to the consultation launch NHS England published new service specifications relating to cancer care for TYA services. The documents set out the requirements for care provided by both Principal Treatment Centres and designated hospitals. All teenagers aged between 16 and 18 years of age have their care managed and delivered by the TYA Principal Treatment Centre. Young adults aged between 19 and 24 years of age (up to their 25th birthday), can choose whether to have treatment at either a TYA Principal Treatment Centre or a TYA designated hospital, which may be closer to home. Each teenager and young adult, irrespective of where treatment is carried out, must be discussed in the TYA multidisciplinary team (MDT) meeting which is hosted by the TYA Principal Treatment Centre. The key aim will be to ensure that pathways of care from diagnosis to treatment are clear across the age ranges and that there is access to fertility preservation, sexual health advice and importantly clinical trials in the right place and at the right time.

Work to consider how providers will deliver care as recommended in the new service specifications is in the early stages, supported by Teenage and Young Adult Cancer Networks. This is likely to require some more detailed exploration of the services currently in place to determine any recommendations for change. It will be important to ensure that there is engagement across children's and adult cancer care so that the interdependencies between services are considered and the important requirements at key transition ages are well managed. More broadly, NHS England has committed to enhance children's and young adults' 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 and young adults feel empowered to make decisions about their health and social care needs.

Concerns about the disaggregation of services for children and teenagers (currently co-located with the workforce closely integrated) were raised by staff members and by The Royal Marsden in its formal response to the consultation. These were concerns about the implications for patient experience of children moving on from the paediatric service, and about the impact on the teenage and young adult service.

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Feedback was that the transition of care would be harder than now where both services are currently on the same site, and many of the consultants in the paediatric team also lead the service for teenagers and young adults, ensuring continuity of care. The importance of having a focus on teenagers aged 16 to 18 was raised in consultation, including to ensure pathways for this age group are clear and that high-quality, age appropriate care is available for them.

Other consultation feedback about the TYA service focused on the potential risk to clinical trials. Survey respondents were particularly concerned about the impact on continuity of access to clinical trials for 16 to 18-year-olds. This is among the research risks we have identified in Section 7.9.

The Royal Marsden also highlighted that the relocation of the Children's Cancer Principal Treatment Centre including clinicians who also work in the TYA service would mean the teenage and young adult service may have to be provided differently, with potential impacts for workforce and estates. The Royal Marsden is undertaking a piece of work to understand the nature of the issue which will inform the development of an options analysis to identify the best way to do this. NHS England is committed to supporting this ongoing piece of work which may include provision for stranded costs. This is provided in more detail in Section 8.8.

### **Impact of evidence on decision-making**

*Source of evidence:* This evidence has been provided through consultation feedback and feedback from discussion with The Royal Marsden.

*Is this information new?* Yes. This consultation feedback has increased our awareness of the risks of the reconfiguration on transition to TYA services, emphasising the importance of managing this during implementation.

*Does the information potentially have a material impact on our understanding of the options (specifically, differences between them)?* No. The impacts on The Royal Marsden TYA services are likely to be similar regardless of which provider is selected as the future Principal Treatment Centre. We have previously assessed both potential providers to understand how transition arrangements would be supported.

*Is the information material to implementation?* Yes. The feedback highlights the importance of the chosen provider continuing to work collaboratively with The Royal Marsden (with support from stakeholders, including NHS England) to ensure that its TYA services are not negatively impacted by the Principal Treatment Centre reconfiguration and that smooth transition to TYA services is as smooth as possible for all patients.

## How we have listened to feedback

The feedback we received, and actions taken to address the feedback are summarised in the ‘you said, we did’ table below.

Table 22: Transition from children’s services to TYA - You said, we did

You said	We did
<p>Moving the Principal Treatment Centre may have a negative impact on patient experience due to the need for patients to transition from a different site to The Royal Marsden which will remain the Principal Treatment Centre for TYA services.</p> <p>There would also be an impact on the existing TYA service which is provided from the Oak Centre for Children and Young People with some of the same staff who run the paediatric service. (This is covered in more detail in Section 7.3.2)</p>	<p>Both providers have also explained their current approach to transition to TYA services and adherence to NICE guidelines (we took this into account during the pre-consultation evaluation of the options). Detailed planning work would be needed in the service transition phase to design pathways and ensure these are well managed. There is precedent for this in other parts of the country. In 2019/20, there were 190 15-year-old patients being treated by the current Principal Treatment Centre. This provides an indication of how many patients may transition to TYA services per year.</p> <p>The Royal Marsden is currently developing an impact assessment of the relocation of the Children’s Cancer Principal Treatment Centre on its TYA service. The outputs of this will inform the work programme for the transition and implementation phases of the programme.</p>

We recognise the importance of further work during the transition phase to be undertaken collaboratively between the future provider and The Royal Marsden.

***Recommendation #7: Effective transition from the Children’s Cancer Principal Treatment Centre to the Teenage and Young Adult Cancer Principal Treatment Centre must be considered during service planning. The future provider should work in close collaboration with The Royal Marsden and wider network, with input from patients, parents and carers, to agree how pathways can be optimised with a particular focus on the 16 to 18 age group. The Implementation Oversight Board should monitor progress and support any barriers to be addressed.***

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***Recommendation #8: NHS England and Integrated Care Boards to continue to work with The Royal Marsden and other stakeholders to support ongoing sustainability of the teenage and young adult service at Sutton, including through the provision of stranded costs.***

## 7.4 Theme 3: Travel and access

### 7.4.1 Parking

*This sub-theme looks at the future provision and access to parking on the Principal Treatment Centre site and at University College Hospital, for patients and families of the Principal Treatment Centre. It also outlines the arrangements for staff parking.*

#### **Evidence previously considered**

The pre-consultation business case outlined the parking arrangements for each provider, if they were to become the future Principal Treatment Centre and confirmed that both providers were committed to addressing recommendations arising from the Integrated Impact Assessment which include the provision of dedicated on-site parking. The Equality and Health Inequalities Impact Assessment (EHIA) sub-group<sup>55</sup> put forward recommendations for high quality, on-site, accessibility arrangements including dedicated parking and drop-off facilities, as well as timeline reimbursements for parking costs. As both options could offer parking at least equivalent to current provision, parking was not felt to differentiate the options for the purpose of decision-making but was identified as a requirement for implementation planning.

#### **Review of further evidence**

Consultation feedback highlighted the concerns that patients, families, and staff had about parking at the future Principal Treatment Centre. They felt that current parking arrangements at both sites was generally poor. Survey respondents expressed concerns that both sites would need more car parking spaces. This showed that parking arrangements for the future Principal Treatment Centre should be clarified with providers.

#### **Patient parking**

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<sup>55</sup> An EHIA sub-group was established in December 2022 to support the EHIA process. Its members included professionals and patient representatives from across the Principal Treatment Centre area. There is more detail in Section 8.2.

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As part of the final Integrated Impact Assessment and in response to concerns raised in consultation, both potential providers and University College London Hospitals were asked clarification questions which included providing further detail outlining their parking arrangements for patients and carers. Both Guy's and St Thomas' and St George's confirmed that:

- Parking allocation will be at least equivalent to the current provision at The Royal Marsden (which is four accessible spaces for Blue Badge holders and four dedicated spaces for Principal Treatment Centre patients).
- Free parking will be provided for patients who regularly attend hospital<sup>56</sup>. The expectation is that parking will either be free at the point of entry or reimbursed on the same day.
- Hospital volunteers will help families get from the car park to the correct location for their appointment in the hospital.
- Drop-off zones will be available outside (or near to) the entrance to the Principal Treatment Centre.

Guy's and St Thomas' confirmed that:

- The most likely location for dedicated parking for immune-suppressed Evelina London patients is St Thomas' Hospital car park.
- An updated system for managing spaces would be implemented.
- It would also explore other options if selected as the future Principal Treatment Centre, such as allocating dedicated spaces within a local car park that is within close proximity of Evelina London. This approach has been endorsed by the Trust Operations Board.
- Guy's and St Thomas' key principles when determining future parking provision will be to provide the committed parking spaces without adversely impacting current patients as well as seeking to improve parking provision for all.

St George's clarified that:

- It does not have any dedicated parking for children with cancer at present.

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<sup>56</sup> This is defined as more than three times a month, as per Government mandate.

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- If selected as the future Principal Treatment Centre, there will be 20 dedicated parking spaces for parents and visitors of the Principal Treatment Centre. Overflow, if needed, can be accommodated within the other parking areas in the Trust.

University College London Hospitals confirmed that:

- There are no patient or visitor car parking facilities at University College Hospital but there are drop-off/pick-up zones outside the hospital and Blue Badge holders can arrange dispensation for on street parking in the surrounding areas, which is outlined in the patient information leaflet.
- Accessibility at University College Hospital, including parking and hospital transport arrangements, will be reviewed and a plan developed by the regional team as part of next year's work plan.

To provide lessons learnt, best practice and standard provision to support further planning for parking during implementation, we reviewed parking provision in other Principal Treatment Centres in big cities. This showed that there is a wide range of provision across providers, with features such as drop off points, discounted rates for those undergoing chemotherapy and radiotherapy and free parking for patients of children staying overnight. This information will feed into implementation plans for parking and inform best practice, alongside a review of Government guidelines<sup>57</sup>.

## Staff parking

Although driving is currently a preference for many Principal Treatment Centre staff, this is unlikely to be possible at either of the potential providers as both have limited parking availability for staff. However, both organisations have developed Green Travel Plans which cover active travel plans for staff. As a result, in both cases, the future Principal Treatment Centre will be able to deliver the London and South East Clinical Senates' recommendation to identify plans to increase active transport and decarbonise transport for staff. It is anticipated that the majority of staff will travel to work via public transport, as discussed in Section 7.4.2.

## Impact of evidence on decision-making

*Source of evidence:* This evidence has been provided through consultation feedback and additional provider response.

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<sup>57</sup> [NHS car parking guidance 2022 for NHS trusts and NHS foundation trusts](#)

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*Is this information new?* No. The importance of parking requirements was not new, the consultation provided more insight into parking requirements that will inform implementation plans.

*Does the information potentially have a material impact on our understanding of the options (specifically, differences between them)?* The clarification questions confirmed that both potential providers are committed to offering parking capacity to at least match current levels. This therefore does not materially affect our understanding and differentiation of the options.

*Is the information material to implementation?* Yes. Consultation feedback confirms the importance of parking and the need to consider arrangements in more detail as part of implementation.

### **How we have listened to feedback**

The feedback we received, and actions taken to address the feedback are summarised in the 'you said, we did' table below.

Table 23: Parking - You said, we did

You said	We did
There needs to be sufficient parking provision at the future providers that is dedicated to the service and is comparable to the current provision at The Royal Marsden.	Both the potential providers have confirmed parking capacity would be available at the future Principal Treatment Centre. NHS England has made a recommendation around provision of parking and will monitor progress and feedback.

The implementation plan for the chosen provider will seek to provide appropriate parking capacity and dedicated, free parking for families with children who are immunosuppressed, meet disability eligibility criteria or are too unwell to travel via public transport. It would be beneficial for the future provider to conduct a thorough analysis of current parking in order to determine how many people typically park at the Principal Treatment Centre per day and how long they normally stay for on average; this will provide further assurance around future capacity. This has fed into our recommendation below:

***Recommendation #9: Parking possibilities must be available for patients and carers at the future provider and University College London Hospitals, and they must be easily accessible from the hospital. Processes around payment must be easy to understand and accessible (catering for families experiencing digital exclusion and available in inclusive formats).***



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## 7.4.2 Travel times and costs

The sub-theme addressed the impact of the proposed reconfiguration of the future Principal Treatment Centre on the time and cost for patients and staff to travel to the future centre.

### Evidence previously considered

For the pre-consultation evaluation, we undertook a comprehensive travel time analysis to understand the effect on travel times for children and their families. The analysis looked at travel times by public transport and car to The Royal Marsden and compared this with journey times to both Evelina London and to St George's Hospital. This analysis was conducted on a catchment population basis by experienced independent NHS analysts, the Insights Team at NHS North East London.

The original analysis showed that both options increased travel time by car and reduced travel time by public transport compared to the current location of the Principal Treatment Centre and is included in the interim Integrated Impact Assessment (pre-consultation business case Appendix 1).

A travel time analysis was also completed for the pre-consultation evaluation of the options, which showed that a greater proportion of patients would have longer travel times if Evelina London was chosen as the future Principal Treatment Centre. This travel time analysis is explained in detail on our consultation website<sup>58</sup>.

### Review of further evidence

The feedback from consultation confirmed the findings from pre-consultation business case and pre-consultation feedback that travel time is an important and pressing issue. Of survey respondents, 15% thought time taken/distance of journey was important and 8% thought 'convenient location' was important.

### Travel time analysis

Refreshed travel time analysis was undertaken for the Integrated Impact Assessment. This analysis extended to the impacts for different ethnic groups (outlined in Section 7.4.4). Since the original travel time analysis was conducted, the drive time data underpinning the travel time software used has been updated. There was no differential impact of this update on times to individual provider locations or between London and non-London populations. As a result, we have not updated the original travel time analysis as the overall differential impact between potential locations remains the same. We also conducted sensitivity testing for comparing driving and public transport times when travelling in 'peak' and 'off-peak' times.

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<sup>58</sup> <https://www.transformationpartners.nhs.uk/childrenscancercentre/key-information/travel-times/>

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Results showed very little difference in peak and off-peak travel times for the catchment population. This is described in more detail in Section 8.4.1.

Since the original travel time analysis, we also responded to feedback asking for a travel time analysis across the whole treatment pathway, rather than a single journey. In summary, a family with one of the longer journeys to the Principal Treatment Centre (top decile), undertaking 15 visits in a year, could see an additional 20 to 24 hours of travel time if travelling to either future Principal Treatment Centre location. A family with a median journey length, with the most typical experience (up to three visits per year) would see an annual time impact of 30 to 39 minutes. More detail is included in the Integrated Impact Assessment (Appendix 4).

### Travel cost analysis for patients

The refreshed Integrated Impact Assessment also includes consideration of travel poverty (a difficulty or inability to make necessary journeys due to a combination of income, cost and service availability). We completed a travel cost analysis to understand the financial impact of the change.

This travel cost analysis (see Table 48 (Section 8.4)) was based on driving costs only, due to data availability and the preference for most patients to drive to the Principal Treatment Centre<sup>59</sup>. This analysis shows that driving to either of the future providers is cheaper than the current journey cost, when looking at the entire impacted population. This is due to the distribution of the population with a higher density in London, and also that travel cost takes into account miles travelled, not traffic density, which accounts for the disparity between the travel time and cost analysis. The analysis also showed that the cost of driving to University College Hospital was, on average, similar to driving to The Royal Marsden. Overall population findings do not negate the fact that some families will face longer, more costly journeys and these impacts need to be mitigated.

Inner London congestion (£15.00) and Ultra Low Emission Zone (ULEZ) charges have not been applied to these travel costs, as reimbursement schemes are available for these. Patients who have been clinically assessed as needing to travel by car, have a compromised immune system, require regular therapy or assessment, or require recurrent surgical intervention, are eligible to reclaim congestion charges and ULEZ fees. The expectation is that this will apply to all patients under the care of the future Principal Treatment Centre. NHS hospitals are registered with Transport for London to allow reimbursement of ULEZ or

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<sup>59</sup> The final IIA contains illustrative public transport costs for exemplar journeys from areas of higher deprivation across the catchment.

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congestion zone charges. This happens through the online payment system. Reimbursement usually happens on the same day as incurring the charge. It is acknowledged that reimbursement for ULEZ charges (applicable to both potential Principal Treatment Centre providers, University College London Hospitals and The Royal Marsden) and congestion zone charges (applicable to Evelina London and University College Hospital) is not available for friends or family visiting a child in hospital.

We also estimated the impact on travel costs for patients travelling by public transport. Due to the complexity of public transport fares, we are unable to conduct a systematic analysis of public transport cost across the catchment population. We analysed five example journeys from areas of higher deprivation within Integrated Care Boards in the Principal Treatment Centre catchment<sup>60</sup>. This analysis is included in the Integrated Impact Assessment (Appendix 4). It shows that the relative impact on public transport costs is greater for the example journeys starting in Croydon and Reigate and Banstead. Although the example journeys from Swale and Hastings do not have a large relative impact between The Royal Marsden and each location, the absolute costs for public transport from these areas are higher. However, it should be noted that these cost comparisons are illustrative only and may not align with individual experiences<sup>61</sup>.

### **Travel cost analysis for staff**

We also conducted a travel cost analysis for staff in response to concerns that their living costs would be affected by the Principal Treatment Centre reconfiguration. The travel cost analysis showed that Evelina London would have a higher journey cost difference for staff travelling by car than St George's Hospital. More detail is included in Section 8.4.5. Section 7.2.4 addresses staff concerns and the mitigations that would be in place, such as transfer arrangements.

We are aware that although driving is currently a preference for many Principal Treatment Centre staff, this is unlikely to be possible at either of the future providers due to a lack of staff parking. However, both organisations have developed Green Travel Plans which cover active travel plans for staff. As a result, in both cases, the future Principal Treatment Centre will be able to deliver the London and South East Clinical Senates' recommendation to identify plans to increase active transport and decarbonise transport for staff.

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<sup>60</sup> Public transport search parameters (in Google maps) were set to the fastest journey that arrives at the destination by 12pm on a Wednesday. Any time return fares were then recorded for each journey (search completed on 8 February 2024).

<sup>61</sup> Choice of mode of transport, timing, route and concessions held will all affect the cost and the examples shown here may not align with individual experiences.

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We have also considered the impact on public transport costs by reviewing five individual case studies (the variation in public transport times/cost meant that a travel cost analysis would not be representative). We compared their current journey time by car to The Royal Marsden to their prospective journey time by public transport to both potential providers (as many staff will use public transport in future, given both potential providers' more central location<sup>62</sup>). The methodology for this analysis is explained in more detail in Section 8.4.

Based on this sample, the results confirm that travel costs for staff who currently drive but will use public transport to get to the future Principal Treatment Centre are likely to increase. TUPE protections and inner London high cost area supplement should help to mitigate these impacts. Arrangements for pay are outlined in Section 7.5.2. However, it should be noted that these are example journeys only and there will be a wide range of experiences for members of staff. Those who live close to The Royal Marsden are likely to see the largest impact on their travel costs relatively speaking. However, longer distances are not linked to higher costs in a linear fashion as the cost of travel depends on the nature of public transport into London.

To support the development of our mitigations for changes to travel time and costs for patients and staff, we conducted a review of the North Central London Integrated Care System Start Well Programme mitigations and of the North West London Elective Orthopaedic Programme mitigations to ensure that we have considered all available options. A comparison with our proposed mitigations confirmed that our mitigations included an appropriate level of detail. Our full mitigations for all impacts in the Integrated Impact Assessment are included in Appendix 4.

### **Impact of evidence on decision-making**

*Source of evidence:* Final Integrated Impact Assessment.

*Is this information new?* Yes. Travel time analysis for ethnic groups other than white and travel cost analysis for patients is new. The sensitivity analysis on the travel time analysis is also new. Given the limitations in the analysis conducted for public transport costs for staff, such as small sample size and individual choice, this is used to support our understanding of existing concerns about travel cost impact rather than constituting new information.

*Does the information potentially have a material impact on our understanding of the options (specifically, differences between them)?* No. Analysis shows increased travel costs for both options for staff by public transport, and decreased travel costs for patients by car. Reduction

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<sup>62</sup> Public transport search parameters (in Google maps) were set to the fastest journey that arrives at the destination by 12pm on a Wednesday. Any time return fares were then recorded for each journey (search completed on 8 February 2024)

in average travel cost by car is slightly better for St George’s, and particularly beneficial for patients living in deprived areas and ethnic groups other than white.

*Is the information material to implementation?* Yes. Impacts to staff and patients on increased travel time and cost should be accounted for in the Integrated Impact Assessment mitigations.

**How we have listened to feedback**

Further evidence validates concerns reflecting increased travel costs for staff, however, it suggests that, on average across the Principal Treatment Centre catchment population, journey travel costs should be reduced. TUPE protections and inner London high cost area supplement should help to mitigate the impact on staff of increased travel costs (acknowledging TUPE protections will only last up to four years).

The findings of this analysis have fed into the recommendations listed below, numerous mitigations in the Integrated Impact Assessment and consideration of the following sub-themes which are explored subsequently.

- Inclusive support for travel planning, identifying patients/families who might need help with transport as early as possible in their care pathway.
- Patient Transport (see Section 7.4.3).
- Accommodation (see Section 7.4.5).
- Alternative locations such as remote appointments and children’s cancer shared care unit.

Table 24: Travel time and cost - You said, we did

You said	We did
<p>Travel time is an important and pressing issue, and increased costs associated with travelling to the future Principal Treatment Centre are a concern. Information needs to be provided about what help is available to support staff and patients.</p>	<p>The Integrated Impact Assessment incorporates refreshed travel time analysis and travel cost analysis and associated mitigations. We have also clarified the reimbursements and support that is available regarding travel costs. We have updated recommendations for the mitigation of the impact of increased travel time and cost, including the provision of information on what support is available.</p>

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### 7.4.3 Non-emergency hospital transport

Some patients of the Principal Treatment Centre will be eligible for non-emergency patient transport services (PTS). These services provide free transport to and from hospital for people including those whose condition means they need additional medical support during their journey.

#### **Evidence previously considered**

The pre-consultation business case confirmed that both potential providers of the future Principal Treatment Centre and University College London Hospitals had non-emergency patient transport teams.

The Equality and Health Inequalities Impact Assessment sub-group recommended that transport services should be provided directly to patients and their families, with clear eligibility criteria.

#### **Review of further evidence**

Questionnaire respondents saw access to free hospital transport as an essential for the future Principal Treatment Centre. Key feedback and information from provider responses included:

- Some staff wanted proposals to provide greater support for families and patients to get to hospital.
- Other questionnaire respondents noted that hospital transport can be unreliable and wanted assurances about flexibility for patients who missed appointments due to problems with hospital transport.
- Some questionnaire respondents highlighted that the arrangements for hospital transport for both providers needed to be communicated more clearly; some concerns related to services that would be provided in the future model that people were not aware of. As part of the final Integrated Impact Assessment, both providers were asked clarification questions which included providing further detail outlining their hospital transport arrangements.
- Guy's and St Thomas' explained that all patients using the service would be eligible for solo patient transport (that is, transport for them and a parent/carer – not with other patients too) if they met patient transport eligibility criteria. The Trust's patient transport service is assessed regularly, and it is currently exploring plans to implement shuttle buses to and from nearby train stations for those wishing to travel

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by train but who may require support to access the hospital (this was suggested in consultation responses).

- St George's noted that clinical advice is sought to ensure patient need and requirement is captured and there is an appeals process for anyone not satisfied with the decisions made regarding eligibility. Provision is as per the NHS England non-emergency patient transport services requirement.
- Both potential providers confirmed that their assessment and prioritisation for the provision of hospital patient transport is aligned with the NHS England non-emergency patient transport services eligibility criteria and is based on eligibility and the clinical need of the patient. However, we asked both providers to confirm these arrangements and clarify how the eligibility criteria were determined to provide further assurance.

St George's, Guy's and St Thomas' and University College London Hospitals also confirmed their eligibility criteria and level of hospital transport provision, this is provided in Appendix 4.

Accessibility at University College Hospital, including parking and hospital transport arrangements, will be considered as part of the dedicated travel and access working group that all providers have committed to as part of the implementation phase.

### **Impact of evidence on decision-making**

*Source of evidence:* This evidence has been provided through consultation feedback and additional provider response.

*Is this information new?* This information provides further detail which validates previous information, therefore is not 'new'.

*Does the information potentially have a material impact on our understanding of the options (specifically, differences between them)?* The clarification questions confirmed that both providers will provide non-emergency patient transport services as per the NHS England non-emergency patient transport services requirements and eligibility criteria. Regardless of the provider of the future Principal Treatment Centre, accessibility at University College Hospital will be reviewed as part of next year's work plan. This therefore does not materially affect our understanding and differentiation of the options.

*Is the information material to implementation?* Yes. Consultation feedback confirms the importance of non-emergency patient transport services and the need to consider arrangements in more detail as part of implementation.

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## How we have listened to feedback

More detail about hospital transport arrangements has been provided in response to feedback from consultation. This is summarised in the 'you said, we did' table below. Feedback also highlighted the need to further develop hospital transport plans as part of implementation. Based on consultation responses, we understand that the implementation of hospital transport should include mitigations for unreliable hospital transport. Further mitigations are outlined in Appendix 4.

Table 25: Non-emergency hospital transport - You said, we did

You said	We did
There needs to be adequate hospital transport provision. Hospital transport can often be unreliable, and eligibility criteria need to be reviewed.	Providers have clarified their hospital transport arrangements, and we have made a recommendation that the future provider should develop a family-centred strategy around non-emergency transport, including monitoring of performance.

We have also provided a recommendation for the future provider regarding hospital transport:

***Recommendation #10: Alternative methods of patient transport to and from hospital should be provided and its performance monitored (e.g., reliability of timing) by the future provider and University College London Hospitals.***

### 7.4.4 Impact on equality groups

This sub-theme addresses the impact of the change on travel and access for people with protected characteristics or other characteristics and aims to assess whether there is a disproportionate impact on these groups. The Integrated Impact Assessment (Appendix 4) includes more detail related to the impact on equality groups, including impacts outside of travel and access.

### Evidence previously considered

The original Equality and Health Inequalities Assessment (EHIA) travel time analysis explored differences in travel times between socio-demographic groups within the Principal Treatment Centre catchment area. It found that:



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- By public transport, children living in the most deprived areas and rural areas would, on average, have a shorter journey for both options than to The Royal Marsden compared to other children.
  - By road, children living outside London or in rural areas would, on average, have a longer journey for both options than to The Royal Marsden, compared to other children.

The interim Integrated Impact Assessment for the pre-consultation business case drew on a comprehensive description of the population of the Principal Treatment Centre catchment area (identifying need) and used travel time analysis to support an assessment of differential impacts on populations with protected characteristics or other vulnerabilities (the "Core20PLUS5" population). The EHIA sub-group put forward a series of mitigations for any adverse impacts (the main themes are described in Section 9 of the pre-consultation business case and are outlined in Section 4.4).

### **Review of further evidence**

Consultation feedback from equality groups (included in Appendix 2) was broadly in line with other survey respondents, with more concerns around travel and access from disabled people. The London and South East Clinical Senates also recommended further consideration of how the future service will meet the five strategic objectives for health inequalities in the NHS Operating Plan. Therefore, in addition to the work done at pre-consultation business case, we have now analysed the specific impact on travel costs for deprived populations and the impact on journey times for different ethnic groups to ensure that we have considered potential adverse impacts for all.

Our travel cost analysis of deprived populations shows that for every Principal Treatment Centre location (current and potential), the median travel cost for the most deprived population is more expensive than for the general population. However, both potential providers would generate cheaper travel costs by car for deprived populations than at present. St George's Hospital has a lower median cost than Evelina London but a higher variance in travel costs. A larger proportion of the deprived population would pay more than £25 at St George's Hospital than The Royal Marsden and Evelina London for estimated return journey by car. Table 47 (in Section 8.4) outlines the travel cost analysis for the most deprived population for off peak arrival at midday.

The updated travel time analysis also included an analysis of the change in journey times (by car and by public transport) for different ethnic groups ('white' and 'other than white'). This analysis found that the increase in journey times by car would be less for ethnic groups other than white than for the white population (likely due to density of ethnic groups other than



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white population in London compared to the south east), but journey times by car would still be higher for both groups than current journey times. Journey times by public transport would reduce for all, but this reduction would be less for ethnic groups other than white. This is described in more detail in Section 8.4.2.

In order to ensure equity of access, in response to consultation feedback, we have also considered the monitoring mechanisms that could be put in place. The quality and outcomes metrics for this are outlined in Section 8.

In addition to the outcomes metrics in Section 8, we expect the future provider to:

- Conduct a regular Health Equity Audit (HEA) to assess whether resources are distributed fairly.
- Develop and implement a mechanism for monitoring uptake of mitigating actions and process for:
  - travel cost reimbursement
  - hospital provided patient transport
  - family accommodation
  - language translation/interpretation services
  - referral to benefits advice services and/or third sector organisations for financial advice and support.
- In collaboration with Integrated Care Board (ICB) commissioners, we will consider use of Schedule 2N within the NHS Standard Contract to set out specific actions that the provider will take to reduce inequalities
- We also request provider level data for monitoring outcomes if national data is not available/representative.

### **Impact of evidence on decision-making**

*Source of evidence:* Final Integrated Impact Assessment.

*Is this information new?* Yes. The travel time and cost analysis for socio-economic groups and ethnic groups is new.

*Does the information potentially have a material impact on our understanding of the options (specifically, differences between them)?* No. Analysis shows a proportionately smaller travel time impact for ethnic groups other than white for both options, as well as decreased travel

costs for patients from more deprived areas. This indicates that the change could improve ability to access services for these populations. There is minimal difference between the analysis for the two options.

*Is the information material to implementation?* As described in the pre-consultation business case, the future provider should monitor outcomes and take actions to reduce inequalities. This should be considered further as part of implementation. The new information provided by the analysis does not negate this requirement.

### How we have listened to feedback

Following responses from the consultation and London and South East Clinical Senates, we have conducted travel analysis for equalities groups. The summary of our actions in response to the feedback is provided below.

Table 26: Impact on equality groups - You said, we did

You said	We did
<p>Patients in deprived areas and ethnic minorities are likely to experience different impacts on travel time and cost compared to the rest of the population.</p>	<p>The EHIA describes mitigations around possible impact on health equity, including separate analysis for different ethnic groups, which shows that ethnic groups other than white have a lower travel time impact compared with the white population. Additionally, analysis shows that, on average, there would be decreased travel costs for patients from deprived areas, compared to travel to the current Principal Treatment Centre. <i>This does not negate the fact that some individual families will experience longer travel times or higher costs and that this impact needs to be mitigated as much as possible.</i></p>

The future provider should monitor outcomes and take actions to reduce inequalities, as outlined in our recommendation below. This should be considered further as part of implementation. Suggestions for mitigations for this are outlined in the Integrated Impact Assessment [Appendix 4].

***Recommendation #11: The provider of the future Principal Treatment Centre and University College London Hospitals should ensure that accessibility arrangements meet the needs of equality groups (for example, cost reimbursement for those***

***experiencing financial difficulties, translation and inclusive communications for those that require it or reasonable adjustments for those with disabilities) and are regularly monitored against equality frameworks.***

#### **7.4.5 Sufficiency of on-site accommodation**

For many patients and their families, overnight family accommodation and the ability to stay with the child on the ward as they receive treatment is really important. We address the provision and access to this in the following section.

#### **Evidence previously considered**

The pre-consultation business case outlined the proposals for care facilities at both providers. Both potential providers have various accommodation facilities including Ronald McDonald Houses nearby and would provide accommodation on the ward, allowing parents to sleep next to their child.

The EHIA sub-group recommended that good quality, overnight family accommodation (within a short walking distance), including capacity to stay with the child on the ward would serve to mitigate some of the adverse impacts of the Principal Treatment Centre reconfiguration (outlined in the pre-consultation business case).

#### **Review of further evidence**

Consultation feedback highlighted the importance of sufficient accommodation provision, particularly with increased journey times, but there were concerns around capacity of family accommodation for both potential providers. Concerns were also raised around the distance between the hospital and family accommodation for Guy’s and St Thomas’.

The clarification questions sent to both providers included a request for more detailed accommodation plans. Key arrangements for each provider are outlined in the table below.

Table 27: Parent/carer accommodation arrangements

Guy’s and St Thomas’	St George's
<b>On ward accommodation</b>	
Suggested floor plans for the proposed children’s cancer inpatient ward include pull-down full-size beds at every bedside for a parent or carer to sleep next to their child.	Suggested floor plans for the proposed children’s cancer inpatient ward include the potential for six additional ensuite bedrooms which could be used as family suites. (Each interconnects with one other bedroom.)

<p>There are rooms for parents on the first floor of the children’s hospital, close to the children’s intensive care unit.</p> <p>There are communal lounges, washing machines, kitchens, and playrooms for children.</p>	<p>Beds for parents or carers to sleep next to their child.</p> <p>There are three family rooms close to the children’s intensive care unit.</p> <p>The proposed children’s cancer centre would have co-located facilities for dining, play, recreation, relaxation and study.</p>
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**Overnight family accommodation nearby**

<p>Families staying at Ronald McDonald House can stay as long as their child is being treated at Evelina London.</p> <p>At Ronald McDonald House, there are 59 ensuite bedrooms, all of which can sleep up to four people and a room on each floor that can accommodate up to six people.</p> <p>If families are unable to stay in Ronald McDonald House, Gassiot House Accommodation at St Thomas’ Hospital has rooms which can be booked on a nightly basis. Family rooms are available on request.</p> <p>Families staying at Ronald McDonald House, Gassiot House, and on the first floor of Evelina London will not pay for their stay.</p>	<p>If a family is eligible for free accommodation, they will be supported with their accommodation. For those eligible, additional on-site overnight accommodation is available for long-stays at the Pelican Hotel and Ronald McDonald House (there are eight ensuite rooms available in Ronald McDonald House).</p> <p>St George’s have indicated that there is potential to expand the Ronald McDonald House in future.</p>
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To provide further assurance that arrangements for accommodation had been properly considered, we asked providers to clarify accommodation eligibility criteria. Both providers confirmed that they consider patient travel requirements when booking appointments. For instance, if families are travelling long distances to outpatient appointments, consideration would usually first be given to providing a later appointment or a virtual appointment where this is appropriate. Other considerations highlighted by Evelina London include how unwell

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the child is, and whether the parents have other children with them. The approaches to accommodation provision of both providers are both flexible according to patient need.

An analysis of family accommodation capacity requirements against potential demand should be conducted by the future provider to inform detailed plans for accommodation during implementation and detail how it will address further growth.

### **Impact of evidence on decision-making**

*Source of evidence:* This evidence has been provided through consultation feedback and additional provider responses.

*Is this information new?* Yes, the information provided on accommodation and Ronald McDonald provision was new. Additionally, the arrangements for payment of family accommodation was new.

*Does the information potentially have a material impact on our understanding of the options (specifically, differences between them)?* While both have Ronald McDonald accommodation, St George's has a much smaller facility compared to Evelina London, although it is recognised that this benefit for Evelina London is likely to be offset by the higher demand from children and their families at Evelina London. This isn't differentiating on current information. The lack of capacity would need to be mitigated by funding arrangements for alternative accommodation for both providers, however recognising this has an impact on public money.

*Is the information material to implementation?* Yes. There remains a risk around capacity to accommodate future demand for on-site family accommodation that will need to be managed and mitigated during the service transition phase.

### **How we have listened to feedback**

Both potential providers have facilities for accommodation, however the provider of the future Principal Treatment Centre will need to accommodate increased demand, and arrangements for this will need to be put in place. There are a range of ways, including through charitable funding and also NHS funding for private accommodation, should the accommodation offer need to be expanded. It will be important that families are supported to access accommodation easily where needed. We recognise concerns raised through the consultation around access and availability to suitable accommodation. We have included further development of arrangements for family accommodation and on ward accommodation within an estates recommendation in Section 7.8.3.

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#### **7.4.6 Providing care as close to home as possible**

In its role as the host of the Children's Cancer Network (described in Section 7.2.5), the future Principal Treatment Centre has a role to ensure that high quality care is accessible in the hospitals within the network.

There are two children's cancer Operational Delivery Networks covering London and part of the south east and east of England regions. They lead agreed work to support implementation of the national service specification requirements in their respective geographies.

#### **Evidence previously considered**

Principal Treatment Centres work in partnership with paediatric oncology shared care units (POSCUs) at hospitals across their catchment area so that children with cancer can receive supportive care and some specified cancer treatments, as close to home as possible.

- The pre-consultation business case described the parallel ongoing POSCU transformation work (through the POSCU Transformation Programme) across the system and outlined the links between this work and the Principal Treatment Centre reconfiguration, specifically how the two programmes will work together to deliver coordinated children's cancer care, as set out in the national service specification.

#### **Review of further evidence**

- Consultation feedback encouraged ongoing communication and coordination of care between the Principal Treatment Centre reconfiguration programme and the POSCU Transformation Programme to ensure patients could get more care closer to home, reducing their need to travel, and to ensure the experience of care in shared care units was consistently good.
- We have further developed the description of the POSCU Transformation Programme, so that we can articulate the potential impact of this:
- In 2021, NHS England published changes to the national service specifications for children's cancer. The Principal Treatment Centre and POSCU children's cancer service specifications set a strategic direction for excellent cancer care for children, including care as close to home as possible, with the right level of care to support greater access and consistency of support at a local level. This will mean changes for some of the current POSCUs. In May 2023, the teenage and young adults service specifications were also published.

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- In relation to POSCU implementation, it is likely that change will be required for some units. NHS England teams in London, the south east and east of England<sup>63</sup>(linked to the North Thames network) are working together to consider how to implement the changes outlined in the service specifications. They will consider how to address the identified gaps in the existing services and the considerations to address these, for example with considerations of staff time, training and education across a range of staff groups and with the management of clinical trials. They are reviewing information from hospitals to determine how to implement the new care levels with good geographical coverage so that all children and young people and their families have the same experience of care, delivered close to home (within POSCUs), wherever this is possible. This is a separate piece of work which will be supported with its own implementation and engagement plan.

In order to reduce the number of journeys required to the Principal Treatment Centre, enablers for shared care through Principal Treatment Centre reconfiguration include:

- The Principal Treatment Centre has a defined role for ensuring the provision of high quality cancer care and, will support options for receiving care closer to home through POSCUs and this will evolve over time.
- On diagnosis, the Principal Treatment Centre staff will talk with families on support available in the community. This will include information about the care which their local POSCU is able to provide and advice about how to access care that reduces the number of journeys required to the Principal Treatment Centre.
- Excellent communication between the Principal Treatment Centre and children's cancer shared care unit (including shared patient clinical records) and between both services and patients/patient families will be important.
- The POSCU Transformation Programme underway across the North Thames and South Thames Children's Cancer Operational Delivery Networks will be key to optimise shared care.

### **Impact of evidence on decision-making**

*Source of evidence:* This evidence has been provided through consultation feedback.

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<sup>63</sup> This work is being developed with East of England. However, East of England patients would generally be treated at Great Ormond Street Hospital, rather than The Royal Marsden.



- *Is this information new?* This information provides further detail around how the Principal Treatment Centre and POSCUs could work together which validates previous information, therefore is not 'new'.
- *Does the information potentially have a material impact on our understanding of the options (specifically, differences between them)?* The POSCU Transformation Programme will be important, irrespective of which option becomes the future Principal Treatment Centre and doesn't impact our understanding of the options as both potential providers would have a key role in working with POSCUs as the host of the Children's Cancer Network.
- *Is the information material to implementation?* Consultation feedback related to children's cancer shared care units confirms that we should continue to work closely with the POSCU Transformation Programme to maximise the opportunities presented by both programmes working together to improve care for patients.

### How we have listened to feedback

- The POSCU Transformation Programme should continue to be championed throughout implementation of the Principal Treatment Centre reconfiguration and this could help to mitigate against some care, travel and access concerns raised through consultation.

Table 28: Providing care as close to home as possible - You said, We did

You said	We did
Ongoing communication and coordination of care between the Principal Treatment Centre reconfiguration and the POSCU Transformation Programme should be encouraged.	We have developed the description of the relationship between the Principal Treatment Centre reconfiguration and the POSCU Transformation Programme and articulated the enablers for shared care through Principal Treatment Centre reconfiguration.

Consultation feedback related to children's cancer shared care units confirms that we should continue to work closely with the POSCU Transformation Programme to maximise the opportunities presented by both programmes working together to improve care for patients. This has driven our recommendation that:

***Recommendation #12: The provider of the future Principal Treatment Centre should work with the Children's Cancer Network to support the development of plans and model of care within children's cancer shared care units so that all children and***



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***young people have the same experience of care, delivered close to home whenever this is possible.***

#### **7.4.7 Minimising the impact of travel costs**

The reconfiguration and related changes in travel arrangements for some patients and their families could lead to higher costs of travel, parking and accommodation. This sub-theme addresses how the programme should minimise the impact of this, and the support available to families to mitigate the change.

#### **Evidence previously considered**

The original Equality and Health Inequalities Impact Assessment (EHIA) sub-group considered the potential impacts (positive and adverse) of Principal Treatment Centre reconfiguration. These were outlined in the pre-consultation business case.

The group put forward a series of recommendations that could be used to mitigate the adverse impacts of the change. This included the provision of systems and processes aimed at reducing the financial impact of travel, such as reimbursement schemes for travel costs or supporting patients to access other financial support.

#### **Review of further evidence**

Consultation feedback showed that people were concerned that the cost of travel would increase, with this having the potential to impact their quality of life – as we had heard in pre-consultation feedback. Specific concerns raised included the fact that, as now, only one family member would be eligible for reimbursement for travel costs, despite the wider network of support involved in helping a child with cancer. People from ethnic minority communities and families on low incomes highlighted that it may not be possible for them to pay for travel/parking upfront meaning that a system based on reimbursements would exclude them from care.

In addition to the consultation feedback, the updated travel cost analysis showed that while, on average, travel cost reduced due to the change, some patients and their families would see significant cost increases, particularly when this cost increase often impacts multiple journeys.

In response to this feedback, NHS England asked the potential providers for further information on support for families applying for travel cost reimbursements.

Arrangements consistent across both providers include:

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- National Healthcare Travel Costs Scheme, covering fuel costs, parking, tolls and public transport fares for one parent/carer and the child for those receiving income-related benefits.
  - Patients who have been clinically assessed as needing to travel by car, have a compromised immune system, require regular therapy or assessment, or require recurrent surgical intervention, would be eligible to reclaim congestion charges and Ultra Low Emission Zone (ULEZ) fees. The expectation is that this will apply to all patients under care of the Principal Treatment Centre.
  - NHS Trusts are registered with Transport for London (TfL) to allow reimbursement of ULEZ or congestion zone charges. This happens through the online payment system. The TfL system provides same day reimbursement and dedicated staff will clearly communicate that ULEZ and congestion charge will be repaid on the same day.
  - Dedicated support staff for families when they arrive, supporting them with reimbursements and parking queries.

Prospective funding is not a model currently utilised across the NHS, and therefore unlikely to be possible for patients at this stage. However, at implementation stage, a Travel and Access workstream should explore alternative options to ensure families who could not afford the upfront cost were not left out of pocket. We also discussed the potential options with Young Lives vs Cancer in order to understand whether upfront funding may be possible in future, and this may be a further avenue for the workstream to explore at implementation stage.

In response to feedback, we also reviewed the financial support available for those travelling by public transport. Detail is provided in Appendix 4.

### **Impact of evidence on decision-making**

**Source of evidence:** This evidence has been provided through consultation feedback and further research by NHS England.

**Is this information new?** No. This information provides further detail around financial support, building on the pre-consultation business case information. This is not new information. The new information from the travel cost analysis is assessed in Section 7.4.2.

**Does the information potentially have a material impact on our understanding of the options (specifically, differences between them)?** No, the financial reimbursement and support arrangements are, for the most part, consistent across both future providers and therefore this new evidence doesn't impact our understanding of the options. The congestion charge is

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relevant to Evelina London and University College London Hospitals, but not St George's Hospital, however, reimbursement arrangements exist.

[Is the information material to implementation?](#) Consultation feedback related to financial reimbursement shows that the future provider should continue to develop plans to minimise the impact of travel costs during implementation.

### **How we have listened to feedback**

While travel cost analysis demonstrates a lower average travel cost as a result of the Principal Treatment Centre reconfiguration, the proposed service change will generate additional costs for some people, and we recognise that all travel costs place a burden on people. Consultation feedback highlighted the need for the future provider to minimise the impact of travel costs, whether that be through financial reimbursements or specific support. Feedback suggested that administrative support for reimbursements would be particularly important. We have set out the financial support available and future mitigations including suggestions for administrative support in Section 8.4 as well as further analysis potential cost impact. We also have recommended that further consideration takes place at implementation phase.

***Recommendation #13: The future provider and University College London Hospitals should further consider mechanisms to support families or staff who can't pay for travel costs or hotel accommodation, such as easier access to automatic reimbursement mechanisms or collaboration with local hotels if appropriate.***

#### **7.4.8 Safety of patients when travelling (via public transport)**

This sub-theme addressed the safety of patients, particularly immune-suppressed patients, when travelling on public transport.

#### **Evidence previously considered**

The original travel time analysis and pre-consultation evaluation of the options considered travel times by public transport and road to both Evelina London and St George's Hospital compared to the current Principal Treatment Centre. The scoring was weighted so that journey times for people living in the areas categorised as being in the most deprived 20% of areas in England were as important as journey times for people living in the other 80% of areas.

The travel time analysis showed that both options improved public transport access compared to the current service.

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In pre-consultation engagement, we heard concerns from parents and staff about the risks to children with cancer of travelling on public transport.

In our consultation document, we explained that The Royal Marsden, in collaboration with Great Ormond Street Hospital and University College London Hospitals (which also provide specialist cancer services) has guidance which advises children and families that it is safe to travel on public transport for children with cancer, even with a weakened immune system. The guidance says that for some patients it might not always be appropriate to be in crowded areas, depending on the treatment they are receiving. It says that clinicians should assess patients on a case-by-case basis.

Although hospital guidance says it can be safe, parents and carers have told us they have worries about travel and would prefer to travel by car.

### **Review of further evidence**

In consultation we heard that people were concerned that if patients travelled by public transport, there would be an infection risk due to their low immunity levels. Some survey respondents reflected that they were advised to not use public transport when their child was undergoing cancer treatment.

### **Impact of evidence on decision-making**

*Source of evidence:* This evidence has been provided through consultation feedback.

*Is this information new?* No. This information concerns raised during pre-consultation engagement.

*Does the information potentially have a material impact on our understanding of the options (specifically, differences between them)?* No, as this information is not new, it does not impact our understanding of the options.

*Is the information material to implementation?* These concerns should be factored in when considering travel arrangements and mitigations for drivers during implementation phase.

### **How we have listened to feedback**

The concerns raised through consultation have informed our final Integrated Impact Assessment and the mitigations for parking, accommodation, and financial reimbursement. These mitigations provide support for drivers, potentially reducing the need to travel to the Principal Treatment Centre via public transport.

Table 29: Safety of patients when travelling (via public transport) - You said, we did

You said	We did
<p>Concern that travelling by public transport can present an infection risk for patients who are very unwell.</p>	<p>Mitigations have been developed to make alternatives to public transport (driving by vehicle and hospital transport) as easy as possible including through provision, improved processes, methods of reimbursement, recognising, however, that some patients' journey times by car will increase.</p> <p>It will also be important to ensure patients, families, staff and others are aware of the existing guidance on when public transport should be avoided so that people who choose/need to use it can do so with confidence.</p>

## 7.5 Theme 4: Workforce sustainability

### 7.5.1 Workforce risks and mitigations

This sub-theme addresses the risks of transitioning the current workforce to the future Principal Treatment Centre, and the mitigations that would need to be put in place to address this.

#### Evidence previously considered

Maintaining and developing specialist oncology skills within the Principal Treatment Centre is very important to the quality of the future service. The teams leading and coordinating specialist care for children with cancer are based at The Royal Marsden site in Sutton. Life-saving intensive care, most children's cancer surgery, and many other specialist services needed by children with cancer are led and coordinated by the teams at St George's Hospital. There are 248 staff who work under the Principal Treatment Centre and key services (198 staff work at The Royal Marsden and 50 staff<sup>64</sup> work at St George's Hospital). Staff who are in scope from the respective organisations will transfer under the transfer of undertakings and protection of employment regulations (TUPE) to the future centre. A staff consultation will be carried out ahead of transfer as part of a comprehensive transfer plan to ensure legal compliance and awareness of individual needs.

<sup>64</sup> Around 50 WTE posts are funded to provide care to children as part of the Principal Treatment Centre. Headcount of staff is higher. Staffing groups include medical, nursing, allied health professional and support staff for the paediatric intensive care unit, surgical, theatres and ward teams. They can draw on wider teams who can support in the delivery of care for children who have not been included in the funded baseline for this service.

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Approximately 170<sup>65</sup> staff who work at The Royal Marsden are expected to be in scope for TUPE as more than 50% of their time is contracted to work within the Principal Treatment Centre. If the service was to move to Evelina London, four staff who work at St George's Hospital would also be in scope for TUPE.

Consideration of the capability of either potential provider for the future Principal Treatment Centre to attract and retain staff was therefore reflected in the development of the evaluation criteria and assessment. Two relevant criteria formed part of the enabling domain. These were:

- organisational support to staff – assessed on published workforce statistics, making the assumption that risks of transition could be mitigated by moving to an organisation that current staff rate highly
- impact on staff – benefits that would be offered to staff compared to current ones such as nursery provision, education and development benefits and staff wellbeing. This sub-criterion also looked at the impact on staff of travelling to either future option.

With regards to organisational support for staff sub-criterion:

- Evelina London scored higher because the children's services specific data from Guy's and St Thomas' staff survey results were higher and its staff turnover was lower than the equivalent for St George's. The panel acknowledged that St George's vacancy rate was lower than Evelina London's.

With regards to impact on staff sub-criterion:

- St George's Hospital scored higher because fewer staff would have longer journeys by public transport than now, and because St George's was assessed by the panel to offer an enhanced package of professional training.

The expert enabling panel scored both organisations the same on continuous professional development for staff. Other benefits, including childcare and staff wellbeing support, scored equally highly for both options.

Both potential providers included a list of key risks to delivery of the reconfiguration as part of their short form business cases. These key risks, alongside mitigations for each were

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<sup>65</sup> Calculated using 19/20 data (all TUPE would be recalculated post-decision). There may be wider teams who support in the delivery of care for children with cancer who have not been included in the funded baseline for this service.

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outlined in the pre-consultation business case (PCBC). Programme level risks and issues were also outlined in the PCBC, which highlighted some workforce related transition risks.

### **Review of further evidence**

Consultation feedback highlighted that patients, family members, staff and some organisations felt that there were risks of the reconfiguration for the future workforce of the service that needed to be appropriately managed. The feedback reflected risks that we have previously identified allowing us to confirm our understanding of these.

There is a **risk that staff do not want to move to either option** – for example, feedback mentioned the extra distance staff would have to travel, the increasing cost of travel, the lack of a financial incentive to move, and the potential detrimental impact on work-life balance. Under both options, staff were likely to incur additional time and cost by travelling further into London likely by public transport. This is considered under Risk 1.

Concerns around wider shortages in the NHS cancer workforce and the impact on recruitment were mentioned. NHS England is aware of this risk<sup>66</sup> and it was also mentioned in organisational responses to the consultation, such as from Children’s Cancer and Leukaemia Group, which referenced the specialist nature of the children’s and young people’s cancer workforce. This is considered in Table 30 and referenced further in Section 8.6. A risk to the integration of the new workforce (Risk 2) was raised by the London and South East Clinical Senates, through consultation feedback and organisational responses. Mitigations for this are described below.

In response to recruitment and retention risks raised by staff during consultation, we asked the potential providers additional questions regarding how they would manage the risks associated with workforce transition and how they would mitigate these risks having an impact on the future services. Both provided up to date risk registers in response to our questions. We analysed the risks highlighted by each potential provider and identified the key overall workforce risks below (*workforce risks to other services are detailed in Section 8.6*).

*Risk 1: There is a risk that a higher proportion than expected of the existing workforce won’t be retained and the staffing profile may change from that modelled in the proposals, due to staff decision not to transfer to the future location. This may impact a) the resilience of the*

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<sup>66</sup> The [NHS Long Term Workforce Plan](#) recognises the challenges places on cancer services due to rising demographic pressures and a changing burden of disease. In order to ensure the NHS can meet the patient need, both now and in the future, there a requirement for further sustained workforce growth.



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*current service during the period up to service transition; and b) lower than expected level of staff transferring to the future provider due to higher annual turnover than expected.*

**Description of risk and potential impact:** This risk raises concerns about the potential impact on the current service and on the future service. There could potentially be a destabilising impact on the current service which is essential to deliver and maintain children's cancer service to south London and much of the south east until service transition.

Service stability and staff vacancy rates could be compounded by natural staff turnover rates which average 15.40% in London each year (this figure varies by staff group and location) and the wider shortages in the cancer workforce (mentioned by the Children's Cancer and Leukaemia Group and some staff during consultation) which is currently impacting recruitment rates. Given that current services will not transfer to the future Principal Treatment Centre before October 2026, a relatively significant proportion of the current Principal Treatment Centre workforce could naturally be lost before the service relocates. If implementation is delayed, this could compound this risk and impact workforce plans. However, the need to plan for the future service transition could provide an opportunity to develop a workforce strategy to recruit to vacant posts new staff who are willing to transfer. Stakeholder engagement and collaboration would support the development of this workforce strategy, as well as clear and regular communications with staff.

**How does this risk vary across the options:** Modelling for staffing gaps can only be estimated for the future Principal Treatment centre as confirmation of staff who will transfer will occur only once a decision on the future location of the service is made. Within consultation feedback, Risk 1 was identified as affecting both options, but some felt that the risk of attrition and subsequent gap in workforce was higher for Evelina London because part of the Principal Treatment Centre is already provided by staff at St George's Hospital and these staff would remain with the service if it were successful in becoming the future centre. This risk was reviewed within the workforce working group; it was determined that the impact of this risk is unknown as the number of staff transferring under both options cannot be confirmed until the service transition period, after a decision is made. However, it is important to note that the vast majority of the workforce who lead children's oncology and would be in scope for TUPE, bringing their expertise with them, are based at The Royal Marsden. This expertise is not currently replicated at either Evelina London or St George's Hospital. Specialist skills are also required in staff groups who deliver key patient pathways as part of the Principal Treatment Centre, such as children's intensive care and other specialities, which are currently delivered at St George's Hospital. Training for these staff needs to be delivered regularly to maintain skills and competency and would also be a part of onboarding for new staff joining the service as a result of natural turnover. The future



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provider would need to carry out a detailed workforce mapping exercise to determine any gaps in staff roles or competencies including details of staff in the current service who are expected to transfer. During the service transition and implementation phases, the risk therefore exists for both providers and mitigations should be developed appropriately. The independent consultation feedback report suggested that staff would be impacted by travel times, cost and wider impacts under both options (see Section 7.5.2). Feedback from staff at The Royal Marsden through the public consultation did not reveal an overall preference for one site or the other.

**Mitigations** to reduce the likelihood of this risk having an impact include strategies to support retention, training and recruitment, in order of preference:

- **Retaining the specialist workforce that currently provides children’s cancer care across all staff groups would be a high priority.** Our review and additional responses from providers have outlined approaches and plans to be put in place to retain as many staff as possible.
  - Staff transferring to the future Principal Treatment Centre under protected regulations would have protection for up to four years – meaning alongside pay protection, they would be eligible to receive support for excess travel costs (claims would be reviewed by the future provider on a case by case basis). They would also be entitled to inner London high cost area supplement. Additional benefits packages/arrangements for flexible working, and training and development packages could also be explored to help offset impacts on travel time and cost. Pay and benefits considerations are outlined further in Section 7.5.2. The Implementation Oversight Board will support and monitor the formal staff transfer process as part of its role in oversight and assurance. An agreed forum and process would include named contacts to discuss contentious issues, and this would include any escalation arrangements. Appropriate HR, trade union and legal representation and support will be arranged during this process.
  - Both providers identified extensive engagement with staff working for the current Principal Treatment Centre as a priority activity following the decision about the location of the future centre. This would include early opportunities for teams to meet, opportunities for co-design of the service, and opportunities for staff to raise concerns and potential mitigations. This would also provide opportunities for frequent staff check-ins, which will be important in understanding morale and risk of staff attrition. Guy’s and St Thomas’ suggested rotational posts and clear clinical leadership from The Royal

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Marsden. St George's Hospital described joint staff briefings and effective and open communication.

- The **existing workforce at the future provider could be trained and upskilled**, where required and appropriate, to deliver paediatric oncology care to mitigate gaps for members of current Principal Treatment Centre staff who are not in scope for TUPE or who do not TUPE to the future centre. We asked the providers to outline their training plans and how they would mitigate the risks associated with skills gaps. As part of the pre-consultation evaluation of the options, detail on future training and benefits was provided by both potential providers. They both scored equally on continuing professional development. St George's scored slightly higher for an enhanced package of professional training. Education would not mitigate experience required for some senior consultants for which recruitment may be required to ensure there was the relevant expertise to lead the service. The future provider will therefore need to develop a detailed workforce plan to mitigate recruitment, retention and skills gaps. The training and development opportunities to be provided to current Principal Treatment Centre staff should they move is covered in Section 7.5.2. Training plans for specific staff groups are provided in Table 30.
  - Guy's and St Thomas' outlined a specific training plan for the Principal Treatment Centre, established together with the paediatric oncology team from The Royal Marsden and co-led by Evelina Education and the current Principal Treatment Centre educators, informed by a learning needs analysis completed in the first six months post decision.
  - St George's outlined that all clinical and support teams will have access to the experience of The Royal Marsden and St George's Hospital staff who have delivered children's cancer services for many years, helping to support continuous 'on-the-job' learning.
- Experience from other service reconfigurations is that it is reasonable to expect some attrition when services move even when services are closely located to one another. However, experience also shows that recruitment to vacancies is possible, especially when there is a clear vision for delivery of the new service. The future Principal Treatment Centre would need to plan for this, and it would be expected to be a significant feature of the provider's work during the service transition phase. The consultation raised concerns around recruitment, particularly given wider recruitment issues in the NHS, and the need for clear and robust recruitment plans. Through additional clarification questions, the providers have outlined their recruitment plans which are provided by staff group in Table 30.

## Additional mitigations for retaining resilience in the service for the next 2.5 years:

Recognising the importance of retaining resilience within the service, it will be important that the Implementation Oversight Board continues to monitor and support Trusts to take remedial actions should the risk occur, while also working with the future Principal Treatment Centre, Children's Cancer Network, shared care units and specialist cancer providers to ensure there is a clear workforce strategy for paediatric cancer services across the region. Actions by the future provider would include monthly reporting of workforce metrics to the Implementation Oversight Board, with an agreed threshold to allow monitoring of trends and early identification of potential issues in workforce gaps. Support from Integrated Care Boards and NHS England regions will also be required to ensure there is sufficient resourcing available to meet workforce strategies including training and education. The London and South East Clinical Senates also recommended that, once the decision is made, implementation should be undertaken in a timely fashion to ensure safe transition that provides continuity of care and to relieve anxiety among staff and patients. Further mitigations for Risk 1 are described in more detail in Section 7.5.2.

### *Risk by workforce group*

In considering the risk profile, it is noted that transition risks differ by staff group and sometimes between providers. We have therefore considered the largest staff groups in more detail below, based on information shared by both potential providers. The workforce risks regarding research staff are covered in Section 7.9. The proposed mitigations for risks identified have been provided by both potential providers in response to clarification questions. They demonstrate assurance around understanding and plans to mitigate workforce gaps, and differential risks between the two options. The information they have provided suggests variation in perceived risk profile. One risk of note is in respect of paediatric oncology surgery which Evelina London does not provide. Evelina London has provided plans for addressing this.

Table 30: Risks by staff group

Provider	Risks identified	Proposed mitigations from the potential providers
<i>Medical workforce</i>		
Guy's and St Thomas'	Majority of consultants are assumed to transfer for paediatric oncology, if this is lower than	These are highly specialist roles which require significant training and experience. Guy's and St Thomas' would seek to attract staff

Provider	Risks identified	Proposed mitigations from the potential providers
	<p>expected, there will be a significant gap for consultants. This is a risk across both providers as all the consultants who would be eligible to transfer are based at The Royal Marsden.</p> <p>It is expected that the medical training programme will be established at the future provider in collaboration with the regional Workforce, Training and Education team, meaning there is low risk around doctors in post graduate training transferring to the future service.</p> <p>Management of the medical trainee programme would need to be planned in collaboration during the transition period to ensure a smooth transition and minimal disruption to education and services.</p>	<p>to transfer through collaboration and opportunities.</p> <p>Other mitigations could include continued working with oncology, radiology, and palliative care consultants providing teenage and young adult services at The Royal Marsden for some sessions, which could cover a gap during the service transition/implementation period.</p> <p>Recruitment for paediatric oncology consultants would be required should lower numbers transfer.</p>
St George's		<p>St George's recognises that recruitment to any shortfall within the consultant workforce would be challenging, as training numbers in the UK are fixed and are unlikely to take into account loss of consultants from the workforce through the Principal Treatment Centre transition process. The Trust would seek to mitigate this through providing flexible contracts and opportunities to fill gaps left by those who do not wish to transfer, identifying compensation benefits that would draw newly qualified consultants to the future Principal</p>

Provider	Risks identified	Proposed mitigations from the potential providers
		Treatment Centre and/or undertaking international recruitment.
<i>Surgical teams</i>		
Guy's and St Thomas'	<p>Although Evelina London has existing surgical strengths in a range of paediatric specialties, it does not have surgeons, anaesthetists or theatre teams who currently perform paediatric oncology surgery. Theatre teams would be required to undergo training to develop competencies in paediatric oncology management. The development of this service (including surgical capacity of approx. one whole time equivalent (WTE)) would need to be a key priority during transition and into implementation.</p> <p>In feedback, CCLG (along with other respondents) highlighted that necessary training and expertise to provide top level surgical oncology would need to be carefully managed as it is a complex challenge.</p> <p>Consideration must also be given to skills required for anaesthetic and theatre teams to manage oncology patients. These skills exist in the current service at St George's Hospital.</p>	<p>If successful, Guy's and St Thomas' envisions building this expertise through different workforce models, training, national/international recruitment or a mixture of both.</p> <p>It would explore options for support from colleagues at St George's Hospital and potentially other London hospitals such as Great Ormond Street Hospital. As is commonplace in the NHS, surgeons from these organisations could split their time, working at more than one hospital where their expertise is needed.</p> <p>Training opportunities for existing paediatric surgeons to expand their expertise to include oncology (including tumour resections) would be explored with Guy's and St Thomas' current workforce and recruited paediatric surgeons.</p> <p>If needed, it could look to recruit nationally/internationally.</p> <p>Guy's and St Thomas' recruits consultant anaesthetists on a</p>

Provider	Risks identified	Proposed mitigations from the potential providers
		<p>regular basis (and has no current anaesthetic vacancies) and would recruit in line with business-as-usual recruitment requirements.</p> <p>Theatre nurses would be recruited through a specific recruitment drive.</p>
St George's	St George's Hospital already has paediatric cancer surgeons, anaesthetists and theatre team on site. If St George's Hospital becomes the future Principal Treatment Centre, there would be no additional risks to provision (outside business-as-usual risks).	n/a
<i>Nursing staff</i>		
Guy's and St Thomas'	Nursing is the biggest staff group of the current Principal Treatment Centre, with c.122 nursing posts (as outlined in Section 5.4 of the pre-consultation business case) at The Royal Marsden (includes qualified and unqualified staff). These nurses have competencies and experience in paediatric oncology that cannot be easily recruited into. This represents a risk if a large proportion do not	<p>In the event of low transfers, this would be addressed through a combination of external recruitment and training of nurses within Guy's and St Thomas'.</p> <p>The training programme for nurses would commence 6-12 months prior to transfer and would be established with The Royal Marsden.</p> <p>Guy's and St Thomas' anticipates launching a vibrant large-scale nursing campaign to attract</p>

Provider	Risks identified	Proposed mitigations from the potential providers
St George's	TUPE to the future Principal Treatment Centre.	<p>oncology nurses with the right level of expertise, skills and knowledge.</p> <p>Currently recruits over 50 nurses into paediatrics within a year, providing confidence in ability to recruit.</p> <p>St George's points to its senior nursing staff as well as practice educators who are competent and understand the specific requirements of Principal Treatment Centre nursing, and who have a track record of training intensive care unit and ward nursing staff.</p> <p>It will additionally look within the existing St George's workforce, providing appropriate training across nursing teams to support the service, as well as looking to recruit internationally.</p>
<i>Pharmacy</i>		
Guy's and St Thomas'	Both providers will have new pharmacy requirements – covering clinical pharmacy, clinical trials, and aseptic/chemotherapy manufacture. Guy's and St Thomas' does not have a paediatric aseptic pharmacy so this	<p>Engagement and co-design with The Royal Marsden pharmacy team to increase likelihood of pharmacy staff transferring over.</p> <p>Specific recruitment drive for pharmacy which will be augmented through opportunity to train staff to</p>



Provider	Risks identified	Proposed mitigations from the potential providers
	<p>service would have to be developed within its wider aseptic pharmacy if The Royal Marsden pharmacy team does not transfer. St George's already provides aseptic pharmacy services as a children's cancer shared care unit</p>	<p>meet required qualifications and competencies.</p> <p>Some sharing of capacity within the wider aseptic programme at Guy's and St Thomas'.</p>
St George's	<p>so the risk is lower, however this will require development to meet Principal Treatment Centre requirements.</p>	<p>St George's already has some aseptic pharmacy provision and has provided mitigations for hard to recruit to posts, to increase the number of staff transferring over. Mitigations include premiums, alternative staffing models and training existing workforce.</p>
<i>Radiotherapy</i>		
<p>University College London Hospitals NHS Foundation Trust</p>	<p>There are 11.45 whole time equivalent posts identified working within radiology and radiotherapy services within the current Principal Treatment Centre. Staff trained to deliver radiotherapy pathways may re-locate to University College London Hospitals under the current proposal, whereas some radiology staff may transfer to the future Principal Treatment Centre location.</p> <p>Staff eligible to transfer to University College London Hospitals may be further impacted by increased travel time and costs to the central London location.</p>	<p>Post decision making, further work will need to be undertaken to determine the appropriate destination of this specific workforce.</p> <p>Under TUPE protections, relocated staff will be eligible to receive support for excess travel costs for up to four years (claims will be reviewed by the future provider on a case by case basis). They will also receive inner London high cost area supplement.</p> <p>There will also be additional benefits through co-location of all radiotherapy services for these staff in terms of staff experience</p>



Provider	Risks identified	Proposed mitigations from the potential providers
		and wider opportunities for development of specialist skills.

*Risk 2: There is a risk that once transferred, the workforce does not successfully integrate with new colleagues and systems, leading to poor ways of working, low morale and increased staff turnover.*

**How does this risk vary across the options:** Different perspectives were set out in consultation feedback reflecting different views about the service transition. For example, some felt that it would be more straightforward for St George’s Hospital as it is already part of the current service with existing relationships, systems and processes; others were attracted by the idea of working in Evelina London as a specialist children’s hospital and spoke about the benefits this could give patients and families.

**Mitigations:** Organisational development, leadership and culture development will be key to successful integration and service development. Equitable arrangements for staff transferring from The Royal Marsden, existing staff within the future provider, and newly recruited staff should be further considered and developed during implementation to successfully integrate the team.

- By way of mitigations, Guy’s and St Thomas’ has described that:
  - There will be a comprehensive programme of training, induction and rotation of staff prior to the transfer. Senior nursing staff provide will provide ‘floor walking support’. Those staff recruited will be appropriately skilled and will be trained and undertake rotations at the current Principal Treatment Centre, Great Ormond Street Hospital and Guy’s and St Thomas’ teenage and young adult cancer service prior to transfer.
  - There will be detailed co-design with leadership from current Royal Marsden clinicians and operational managers.
  - Commonality in both sites having the Epic system (which is in use at The Royal Marsden, Guy’s and St Thomas’, King’s College Hospital and University College London Hospitals) will support the transfer as staff will be familiar with

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the system and will input to the development of specific paediatric oncology protocols, such that transition to a new environment may be smoother.

- It will utilise lessons learnt and best practice from its experience of integrating large services, including women's services (700 staff) and children's community services (600+ staff).
- St George's has provided the following mitigations:
  - An organisational development programme will be implemented to manage concerns, support resolutions and build a new Principal Treatment Centre team culture including early staff engagement. A communications campaign will be developed to run pre- and post-transition, co-produced with staff to ensure it meets their needs.
  - A comprehensive induction and welcome programme will be provided to all staff transferring in, including opportunities for early site visits for familiarisation and informal meetings with St George's staff.

### **Impact of evidence on decision-making**

*Source of evidence:* This evidence has been provided through consultation responses, organisational response and provider information releases.

*Is this information new?* While these risks were known when undertaking the options evaluation, feedback from the consultation has provided enhanced understanding of the risk which has enabled more comprehensive mitigations to be developed. No new risks have emerged.

*Does the information potentially have a material impact on our understanding of the options (specifically, differences between them)?* This feedback is consistent with the risks that informed the options evaluation and does not provide new information that would impact the understanding of the options. More comprehensive plans around retention and recruitment provide assurance for mitigations of these risks. They demonstrate assurance around understanding and plans to mitigate workforce gaps, and differential risks between the two options. The information provided by both potential providers suggests variation in perceived risk profile. One risk of note is in respect of paediatric oncology surgery that Evelina London does not provide. In respect of this, Evelina London has provided plans for training and recruitment, including wider development opportunities.

*Is the information material to implementation?* Yes. Managing the workforce transition risks will be key to successful implementation of the Principal Treatment Centre. We have set out specific recommendations relating to this below.

### How we have listened to feedback

Consultation feedback and the additional mitigations provided by Guy’s and St Thomas’ and St George’s provide further detail to support the development of mitigations to the significant workforce risks that will be important during the implementation phase. The below table provides our response and additional work to address the concerns raised about the workforce risks.

Table 31: Workforce risks and mitigations - You said, we did

You said	We did
<p>Risks associated with transition need to be appropriately managed, as some staff may not TUPE to either proposed site, or University College Hospital, in the future. Mitigations for expected staffing recruitment gaps should be considered and strengthened.</p>	<p>The potential providers have provided further plans to bridge their workforce gaps and more detailed mitigations if staff eligible for TUPE decided not to transfer. Trusts have also provided further detail on key challenges and mitigations that may impact on the success of the future Principal Treatment Centre and their plans to mitigate against these risks.</p> <p>We recognise that the risks associated with transition (including the staffing gaps within the wider cancer workforce) are significant and need to be managed. Alongside Trust mitigations, recommendations have been developed for regional oversight to monitor impact in real time, this would include the co-development of sustainable long-term workforce solutions.</p>

Below, we have set out recommendations for the future provider, working with stakeholders including The Royal Marsden, to mitigate and manage these risks. The Implementation Oversight Board would have close involvement with the workforce planning during the transition and implementation phases; workforce risks will be regularly escalated and reviewed.

***Recommendation #14: The Implementation Oversight Board should continue to develop mitigations and contingency plans for the potential changing profile of the***

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**existing workforce (for example, if fewer staff are retained than expected, fewer staff transfer or staff resign), monitor resilience and support delivery of the current service. Where needed, identify mitigating actions to ensure that the services can continue to deliver high quality care.**

**Recommendation #15: As a high priority, the future provider should support retention of current workforce, including through clear and timely communications, close engagement and providing assurance about future arrangements. Salary and benefits should also undergo a clear impact assessment, with financial mitigations provided where possible.**

**Recommendation #16: The future provider should work with The Royal Marsden (and St George's if applicable) to develop an organisational development strategy to preserve and support the transfer of organisational memory, key skills, and competencies and support integration of multiple teams. Ensure staff working in the future Principal Treatment Centre receive equivalent benefits, with appropriate onboarding processes, organisational culture and values integration, and buddying processes between staff.**

**Recommendation #17: A workforce strategy should be co-developed between organisations and collaboratively with support from the wider network, aligned to regional workforce strategies. This should be developed through the workforce workstream, with staff and HR representation, and should include detailed training and education plans (including engagement with relevant leads for training posts in service), as well as recruitment and retention plans.**

**The Royal Marsden to work with the future provider to consider value of @Marsden model as a vehicle for continuity, collaboration and making best use of available skills and expertise.**

Workforce planning will be very important when developing plans for reconfiguration, as highlighted by consultation feedback. A detailed workforce model will be developed as part of implementation, co-designed by the current Principal Treatment Centre staff. Recruitment for any skills gaps, education and training for staff, rotas and job planning consistency and policy alignment, will all be important aspects of the co-developed workforce plan. The workforce plan will need to align to the financial plan.

We have also made the following recommendation for the future Principal Treatment Centre provider below:

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***Recommendation #18: The future provider should develop a detailed workforce modelling baseline and plan, against competencies required to deliver the Principal Treatment Centre and recruitment and retention gaps. They should also carry out a mapping exercise to determine any gaps or new roles that will be required to deliver the services with the appropriate workforce as part of transition planning.***

### **7.5.2 Pay and benefits packages**

It will be important that, at the point the services transfer, the future Principal Treatment Centre has the skills required to provide the necessary services. Some of the current Principal Treatment Centre workforce will transfer but other workforce gaps will be filled by recruitment and training of current staff.

This sub-theme addresses the future training and development opportunities, salary and benefits package offered to staff.

#### **Evidence previously considered**

At pre-consultation evaluation of the options, there was a sub-criterion that looked at ‘non-pay’ benefits that would be offered to staff compared to those received currently at The Royal Marsden (such as nursery provision, education benefits, staff wellbeing offer), impact on training programmes (professional programmes and continuous professional development (CPD)) and changes to staff travel times. Equivalence or improvements on existing experience was deemed important for attracting and retaining current and future staff. The Royal Marsden staff, as stakeholders, had asked for this criterion to be included as they wanted to be confident that a future employer would create the same positive environment that exists at The Royal Marsden.

Both potential providers calculated their pay costs in their initial proposals to ensure these were affordable, and these were included in their Short Form Business Cases.

#### **Review of further evidence**

The independent consultation feedback report outlined ‘exceptional training and development opportunities for staff’ as one of the things that mattered most to members of staff for the future Principal Treatment Centre, as we heard during pre-consultation engagement including during work to design the evaluation criteria. The training and development opportunities, including study leave and further development opportunities, were outlined in Section 5.4.5 of the pre-consultation business case and fed into the pre-consultation evaluation of the options.

Consultation feedback also showed that staff wanted financial assurance of the impact of Principal Treatment Centre reconfiguration on their net pay. They were specifically

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concerned about how additional expenses (such as travel and/ moving costs) would affect their salary, meaning they could be disadvantaged compared to their current arrangements. Staff were also concerned about having a worse work-life balance due to the change. The travel cost analysis is also included in Section 7.4.2.

The impacts to staff pay are:

- As described in Section 7.4.2 and 8.4, we recognise that there may be an increase in travel costs for many staff members, in addition to the extra time it could take to travel to the future Principal Treatment Centre or to University College Hospital. Feedback has raised that other costs may also be associated with this additional time burden, such as increased childcare costs.

Mitigations to staff pay:

- Members of staff transferring would be eligible to receive support for excess travel costs for up to four years through TUPE protections and would also receive inner London high cost area supplement (20% of salary) instead of the outer London rate as currently (15%). Staff claims for excess travel fares will be reviewed by the future provider on a case by case basis.

We recognise that the move may generate other financial burdens for some staff. Therefore, careful and robust consideration of additional mitigations should be implemented during the implementation phase.

Additional benefits to staff such as flexible working arrangements, childcare and health and wellbeing support were also outlined in the potential providers' proposals.

### **Impact of evidence on decision-making**

*Source of evidence:* The evidence comes specifically from staff feedback in the consultation and provider responses.

*Is this information new?* No. Consultation echoed previous concerns around the impact of the reconfiguration on travel costs and work life balance for staff. Given limitations in the analysis that it is possible to conduct on public transport costs for staff, this is used to support understanding of existing concerns about travel cost impact rather than constituting new information in and of itself.

*Does the information potentially have a material impact on our understanding of the options (specifically, differences between them)?* In both options, staff would likely see increased costs and time to travel to the future Principal Treatment Centre. TUPE protections and inner

London high cost area supplement should help to mitigate the impact of increased travel costs on staff. Consultation feedback does not further differentiate between the options on impact on staff, noting that at pre-consultation options evaluation St George’s scored higher on this sub-criterion.

*Is the information material to implementation?* Yes. Impacts on pay, and non-pay impacts such as work life balance, should continue to be addressed moving forward, and an attractive pay and benefits package developed.

**How we have listened to feedback**

Consultation feedback highlights the importance of a wider package offering and the direct impact on pay for both potential providers and for University College London Hospitals, to ensure that the future Principal Treatment Centre and University College Hospital have sufficient expert staff. Our response to this feedback can be seen below.

Table 32: Pay and benefits packages - You said, we did

You said	We did
<p>Consideration should be given to the benefits staff currently receive (such as on-site nursery care and training), and how that will be delivered in future. Staff should have financial assurance related to the impact of the Principal Treatment Centre reconfiguration on their net pay.</p>	<p>We understand the importance of staff being involved in the development of plans for the future Principal Treatment Centre. In particular, staff need to be able to advocate for key aspects of service change that may affect their roles and pay. Therefore, clear recommendations have been set out for the future provider, which will be monitored via the Implementation Oversight Board. Staff continue to be involved in the development of implementation plans and understand how their job and benefits will be affected.</p> <p>For further assurance, we have reviewed the impact on net pay and recommended that the future provider should undertake a clear impact assessment on salary and benefits to inform their mitigations. Our workforce experts confirmed that additional spending on fares may be claimed via the travel policies of the future provider of the Principal Treatment Centre and University College London Hospitals on a case-by-case basis.</p>



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Salary and benefits packages, as well as work-life balance and flexible working arrangements, should continue to be considered at implementation phase, in order to support the retention of staff within the current Principal Treatment Centre. This is outlined in the 'Supporting staff to transfer' recommendation, which was also described in Section 7.5.1:

***Recommendation #15: As a high priority, the future provider should support retention of current workforce, including through clear and timely communications, close engagement and providing assurance about future arrangements. Salary and benefits should also undergo a clear impact assessment, with financial mitigations provided where possible.***

## 7.6 Theme 5: Radiotherapy

Radiotherapy services will be provided at University College Hospital in the future model for both options for the location of the Principal Treatment Centre. This sub-theme addresses the clinical model, impact, risks and mitigations for radiotherapy services.

### **Evidence previously considered**

Currently, radiotherapy is provided at two sites.

- Conventional radiotherapy, which uses high energy x-rays (photon beams), is delivered for children by the specialist team at The Royal Marsden.
- Proton beam therapy, which uses beams of high energy protons, is based at University College Hospital. As referenced previously (Section 1.4.5) there are other superspecialist radiotherapy treatments there too.

Under both options, conventional radiotherapy for children with cancer would move from The Royal Marsden, bringing all radiotherapy services for children within the catchment area onto one site at University College Hospital (rather than two, as now). Our case for change for radiotherapy is described at Section 1.4.4, Section 1.4.5 and Section 7.6.

### **Review of further evidence**

While not new, consultation feedback highlighted concerns related to radiotherapy being delivered off-site at University College Hospital, in particular concerns regarding:

- increased travel to central London for patients and their families
- fragmentation of care across providers
- capacity of University College Hospital to take on additional radiotherapy services



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- inpatient transfers due to concurrent chemotherapy and radiotherapy and how this would be managed.

We worked with University College London Hospitals NHS Foundation Trust (which already provides proton beam therapy and other specialist forms of radiotherapy for children who live in the catchment and other parts of England) to explore the feedback further and develop mitigations.

We have developed and consolidated the benefits associated with centralisation of radiotherapy services below to support response to the consultation feedback (also described in Section 2.4.2):

- More opportunities for doctors and other professionals delivering radiotherapy for children to work together in one place, allowing them to develop greater expertise and specialist knowledge in treating children's cancers by sharing and growing their knowledge and skills. This would offer the potential to improve the treatments provided and thus achieve even better patient outcomes.
- More opportunities to develop clinical and lab-based research (including opportunities for collection of real-world data) and deliver clinical trials that could help to improve care for children in years to come.
- Opportunities for greater integration of care as children will have access to a wider range of radiotherapy treatments in one place with clinicians working closely together, including with the Principal Treatment Centre as part of the multidisciplinary team, to determine which form of radiotherapy treatment is best. This could support uptake of proton beam therapy while ensuring children who need it continue to receive high quality (photon beam) radiotherapy.
- Opportunities for greater recruitment and retention of very skilled staff with all the benefits of stability and resilience this would bring.

Through the consultation, we heard from many families and patients who described positive experiences of radiotherapy at University College Hospital which support the case for change:

- The Royal Marsden teenagers who have used the service gave positive feedback about it through the consultation including the sense of freedom they gained from being put up in a hotel in central London: “It made me forget I had cancer, I could go to the shops at the weekend.”

University College London Hospitals has also shared patient experience surveys for its proton beam therapy service which support this.

The key concerns raised during consultation and the proposed mitigations are outlined in Table 33 below.

Table 33: Radiotherapy arrangements at University College Hospital

Feedback from consultation	Proposed mitigation from University College London Hospitals and NHS England
Travel and access – concerns around travel into central London	<ul style="list-style-type: none"> <li>• The Integrated Impact Assessment looks in further detail at the impacts of travel, including to University College Hospital. More information related to travel and access is included in Sections 7.4 and 8.4. This includes the development of detailed mitigations for travel and access and associated recommendations.</li> <li>• Patients from Southampton, Great Ormond Street Hospital, and some from The Royal Marsden and Oxford already get their care at University College Hospital. Anecdotal feedback from these patients is positive, and where opportunities for improvement are identified (such as for travel and access) these are supporting ongoing development of the service. Patients and their families also travel for the proton beam (one of only two in the country).</li> <li>• At the moment, patients and parents/carers who live more than an hour away will be given the option of staying in accommodation close by to University College Hospital while they are having their treatment<sup>67</sup>. This can also include the night before if a patient needs to have a general anaesthetic necessitating an early start.</li> </ul>
Sufficiency of capacity at University College Hospital	<ul style="list-style-type: none"> <li>• At present, there are some constraints around capacity within the current services. This should shortly be resolved through commissioning of a fifth LINAC to support</li> </ul>

<sup>67</sup> Accommodation requirements will be assessed by the paediatric radiotherapy team on a patient-by-patient basis. Distance travelled is a key consideration as well as any medical impacts of travel on treatment.

Feedback from consultation	Proposed mitigation from University College London Hospitals and NHS England
	<p>expansion plans. A change to funding arrangements (in advance of Principal Treatment Centre reconfiguration) for the service has also been agreed through the development of a 'complexity' payment to enable University College London Hospitals staff to play a full part in each of the Principal Treatment Centres they support, particularly participating in multidisciplinary team meetings reviewing individual children's cancer care plans, and having the capacity on site at University College Hospital to support additional play and other allied services beyond the immediate radiotherapy, to ensure a high quality experience for the children that attend University College Hospital.</p> <ul style="list-style-type: none"> <li>• The requirement for further capacity will be determined over the implementation period and will depend on a range of variables relating to demand for and capacity of the conventional radiotherapy service at University College Hospital (from both children and adults) which are not possible to quantify with any degree of certainty at the time of drafting due to the rapidly changing nature of both radiotherapy machines and treatment modalities. If a capacity constraint is identified, options include making best use of productivity opportunities generated through renewal of existing LINAC capacity as it comes to the end of its life; making best use of capacity across the wider radiotherapy network for treatment of adults (thus releasing capacity at University College Hospital); if needed, securing business case approvals for a sixth LINAC. University College Hospital has a vacant sixth bunker providing capacity for a sixth LINAC to be installed if required.</li> <li>• Alongside estate, workforce represents another potential capacity bottleneck. Proposals for the future have the potential to offer a more resilient solution for this as</li> </ul>

Feedback from consultation	Proposed mitigation from University College London Hospitals and NHS England
	<p>compared to standalone centres, offering conventional radiotherapy only, where there have been recent challenges with recruitment and retention. As a regional centre of expertise, University College London Hospitals reports that it has not historically struggled with recruitment/retention of staff. While this risk will be kept under review, it is not envisaged to present a significant challenge.</p> <ul style="list-style-type: none"> <li>• As new indications are introduced for proton beam therapy, this will increase the number of patients who are able to access it, reducing the number of children who require conventional photon radiotherapy.</li> </ul>
<p>Potential fragility risk due to University College Hospital being the only site for paediatric radiotherapy across the region</p>	<ul style="list-style-type: none"> <li>• University College Hospital should shortly have five LINACs in operation (rather than four at present) reflecting further investment in this service; pre-existing LINACs will be replaced over the next three to four years as they come towards the end of their life, with new machines offering the potential for efficiencies.</li> <li>• As the only centre for paediatric radiotherapy in London/much of the south east resilience of the service in the event of catastrophic failure (such as fire or flood) would be important and it is expected that University College London Hospitals will continue to develop its business continuity plans to support this, including through mitigations such as: <ul style="list-style-type: none"> <li>○ Prioritisation of capacity at University College Hospital for paediatric work, utilising mutual aid from other providers across the network to deliver other treatments.</li> <li>○ Redeployment of staff to use LINAC capacity elsewhere in the radiotherapy</li> </ul> </li> </ul>

Feedback from consultation	Proposed mitigation from University College London Hospitals and NHS England
	<p>network or further afield where there is existing paediatric infrastructure.</p> <ul style="list-style-type: none"> <li>○ Further development of business continuity/transition plans with the future provider, other system partners and radiotherapy centres around the country after a decision has been made.</li> </ul>
Fragmentation of services	<ul style="list-style-type: none"> <li>● Teams from University College London Hospitals work closely with each Principal Treatment Centre for whom they treat patients including through integration of multidisciplinary teams and the development of clear pathways for treatment. University College London Hospitals has described these to provide further detail of the way in which its staff work closely with each respective Principal Treatment Centre. Examples include:</li> <li>● The management of <b>psycho-social support for patients:</b> teams work flexibly around the needs of the patient and with teams at their host Principal Treatment Centre to provide tailored, coordinated care including handovers, where needed.</li> <li>● <b>Safeguarding:</b> University College London Hospitals provides support for safeguarding radiotherapy patients during their course of treatment, liaising closely with the referring Principal Treatment Centre to ensure effective handover.</li> <li>● <b>Handovers:</b> Once transferred, patients are expected to remain at University College Hospital during the course of their treatment (and therefore aren't expected to be travelling back and forth to their Principal Treatment Centre). If patients decide to/can go home for the weekend during their treatment, a formal handover with their local paediatric oncology shared care unit will take place.</li> </ul>

Feedback from consultation	Proposed mitigation from University College London Hospitals and NHS England
	<ul style="list-style-type: none"> <li>The detail of arrangements for the future Principal Treatment Centre would be determined after a decision is made.</li> </ul>
<p>Questions around how chemotherapy pathways for patients who require it would be managed</p>	<ul style="list-style-type: none"> <li>Some patients will require chemotherapy alongside their radiotherapy; as a result University College London Hospitals takes on responsibility for coordinating and delivering this while the patient is having radiotherapy.</li> <li>University College London Hospitals currently uses a day case unit to provide chemotherapy for patients who need it concurrently with radiotherapy.</li> <li>The radiotherapy team at University College Hospital is part of the multidisciplinary team for each Principal Treatment Centre they support, to ensure that the necessary chemotherapy regime is provided. Paediatric oncologists at University College Hospital work closely with oncologists within the patient's Principal Treatment Centre to manage the treatment protocol with clear handover points. Care is coordinated by clinical nurse specialists and advanced nurse practitioners.</li> <li>University College London Hospitals would work with the future Principal Treatment Centre to agree pathways.</li> </ul>
<p>Arrangements for bone marrow transplant patients as they will need to be transferred and are particularly vulnerable</p>	<ul style="list-style-type: none"> <li>University College London Hospitals will work with the future Principal Treatment Centre to determine which model is best for bone marrow transplant patients.</li> <li>Current models are those established with Great Ormond Street Hospital and with St Mary's Hospital (for treatment of patients with benign conditions), with patient care/transfers being coordinated between hospitals including the use of pre-booked patient transport.</li> <li>University College London Hospitals will work with the future Principal Treatment Centre to agree the best way to take care of patients. The optimal model will depend on which provider is selected as the future Principal Treatment Centre (the proximity of Evelina London to University</li> </ul>

Feedback from consultation	Proposed mitigation from University College London Hospitals and NHS England
	College Hospital could allow for movement of patients back and forth as needed).
No on-site children's intensive care unit at University College Hospital	<ul style="list-style-type: none"> <li>• Historical evidence suggests that radiotherapy patients don't typically need children's intensive care unit services as a direct result of their treatment.</li> <li>• At present, patients who become unwell while they are being treated at University College Hospital and require a children's intensive care unit are transferred to Great Ormond Street Hospital; this is also the case for neurosurgical emergencies (such as shunt blockages). However, patients who are known to the neurosurgery team at King's College Hospital have been transferred there for management of neurosurgical emergencies from University College Hospital.</li> <li>• University College London Hospitals and Great Ormond Street are working together to support the transition for University College Hospital from part of a joint Principal Treatment Centre for children under 13 years to an enhanced level B paediatric oncology shared care unit. This includes high dependency care on site at University College Hospital. Pathways of care will continue to be planned to ensure children access treatment, including critical care, as required.</li> </ul>

### Impact of evidence on decision-making

*Source of evidence:* Additional evidence has been provided through consultation feedback, NHS England review and additional clarifications from University College London Hospitals and The Royal Marsden.

*Is this information new?* Yes – We considered potential risks had been considered prior to the public consultation; concerns raised in public consultation have prompted us to gather extra information from University College London Hospitals to provide further assurances over how these would be managed.

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*Does the information potentially have a material impact on our understanding of the options (specifically, differences between them)?* No. Both potential providers propose that conventional radiotherapy is provided at University College Hospital. We acknowledge that there are some important travel impacts associated with our proposal that would need to be managed through the transition phase, including the areas reflected in public consultation. However, the case for changing the location of conventional radiotherapy services (Section 1.4.5) remains strong.

For reasons outlined above, we propose that the service moves to University College Hospital given its scale and breadth of expertise to provide the future service.

As noted in Section 1.4.5 above, it would be difficult to sustain the conventional radiotherapy service for children at The Royal Marsden without the staff and facilities of the Principal Treatment Centre on site, particularly as patients would require inpatient care and/or care from other paediatric specialists.

We expect the number of children requiring conventional radiotherapy services in the future to fall as more children have proton beam treatments instead, meaning a high-quality 'standalone service' for children would be even harder to sustain. Similarly, with smaller volumes it would be hard to attract specialist staff to work there.

It would not be feasible for either Evelina London or St George's to build an equivalent radiotherapy service to that provided at University College Hospital which has benefited from significant investment and infrastructure, including the proton beam.

*Is the information material to implementation?* Yes. The additional mitigations identified above should be explored further and put in place during implementation.

### **How we have listened to feedback**

Consultation feedback highlighted a range of concerns around our proposals for radiotherapy. While this feedback was not 'new' information, the feedback does highlight the need to manage/mitigate the concerns raised during the implementation phase. The development of mitigations to ensure that consolidation of services doesn't present a fragility risk and that patient pathways are not affected by the reconfiguration will be an important component of future work. It will be important for the future provider to work with University College London Hospitals to develop an implementation plan and agree appropriate transition arrangements. Our response to these concerns is below:



Table 34: Radiotherapy - You said, we did

You said	We did
<p>If radiotherapy services are all provided at University College Hospital, this could lead to fragility and resilience risks, due to capacity and resourcing challenges.</p>	<p>University College London Hospitals has worked with us to develop mitigations for these concerns, including fragility and plans around enhancing capacity should this be required. An implementation plan has been shared by the Trust which incorporates these mitigations and sets out the overall transition period.</p>

As described above, we recognise the importance of appropriately managing and mitigating the risks described above. Our recommendation below takes account of this:

***Recommendation #19: The future provider should work closely with University College London Hospitals, The Royal Marsden, commissioners, and other stakeholders to develop detailed patient pathways, capacity and resourcing plans for conventional radiotherapy services, drawing on the experience of providing care for patients from other Principal Treatment Centres.***

## 7.7 Theme 6: Impact on other services

This sub-theme section summarises the impact of the proposed service change on services outside of the Principal Treatment Centre. The full detail of the service impact, and the actions taken to address each area are outlined in Section 8.6. Within this section, we summarise the findings through the Information Review Framework.

Under section 13NA of the NHS Act 2006, NHS England has a duty to ensure that the organisation has regard to all likely effects of its decision making and to take these into account. This includes the potential impacts that arise on other NHS services.

### **Evidence previously considered**

Potential impacts on the following services were outlined in the pre-consultation business case:

- radiotherapy
- teenage and young adult services at The Royal Marsden
- St George’s Hospital children’s services if the Principal Treatment Centre were to be at Evelina London

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- Evelina London if the future Principal Treatment Centre were to be at St George's Hospital.

The impact on the following services was expected to be minimal:

- social care
- South Thames Retrieval Service
- other trusts and patient pathways in/outside of London.

### **Review of further evidence**

Consultation reiterated that it was important to consider the impact on other services and to take this into account as part of our decision-making. We have further reviewed the impacts of the proposed Principal Treatment Centre reconfiguration which were identified in the pre-consultation business case (PCBC), including potential service impacts that have come to light through consultation and ongoing discussions. The relevant feedback and our considerations are outlined in Section 8.6. Since development of the PCBC, we have identified two additional potential impacts that are also included in Section 8.6. The two additional impacts that we have identified are:

- Recruitment and retention at Great Ormond Street Hospital – concern that recruitment and retention by Great Ormond Street could be impacted if the future Principal Treatment Centre is located closer potentially leading to greater 'competition' for workforce.
- Potential impacts on mIBG (meta-iodobenzylguanidine) therapy – arrangements for ongoing provision of this therapy (currently provided at The Royal Marsden and University College London Hospitals) for some paediatric oncology patients from across the country.

### **Impact of evidence on decision-making**

*Source of evidence:* This has been provided through consultation and further NHS England analysis.

*Is this information new?* The information on potential impacts to recruitment and retention at Great Ormond Street Hospital is new; as is information about mIBG therapy which was highlighted through the consultation.

*Does the information potentially have a material impact on our understanding of the options (specifically, differences between them)?* Potential impacts on services at Great Ormond Street Hospital would be kept under review during transition and implementation phases.

Consultation feedback has indicated that the perceived risk could be greater if the future Principal Treatment Centre is located in closer geographic proximity, for instance, at Evelina London. At this time the risk is not considered to be significant in the context of workforce mitigations identified.

Like radiotherapy, considerations for mIBG therapy would need to be made irrespective of where the future service moves to.

*Is the information material to implementation?* Yes. During implementation, we will continue to work with impacted organisations to mitigate and manage the impact of the reconfiguration.

### How we have listened to feedback

Consultation feedback highlighted new potential impacts on Great Ormond Street Hospital and also the importance of mitigating the impacts on other services which had already been identified in the pre-consultation business case. We have considered this feedback, continuing our work with the providers/services that we anticipate could be affected by the Principal Treatment Centre reconfiguration to review potential impacts and develop mitigations.

Our work, including that undertaken pre-consultation does indicate that potential impacts on other services could be greater if Evelina London is selected as the future Principal Treatment Centre. A range of mitigations would exist to offset this to help ensure there was not a wider impact on NHS services. As such, this does not impact on our understanding of options.

The feedback we received, and actions taken are summarised below for each of the services impact. Please note, the actions taken are a summary of the work outlined in Section 8.6:

Table 35: Newly identified impacts – You said, we did

You said	We did
It is important to reconsider the impact of the Principal Treatment Centre reconfiguration on other services to ensure all potential impacts have been identified.	We further reviewed the impacts outlined in the pre-consultation business case to ensure that due consideration is given and risks and mitigations for each are clearly set out. We identified two additional potential impacts of reconfiguration (on recruitment and retention at Great Ormond Street Hospital and on mIBG therapy). We have outlined plans for addressing

	<p>these additional impacts in Section 8.6 and continue to work with key organisations that would be impacted to further understand the implications of the Principal Treatment Centre reconfiguration.</p>
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Relevant recommendations we have made to address these impacts are listed below:

***Recommendation #20: The future provider, along with NHS England, Integrated Care Boards and other system partners should work with organisations/services which could be impacted by Principal Treatment Centre reconfiguration to ensure that risks are monitored so that mitigations can be identified in a timely way, including through collaborative working and existing networks.***

## 7.8 Theme 7: Estates and facilities

This sub-theme addresses the demand and capacity models, whether the options have sufficient bed provision and the quality of the estate that the Principal Treatment Centre would be provided in.

### 7.8.1 Ensuring appropriate physical capacity

#### **Evidence previously considered**

Both potential providers developed activity plans for the delivery of the future Principal Treatment Centre based on 2019/20 activity data. The expert panel which evaluated enabling factors was content with both Trusts' plans for beds and other elements of the service, and they believed that both potential providers would be able to provide a resilient service<sup>68</sup>. Both have committed to working with children and their families and key partners, including staff and researchers, to co-design the facilities during service transition and implementation phases.

The activity analysis of the existing services, outlined in the pre-consultation business case (PCBC) was used to identify the need for 20.1 beds in total in the future service, operating at 80% occupancy. Reflecting the fact that the service would be provided differently in the

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<sup>68</sup> There is no indication that these activity levels would decrease and nor is there an intention to require reductions as part of the reconfiguration. The data makes no assumptions about changes in the model of care including changes to pathways that could happen as a result of new treatments or therapies which could be provided in the future.

future it was agreed that activity (rather than the existing bed base) would be used as the basis for future capacity projections<sup>69</sup>.

Table 36: Admitted patient bed requirements based on 2019/20 activity data from the current Principal Treatment Centre

	Ward bed days required	Occupancy	Beds required
The Royal Marsden – ward	4,738	80%	16.2
St George’s Hospital - ward based activity	326	80%	1.1
St George’s Hospital – ward based critical care	819	80%	2.8
Total	5,883	80%	20.1

The total bed days required were identified using the data lake and confirmed with all the Trusts involved in the process. The occupancy assumptions were provided by both potential providers as part of the evaluation process and they both confirmed these beds would be staffed 365 days per year, 24/7.

Our PCBC (Section 3.5) set out our expectation of no growth in demand for children’s services over the next 20 years. Although the number of children diagnosed each year with cancer (incidence) has increased over the last decade, it is doing so in line with recent growth in the child population (an increase of around 1% per year). As the child population of the Principal Treatment Centre catchment area is projected to decrease over the next 20 years<sup>70</sup>, we do not anticipate an increase in childhood cancer incidence or associated pressures on capacity.

The capacity required by each provider is included in Table 37 below<sup>71</sup> (more information is included in Section 5.4.2 of the PCBC):

<sup>69</sup> 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.

<sup>70</sup> [Subnational population projections for England - Office for National Statistics](#)

<sup>71</sup> Providers make their own assumptions about occupancy based on their own operational models. St George’s have modelled a higher occupancy rate (85%) than Evelina London (80%) however their physical capacity is sufficient for occupancy rates of 80%.

Table 37: Capacity required by each provider

Capacity required	Bed days	Occupancy	Beds required	Beds in proposal
<b>Ward beds</b>				
Evelina London	5,883	80%	20.1	20
St George's Hospital	4,738	85%	15.3	22
<b>Children's intensive care unit beds</b>				
Evelina London	632	80%	2.2	2.2
St George's Hospital	Provided in existing resources.			

Evelina London's current design is for 20 beds (with an assumption that 0.3 beds are provided by University College Hospital as part of the radiotherapy service). It assumes absorbing critical care requirement (calculated as 2.2 beds) within its paediatric intensive care unit, which has a physical footprint of 30 beds<sup>72</sup>. 25 of these beds are currently funded and open.

St George's Hospital'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 at St George's Hospital, 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 at St George's Hospital, it would not require any additional capacity for this.

The PCBC outlined the activity assumptions for the service transferring, the occupancy or other assumptions used, 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).

### Review of further evidence

Prior to launching the consultation, we responded to feedback from the London and South East Clinical Senates who asked us to provide further assurance regarding theatre capacity, surgical resource, isolation cubicles and paediatric competent 24/7 interventional radiology

<sup>72</sup> At present there are 19 x Level 3 intensive care beds at Evelina London. Evelina London has flexibility to increase Level 3 capacity and provides high dependency care beyond the infrastructure of the intensive care unit including in a recently established 10 bedded unit (of which 6 beds are currently open). 30 beds represents the total capacity combined over these two units.

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rotas at Evelina London. In response to this, further detail was provided by Guy's and St Thomas', reviewed by us and is reflected in the PCBC.

Feedback from the public consultation reflected some concerns related to children's intensive care unit/critical care capacity at both sites as well as the radiotherapy capacity at University College Hospital.

Information related to this feedback is set out below.

*Critical care capacity:*

As reflected in consultation feedback, NHS England recognises that capacity for children's intensive care requires careful management to ensure effective use of all levels of critical care capacity (ward based, high dependency and intensive care). Paediatric intensive care services provide care both on a regional and, at times, a national footprint. Capacity related to this specific service change which St George's Hospital already provides and which Evelina London has shown it can provide, has been demonstrated.

In response to wider concerns reflected about intensive care capacity for paediatrics, London is implementing changes to the delivery of paediatric critical care, enabling care to be provided locally for those who require lower levels of care. This is anticipated to have a positive impact on the utilisation of beds within the paediatric intensive care setting for intensive care level children. If demand for access to planned services becomes challenged, there are established escalation plans to ensure that care is delivered within a centre that can manage a child's specific clinical need which might include isolation. These processes of operational alignment are supported by the paediatric critical care operational delivery networks which exist across the country.

*Radiotherapy capacity* – see Section 7.6 in which our consideration of this feedback is set out.

*Inpatient bed capacity*

During the pre-consultation phase, The Royal Marsden shared information which suggested that current demand for the services may lead to surges in activity which can mean more beds might occasionally be needed. This also includes demand for isolation cubicles which are needed to provide care for children undergoing bone marrow transplant.

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



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accommodated within 20 beds 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 potential providers to review their plans and let us know how they would meet increases in demand. Assurances received provide confidence that both options have some flexibility to meet the changing needs of the service if there are unexpected increases in demand<sup>73</sup>.

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.

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. This demonstrated that service requirements could be accommodated within 20 beds as per the original activity analysis from the data lake. Once sub-national projections are released by ONS, we recommend the provider update the demand and capacity analysis with a view to annual requirements.

To ensure that the service could respond to an unexpected increase in demand, we asked both potential providers to review their plans and let us know how they could provide flexibility in their designs to meet increases in demand.

- 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 existing plans) within the proposed footprint for the service. Latest plans include 16 ensuite single rooms (including four cubicles suitable for bone marrow transplant (BMT) patients)<sup>74</sup>.

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<sup>73</sup> Before the service opens, there could be reasons why changes need to be made, such as new treatments or changes to the service delivery model, including those resulting from the Paediatric Oncology Shared Care Unit Transformation Programme. Further work would also be needed with University College London Hospitals to design the way in which care for patients requiring radiotherapy would be provided, this may have a small impact on bed requirements. We are assured that, within reason, both Trusts offer flexibility to do this.

<sup>74</sup> At PCBC plans for Evelina London reflected 12 ensuite rooms (including four with BMT HEPA-filtration) and two four-bedded bays. In plans shared with NHS England (January 2024); the Trust replaced one of the bays with four ensuite rooms. The Trust has also developed plans that demonstrate the ability to accommodate eight HEPA filtered BMT cubicles, if needed.



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- The St George's Hospital design has not changed and is for 22 beds (including 10 isolation rooms suitable for bone marrow transplant patients) plus six adjacent rooms that could potentially be used for family suites or for additional demand if required.

Both providers have therefore described options which would allow for a 20% increase in demand. 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.

The final design of the unit is expected to be agreed during the transition phase, in consultation with clinicians currently providing the service as well as patients and families.

### **Impact of evidence on decision-making**

*Source of evidence:* This evidence was provided through information shared by providers, including clarification responses.

*Is this information new?* Yes. Further assurances have been provided relating to the ability to flex capacity within both options for the future Principal Treatment Centre, if required. In particular, Evelina London has submitted more detailed plans demonstrating how additional beds and/or a different mix of beds could be accommodated.

*Does the information potentially have a material impact on our understanding of the options (specifically, differences between them)?* No. The information continues to provide assurance that both potential providers have the capacity to be the future Principal Treatment Centre.

Further work with University College London Hospitals has re-confirmed that a range of options exist to meet demand arising. As there is currently a number of variables, the best solution for the additional capacity will be agreed during the service transition phase. See Section 8.6.

*Is the information material to implementation?* Yes. Estates plans should continue to be reviewed/developed as part of implementation, including with input from current Principal Treatment Centre staff, families and patients.

### **How we have listened to feedback**

The new evidence provides assurance that both potential providers have capacity to be the future Principal Treatment Centre and University College London Hospitals would have capacity to provide the conventional radiotherapy services required for the future centre. Both providers responded to additional information provided and developed their estates

plans to demonstrate they have flexible capacity. Consultation feedback highlights that ongoing consideration of capacity is particularly important for the transition phase of the service, but this new evidence doesn't change how the options were originally evaluated; both offer sufficient capacity as well as some flexibility for the future. Our response to the feedback is provided below.

Table 38: Ensuring appropriate physical capacity - You said, we did

You said	We did
<p>Further assurance needed around capacity including for children's intensive care and inpatient beds.</p>	<p>Comparative analysis of existing population growth analysis to 2021 population forecasts supports our expectations on 0% demand growth based on population growth and incidence forecasts.</p> <p>The Royal Marsden has advised that the service experiences surges in demand, we also recognise there could be changes in the model of care. We have therefore run a sensitivity analysis and both potential providers have provided assurances around their flexibility to provide further capacity if required.</p> <p>Critical care capacity across London needs to be actively managed with particular peaks over winter, but London is implementing changes to the delivery of paediatric critical care, enabling those who require lower levels of care to receive it locally.</p>

Estates plans should continue to be reviewed/developed as part of service transition, including with input from current Principal Treatment Centre staff, families and patients. Both potential providers are committed to this and indeed, during consultation, families expressed a desire to contribute in this way. This has fed our below recommendation:

***Recommendation #21: Sufficient capacity for beds, theatres, and clinical support services should be in place for Principal Treatment Centre, with potential for future capacity expansion should this be required. Ongoing review of capacity requirements for the future service should take place with associated demand/capacity planning and consideration of POSCU transformation, new treatments/therapies and other changes to models of care to enable this.***

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### 7.8.2 Estates solution

This sub-theme considers the estates plans put forward by both potential providers to accommodate the future Principal Treatment Centre – the detail of these is set out in Section 3.2.

#### **Evidence previously considered**

When both potential providers submitted their proposals for the future Principal Treatment Centre, among supporting documentation they provided information on where they thought the children's cancer service would be located on their respective sites and the layout of the accommodation. Guy's and St Thomas' documentation on behalf of Evelina London Children's Hospital described plans for the unit to be based in one of the other buildings on St Thomas' campus.

#### **Review of further evidence**

After submitting its proposal, Guy's and St Thomas' continued to explore options for the location of the service. In agreement with NHS England, it shared its intention to locate the ward within the main children's hospital building, should Evelina London be the future Principal Treatment Centre. This information was approved by the Trust's Finance, Commercial and Investment Board on 12 April 2023. The pre-consultation business case reflects the revised plans for the location of the service.

The revision did not change any other aspect of Guy's and St Thomas' proposal on behalf of Evelina London, such as the facilities that would be available to parents and children.

This information was shared with NHS England after the options have been evaluated and scored. Evelina London's score was not re-evaluated.

As noted above, the future centre would now be within the footprint of Evelina London Children's Hospital alongside other children's services compared to the other option in the North Wing of St Thomas'. Evelina London has cited the following benefits of this proposal being: close location with the paediatric intensive care unit and other specialist children's services/facilities; the fact the Principal Treatment Centre team would be within the children's hospital; and co-location with research facilities. However, in contrast to Evelina London's initial plan, the third-floor space is currently being used for other clinical services with the impact that a series of four decants would be required. Guy's and St Thomas' has provided mitigations for this including staggering of decants and construction work alongside robust programme management.

Consultation feedback highlighted concerns that the Evelina London proposal was across three areas, compared to the St George's proposal that was all in one place. Guy's and St

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Thomas' has developed an option for outpatients for children with cancer to be located in the Day Treatment Centre on the floor adjacent to the Day Case Unit in response to this feedback. The final location of the outpatient unit would be confirmed during the co-design phase.

Guy's and St Thomas' also confirmed that the three areas are generally within a two to three minute walk of each other and other significant services such as theatres, imaging and intensive care. Staff will typically be on the ward or in clinics at specified times, so movement between areas will also be minimal and will not impede working arrangements, which will also be supported by facilities to work in proximity to the ward (such as hot desking / office space).

St George's Hospital's proposal for the location of the service remains unchanged. Positive consultation feedback was received about the proposed configuration of the future cancer centre including the number of ensuite rooms. Further information has been sought from the Trust to support consideration of consultation feedback reflecting some concerns about the hospital feeling busy and chaotic, partly due to the fact it also treats adult patients with some shared facilities which may not provide a positive patient experience for children. There was also a perception this poses an infection risk. People also raised concerns about the wider estate feeling outdated and some of the facilities being poor. St George's Hospital's proposal is for a dedicated, specially designed children's cancer centre containing the inpatient ward, day care unit and outpatients unit – children would receive the majority of their care here. The future centre would be close to the children's intensive care unit, which is on a corridor with other children's services, reducing mixing for children with cancer with adult areas for the majority of their care.

### **Impact of evidence on decision-making**

*Source of evidence:* Information was shared by Guy's and St Thomas' on behalf of Evelina London with further detail also provided by St George's.

*Is this information new?* Yes. The proposed location for the Evelina London service was updated in April 2023, following the pre-consultation evaluation of the options and was reflected in the pre-consultation business case (Section 5.1). Guy's and St Thomas' has also developed a potential option for outpatients to be located in the Day Treatment Centre if preferred.

*Does the information potentially have a material impact on our understanding of the options (specifically, differences between them)?* No, while the estates solution offered for Evelina London has been updated, the capacity and facilities offered in the updated estates solution

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is the same as assessed at the pre-consultation options evaluation and the updated location is associated with both benefits and challenges. Considerations related to this are set out above – they include potential benefits associated with the centre being within the Evelina London footprint alongside a recognition this option has more complexity due to the number of decants required. Guy's and St Thomas' has provided mitigations for this, including staggering of decants and construction work, alongside robust programme management. This information doesn't materially impact our understanding of the options.

*Is the information material to implementation?* The estates design will be progressed by the future provider during the implementation phase through the RIBA design stages (currently at RIBA stage 2 for Evelina London and 2/3 for St George's). The design will take into account relevant building standards and guidance, demand and capacity analysis and feedback from ongoing staff and patient and family engagement.

### **How we have listened to feedback**

We have heard that staff, families and patients want to be involved in the design of the future centre; more detailed service planning would also be required to ensure that future estate best meets the needs of the service. This has fed our below recommendation:

**Recommendation #22: The estates solution for the future provider should continue to be developed during the service transition phase, with clinical and patient and carer input to the design.**

### **7.8.3 Safe spaces/play areas (to ensure effective infection control)**

This sub-theme addresses provision of age-appropriate areas and facilities for play within the future Principal Treatment Centre.

### **Evidence previously considered**

The evaluation sub-criterion 'quality of facilities' under the 'patient and carer experience' domain reflected criteria including age-appropriate environments, play facilitation, patient privacy and dignity, and the education model.

The expert panel gave the same maximum points to both organisations on four aspects of quality of facilities – age appropriateness, education, play specialists and support for parents to stay with their child. Evelina London scored lower against the privacy and dignity component.

### **Review of further evidence**

Consultation feedback showed that there was a desire for equivalent play, education and outdoor play spaces to those which currently exist at the Oak Centre for Children and Young

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People in Sutton at the future Principal Treatment Centre provider. Some questionnaire respondents were concerned that neither option has a separate schoolroom for children with cancer as exists in the current centre. This is seen as important for motivating children to get up and about. There were also concerns about whether they would provide dedicated play areas for children with cancer.

There were specific concerns raised about capacity at Evelina London if it were to become the future Principal Treatment Centre, this related to capacity for rehabilitation, schools and play areas.

Feedback highlighted some concern about St George's Hospital's existing estates which were perceived to be outdated with poor facilities. There was also concerns from some that the hospital also treats adults with a perceived impact on privacy, and about the broader environment.

In response to this feedback, we asked both potential providers clarification questions to obtain additional detail around plans for specific play areas/communal safe spaces.

Guy's and St Thomas' confirmed that Evelina London's present clinical areas have been co-designed with families and all include play areas. The current plan for the children's cancer service includes a playroom, parent lounge and adolescent room. The inpatient ward would be adjacent to the atrium floor which includes a cafe, seating, and is where activities are often provided, as well as a terrace and outdoor seating space. The day treatment and outpatient units also include play areas. Education can be provided in the Evelina Hospital School in the atrium but is also provided by teachers visiting the wards. Archbishop's Park is opposite the hospital and is used by many of Evelina London's patients and families at present as a place of respite.

Infection prevention and control is a key consideration for Evelina London including through ward design. Access to the ward will be restricted to ensure no infection control issues (as at present).

St George's Hospital's plans are for a dedicated, specially designed children's cancer centre containing the inpatient ward, day care unit and outpatients unit – children would receive the majority of their care here. The future centre would be close to the children's intensive care unit, which is on a corridor with other children's services, reducing mixing for children with cancer with adult areas for the majority of their care.

Shared access to therapies and recreation spaces would be available within the children's cancer centre. Access would also be available to dedicated external space for play and

recreation. Education would be provided in the children’s cancer centre in a dedicated classroom or by the bedside, as well as by teachers visiting the wards, as per the Evelina offer. This offer has not changed since the pre-consultation evaluation of the options.

Under both options, we anticipate plans will be refined further (with input from service users and staff) after a decision has been made.

**Impact of evidence on decision-making**

*Source of evidence:* This evidence has arisen through consultation responses from patients and their families, and further detail on estates plans provided by Evelina London.

*Is this information new?* No. The information around play areas / communal safe spaces is not new; some further detail has been advised by trusts since the consultation.

*Does the information potentially have a material impact on our understanding of the options (specifically, differences between them)?* No. As noted above, quality of facilities was assessed at the pre-consultation evaluation of the options as part of the patient and carer experience domain. The consultation feedback highlighted the strong desire for appropriate play spaces and spaces for education. We have noted there are some differences in the way the options would deliver this.

*Is the information material to implementation?* Yes. It will be important for the future provider to have play areas and safe spaces in its plans, drawing on existing experience of managing immunocompromised patients as well as feedback from staff within the current service, patients and their families.

**How we have listened to feedback**

Feedback highlights the importance of play areas and safe spaces for patients and families.

***Recommendation #23: The future provider should develop detailed design work to ensure appropriate space is provided for accommodation, education, indoor and outdoor play space drawing on engagement with patients, carers, staff and wider stakeholders on their needs, in line with advice from the London and South East Clinical Senates.***

Table 39: Safe spaces/play areas (to ensure effective infection control) - You said, we did

You said	We did
Equivalent play, education and outdoor play spaces should be	We have asked the potential providers clarification questions to confirm their safe spaces and play area



<p>provided by the future Principal Treatment Centre.</p>	<p>arrangements – both have confirmed this would be available.</p> <p>We have made recommendations around provision of this space and will monitor progress and feedback.</p>
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## 7.9 Theme 8: Research

The research facilities and capabilities for paediatric cancer are an important aspect of the clinical model for the Principal Treatment Centre. Research and clinical trials into children’s cancer have the potential to support significant improvements in key outcomes.

### **Evidence previously considered**

Research facilities and capability are deemed a crucial aspect of the clinical model for the Principal Treatment Centre; the current research undertaken by The Royal Marsden working with The Institute of Cancer Research (ICR) is particularly strong. Further detail is set out above at Section 2 and in our pre-consultation business case (PCBC) in Section 3.4.

Reflecting its vital role, one of the domains within the evaluation criteria was research. The research panel considered each proposal to assess both potential providers’ current research performance and vision, research workforce and current capacity, and excellence including physical space for research. Detail of proposals and scoring outcomes is within the PCBC but, in summary, the Evelina London proposal scored 14.88% and St George’s scored 11.16%.

Pre-consultation, a number of risks relating to research were identified which will need to be closely monitored and mitigated.

### **Review of further evidence**

We received consultation feedback related to research from over 15 organisations, which highlighted how important research is and its continuation with the future service.

The key research risks and mitigations have been reviewed and refined since the PCBC was developed. We have considered further detail on risks and relevant feedback and made updates to risks and supporting mitigations previously identified, strengthened by information shared through consultation. These updated research risks and mitigations are included in Table 40. A detailed response to consultation feedback from the Institute of Cancer Research (ICR) is in Appendix 5.



Table 40: Updated research risks and mitigations

Risks	Mitigations
<p>There is a risk that research grant income is lost, thereby significantly impacting on the scale and scope of children’s cancer research.</p> <p>Risks pertain to a range of factors including: the need to set up multi-site trials, including at the future centre; recruitment; a potential lack of confidence from funders who are currently working very closely with The Royal Marsden on a wide-range of trials and research; clinical scientists potentially having reduced access to clinical teams and patients; and reduced opportunity for in-person discussions and collaborations.</p>	<p>The Royal Marsden, with support from the ICR could meet with research funders (as appropriate) to discuss this proposed reconfiguration and encourage continued research funding, assuring them of the opportunities and giving them confidence in how the transition will be managed. After a decision is made, the future provider would join too.</p> <p>High impact research has previously recruited patients from all over the UK or in pan-European trials. It should therefore be feasible to continue to obtain funding for well designed, innovative, multicentre studies.</p> <p>Recruiting children from a nearby site with a co-located children’s intensive care unit will remove one of the risks which funders and ethics committees could be concerned about. Organisations will need to work closely together during the implementation phase.</p>
<p>There is a risk that access to research trials for children’s cancer is impacted through the reconfiguration of the Principal Treatment Centre. There is also a risk that companies do not want to open trials in an environment where significant change (and transfer of services) will be taking place.</p>	<p>The evaluation criteria for the Principal Treatment Centre reflected attributes that will be important to the future success of research, ensuring patients are supported to have access to clinical trials and research. The sub-criteria covered people, place, and performance and capability.</p> <p>Much high impact research does not now rely exclusively on patients being co-located with the scientific researchers.</p> <p>Both potential providers are committed to working with the ICR and The Royal Marsden to build on and identify strategies to manage risks.</p>

Risks	Mitigations
<p>There is a risk that the specialised workforce may be lost if staff do not move with the service for example due to family circumstances or economic constraints. The future Principal Treatment Centre may also face challenges in attracting ‘top tier talent’.</p> <p>Specific risks are also identified in relation to the ability of patients to be consented and recruited to trials if there is not the right expertise of staff in the future Principal Treatment Centre. This could be the case if some of the current Principal Treatment Centre staff do not choose to transfer.</p>	<p>Risks and mitigations for workforce transition are outlined in Section 7.5.1.</p> <p>Mitigations provided by Guy’s and St Thomas’ specifically in relation to research staff through provider clarifications include:</p> <ul style="list-style-type: none"> <li>• Early engagement with academic and industry partners (including ICR) to address any risks to research and to ensure research teams are engaged in transition, funding is maintained for posts, and planning takes place to mitigate the possibility of research staff attrition</li> <li>• It may be easier to recruit paediatric research nurses and coordinators because of an available trained workforce and study portfolio.</li> </ul> <p>Specific mitigations provided by St George’s for research staff through provider clarifications include:</p> <ul style="list-style-type: none"> <li>• Early engagement.</li> <li>• Identification of key person specifications and look for opportunities within existing workforce.</li> <li>• Skills transfer process.</li> </ul> <p>The Royal Marsden @ model approach may also be explored to maintain the reputation of the research teams, as per our recommendation in Section 10.3.</p>
<p>There is a possibility that splitting paediatric and teenage and young adult</p>	<p>Alongside wider arrangements for supporting transition between the two services, the future provider will need to work closely with</p>

Risks	Mitigations
<p>cancer services across different sites may lead to challenges in providing equitable access to clinical research for 15, 16 and 17-year-olds. This may also impact younger children being identified and how trial provision works between sites. Children currently on a trial may be impacted when they transition to teenage care.</p>	<p>the teenage and young adult service to develop plans for managing clinical trials between the two groups. There may also be opportunities to learn from other centres around the country and other services. Different trials will be available at different sites with further plans to be developed to support access to these, where appropriate teenagers could potentially remain at the children's site for their trials.</p> <p>Other mitigations include thorough planning nationally to ensure children across any Principal Treatment Centre have better, more equitable access to trials.</p> <p>The Royal Marsden's reputation for teenage services is world renowned and this will not change.</p>
<p>There is a risk that the future Principal Treatment Centre fails to demonstrate compliance with recommendations for rapid trial setup and delivery which may lead to losing research knowledge in a crucial area.</p>	<p>Retention of staff will help to ensure research knowledge is not lost. Recruitment and retention plans for the future provider are discussed in Section 7.5.</p> <p>Close engagement with stakeholders will be important to manage this risk.</p>
<p>There is a risk that patients and families are not assured that the new research offering is equal to or better than the services at The Royal Marsden.</p>	<p>This will be addressed as part of implementation. Information should be appropriately communicated to patients and families.</p>
<p>There is a potential risk of a decline in charitable funding for the immediate future for children's cancer services if they are moved. The Royal Marsden Cancer Charity, which supports The Royal Marsden NHS Foundation Trust, raises money for paediatric services.</p>	<p>NHS England London will work with the ICR and The Royal Marsden to meet with charitable funders (as appropriate) to discuss this proposed reconfiguration and encourage continued charitable funding.</p> <p>Research funding was part of the information taken into account as part of the pre-consultation evaluation of the options.</p>

Risks	Mitigations
<p>In 2019/20, The Royal Marsden secured £38 million for research, with £1 million dedicated to children’s cancer research.</p>	<p>Funding will continue to be important in the future. Detail of how charitable funding is reflected in both potential providers’ plans is set out in the Section 8.8.</p>
<p>In the future, under these proposals, research will be conducted across at least two sites, where clinical oncology teams are based on one site and scientists on another; this will also require cross-site working and transfer of samples and data. There are associated risks including discontinuity in current research and clinical trials.</p>	<p>It will be important to consider:</p> <ul style="list-style-type: none"> <li>• the structure of employment arrangements</li> <li>• cross-site working arrangements</li> <li>• robust consent processes</li> <li>• governance arrangements in line with the Human Tissue Act 2004</li> <li>• logistics for handling, storing and transporting samples between sites</li> <li>• arrangements for managing data including patient records.</li> </ul> <p>Mitigations to support collaboration between clinical oncology teams at the Principal Treatment Centre and scientists at the ICR may include:</p> <ul style="list-style-type: none"> <li>• joint appointments</li> <li>• mutual honorary contracts</li> <li>• split site working</li> <li>• exploring funding opportunities to ensure continuity of funding for posts</li> <li>• cross-site training including of cancer research nurses (and other professions) if the potential for gaps is identified.</li> </ul> <p>Care planning and investment may be required to ensure infrastructure is in place for handling, storage and transporting samples.</p>

Risks	Mitigations
	Learning from other sites across London including Great Ormond Street Hospital can ensure we use best practice on how to transport tissue samples.
The Royal Marsden currently supports 'managed' and 'compassionate access' programmes to facilitate access for patients to innovative medicines where no open clinical trial is available. The impact of losing this is that children and young people could miss out on accessing treatment that could potentially increase their chance of their cancer responding, and with fewer side effects, and thus impact on the outcome.	The future provider will need to work closely with the ICR, The Royal Marsden and other stakeholders (such as pharmaceutical companies) to support continued access on a similar basis to current provision. It will be important that the future Principal Treatment Centre maintains and builds partnerships with pharma partners so that they have confidence in the ability of the future Principal Treatment Centre to govern and deliver programmes safely with appropriate reporting, within clinically necessary time frames.

As well as close working with the ICR, consultation feedback suggested use of The Royal Marsden @ Model or ICR @ Model to help retain staff and research capability could be beneficial. This is something that should be explored further as part of implementation (see Section 11). It could help to mitigate many of the research risks highlighted above by ensuring a more seamless transition of research capability and collaborative working.

In its consultation response, St George's set out that it is well placed to support the Principal Treatment Centre's ongoing partnership with the ICR given its proximity, particularly as the new hospital planned to be built in Sutton would see the St George's, Epsom and St Helier Group co-located with the ICR. It also shared new information that City, University of London and St George's, University of London are exploring a merger. The consultation response from City, University of London stated that "*this will create an extraordinary research and health education capability,*" it also highlighted that it will "*bring research in computer science, engineering, psychology, social services and more,*" and that it has "*ambitious plans to invest in St George's campus to develop further impact and entrepreneurship facilities, and to support multidisciplinary research contributing to health.*"

While at a relatively early stage, these developments indicate the potential for St George's to strengthen its research platform through wider opportunities that could emerge from the

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merger. City, University of London is not a medical or life sciences university but, as indicated above, has other expertise.

### **Impact of evidence on decision-making**

*Source of evidence:* This evidence was provided through the consultation and provider responses

*Is this information new?* Yes. Information about a potential merger between St George's, University of London and City, University of London is new information.

Information provided about risks to research have provided more information which has helped us refine risks and mitigations that would be needed during the transition and implementation phases.

*Does the information potentially have a material impact on our understanding of the options (specifically, differences between them)?* The information shared by St George's and City, University of London reflects potential opportunities for St George's to broaden its research platform (including in areas such as computer science and engineering among others). While some opportunities may exist in the future, we do not currently have evidence to suggest this would have a material impact on our understanding of the options.

Information provided about research risks provides a further focus on things that will need to be managed through service transition and implementation phases.

*Is the information material to implementation?* This information has been used to strengthen mitigations and the importance of co-design with the ICR, The Royal Marsden and other key research stakeholders and should continue to feed into subsequent business cases and communications.

### **How we have listened to feedback**

The research mitigations outlined above help to show decision-makers that we are committed to working with the future provider to support continued development of research. These mitigations should be developed further as part of implementation and the future Principal Treatment Centre provider should work closely with the ICR and The Royal Marsden during implementation. We also believe that the establishment of an expert advisory group to help oversee and manage risks related to research during transition could play a valuable role.

The feedback we received, and actions taken are summarised below:

Table 41: Research - You said, we did

You said	We did
<p>You have concerns about potential impacts on research and clinical trials if these are not carefully managed.</p>	<p>Both proposals were previously scored against the research domain evaluation criteria to inform an understanding of their respective strengths.</p> <p>We reviewed ‘new’ research risks/mitigations. This emphasised the importance of close, collaborative working between stakeholders during the implementation phase. It has further informed our understanding of the risks which will be important during the next phase of the programme.</p>

We have made the following recommendation for research:

***Recommendation #24: Work closely with the Institute of Cancer Research, The Royal Marsden and other key stakeholders to maintain and support the development of research and access to clinical trials for children and young people. We suggest that a dedicated work programme focused on enabling this through the management of risks is established with support from an Expert Advisory Board.***

***The future provider should also work with The Royal Marsden to explore potential for a @Marsden model as a vehicle for supporting collaboration, continuity of research and clinical trials.***

## 7.10 Theme 9: Strength of case for change

### Evidence previously considered

There is a compelling clinical evidence base which underpins the national service specification and our case for change is set out at Section 1.4.1 of this decision-making business case.

### Review of further evidence

#### Positive feedback on the case for change

There was strong support for the case for change from healthcare organisations, professional bodies and clinicians, some of which is set out below. The independent



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consultation feedback report states that no direct objections to the case for change were recorded by affected clinical and non-clinical NHS staff (for example, in relation to the statement that a level 3 intensive care unit should be co-located with the Principal Treatment Centre), although some staff expressed concerns about aspects of the proposals.

As well as firmly supporting the change, some clinicians and organisations urged us to complete the reconfiguration quickly to secure the benefits for children it will bring as soon as possible.

Organisations which gave their support for the case for change included British Association of Paediatric Surgeons, Children’s Cancer and Leukaemia Group, Children’s Hospital Alliance, Great Ormond Street Hospital for Children NHS Foundation Trust, Kent and Medway Cancer Alliance, Royal College of Paediatrics and Child Health, South Thames Paediatric Network and University College London Hospitals NHS Foundation Trust. Some comments are reflected below. Other responses can be found in the independent consultation feedback report (Appendix 2).

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. More details are provided below.

We examine the positive feedback on the case for change through thematic analysis provided below:

### **The importance of meeting the national service specification**

The importance of the future Principal Treatment Centre being on the same site as a level 3 paediatric intensive care unit was affirmed by many professional organisations and clinicians in their responses to the consultation.

Great Ormond Street Hospital NHS Foundation Trust’s Chief Executive said: “I would like to confirm our position remains that the outcome of this process must deliver against the new cancer service specifications – in particular, the co-location of paediatric intensive care services. The immediate adjacency of appropriately skilled staff and facilities to care for any child who may become critically unwell during their hospital treatment is essential for their safety, particularly for those who are under 13 years old.”



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South Thames Paediatric Network (STPN), which covers south London and much of south east England, said: “The STPN Board supports NHS England’s position that the children’s cancer Principal Treatment Centre (PTC) must move to a site that provides both intensive care for children and other specialist children’s services, and that this change must happen without further delay.”

A member of staff at The Royal Marsden said: “To have an intensive care unit on site would be very much a positive. No one talks about the move in a positive way, but it would be much nicer to wheel the patient down the ward to ITU than to transfer them to another hospital. It could be amazing, it could be a very positive move.”

### **The importance of ending hospital transfers of very sick children for intensive care which add risks and stress**

Some parents shared their experiences of their child being transferred from The Royal Marsden to St George’s Hospital for intensive care.

#### *Case study one:*

One mother said: “I wish intensive care and the chemotherapy services would be in one place. My son was transferred nine times. It was a nightmare. He got an infection every time he started a cycle of chemotherapy. He had nine cycles. After the third time, you expect it to happen, but it doesn’t make it any easier.” She added: “One or two nurses at least go with you in the ambulance. It would save money to have intensive care and children’s cancer services in one place.” (Site visit, The Royal Marsden, December 2023).

#### *Case study two:*

Another child very sadly died five days after being transferred from The Royal Marsden to St George’s Hospital for intensive care. Their mother said, when they arrived at St George’s Hospital, they were met with a whole new team of people they didn’t know, who cared for their child brilliantly, but they did not have the support network that they had at The Royal Marsden where their child had been treated for several years. Had they been in one specific place they would have had support from the same people and been in the same building. The situation was described as very difficult – lots of anxiety, emotion and adrenaline. Their consultant (from The Royal Marsden) wasn’t there (at St George’s Hospital) and so they couldn’t see them or other members of their team when difficult conversations were happening, and decisions were being made. When their child died, it felt like there was a real disconnect between the hospitals.

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A staff member at The Royal Marsden said: “As a clinician in the acute service, my team regularly encounters situations where deteriorating patients need to move rapidly from The Royal Marsden but it takes time to access a bed in, or close to, a children’s intensive care unit, or there is a wait for the South Thames retrieval service, meaning that patients often wait some hours or even overnight from the decision to transfer to the actual move. Delay in the ability to move a patient is among the most stressful situations of all for the responsible consultant and the clinical team, as well as for parents/patients who have been informed of the decision to transfer but then have to wait. Through the excellent team work of staff at The Royal Marsden significant patient harm around the time of transfer has been avoided to date, but the situation is nevertheless very unsatisfactory and undeniably high risk. It is for these reasons ... that I strongly endorse the recommendation for colocation of children’s cancer services with PICU.”

### **The importance of intensive care specialists being able to provide face to face advice on the care of children on the ward**

A mother (quoted above) whose child sadly died from their cancer spoke about the time at The Royal Marsden when the child was deteriorating. Instead of an intensive care team being on site and able to provide face to face review and reassurance, they were at the end of the phone. When in intensive care, the child needed a line insertion for medications to support their blood pressure. This could have been completed earlier if the intensive care team had been on the same site and transfer to the children’s intensive unit completed more quickly.

### **The importance of improving children and families’ experience when patients require intensive care and some other specialist children’s services.**

One father talked about his daughter being transferred from The Royal Marsden to St George’s Hospital for an operation. They were concerned that the new clinical team would not have time to read their child’s notes properly; there was a disconnect between teams which meant there was a lack of continuity when difficult conversations were had, or decisions were made. He commented: “Having to move to a different hospital was necessary because the operation needed to happen, but it posed such a risk to her health, which was unnecessary.”

A member of staff at The Royal Marsden said: “Not all patients follow the textbook: it would be good to have access to extra services, not just those that are specified [in the service specification].”

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British Association of Paediatric Surgeons said: “[British Association of Paediatric Surgeons] fully supports the need for a change to cancer services in south London as described by Professor Richards and are pleased that it is recognised that, wherever the service is placed, there will need to be experts in Oncology, Radiology and Pathology in relation to Cancer Care.”

Kent and Medway Cancer Alliance’s response to the consultation said both patients and clinical respondents were clear that, among the requirements that must be met in the future Principal Treatment Centre, were:

- co-location of paediatric intensive care unit with the Principal Treatment Centre to meet 2021 clinical requirements for Principal Treatment Centres.
- co-location with as many paediatric subspecialties as possible for maximal expertise / opinion / timely review.

### **The importance of the Principal Treatment Centre being able to provide types of new treatment which can only be given at a children’s cancer centre which is on the same site as a children’s intensive care unit**

Children’s Hospital Alliance – on behalf of its members except Great Ormond Street which replied separately – said: “This case for change is about the future of care and ensuring consistent access, outcomes and opportunities to participate in research for children with cancer across the country. To achieve this, we believe that co-location with the wide range of dedicated paediatric specialties that these children may need is a crucial component of this proposed change.”

University College London Hospitals NHS Foundation Trust’s response to the consultation said: “The research, recruitment and retention benefit to a Principal Treatment Centre which is unrestricted by any lack of supporting clinical infrastructure is an important benefit of either option.”

### **Opposition to the case for change**

A few children and young people expressed their wishes that the change did not happen at all and that the Principal Treatment Centre remained at The Royal Marsden. Those who expressed this wish, expressed it strongly. One young person, during the play specialist session, stated that they did not want the Principal Treatment Centre to move from The Royal Marsden. However, if the Principal Treatment Centre had to be moved, the young person said: ‘If [a Principal Treatment Centre] could be built next to The Royal Marsden, that

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would be a dream of mine' (Young person, 13 years old, play specialist session at St George's Hospital, November 2023)

There was feedback from parents, carers, and advocates who thought that the change should not happen (15% of respondents to the consultation questionnaire stated that they did not want the service to move from The Royal Marsden). Some called on NHS England to rethink the move, keeping very specialist cancer treatment services for children at The Royal Marsden, and considering alternative proposals. This included some parents whose children had been transferred for intensive care and who felt the experience was well managed. Some felt that as only a small number of very unwell patients are transferred for intensive care, there is not a problem that needs to be fixed. They also argued that future treatments currently in development would minimise the need for intensive care and hence the need for children to be transferred. Another argument was that the risks of the move outweigh the benefits, including risks to research, loss of expertise, and the added stress and costs to families of journeys to the centre. The independent consultation feedback report identified that the reason why many of those opposing the case for change feel as they do is that the proposals from Evelina London and St George's do not appear, for them, to guarantee the experience, expertise, quality of care, and research capability of The Royal Marsden.

Consultation feedback from parents and carers included:

- 'I can't see any reason why they need to move because it is a purpose-built cancer hospital for the children and they have also got the Institute of Cancer Research right next door' (Parent/carer engagement session, November 2023).
- 'Huge risk that services will be negatively impacted if this goes ahead' (Parent, public listening event, November 2023).
- 'Rarely does it become a need for a blue light service' (Parent/carer Engagement session, November 2023).

One young person now under the care of the teenage and young adult service but with experience of the children's cancer service, argued there were positive advantages to separation of most cancer care from the intensive care service.

- 'I was transferred five times to St George's Hospital for intensive care. They have saved my life so many times. Then we can put that aside and come here.' (Young person with cancer, site visit to The Royal Marsden, December 2023)

### Alternative suggestions

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Alternative suggestions for the future location of the Principal Treatment Centre put forward by the #HeartheMarsdenKids petition, which had received 10,394 signatures by the time the consultation closed, and by respondents to the consultation included:

- A 'risk-adapted' model that retains the Principal Treatment Centre at The Royal Marsden and St George's Hospital. Any patients who, upon diagnosis, were deemed likely to require children's intensive care throughout the course of their treatment would receive their specialist care at St George's Hospital to minimise the need for transfers. This would mean all other patients would continue to receive care at The Royal Marsden.
- A 3-stage solution, which involves (1) adoption of the risk-adapted model outlined above, then (2) adoption of new technologies to support a hub and spoke model by which intensivists based at a 'hub' can support 'spoke' services; with a trial at The Royal Marsden and (3) the building of a new children's specialised services hospital at a South Thames location.
- Utilisation of the new hospital to be built in Sutton, next to The Royal Marsden, by including a level 3 children's intensive care unit.
- Some people wanted a single-site solution, with all the services that children with cancer could need on the same site.

We have reviewed the alternative solutions suggested by the #HeartheMarsdenKids petition and other respondents. This included during the Programme Board's work to evaluate possible solutions for the future Principal Treatment Centre, evaluating the option of a joint site Principal Treatment Centre. However, due to the need to comply with the national service specification, any option that retained very specialist cancer treatment services at The Royal Marsden was discounted because it would not deliver a solution that removed the underlying risks of the current service arrangement or that was compliant with the national service specification.

Solutions put forward are not viable because:

- The **risk-adapted solution** does not remove the underlying clinical risks associated with the current arrangements. While a split-site arrangement persists, these can only ever be mitigated.
- Only delivery of the national service specification can remove the underlying risks of the current split-site arrangements.

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- Clinicians who provide the current service made it clear in the consultation that they strongly support the national service specification. They believe that separation of very specialist cancer treatment services for children from children's intensive care services and other specialist services for children is not a viable long-term solution.
  - The removal of the unnecessary clinical risks inherent in the separation of very specialist cancer treatment services for children from children's intensive care services is the key driver of this reconfiguration – the risk adapted model would not deliver this.
  - Co-location of services with intensive care optimises patient safety.

The proposal for a **three-step solution** which starts with the risk-adapted solution cannot progress because the first step is not viable, as explained above.

There are no plans for a level 3 paediatric intensive care unit to be built at the **new hospital at Sutton** – south London has three paediatric intensive care units for its population and a new one would not be clinically viable but could risk destabilising existing paediatric intensive care units, for instance at St George's Hospital.

Services for children with cancer cannot be all on a **single site** because:

- a) paediatric radiotherapy is a specialist service reliant on a specialist workforce and related equipment to provide this care which is reliant on having a broader paediatric infrastructure for safe delivery. It would not be viable to retain the photon beam service at The Royal Marsden (as a standalone service after the Principal Treatment Centre moves) nor to build a new service on either proposed site for the future service; instead, there are a number of benefits of consolidating this service at University College Hospital which provides a wide range of radiotherapy services including (one of only two) proton beam therapy services in the country alongside other superspecialist types of radiotherapy. (For more detail, see the case for change for radiotherapy at Section 1.4.5 of this decision-making business case.)
- b) neurosurgery has key interdependencies with major trauma centres at St George's Hospital and King's College Hospital and with other services these hospitals provide and is therefore a 'fixed point' which will not change<sup>75</sup>. Children with cancer will continue to go to one or the other centre for neurosurgery, in similar proportions as they do now.

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<sup>75</sup> This was agreed by the Programme Board for the Reconfiguration Programme as part of the options development process which defined the fixed points.

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- c) surgery for bone sarcoma, retinoblastoma and liver cancer are all delivered at hospitals which have specific expertise in these areas.

However, both options would offer more services on one site if they were to become the future Principal Treatment Centre than are available at The Royal Marsden and, under both options, children would benefit from provision of more holistic care. If the Principal Treatment Centre was at Evelina London, children would travel for radiotherapy and neurosurgery, if it was at St George's Hospital, children would travel for radiotherapy, specialist cardiology and nephrology services.

### **Impact of evidence on decision-making**

*Source of evidence:* This evidence was provided through the consultation from children and young people affected by cancer, their family members and advocates, members of the public, organisational responses (from charities and not-for-profit organisations) and the petition described. Throughout the thematic analysis above, we have also identified the individuals and organisations who have provided the support. (No objections to the case for change were recorded by affected clinical and non-clinical NHS staff).

*Is this information new?* No. This information is not new. However, it provides additional support and validation for the case for change. The parameters of the clinical model and need to adhere to national service specification were a fixed point and hurdle criterion, and fed the options evaluation and therefore the alternative suggestions are also not new.

*Does the information potentially have a material impact on our understanding of the options (specifically, differences between them)?* No – this information is not new.

*Is the information material to implementation?* This information provides discussion points to address through further stakeholder engagement at implementation phase. The information used to strengthen the case for change should continue to feed into subsequent business cases and communications demonstrating the need for the service change.

### **How we have listened to feedback**

This decision-making business case sets the compelling clinical evidence which underpins the case for change: the national guidelines, reports and the responses to the development of a previous version of the service specification and public consultation in 2019 by “an overwhelming majority of clinical experts and parents of children with cancer” which led to Professor Sir Mike Richards' report in 2020 and then to the national service specification in 2021.



It is clear from the feedback to the 2019 consultation that while a “reasonable interim solution”, such as is in place now, can provide mitigations, “the final status of a patient focused service” must be for children’s cancer services to be on the same site as a children’s intensive care unit. This is part of the consultation response from the Children’s Cancer and Leukaemia Group.

It is also clear from the clinicians’ and professional organisations’ responses to our public consultation in 2023 that there is strong support for the case for change from clinicians including all the affected clinical and non-clinical NHS staff who commented on the case for change.

Our response to the feedback received and actions taken to address the feedback are summarised in the ‘you said, we did’ table below.

Table 42: Strength of case for change - You said, we did

You said	We did
<p>Several alternative proposals could be considered, including a risk-adapted solution, making use of the potential new hospital to be built at Sutton, or a suggested 3-stage solution involving adopting new technologies.</p>	<p>We have previously considered these alternative proposals, which unfortunately do not remove the underlying risks of the current arrangements whereby the very specialist cancer treatment services provided at The Royal Marsden are not on the same site as a level 3 children’s intensive care unit that can give life support or associated children’s services. Nor do they comply with the national service specification. The future Sutton hospital will not have a level 3 children’s intensive care unit, as it would not be clinically sustainable.</p>
<p>Throughout the consultation there were calls for a single site solution, with concerns related to radiotherapy not being available on-site in either of the proposed options.</p>	<p>University College Hospital is the only viable option with relevant scale and breadth of expertise to provide the future service. It would not be feasible for either Evelina London or St George’s to build an equivalent radiotherapy service to that provided at University College Hospital which has benefited from significant investment and infrastructure, including the proton beam and a highly specialised workforce.</p>



## 7.11 Theme 10: Deliverability

### 7.11.1 Timelines to deliver

#### Evidence previously considered

An indicative high-level timeline for delivery was included in the pre-consultation business case which showed that the move of the service would take place over a 2.5 year period, and not before 2026. This was agreed by the Programme Board to help ensure timely transition of the service, including realisation of associated benefits.

#### Review of further evidence

Consultation feedback was that implementation should be undertaken in a timely fashion to ensure safe transition (ideally within the next 2.5 years). We asked the providers to provide updated implementation timelines in response to this (outlined below). The detailed implementation plan for both providers is outlined in Appendix 12.

Table 43: Timelines for implementation

St George's		Evelina London	
Task	Completed by	Task	Completed by
Commence procurement	May 2024	Commence procurement	September 2024
Outline business case (OBC)	August 2024	OBC	September 2024
Appoint Principal Supply Chain Partner (PCSP)	September 2024	Appoint PSCP	October 2024
Full business case (FBC)	November 2024	FBC	December 2024
Start on site	February 2025	Start on site	January 2025
Construction complete	August 2026	Construction complete	September 2026
Service operational	October 2026	Service operational	October 2026

#### Impact of evidence on decision-making

*Source of evidence:* Additional provider responses.

*Is this information new?* No – this confirms the previous commitment and feasibility of the 2.5 year timeline.

*Does the information potentially have a material impact on our understanding of the options (specifically, differences between them)?* No, as not new information.

*Is the information material to implementation?* Yes. These timelines should drive delivery. It will be important that oversight of this is provided by the Implementation Oversight Board.

### How we have listened to feedback

The updated implementation timelines for both potential providers set out a plan for the service to be operational by October 2026 (which is within 2.5 years of when the decision is due to be made). This doesn't impact our understanding or differentiation of the options as both provider timelines are in line with timelines set by Programme Board and agreed by NHS England. Operational risks to delivery are provided in Section 11.

The updated timelines provide further assurance for delivery to decision-makers. The timelines for the future provider will be developed in more detail during implementation. Detailed implementation plans from each of the potential providers are in Appendix 12.

The feedback we received, and actions taken are summarised below:

Table 44: Timelines to deliver - You said, We did

You Said	We Did
<p>Implementation should be undertaken in a timely fashion to ensure safe transition. Realistic timelines for this should be provided, and mitigations for implementation risks should be developed.</p>	<p>The providers have provided updated implementation timelines, with updated risks and supporting mitigations. We continue to assume a transition period of 2.5 years before the future Principal Treatment Centre transfers. Detailed plans for underlying workstreams will be developed after a decision is made. Delivery of plans will be monitored by the Implementation Oversight Board to ensure that the service transfer is safe and sustainable, conducted in a timely manner so that benefits of the change can be realised.</p>
<p>Important to give clear, open communication about the timeline, key</p>	<p>The Trusts have shared implementation plans with key milestones (included within this</p>

<p>milestones and ways to get involved. Reassurance around staff retention and impact on care should be given on a regular basis.</p>	<p>decision-making business case). Regular reporting will be required as part of implementation on delivery of the plans and recommendations, including comprehensive information sharing.</p>
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***Recommendation #25: In order to realise benefits of the service change in a timely way it will be important that the future provider of the Principal Treatment Centre works proactively to enable the safe transition of the service in line with plans. Collaborative working with partners will be a key enabler to this and should support the development of more detailed plans and business cases informed by and co-designed with staff, patients, families and other stakeholders.***

### 7.11.2 Risks and mitigations for delivery

#### Evidence previously considered

At pre-consultation business case stage, both providers outlined the key risks to delivery from a management perspective with their associated mitigating actions.

#### Review of further evidence

Both Trusts were asked to provide updated risk logs for implementation, along with mitigations for each risk as part of additional clarification questions. A summary of programme risks is outlined in Section 11.2

The capital and estates risks were also outlined by both Providers and are reflected in 8.8.6.

#### Impact of evidence on decision-making

*Source of evidence:* Additional provider responses.

*Is this information new?* No – the risk logs provide further assurance around the mitigations outlined for these risks. No substantial ‘new’ risks were identified.

*Does the information potentially have a material impact on our understanding of the options (specifically, differences between them)?* No, as not new information.

*Is the information material to implementation?* Yes. Risks should continue to be monitored, managed and mitigated through implementation to ensure successful delivery within the timeline.

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## How we have listened to feedback

The updated risks from both potential providers provide assurance that they are aware of potential issues that may arise during implementation. Both providers have developed mitigations for risks and therefore this updated information doesn't impact our understanding of the options. We have incorporated these risks into the active programme risk register, and these will continue to be monitored throughout implementation and the first few years of practice, with risks being escalated to the Implementation Oversight Board and/or commissioners where appropriate.

The feedback we received, and actions taken are summarised below:

Table 45: Risks and mitigations for delivery - You said, We did

You Said	We Did
Recognise, and mitigate for, the fact that establishing a new service brings risks and may negatively impact the service as it transitions to the new site.	While there are risks to the delivery of the future Principal Treatment Centre, the case for change is strong. We will continue to monitor the risks and mitigations to them throughout implementation.

The future provider should continue to monitor these risks throughout implementation. The process for this is outlined in Section 11.2.1.

***Recommendation #26: Work with NHS England/Integrated Care Boards through the identified governance processes to ensure recommendations and mitigations are implemented with necessary support in place. This should include active management of risks including over the transition period and early implementation phase.***

***Recommendation #27: Establish a Travel and Access group with representatives across providers and commissioners to implement the recommendations set out within the Integrated Impact Assessment.***

***Recommendation #28: Successful change requires strong clinical leadership. To enable successful implementation, clinical leaders from the current Principal Treatment Centre and future provider will need to be identified, developed and supported.***

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***Joint roles between organisations are also likely to be an important enabler to effective integration between teams and should be established to support the change process.***

***Recommendation #29: Consideration and plans developed to support families preserve memories and legacies, and support families throughout the transition and implementation period.***

### **7.11.3 Funding**

#### **Evidence previously considered**

A financial impact assessment was conducted at pre-consultation business case stage. Affordability was a hurdle criterion and therefore did not impact which option was selected as preferred. The fact that affordability is a hurdle criterion means that, so long as our work shows that both proposals remain affordable, finance will not impact which option is selected. Instead, we are focusing on which option can best provide what we are looking for: a future Principal Treatment Centre that builds on the strengths of the current service, meets the national service specification, is affordable in both capital and revenue terms, and will give best quality care to achieve world-class outcomes for children with cancer for decades to come.

Both proposals were affordable in both capital and revenue terms within the pre-consultation business case financial impact assessment.

#### **Review of further evidence**

Concerns related to the requirement for additional funding (for estates improvements for out-of-scope areas) at St George's Hospital were raised during consultation. Funding in relation to this business case relates to the proposed reconfiguration of the service and development of cancer centre in one of two proposed future locations. Funding for other parts of the estate at either site are out of scope. As part of the decision-making business case we have confirmed that both proposals remain affordable (included in Section 8.8).

Concerns were raised through consultation that the future provider would not be able to meet the current levels of charitable funding for the service, and that this would impact affordability. Both proposals have elements of charitable funding, although less than current levels. The proposals remain affordable due to different operational and clinical models, including service adjacencies, and overhead efficiencies. The affordability of both proposals is further outlined in Section 8.8.

Concerns were also raised around private patient income assumptions. Both potential providers of the future Principal Treatment Centre 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 proposals have outlined sufficient capacity for physical space and workforce to meet NHS demand as per current demand and capacity analysis.

### Impact of evidence on decision-making

*Source of evidence:* Additional provider responses.

*Is this information new?* No – both proposals remain affordable.

*Does the information potentially have a material impact on our understanding of the options (specifically, differences between them)?* No. Both potential providers continue to meet capital and financial revenue hurdle.

*Is the information material to implementation?* Yes. Capital and revenue affordability of the programme should continue to be monitored and managed through the outline business case and full business case.

### How we have listened to feedback

Our review of affordability doesn't impact our differentiation of the options; capital costs are consistent with those outlined in the pre-consultation business case.

This additional evidence provides assurance that both options are affordable and that any potential negative financial impacts on St George's Hospital if Evelina London are selected can be mitigated.

The feedback we received, and actions taken are summarised below:

Table 46: Funding and financing - You said, we did

You said	We did
There is general concern around funding for the options (including research), and financial sustainability challenges for both of the options.	Both options are affordable from both a funding and financing perspective. As the future provider develops its outline business case and full business case, it will need to continue to

	demonstrate affordability with mitigations in place for associated risks.
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***Recommendation #30: The future provider should demonstrate capital and revenue affordability of the scheme through development of the outline business case and full business case, with mitigations in place for associated risks.***

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## Impact of the proposal





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## 8. Impact of the proposal

### 8.1 The change impacts that need to be assessed

Both the shortlisted options are compliant with the national service specification, offer capacity to meet the needs of the service and are deemed viable options (via the pre-consultation evaluation of the options process).

It is recognised that in gaining the wider benefits from our clinical model, some families would need to travel further for care compared to now (and some would have shorter journeys). Therefore, the main change considered by the Integrated Impact Assessment is the proposed change in location of the current Principal Treatment Centre and the implications of this change on patient travel arrangements such as journey time, complexity of journey (including parking arrangements) and cost. This change will affect current (at the time-of-service transfer) and future patient cohorts, as well as staff groups.

Also of note is the prospect of the service change process itself and the uncertainty that it may cause for patients and their families. For example, they may have concerns about moving to a site they have not been to before (including accessibility of the site) or potential changes in their relationships with known healthcare professionals. While these concerns are something that any patient or family may experience, it may be of more consequence for certain groups, such as those with communication difficulties or disability, and this needs to be considered.

As part of understanding the impact, we have conducted an Equality and Health Inequalities Impact Assessment (EHIA) to assess the potential impact of this programme on population groups with a protected characteristic, or who face health inequalities. The EHIA for this change programme is embedded within the Integrated Impact Assessment which is a set of collated evidence that provides information about the potential positive and negative impacts of proposed changes to services, alongside a set of potential solutions (mitigations) that may help to address some of the areas identified.

Beyond patients and staff of the Principal Treatment Centre, the proposed change in location of the current Principal Treatment Centre will also have an impact on wider services in south London and much of the south east. These impacts, and the mitigations required to address these, are also outlined below.

The implementation of the move will have a financial impact, both in terms of capital and revenue, and an environmental impact. These are assessed in Section 11.

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## 8.2 The Equality and Health Inequalities Assessment process

The development of the Equality and Health Inequalities Assessment (EHIA) occurred in two phases: the interim EHIA which was developed prior to consultation, and the second phase which took place after the consultation, allowing for refreshed analysis and reflection of the consultation feedback on additional impacts or mitigating actions.

An EHIA sub-group was established in December 2022 to support the EHIA process (led by the NHS England London Public Health team). The sub-group, which met between March and July 2023, included professionals and patient representatives from across the Principal Treatment Centre area, including those working for NHS England, in NHS Integrated Care Boards and in local authorities.

The EHIA enables an assessment of the equality and inequality issues which arise, so that we can meet our statutory duties, as well as properly consider how to put in place mitigations to reduce any inequalities.

People in professional roles included those with expertise in children's cancer care, patient engagement, equality and diversity, public health, and health inequalities. They were independent of both the potential providers of the future Principal Treatment Centre. Both potential providers had the opportunity to provide input to the interim EHIA and reviewed the recommendations made within the Final IIA.

The EHIA sub-group reviewed several sources of information to inform a summary of the potential positive and adverse impacts of the proposed Principal Treatment Centre relocation for people with protected characteristics or other characteristics. The interim EHIA had:

- An equalities profile. This report describes the epidemiology of childhood cancer and socio-demographics for the catchment area of the Principal Treatment Centre. A summary of the findings of this report are included in the Geography and Demography section of the IIA (Appendix 4)
- A travel time analysis of the estimated changes to travel time for patients within certain demographic groups or areas
- Qualitative insight collected through patient engagement activities.

The sub-group considered each of the population groups shown in Table 51 and was asked to ascertain any differential impacts of the proposed changes in relation to both the Public Sector Equality Duty, and on inequalities in access to, and outcomes from, the service.

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Following the consultation, a Travel and Access working group with membership from professionals and a childhood cancer charity representative from across the Principal Treatment Centre catchment area was established to:

- review the outputs from consultation
- review additional and updated evidence
- confirm existing mitigating actions and identify new ones.

### 8.3 Interim Equality and Health Inequalities Impact Assessment (EHIA)

As part of the evidence to assess the impact of the proposals, a travel time analysis was undertaken by experienced independent NHS analysts to understand the effect on travel times for children and their families.

The analysis looked at travel times by public transport and car to The Royal Marsden and compared this with journey times to both Evelina London and to St George's Hospital. This analysis was conducted on a catchment population basis. This means that journey times were modelled for all children resident in the Principal Treatment Centre catchment, based on the Lower Super Output Area<sup>76</sup> where they live. The travel times are for the fastest trip departing from the resident origins for arrival at midday on a Wednesday. Details of the methodology can be found in Appendix 4.

The likely impact on median travel times for a change in location of radiotherapy services, currently provided at The Royal Marsden, was also analysed.

It should be noted that the main purpose of the population-based travel analysis is to assess the impact of the proposed change on groups with protected characteristics or other vulnerabilities. It is in *addition* to the comparison (and scoring) of changes to patient travel undertaken as part of the evaluation of the patient experience component of pre-consultation evaluation of the options.

Both sets of travel time analyses utilise the same underlying methodology. This is explained in more detail in Appendix 4.

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<sup>76</sup> Lower Super Output Areas (LSOAs) are a small area of geography averaging approximately 1,500 people. Each LSOA has a population weighted centroid (PWC) which represents the centre of the distribution of residents across the LSOA. These were used as the child resident origin points for the analysis.

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### 8.3.1 Current travel times to The Royal Marsden

Please see the Appendix 4 for more details on the current travel times to The Royal Marsden (including graphs).

#### Journeys by road vehicle

The median travel time for driving to The Royal Marsden was 52 minutes. This increases to a median of 61 minutes for journeys from outside London. For those non-London residents with the longest journeys, the travel time is 95 minutes. Overall, 66% of the Principal Treatment Centre catchment population has a travel time of less than an hour, with journey times ranging from a minimum of three minutes to 85 minutes at the 90<sup>th</sup> percentile. For residents living in areas categorised as the most deprived, 46% have a travel time of less than an hour.

#### Public transport

Public transport travel times to The Royal Marsden had a median travel time of 97 minutes. This increased to a median of 133 minutes for journeys from outside London. For non-London residents with the longest journeys the travel time is 180 minutes. Overall, 20% of the Principal Treatment Centre catchment population has a travel time of less than an hour, with journey times ranging from a minimum of five minutes to 165 minutes at the 90<sup>th</sup> percentile. For residents living in areas categorised as the most deprived, 14% have a travel time of less than an hour.

### 8.3.2 Impact of the proposed options on journey time

Please see Appendix 4 (IIA) for more details on the impact of the proposed options on journeys for children resident in the Principal Treatment Centre catchment<sup>77</sup>.

The impact on journey times is summarised to either potential future Principal Treatment Centre location, without differentiating between them. This is in keeping with the principles of the EHIA. It should also be noted that the travel analysis is intended to provide an *indication* of the average quickest journey to each destination. It represents modelled estimates only and individual experiences may not completely align with analysis presented.

#### Journeys by road vehicle

Modelled travel times by road vehicle to either potential future Principal Treatment Centre location are increased as compared to current travel times to The Royal Marsden. Non-London residents are the most negatively impacted, with increases in travel time of approximately 30 minutes. For non-London residents with the longest journey times, this

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<sup>77</sup> The IIA also includes further travel time analyses to each potential future Principal Treatment Centre location for children living in different local authorities within the catchment.

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increase could be up to 41 minutes. Overall, 46% of the Principal Treatment Centre catchment population would have a travel time of less than an hour by road vehicle (compared to 66% for the current location).

For residents living in areas categorised as the most deprived, 40% would have a travel time of less than an hour (compared to 46% for the current location).

### **Public transport**

Modelled travel times by public transport to either potential future Principal Treatment Centre location are reduced as compared to current travel times to The Royal Marsden. There would be a reduction in travel time for both London and non-London residents to either location, with non-London residents experiencing the greatest benefit (with a reduction of at least 20 minutes). For non-London residents with the longest journey times, this reduction could be at least 26 minutes.

Overall, 37% of the Principal Treatment Centre catchment population would have a travel time of less than an hour by public transport (compared to 20% for the current location).

For residents living in areas categorised as the most deprived, 33% would have a travel time of less than an hour (compared to 13% for the current location).

### **Radiotherapy services**

Travel time analysis found that travel time by road will increase on average by 22 minutes to University College Hospital (as compared to The Royal Marsden) while the same journey by public transport will reduce by 27 minutes.

For those living in areas categorised as the most deprived, journey times to University College Hospital (as compared to The Royal Marsden) will increase on average by 20 minutes by road and reduce by an average of 40 minutes by public transport.

## **8.4 Final Equality and Health Inequalities Impact Assessment (EHIA)**

The final EHIA builds on the interim report and incorporates evidence gathered through:

- Sensitivity analysis against updated algorithms and peak travel times.
- Additional analysis on ethnicity groups: this considers the impact of the proposed changes on ethnic groups other than white and whether there is a potential disproportionate impact.
- Additional analysis on travel cost: this considers the financial impact of travel arrangements to the proposed options for the future centre for patients and staff.

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- A consideration of the likely cumulative impact of changes in both travel costs and time over a given time period.
  - Review of the consultation responses: This enabled the final IIA to incorporate any additional impacts or mitigating actions which had not been identified as part of the interim report. This review also considered responses from those in certain protected characteristic groups and/or living in particular areas where a potential disproportionate impact has been highlighted.

To review the consultation findings and new analysis, a Travel and Access working group was established. Its membership included professionals from across the Principal Treatment Centre area and a childhood cancer charity representative.

#### **8.4.1 Sensitivity analysis of travel time**

Arising from the public consultation, one of the most common concerns shared by respondents across all consultation strands related to access, travel and transport to services, particularly for private transport as the most common way to access the Principal Treatment Centre. After the travel time analysis for the Interim IIA was conducted, the data and algorithms within the travel time modelling software ([TravelTime](#) API) were updated, taking into account changes to highway infrastructure and traffic density.

Therefore, sensitivity analysis was conducted using this new data to test and validate the previous findings. The updated algorithm showed that absolute driving times are extended by approximately 15 minutes to either potential future Principal Treatment Centre as well as to University College Hospital. There was no differential impact of this update on times to individual provider locations, or between London and non-London populations. As the overall differential impact between potential locations remains the same, we have not updated the original travel time analysis. However, we recognise that this is an additional time burden, with increased importance of travel mitigations.

In addition, we also conducted sensitivity testing for comparing driving and public transport times when travelling in “peak” and “off-peak” times. The main travel time analysis uses off-peak analysis.

- Peak travel times are journeys calculated to arrive by 9.30 a.m. on a Wednesday.
- Off peak travel times are journeys calculated to arrive midday on a Wednesday.

The results are such that there is very little difference in peak and off-peak travel times for the catchment population. For driving, arrival at the destination for 9.30am requires a journey start time before peak traffic densities have built up. This allows a faster drive time at the

start of the journey, resulting in an overall drive time similar to off-peak (within one minute's difference). Similarly, availability of more frequent and faster public transport options during peak hours also means that peak and off-peak travel times are not very different (within one to two minutes difference).

### 8.4.2 Travel time analysis by ethnicity

The release of 2021 Census data has allowed us to look at travel times by ethnic group.

By public transport, travel times to either future Principal Treatment Centre location are up to 20 minutes faster for the white population, compared to up to 13 minutes faster for those from ethnic groups other than white, when compared to travelling to the current Principal Treatment Centre Sutton site.

When driving, travel times to either future Principal Treatment Centre location are around 26 minutes longer for the white population, compared to up to nine minutes longer for those from ethnic groups other than white, when compared to travelling to the current Principal Treatment Centre Sutton site. The relatively small negative impact on driving times for children from ethnic groups other than white indicates that the change could improve help reduce inequalities in access to services for these populations.

The table below demonstrates this analysis (more detail is included in Appendix 4):

Table 47: Travel time analysis by ethnicity (minutes)

Mode of transport	Public transport		Driving	
	White	Other ethnic groups	White	Other ethnic groups
The Royal Marsden	107	74	64	60
St George's Hospital	87	61	90	66
Evelina London	77	56	90	69
University College Hospital	79	59	98	82

### 8.4.3 Travel cost analysis (patients)

As well as impact on overall time travel time, an important consideration is that of travel poverty (a difficulty or inability to make necessary journeys due to a combination of income, cost and service availability). We have completed a travel cost analysis to understand the



financial impact of the change<sup>78</sup>. Overall population findings do not negate the fact that some families will face longer, more costly journeys and these impacts need to be mitigated.

Table 48: Travel cost analysis for patients by car based on mileage, for a return journey

Analysis for off peak arrival midday	Population weighted median journey cost (£)	Difference in median cost (£)	% of population that see increase of more than £5
Royal Marsden (Surrey)	8.35	0	n/a
Evelina London	6.13	- 2.22	11.9%
St George's Hospital	5.40	- 2.95	0%
University College Hospital	7.73	-0.62	16.4%

The travel cost analysis shows that, on average, the cost of driving to the future location of the Principal Treatment Centre is cheaper than current travel costs regardless of the chosen provider, due to the distribution of the population with a higher density within London and as mileage does not take account of traffic density. However, a larger proportion of patients and their families will see costs increase by more than £5 should Evelina London rather than St George's Hospital be the future Principal Treatment Centre provider.

Travel cost analysis was also conducted for children living in the most deprived areas of the catchment<sup>79</sup>. This also demonstrated that both options on average have lower travel costs for the most deprived populations than the current Principal Treatment Centre location. The reduction in median cost between the current location at The Royal Marsden and options for future locations is larger for those from the most deprived areas. While St George's Hospital has the lowest median cost, Evelina London has a higher proportion of the population who would have an average travel cost of less than £5 per return journey. Further detail on travel cost is included in the IIA (Appendix 4).

<sup>78</sup> Driving costs are based on average fuel cost per mile along the road network, set to the government advisory fuel reimbursement rate. The inner London congestion charge (£15.00) and ultra-low emissions zone (ULEZ) charge (£12.50) are not applied as travel to hospital appointments by children with cancer would be eligible for reimbursement for both charges.

<sup>79</sup> This includes populations in the catchment area that live in the 20% most deprived areas in England (IMD 1 - 2019).



Table 49: Travel cost analysis for patients living in the most deprived areas, for a return journey

Analysis for off peak arrival midday	Population Weighted median journey cost (£)	Difference in median cost (£)
Royal Marsden (Surrey)	13.4	n/a
Evelina London	7.9	-4.5
St George's Hospital	7.3	-5.1
University College Hospital	8.13	-4.3

#### 8.4.4 Cumulative travel time and cost

To give an indication of the likely cumulative impact of additional travel time and cost, we estimated the additional travel time and cost that could accrue over a year of treatment that involved three, 15 or 30 separate visits to a Principal Treatment Centre (46% of patients had three or fewer visits to the current Principal Treatment Centre in 2019/20). The full details of this analysis can be viewed in the Integrated Impact Assessment. However, in summary, a family with one of the longer journeys to the Principal Treatment Centre, undertaking 15 visits in a year could experience £29-£35 worth of additional fuel costs, and an additional 20-24 hours of travel time if travelling to either future Principal Treatment Centre location over the 15 visits.

It should be noted that there will be a wide range of treatment patterns and numbers of visits between patients, due to the different types of treatment protocols, responses and experiences of those undergoing treatment for childhood cancer. For these reasons, any conclusions drawn about the “typical travel cost or time incurred over the treatment period” must be interpreted with caution.

#### 8.4.5 Travel time and cost analysis (staff)

We also conducted a travel cost analysis for staff in response to concerns that their living costs would be affected by the Principal Treatment Centre reconfiguration. Section 7.5.1 addresses these concerns and the mitigations that would be in place, such as transfer arrangements.

The travel cost analysis showed that Evelina London would have a higher journey cost difference for staff travelling by car than St George's Hospital:

- The median journey cost difference for The Royal Marsden staff moving to Evelina London would be an increase of £3.41.
- The median journey cost difference for St George’s Hospital staff moving to Evelina London would be an increase of £2.46.
- The median journey cost difference for The Royal Marsden staff moving to St George’s Hospital would be an increase of £0.42.

We are aware that although driving is currently a preference for many Principal Treatment Centre staff, this is unlikely to be possible at either of the future providers due to a lack of staff parking. We therefore considered the impact on public transport costs by reviewing individual case studies (the variation in public transport times/cost meant that a travel cost analysis would not be representative). This is explained in more detail in Section 7.4.2. Based on the sample and methodology used, the results indicate that travel costs for staff who currently drive but will use public transport to get to the future Principal Treatment Centre are likely to increase.

It is also important to note that these are example journeys only and there will be a wide range of experiences for members of staff. Those who live close to The Royal Marsden are likely to see the largest impact on their travel costs relatively speaking. However, longer distances aren’t necessarily linked to higher costs in a linear fashion as the cost of travel depends on the nature of public transport into London.

## 8.5 Summary of impacts assessed in the Equality and Health Inequalities Assessment (EHIA)

The EHIA indicated that both options have similar impacts compared to current provision, but there are small differentiating factors. The impact of the reconfiguration of the Principal Treatment Centre and moving radiotherapy services to University College Hospital is summarised in the table below. The impact of the new information from the final EHIA on decision making, and recommendations regarding the findings and mitigations, is in Section 7.4.2 for travel times and costs and Section 7.4.4 for impact on equality groups.

Table 50: Summary of impacts assessed in the Equality and Health Inequalities Assessment (EHIA)

Area	Detail
Health inequalities	For deprived populations, there are longer travel times by driving and shorter times by public transport, however these impacts are proportionately smaller than for the general population. Travel costs for populations living in the most deprived areas would be lower than their

	<p>current estimated driving cost, however their costs are still higher than those estimated for the general population.</p> <p>For ethnic groups other than white, the increase in travel times is less than for the white population. The change could therefore be argued to be narrowing health inequalities in this respect.</p> <p>Travel time analysis shows that children living in rural areas experience a disproportionately negative impact on journey times for driving but a positive impact for travel via public transport.</p> <p>For other protected characteristics and/or groups who typically face inequalities in health or healthcare access, travel time analysis has not been possible due to data availability. It is recognised that travel, access and experience of change may pose challenges for these groups. The assessment of the EHIA sub-group, informed by feedback from the consultation, on which groups may be disproportionately impacted in terms of their ability to access the service, experience of service change, or outcomes, is summarised in Table 51 below. Further detail on this assessment is described in more detail within Appendix 4.</p>
<p>Longer journey times for patients and visitors</p>	<p>Modelled travel times by <b>road vehicle</b> to either potential future Principal Treatment Centre location are longer than current travel times to The Royal Marsden. Non-London residents are the most negatively impacted, with increases in travel time of approximately 30 minutes.</p> <p>Modelled travel times by <b>public transport</b> to either potential future Principal Treatment Centre location are shorter than current travel times to The Royal Marsden. There would be a reduction in travel time for both London and non-London residents to either location.</p>
<p>Radiotherapy</p>	<p>For those living in areas categorised as the most deprived, journey times to University College Hospital (as compared to The Royal Marsden) will increase on average by 20 minutes by road and reduce by an average of 40 minutes by public transport.</p>
<p>Patient provision</p>	<p>There is no impact on the level of provision or patient choice through the proposed change in location of the Principal Treatment Centre.</p>

	The development of paediatric oncology shared care units (POSCUs) under the POSCU Transformation Programme may provide patients with the choice to access some elements of care more locally.
Travel times and costs for staff	Analysis of staff travel costs has shown they may increase substantially for both providers. It should be noted that the analysis was based on a small sample size.  TUPE protections and inner London high cost area supplement should help to mitigate the impact of increased travel costs on staff, for both options.
Transportation cost	The proposed change reduces median transportation cost (for the Principal Treatment Centre catchment population as a whole) by road vehicle for both options, with the average journey being >£2 less expensive. Travel costs to St George's Hospital are around 70p less expensive (population weighted) than to Evelina London.

The assessment of the EHIA sub-group, informed by feedback from the consultation, on which groups may be disproportionately impacted in terms of their ability to access the service, experience of service change, or outcomes, is summarised below.

Table 51: Impact on ability to access the service, experience of service change, or outcomes for protected characteristic groups

<b>Is there likely to be a disproportionate impact on ability to access the service (travel/onsite access), experience of change or of the services being co-located with other services?</b>			
<b>Those with protected characteristics under the Equalities Act 2010</b>		<b>People who typically experience inequalities in health status or access to healthcare</b>	
Age	✓	Looked after and accommodated children and young people	✓
Sex	x	People or families on a low income/living in more deprived areas	✓
Disability (other than a cancer diagnosis) and spectrum disorders	✓	People with poor literacy and/or language barriers	✓

Ethnicity (including Gypsy, Roma and Traveller ethnic groups)	✓	People with caring responsibilities (including young carers)	✓
Pregnancy and maternity	✓	People living in more remote areas	✓
Religion or belief	✗	Newly arrived groups: refugees, asylum seekers (including unaccompanied children)	✓
Marriage/civil partnership	✗	People with addictions and/or substance misuse issues	✓
Gender reassignment	✗	People involved in the criminal justice system: offenders in prison/on probation, ex-offenders	✓
Sexual orientation	✗	Homelessness. People living on the street, staying temporarily with friends/family or in hostels or bed and breakfasts	✓
		Family structure: single parents/carers	✓
		Families experiencing digital exclusion	✓

The EHIA mitigations were outlined pre-consultation and have been developed following the consultation feedback and new evidence. These mitigations will need to be implemented and monitored during the implementation period. Governance arrangements and the process for monitoring of mitigations is in Section 11.2 and within the Integrated Impact Assessment. The mitigations cover the following areas and are included in full in Appendix 4:

- Systems and processes aimed at helping patients and families plan their journeys to hospital.
- Systems and processes aimed at reducing the financial impact of travel.
- Systems and processes aimed at providing good onsite accessibility.
- Aspects of care planning that may help travel arrangements.
- Systems or processes that may support patients in their experience of the service change process.

We have developed the following recommendation for implementation of the mitigations above, and other recommendations, within the IIA:

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***Recommendation #27: Establish a Travel and Access group with representatives across providers and NHS England to implement the recommendations set out within the Integrated Impact Assessment.***

## 8.6 Impact on wider services

This section considers how changes to the location and provision of the Principal Treatment Centre will impact on wider NHS services and organisations, reflecting our duties to consider these. Some of the information set out below is not ‘new’ but is included here for completeness; these areas were also raised in the public consultation and so, in developing this decision-making business case, we have had the opportunity to re-visit work done previously and ensure that it reflects the latest information that we hold for consideration by decision-makers.

The findings through the Information Decision Framework, impact on decision-making and recommendations are detailed in Section 7.7.

### 8.6.1 The Royal Marsden

#### **Teenage and young adult services**

Irrespective of the future location of the proposed future Principal Treatment Centre, The Royal Marsden will continue to be the Principal Treatment Centre for teenage and young adult (TYA) cancer services.

The Royal Marsden’s TYA service is based in the same building as the children’s cancer service and the workforce is closely integrated. As a result, the relocation of the children’s service will require The Royal Marsden to review how the TYA service is provided. This will include reviewing the mix of clinical specialists across its Sutton and Chelsea sites to ensure there is an appropriate skill mix to address the cancer presentations most prevalent in young people, and consideration of any estates implications.

We and The Royal Marsden have been working and will continue to work together to understand the full impact on TYA services at The Royal Marsden and to put mitigations in place. A piece of work to look at outline requirements is underway with an interim update expected to be provided to The Royal Marsden Board in late March 2024 with further work to follow. The Royal Marsden is looking at other models around the country to inform this work.

We are committed to working with the Trust as part of the implementation phase to ensure there is a sustainable model for this service. This includes support for stranded costs as set out Section 8.8.4.

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More broadly, it is important to note that the transition of care between the proposed future Principal Treatment Centre and the TYA service at The Royal Marsden will need careful planning to ensure risks associated with the services being on different sites are mitigated. Evelina London and St George's Hospital were asked to consider this in their proposals under the clinical domain transition sub-criterion. Consideration of transitional arrangements for children moving on to TYA services will form an important part of implementation planning. This will also include planning for patients who are part of the service at the time of its transfer, specifically those who may go through pathway changes more than once. Mitigations to manage risks relating to continuity of research for this patient cohort will also need to be made, further detail on these is reflected in Section 7.9 and the relevant recommendations are included in Section 10.3.

### **Radiotherapy services at The Royal Marsden**

Radiotherapy services provided by The Royal Marsden for teenagers and young adults, and adults, are not expected to be impacted by proposed changes to the Children's Cancer Principal Treatment Centre. They will continue to be provided at The Royal Marsden.

There are a very small number of children who do not have cancer who require conventional radiotherapy as part of their treatment at The Royal Marsden. Where there is an impact on these children as a result of the proposal, we would work with relevant organisations, including University College London Hospitals, to support the ongoing delivery of their treatment. Any stranded costs associated with the move would be supported by NHS England (as set out at Section 8.8).

#### *Other services:*

Cancer treatments using mIBG therapy are currently provided by The Royal Marsden and University College London Hospitals for children across the country. The Royal Marsden is one of two sites in England and three in the UK. Children (typically those with neuroblastoma) who have this treatment need to be treated in a lead lined room for several weeks. The Royal Marsden has been treating two to three children a year with an increase to four to five children this year, partly related to trial activity. Similarly to conventional radiotherapy, it may not be possible to continue to provide this therapy at The Royal Marsden without the wider paediatric infrastructure.

There is a range of options for the future provision of this service and others, such as radioactive iodine treatment, including consolidating them with the existing services at University College Hospital. Further work will be needed during the service transition phase



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to determine the best option for providing this treatment to children. This will need to be determined by providers working with us.

### **Wider cancer services**

As a robust and stable specialist trust, the loss of the children and young people's service should not destabilise The Royal Marsden or other parts of its service delivery. While the majority of the workforce for the children and young people's service is dedicated, it draws on a range of other services including anaesthetics, pathology, and imaging. There may be some workforce impacts on these services as a result of the move. The Royal Marsden will continue to keep risks under review so that any mitigations needed can be identified in a timely way.

Through the consultation, there were concerns raised around training posts and the potential impact of the reconfiguration on university courses. We met with regional medical education leads to discuss these concerns. Both Guy's and St Thomas' and St George's have confirmed that they will be able to continue to provide trainee placements with the appropriate supervision and support in service for medical trainees. Trainee placements for all specialties will be monitored for impact via the workforce workstream during implementation. Medical placements for all affected providers will continue to be monitored in collaboration with regional leads to ensure there are no adverse impacts to training posts and any issues identified can be mitigated.

We are committed to working with The Royal Marsden (and other stakeholders) up to and during implementation to ensure appropriate support is provided to the organisation.

The children and young people's cancer service had an estimated deficit of £6.7 million in the financial year 2022/2023, and has generated a deficit for the last five years. The proposed service transfer away from The Royal Marsden would remove the headline deficit subject to the effective mitigation of stranded costs including overheads. However, this requires development of mitigations for stranded costs as well as confirmation of provision of funding. Further detail on these costs is in Section 8.8.

There will also be implications for research at The Royal Marsden, highlighted by the Institute of Cancer Research and outlined further in Section 7.9 and Appendix 5.

#### **8.6.2 St George's Hospital**

The following outlines the potential impact on St George's Hospital's children's services if the proposed future Children's Cancer Principal Treatment Centre were to be at Evelina London. Its neurosurgery service, paediatric oncology shared care unit and, potentially, elements of inpatient chemotherapy would be delivered at St George's Hospital (the latter would happen



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if St George's Hospital developed its shared care unit to deliver enhanced level B services – the unit already delivers outpatient chemotherapy). However, other services that it provides for children could be impacted. This is because paediatric cancer care at St George's Hospital is delivered by a wide range of specialties as part of their broader caseload, including paediatric surgery, paediatric intensive care, paediatric acute medicine, gastroenterology, haematology, infectious disease, neurology, and clinical support services such as paediatric pathology and radiology.

The following section describes the potential impact on St George's Hospital which would need to be mitigated. For most of these services, St George's Hospital believes it would be able to mitigate the impact over time. For some services, the impact is potentially more significant.

As part of our work to prepare the pre-consultation business case, we considered these potential impacts with St George's, other NHS partners and the Programme Board where it was noted that these concerns were both real and reasonable, and that mitigations would be important to ensure that St George's services would not be impacted. Although no 'new' information was shared through the public consultation, we have re-visited this to ensure due consideration is given to potential risks/impacts and mitigations, and that this is set out as clearly as possible.

### **Paediatric surgery**

St George's Hospital indicated that the Principal Treatment Centre makes up a significant amount (around 20%) of its elective paediatric surgical caseload<sup>80</sup> and therefore, if the service were to move to Evelina London, there would be negative implications for the service which would need to be mitigated. We have considered these potential impacts through work to better understand them and the mitigations which could be required.

Until a decision on the future location of the service is made, the following risks/impacts are somewhat theoretical, based on potential scenarios which could materialise. In the event the service moves to Evelina London, close working with St George's and other partners will be

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<sup>80</sup> In 2019/20, St George's Hospital delivered the following activity for paediatric oncology, 89 elective inpatient spells of which 82 required theatre time. 108 non-elective inpatient spells, of which 74 spells required theatre time, and 108 day cases, with 52 that required theatre time. Not all activity required theatre time and will vary in complexity.

Recent conversations with St George's indicate that in more recent years, the proportion of planned elective activity undertaken within the Paediatric Surgery speciality is at least 22%, with approx. 80 patients (excluding Neuro related activity) being seen. Up to four surgeons deliver the current workload reflecting 0.96 WTE input. There are eight paediatric surgeons at the Trust.

needed to identify risks/impacts that could materialise and agree how these are best managed/mitigated.

Table 52: Paediatric surgery risks at St George's

Risk/potential impact	Potential mitigations
<p>Surgeons and associated staff would not be eligible to transfer to Evelina London if it became the location of the future Principal Treatment Centre<sup>81</sup>. However, these <b>staff could decide to move</b> to the future centre if Evelina London was recruiting. This could leave vacancies at St George's Hospital with an impact on the provision of other children's services if these vacancies weren't filled and/or other workforce solutions not agreed.</p> <p>St George's has provided the following examples of other services that surgeons who provide Principal Treatment Centre work deliver: <i>thoracic surgery, including complex congenital lung lesions, complications of infections such as empyema, and other lesions requiring surgery.</i></p>	<ul style="list-style-type: none"> <li>• In this scenario, an alternative option could be for surgeons to work across both St George's Hospital and Evelina London on a sessional basis to undertake oncology surgery at Evelina London and other surgery at St George's. This is common practice across the NHS but would rely on agreement being reached between the hospitals and with staff concerned. Arrangements for surgical on-call cover would need to be considered too.</li> <li>• Recruitment of replacement staff to St George's Hospital could be needed – it is anticipated that St George's would be able to recruit into any vacant posts.</li> <li>• Organisational development work to manage and support any workforce transitions to help ensure expertise is not lost at service level would also be important.</li> </ul>
<p>St George's advises that the Principal Treatment Centre work is one of the elements of St George's Hospital paediatric surgery caseload that makes it most attractive to current and future surgical staff. The</p>	<ul style="list-style-type: none"> <li>• There are examples of other paediatric surgery units in London and the south east which do not provide children's cancer service surgery and which are considered sustainable (they include Chelsea &amp; Westminster NHS Foundation Trust which is</li> </ul>

<sup>81</sup> TUPE rights pertain to staff that spend more than 50% of their time working in the service due to transfer – this is not the case for the majority of St George's staff involved in providing care for children under the Principal Treatment Centre. St George's currently has three surgeons with paediatric oncology surgery skills/experience comprising a total of 0.96 WTE.

<p>impact of this could be that the Trust struggles to <b>recruit and retain staff</b> that are needed to deliver the other services that it provides.</p> <p>Without this recruitment, the service could become unviable.</p>	<p>the main specialist elective provider of children’s surgery for north west London; and Barts Health NHS Trust which is also a children’s major trauma centre as is St George’s Hospital). The existence of these units indicates it may be possible to attract and retain high quality staff without the need to have oncology surgery.</p> <ul style="list-style-type: none"> <li>• The wider Paediatric Network across the Principal Treatment Centre catchment area, supported by NHS England and Integrated Care Boards, would work collaboratively to ensure that the surgical case mix delivered by St George’s Hospital continues to be attractive, including by a review of activity flows between centres to ensure service sustainability.</li> <li>• Across a range of specialities there is an opportunity to improve access and reduce variation in waiting times for surgery. It is possible that additional activity (with associated income) could be undertaken at St George’s where appropriate to the speciality and geographical pathway.</li> <li>• How (and where) activity is delivered in the future can be explored meaningfully once a decision has been taken about where the future Principal Treatment Centre will be based. NHS England would support such discussions, including through clinical networks which operate across the regions.</li> <li>• More broadly the Paediatric Network would work together to support and retain (and make best use of) clinicians with specialist skills and expertise, including through joint workforce planning to make best use of their</li> </ul>
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	<p>skills through, for example, shared/joint rotas and joint contracts. This could help support continuity.</p> <ul style="list-style-type: none"> <li>• In this context, if St George’s needed to recruit paediatric surgeons, we expect it would be able to do so. It is recognised that the delivery of surgery is a whole team endeavour including anaesthetists and specialist nurses among others.</li> </ul>
<p>Surgical activity at St George’s Hospital could reduce by volume creating <b>clinical and financial sustainability</b> concerns</p>	<ul style="list-style-type: none"> <li>• As described above and below – there is a range of mitigations that would prevent this if this did become a risk.</li> </ul>
<p>St George’s is concerned about <b>stranded costs</b> which could be associated with loss of this work</p>	<ul style="list-style-type: none"> <li>• Across a range of specialties, there is an opportunity to improve access and reduce variation in waiting times for surgery. It is possible that additional activity (with associated income) could be undertaken at St George’s Hospital where appropriate to the speciality and geographical pathway.</li> <li>• Delivery of cost savings over time, for instance via natural attrition and re-organisation of staff roles and responsibilities.</li> <li>• NHS England has provided, in principle, commitment to support the Trust with stranded costs. See Section 8.8.</li> </ul>

As set out above, a range of mitigations would support the continuity of services at St George’s Hospital if needed. Although there is a risk that the move of children’s cancer surgery from St George’s Hospital to Evelina London (if the future Principal Treatment Centre is at Evelina London) would impact the care given to children without cancer treated at St George’s Hospital, there are a number of mitigations which would minimise any impact of this move on St George’s surgical services for children.

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## Pathology

Paediatric cancer constitutes nearly 20% of St George's paediatric histopathology activity, generating proportionately more workload due to the complexity of work required. This is estimated as 0.7 WTE from the department's 2 WTE consultants who cover paediatric and perinatal histopathology and post-mortem work. This work will be one of the elements of the caseload that makes the department attractive to current and future staff providing valuable experience and professional satisfaction. Without this work, there is a risk that clinicians may choose to work elsewhere. As a result, St George's is concerned about its ability to continue to provide some aspects of these services.

There is a national shortage of paediatric histopathologists and, irrespective of the location of the future Principal Treatment Centre, mitigations and networking arrangements are likely to be needed in the future. If the future Principal Treatment Centre is at Evelina London, mitigations to support continuity of services at St George's could include:

- Proactive development and implementation of networking solutions between different pathology networks to allow for service continuity by leveraging a limited number of paediatric pathologists more effectively across the system. Cross-cover arrangements and mutual aid programs are practical examples of how these networks can function, ensuring that expertise is shared and that services remain resilient despite workforce shortages.
- Digital pathology offers a strategic solution by facilitating remote reporting, enhancing flexibility and responsiveness of pathology services and making it easy to maintain service quality.
- Encouraging professional development and supporting specialisation of existing workforce, including by making roles more attractive through opportunities for research and professional growth.
- Ongoing collaboration in research and clinical trials to maintain the department's attractiveness and support professional development.

A range of focused strategies for workforce development, enhanced integration of digital technologies and careful planning would therefore be important areas of focus to address potential challenges. Support from the wider system would play a role in enabling this.

### Lost opportunities and other services

St George's has identified a range of other considerations regarding its ability to deliver wider improvements and other benefits for non-cancer patients where there are synergies

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between the cancer service and the delivery of treatment to other patients which could support this, including:

- the opportunity for the Paediatric Infectious Diseases Unit at the Trust to continue developing its expertise in managing complex infections in immunocompromised cancer patients.
- the development of bone marrow and stem cell transplant service for non-malignant conditions and associated research opportunities.
- the development of expertise in delivering immunotherapy for non-malignant conditions like aplastic anaemia.
- the extension of experience providing cellular and gene therapies from adults to paediatrics.
- the development of the genomics service, including for adult cancer.
- ongoing development of non-malignant interventional radiology procedures.
- expansion of children's research which the Principal Treatment Centre infrastructure and staff offers.

*Mitigations:*

If the final decision is to locate the future Principal Treatment Centre at Evelina London, St George's would continue to have the opportunity to develop and sustain its children's cancer services including through development of St George's Hospital's paediatric oncology shared care unit to become enhanced level A and potentially level B.

The lost opportunities (summarised above) could be mitigated through a several routes, including through collaborative and close working with partners across the Paediatric Network to which it belongs and through the commitment that has been made jointly across south London to delegate specialised services through which both South East London and South West London Integrated Care Boards have an important role to play. There are other specific partnerships that would also have a role, including the partnership that St George's Hospital has through the Genomic Medicine Service Alliance with Guy's and St Thomas' and the south east.

**Agreed principles for managing the potential impact of service change**

Representatives agreed to the following principles that would underpin detailed work to be taken forward as part of the implementation phase if a decision to locate the future Principal Treatment Centre at Evelina London is made. It is important to note, that although these

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principles were agreed in relation to a discussion about potential mitigations in the scenario referred to above, they would also **apply to a range of other potential scenarios** where collaboration between NHS partners is needed; this includes the management of other potential impacts of the service reconfiguration, including at The Royal Marsden and lost opportunities at Evelina London. The Programme Board has given support for this, including representatives from King's College Hospital. The principles are as follows:

- to support the development and implementation of mitigations that will aim to minimise the impact on all related services arising from a decision to move the Principal Treatment Centre.
- a commitment to work closely together with the shared aim of ensuring continued delivery of high-quality and sustainable care for patients across the catchment area.
- to work together to support and retain clinicians with specialist skills and expertise in the catchment area and in the future system of care, wherever possible, through, for example, shared/joint rotas, joint contracts, a review of arrangements across the network, joint workforce planning.
- to review activity flows between centres and to work with the wider system (including NHS England and Integrated Care Boards) to ensure service sustainability.

As highlighted already, NHS England (London and South East regions) are committed, in principle, to working with Trusts on stranded costs at the appropriate time.

### 8.6.3 Evelina London

#### **Lost opportunities if the future Principal Treatment Centre were to be at St George's Hospital**

Concerns were also raised by Evelina London about the impact on its services if the future Principal Treatment Centre was at St George's Hospital. Evelina London is the only children's hospital in the Children's Hospital Alliance of 12 children's hospitals in England that does not have an oncology service (the other member of the alliance in London is Great Ormond Street). If the future Principal Treatment Centre was at St George's Hospital, Evelina London contends the potential impact on its services and the children they care for would take the form of missed opportunities in their ability to deliver wider improvements and other benefits for non-cancer patients where there are synergies between the cancer services and the delivery of treatment to other patients which could support this. Evelina London highlights the opportunity to develop a comprehensive care model for children with complex needs that could deliver a range of synergies across different clinical specialties



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with the potential to improve care for children with cancer and those with other conditions. Examples of new therapies where there could be synergies include:

- Immune therapies, such as gene and cellular therapies. These therapies are an increasing part of the clinical and research workload for Evelina London in non-cancer areas.
- Stem cell transplantation (bone marrow transplants). If Evelina was successful in its bid to be the Principal Treatment Centre it would provide stem cell transplants for children with cancer, this service also has the potential to support non-malignant disease already managed in the children's hospital, including significant existing services in haemoglobinopathy, haemophilia, inherited metabolic disease and auto-immunity.

It should be noted that if the final decision is to locate the future Principal Treatment Centre at St George's Hospital:

- Evelina London would continue to provide specialist cardiac and renal services to children with cancer, including cardiac surgery and interventional cardiology. Related multidisciplinary teams would be expected to continue.
- Evelina London would continue to share and receive learning to develop and sustain its services from the wide range of networks it is part of, including through collaborative and close working with partners across the paediatric network.

#### **8.6.4 University College London Hospitals NHS Foundation Trust**

Our consideration around radiotherapy services is reflected elsewhere in this decision-making business case, including at Section 7.6 where we consider consultation feedback in relation to our proposals for conventional radiotherapy.

#### **8.6.5 Great Ormond Street Hospital for Children NHS Foundation Trust**

##### **Recruitment and retention**

Feedback from consultation identified that moving the Principal Treatment Centre closer towards Great Ormond Street Hospital than it is currently could impact on the ability of Great Ormond Street's Children's Cancer Principal Treatment Centre to recruit and retain staff with the appropriate training and capabilities if the two centres end up 'competing' for workforce. Feedback from consultation suggested that this risk would be potentially more significant if the future Principal Treatment Centre was at Evelina London because of its geographic proximity.



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Irrespective of whether this becomes a risk, Great Ormond Street Hospital has set out that it would work collaboratively with the future Principal Treatment Centre to support workforce planning for the Principal Treatment Centre, understanding that they will play an important in supporting the successful implementation of new arrangements, including workforce and clinical pathways. They note it will be important to consider the effects of the new arrangements on both Principal Treatment Centres including the opportunities and risks on the relevant workforce. Great Ormond Street is fully supportive of one joined-up paediatric cancer workforce strategy across both South and North Thames Children's Cancer Networks.

A strong model of collaborative working is already exhibited by the separate North and South Thames Children's Cancer Networks that bring together clinicians from across all of the hospitals providing cancer care across the two Principal Treatment Centres.

### **Flow of patients from Great Ormond Street Hospital for Children NHS Foundation Trust to the Principal Treatment Centre for south London and much of south east England**

While there is no change to the catchment area, patient choice could affect the flow of patients between the Principal Treatment Centres based in London.

While evidence suggests that the impact on patient flows for Great Ormond Street Hospital is not likely to be significant, there is a possibility that patients who currently attend Great Ormond Street Hospital may choose to move to the future Principal Treatment Centre (or vice versa). The potential impact on patient flows between different Principal Treatment Centres will be monitored post implementation and, should we identify any notable impact, we will work with Principal Treatment Centres (and wider networks) to mitigate these.

### **8.6.6 University Hospital Southampton NHS Foundation Trust**

University Hospital Southampton NHS Foundation Trust initially raised concerns that the Principal Treatment Centre reconfiguration could lead to an increase in demand for its services as it is the Principal Treatment Centre for patients in the south of England and it shares a catchment area border with much of the Principal Treatment Centre for children living in south London and much of the south east.

We confirmed that there are no plans within the options to move any referral pathways to University Hospital Southampton. As a result, there are likely to be minimal consequences for patient flow (any changes would be due to patient choice only). However, this will continue to be monitored post implementation. Should activity at University Hospital Southampton increase due to patients from the south London and much of the south east

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catchment, we would review the impact on University Hospital Southampton so that appropriate funding is allocated to support new demand.

### **8.6.7 Community and voluntary services**

Young Lives vs Cancer provides a social work psychosocial holistic support service to the current Principal Treatment Centre (alongside other Principal Treatment Centres in the country). Social workers employed by the charity work alongside NHS staff within the children's cancer centre to help families/carers and their children to get what they need throughout their treatment and beyond. The charity is represented on our Stakeholder Group and Programme Board.

Young Lives vs Cancer would plan to transfer its team to the future Principal Treatment Centre, establishing a new working relationship with the future Principal Treatment Centre. Further work would be required during the service transition phase to develop plans to support a smooth transition of the service.

Both proposals articulate plans for providing a wide range of support to patients and their families, including through dedicated staff resource, referrals to psychology and social worker teams or specialist charities.

More widely, it is not anticipated that there will be changes to individual county or borough social care service demand. Integrated Care Boards, alongside local authorities, will continue to have a role in social care engagement with responsibility to patients who live in their postcode area.

### **8.6.8 South Thames Retrieval Services**

As set out in our pre-consultation business case, the South Thames Retrieval Service which is hosted by Guy's and St Thomas' provides critical care paramedics and patient transfers. The service already works collaboratively with The Royal Marsden team to ensure that children at the Sutton site who are at risk of becoming critically ill are proactively moved to a tertiary paediatric centre. South Thames Retrieval Service works on a strict protocol basis across the geography.

South Thames Retrieval Service is fully aware of the proposed service reconfiguration and would continue to provide a seamless retrieval service for children who need to be transferred to or from the Principal Treatment Centre, irrespective of the location to which it ultimately transfers. The South Thames Retrieval Service paediatric intensive care ambulance service is provided by British Emergency Ambulance Response Service, which ensures there are two fully equipped paediatric intensive care ambulances 24/7 and two dedicated technicians to drive the ambulances 24/7. There is a third fully equipped

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ambulance to ensure the availability of two vehicles at all times. This would all continue without disruption during and beyond the service transfer.

The impact on the service of a relocation of the current Principal Treatment Centre is considered minimal. Specific details of the future emergency retrieval pathway will be determined with the future Principal Treatment Centre.

### **8.6.9 Other NHS Trusts, including patient pathways beyond London**

There are not expected to be any significant changes arising from the reconfiguration including:

- Children's cancer shared care unit and neurosurgery services at St George's Hospital.
- Supra-regional services including referral pathways to Stanmore (sarcomas), Barts (retinoblastomas), Hammersmith and Oxford (fertility), Great Ormond Street Hospital (under 1s) will continue as is.
- Trusts across the South East region: There is no expected change for any other Trust arising from the reconfiguration of the Principal Treatment Centre.
- King's College Hospital: King's College Hospital will continue to provide neuro-oncology services as part of its paediatric neurosurgery provision as well as liver surgery. There is the opportunity to support King's College Hospital to become an enhanced level B children's cancer shared care unit and deliver more chemotherapy on site. King's College Hospital, through its Chief Executive and Site Managing Director, has been involved in the Programme Board throughout.

## **8.7 Environmental impact**

Sustainability analysis looks at the potential environmental impacts of changes to service provision and possible refurbishment or construction of new sites. Such analysis supports meeting the duties of the Health and Care Act 2022 which places a duty on NHS bodies to have regard to wider effect of decisions on the sustainable and efficient use of resources.

In considering both potential providers' proposals, the environmental impact in relation to capital build and transport access has been initially assessed and summarised.

Both organisations have published environmental strategies which detail how they will support the national NHS commitment to delivering a 'net zero' health service:

- Guy's and St Thomas' has an established Environmental Sustainability Strategy for 2021 to 2031 which sets out a path forward, in line with NHS commitments to reach

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net zero direct carbon emissions by 2040, and net zero indirect carbon emissions by 2045.

- St George's Hospital has a Green Plan which describes its commitment to delivering its contribution to the net zero plan and to adopt the broader principles of sustainable development.

Both strategies outline plans to reduce emissions from all sources, contribute to improving local air quality, develop sustainable use of resources, and enhance green spaces. Both strategies have been assessed by NHS England as meeting required standards at this stage in their development.

A detailed environmental impact assessment, including air quality and greenhouse gases, will need to be conducted as part of the planning and implementation phase. Ensuring sustainability and reducing carbon emissions will be a key part of the design process, ensuring that everything is completed to the NHS Net Zero Building Standard.

**Models of care:** The future Principal Treatment Centre will have a lead role with regard to the transformation of POSCU (shared care) services and peripheral diagnostic services. This will increase the opportunity for care closer to home, improving patient experience by reducing travel requirements.

**Estates and facilities:** Both potential providers of the future Principal Treatment Centre are proposing internal refurbishment projects where they do not envisage either change of use or modifying the building façade: both should be able to offer developments with lower environmental impact, complying with the NHS Net Zero Building Standard.

**Travel and transport:** The Principal Treatment Centre is a specialised service, and by definition, covers a wide geography. Based on the fact that population densities are higher in proximity of potential Principal Treatment Centre locations, compared to the current location, it could reasonably be predicted that there could be an overall reduction in emissions related to travel, and that there could be a beneficial environmental impact of either potential Principal Treatment Centre location. This potential benefit could be enhanced if the proportion of families (or staff) using public transport rises. However, a detailed carbon emissions assessment will need to be conducted as part of the outline business case and implementation phase of the programme.

The transformation programme associated with the delivery of the national service specification for POSCUs includes the development of enhanced children's cancer service shared care units able to provide a wider range of care, closer to home, for many children.

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Both organisations have developed Green Travel Plans which cover conversion of fleet vehicles (including patient transport) to electric vehicles, supporting use of public transport patients (for those who are able to use it) and active travel plans for staff.

**Environmental resilience:** Both organisations are developing plans to improve operational resilience regarding climate change (in particular, extreme warm weather). As part of the NHS England Emergency Preparedness, Resilience and Response (EPRR) Framework, providers must show they can effectively respond to major, critical and business continuity incidents while maintaining services to patients. Both organisations were rated as being fully compliant in recent EPRR assurance.

## 8.8 Financial impact assessment

### 8.8.1 Introduction

This decision-making business case finance section updates the pre-consultation business case finance chapter. NHS England has laid out the process to follow for service changes in its guidance 'Planning, Assuring and Delivering Service Change for Patients 2018'. This was subsequently updated in March 2022. The key financial test is that any proposal is affordable in capital and revenue terms ahead of public consultation. This test was met before we launched our public consultation in September 2023.

This section summarises the financial details of proposals from both Guy's and St Thomas' NHS Foundation Trust on behalf of Evelina London Children's Hospital and St George's University Hospitals NHS Foundation Trust on behalf of St George's Hospital, with further detail included in the appendices. A summary of work undertaken before the pre-consultation options evaluation is also included for reference.

Before the pre-consultation options evaluation, both Trusts submitted strategic outline case (SOC) level proposals. The programme did not require proposals to be worked up to a formal HM Treasury (HMT) Green Book outline business case (OBC) level because this would entail significant financial costs for each Trust, which would not be a good use of NHS resources. The short form business case format used for national NHS England programmes was therefore used, which typically would summarise detail at strategic outline case or SOC level. Therefore, assurance of the financial content of both proposals is at a similarly high level and focused on capital and revenue affordability, while also taking into account value for money (VfM). Subsequent to the decision-making business case, the successful proposal will be required to produce both outline and full business cases and to go through a full HMT 5 case model assurance process. Both OBC and FBC will need to be presented to and approved by the national Department of Health and Social Care (DHSC)/NHS England joint investment committee.

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Although not technically part of the scoring criteria or financial hurdle test, it is important that proposals deliver value for money (VfM) for the taxpayer. More detail on the economic case is outlined for each Trust in Section 8.8.4. Both proposals deliver a modest and positive VfM outcome.

The fact that affordability is a hurdle criterion means that, provided both proposals are affordable, financial costs will not impact which one is selected. Provided proposals are affordable, financial costs should not determine where services are provided. Instead, the programme is focused on which option can best provide what we are looking for: a future Principal Treatment Centre that builds on the strengths of the current service, meets the national service specification, is affordable in both capital and revenue terms, and will give best quality care to achieve world-class outcomes for children with cancer for decades to come. The impact of the findings of the financial impact assessment on decision making is summarised in Section 7.11.3.

The Programme Board decided that introducing finance as a scoring domain would risk financial scores potentially being the deciding factor in decision-making which would not be appropriate. In terms of the NHS England guidance, proposals are required to show that the capital and revenue costs included in submissions are affordable. There is no requirement in the guidance for finance to be a scoring domain and the Programme Board agreed that financial affordability should be a hurdle criterion.

In May 2022, it was confirmed that £20 million of national capital funding (CDEL) would be made available as a contribution toward the capital costs of the proposals (the availability of which has been re-confirmed, March 2024). Proposals were required to demonstrate the affordability of any additional capital funding requirement above this, which both do at pre-consultation business case and decision-making business case stages.

Standard NHS England short form business case templates were sent to Trusts on 24 August 2022, including business case and financial templates, with a VfM model and summary financial tables, for revenue and capital costs. A letter was sent to both Trusts on 27 October 2022 confirming Specialised Commissioning income assumptions to be included in proposals. The regional assurance team held several working sessions with the two potential provider Trusts through October and November 2022, to ensure that queries were addressed, that proposals used consistent assumptions, and NHS England understood the proposals in sufficient and reasonable detail.

Trusts updated and resubmitted their short form business case as a result of assurance work carried out between November and January 2023. Subsequent to the pre-consultation



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business case and to inform the decision-making business case, both Trusts were asked to submit updated proposals if they wished to. This decision-making business case finance section includes updated content received from both Trusts.

The Trusts were required to submit the standard NHS England short form 5-case narrative business case, a VfM financial model, a SOCNI (Statement of Comprehensive Net Income) and summary financial tables. Supporting schedules including maps, costing schedules or OB forms (outline business case standardised cost forms), drawings etc were also supplied by the Trusts. Both proposals are to refurbish existing estate rather than for new build. Both are at an intermediate design stage – RIBA stage 2 or typically pre-OBC, having developed their design stages from the pre-consultation business case where Guy’s and St Thomas’ was at RIBA stage 0/1 and St George’s at RIBA stage 1/2. Costs have been estimated by specialist cost advisors for both proposals based on NHS estate guidance and benchmark costs, with significant contingencies in place as one would expect at this stage. This approach ensures that significant costs are not incurred developing unsuccessful proposals to a very detailed level.

Submissions were assured on a ‘reasonableness basis’ by the regional finance team and the London Estates Delivery team at the pre-consultation business case stage. Both Trusts were invited to submit revised/refreshed financial content for their proposals prior to production of the decision-making business case. Revised content has been incorporated into this decision-making business case finance section but is not judged as being significant enough to warrant further assurance. The main revisions relate to slightly decreased capital costs for the Guy’s and St Thomas’ proposal, updated internal area sizes as a result of design development to RIBA stage 2, responses to further assurance questions and revisions to Go-Live dates to account for programme slippage. There is no change in the overall cost of the St George’s proposal from the pre-consultation business case. The Trust’s view is that timelines for the build programme have only moved slightly and therefore the movement in mid-point construction is relatively small, and the Trust took a prudent approach to inflation in the original costing.

The pre-consultation business case committed to funding capital charges on a time limited basis and excluded them from the affordability assessment. Subsequently, the Government has agreed additional revenue resources for the NHS to support depreciation and amortisation expenditure, where the expenditure is within the scope of the technical ring-fence as defined in the HM Treasury Consolidating Budgeting Guidance. The purpose of this additional funding is to mitigate the risk that the depreciation costs impact on the funding available for patient care and service delivery. For the purposes of the decision-making business case it is assumed that the Trust proposals fall within this additional depreciation

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funding mechanism. This is consistent with national programme capital investments including elective recovery, diagnostics, digital, mental health, primary care and ambulance services. Should that not be the case, commissioners would revert to the agreement in principle for time-limited funding of capital charges outlined in the pre-consultation business case with the process, time limit and detail for funding capital charges to be discussed between NHS England and the successful Trust. The decision-making business case does not give any warranties or guarantees on capital charges or funding assumptions included in proposal submissions. However, both Trusts have outlined the assumptions on which capital charge calculations are based and both are deemed reasonable at this stage.

Both Trust proposals mitigate out the current deficit that The Royal Marsden has for the service via a blend of overhead efficiencies, income growth for private patients and R&D, and pay/non-pay efficiencies.

Guy's and St Thomas' expect cost efficiencies to be achieved in providing the Principal Treatment Centre, in line with their existing efficiency targets, which will fully mitigate the impact of capital costs after five years. Similarly, the impact of capital charges is mitigated out within five years in the St George's bid. Effectively this means that if there were no national mechanism for funding depreciation, both proposals allow for capital charges to be mitigated out of Trust revenue assumptions after an initial period, and that proposals are affordable in revenue terms therefore with time limited commissioner financial support for those costs.

Both Trusts have submitted requests for transitional revenue support up to 'steady state'. NHS England has made clear that it would consider reasonable submissions, subject to a maximum three-year taper to zero. Such costs will not form part of the revenue hurdle assessment therefore, given that these would be expected to have been absorbed by the 'steady state' year and are non-recurrent. The process and detail for providing transitional revenue support will be discussed between NHS England and impacted Trusts. The decision-making business case does not provide a guarantee of funding or give warranty to any of the transitional costs included in the proposals.

NHS England will also consider funding stranded costs and transitional costs for The Royal Marsden and St George's (if it is not the chosen option). Such costs are likely to be incurred both before and after service transition. NHS England would expect such costs to be mitigated out within three years of the service transfer and will work with both Trusts to ensure that such costs are minimised. It is envisaged that a 'Task and Finish' group to agree stranded and transitional costs and funding, would be set up by NHS England after a decision is made about the future location of the service to include impacted Trusts.



Letters of support have been received from the relevant Integrated Care Board for each of the proposals.

### 8.8.2 Capital costs

Each Trust has used standard NHS costing assumptions on such things as inflation, fees, contingency and optimism bias, plus benchmarked costs for previous Trust developments. We would not expect costs to be identical, but they should be reasonably consistent and explicable. Both Trusts have engaged professional cost consultants and have produced the standard Business Case OB detailed cost forms. These are used in all NHS capital investments to provide a consistent method of presenting costing information. Appendix 6 summarises the line-by-line costings for each of the proposals.

The capital costs of both schemes are set out in the table below:

Table 53: Capital costs of both schemes

Summary cost description	Guy's and St Thomas'	St George's
	£000's	£000's
Works costs	17,346	12,914
Fees	2,602	1,937
Equipment costs	2,660	2,138
Other (non-work costs, optimism bias, inflation, contingency)	14,300	9,827
VAT	6,861	3,980
<b>Total</b>	<b>43,769</b>	<b>30,796</b>

Guy's and St Thomas' gross costs for its Evelina London proposal are £43.77 million and St George's gross capital costs for its St George's Hospital proposal are £30.8 million. £10 million of the Evelina costs will be met by a contribution from the Trust charity, this means that the cost to the NHS of the Evelina London proposal is £33.7 million. The charity has provided a letter of support for its contribution.

Both proposals are refurbishments of existing estate and therefore are expected to be better value for money than a new build solution. Drivers for the cost difference are:

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- A works cost difference of £4.4 million. Work costs at London Evelina are circa £17.3 million set against those for St George's Hospital of £12.9 million. To some extent this will be driven by the difference in location factors which impact on costs. Evelina London being in Lambeth and St George's Hospital being in Tooting means that works costs will be slightly different within central London, a higher cost location.
  - Guy's and St Thomas's proposal is 4,407m<sup>2</sup> in size compared to St George's, which is 4,061m<sup>2</sup>. At pre-consultation business case stage, the former was 4,708m<sup>2</sup> while the latter was 4,210m<sup>2</sup>. The small changes in size reflect further design work done by both Trusts to RIBA Stage 2. At pre-consultation business case stage the Guy's and St Thomas's proposal was at RIBA stage 0/1 and the St George's proposal was at RIBA stage 1/2. The difference in size reflects individual approaches that each Trust has taken, the location in which the service would be based, and available space. The Evelina proposal is 346m<sup>2</sup> larger than the St George's proposal, but it also includes a new aseptic pharmacy of 450m<sup>2</sup> which the Trust requires to provide additional chemotherapy for existing services. However, as it would also be required for this service, the costs have been included within this programme. The direct works and equipment cost given on the OB costing forms for the aseptic pharmacy is just over £2 million. The notional share of total contingency and VAT for the Aseptic Pharmacy adds another £1.6 million to that total. Therefore around £3.6 million of the total cost difference between the two proposals is attributed to the Aseptic Pharmacy. St George's has indicated that aseptic pharmacy requirements will be absorbed within existing facilities.
  - An equipment cost difference of just over £500k. Both Trusts have assumptions that equipment costs will be around 15%-16% of works costs in line with NHS standard business case practice and Health Building Notes (HBN) guidance.
  - Evelina costs include the refurbishment of existing ward space to accommodate services on the third floor of the Evelina London building. All areas to be refurbished are currently clinical spaces within the Evelina departments. The proposal also includes decant costs for services including Renal and Dialysis wards, General ward beds, and Neurophysiology outpatient space. The St George's proposal refurbishes current office space which should be simpler and less expensive to decant and refurbish.
  - Both Trusts assume around 15% of works costs for fees which is a standard NHS business case assumption.
  - Both Trusts assume approximately 10% planning contingency against direct works, fees and non-works costs, which is a standard NHS business case assumption.

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- On the same basis, optimism bias is 24% for Guy's and St Thomas' and 21% for St George's which are in the standard and consistent range.
  - Inflation assumptions are 16% for Guy's and St Thomas' and around 10% for St George's assessed against all costs except VAT.
  - The NHS England Regional Finance and Estates teams met with both Trusts to go through these assumptions which are aligned with what we would expect to see at this stage – total contingencies of between 40%-50% of works costs, fees and equipment costs.
  - The variations in assumptions for contingencies reflect firstly that Guy's and St Thomas' have used a slightly earlier PUBSEC index to St George's, so there would be a higher inflation % in the former's proposal. See Costing Assumptions section below on Public Sector Building Non-Housing (PUBSEC). The higher level of overall contingencies for the Guy's and St Thomas' proposal also reflects the number of necessary clinical decants into adjacent buildings and provisions for flexibility over the concept designs which are still being explored at RIBA Stage 2. This will be tested at OBC stage, and the level of contingency will decrease to reflect the risk reduction from achieving RIBA Stage 3 designs.
  - The differences in works and equipment costs then drive differences in fees, optimism bias, contingency and, to an extent, inflation provisions. Overall levels of contingencies are relatively high in both proposals and are deemed reasonable. Guy's and St Thomas' inflation contingency is higher than St George's. This does not imply that St George's inflation assumption is too low as it has been correctly derived from projecting PUBSEC indices forward.
  - There is no uniform way in which Trusts deliver capital investments although they use common principles. In this case, they have taken slightly differing approaches to specifications and follow the approaches that each Trust has taken historically in delivering capital projects. Both Trusts have adopted clear assumptions in costing their proposals and the capital costs submitted for both proposals are deemed reasonable at this level.

### **Costing assumptions**

The Tender Price Index of PUBSEC measures the movement of prices in tenders for building contracts in the public sector in Great Britain. It is maintained and operated by the Building Cost Information Service (BCIS). The index has a baseline of 100 in 1975 and is updated quarterly to reflect the impact of inflation and increasing prices on the construction

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industry. It is standard in the NHS for costing capital projects. See Appendix 6 for the list of these.

**Guy's and St Thomas'** - Activity and capacity assumptions are based on analysis from the activity data in the agreed data lake. The Trust has developed a number of options for inpatient and bone marrow transplant (BMT) patient accommodation, demonstrating flexibility in the overall bed base and the number of rooms suitable for BMT patients, in the footprint identified. Some minor planning consents may be required. In line with activity data, the base case has modelled 20 beds including four suitable for BMT patients but with an option to flex both the number of beds and the number of BMT rooms should those be required. There is flexibility within the floorplans to provide additional beds (up to 24, including up to eight suitable for BMT). Costs have been prepared by specialist cost advisors, using benchmarking data from previously delivered projects to inform the forecast. The costs are built up from:

- PUBSEC indices for Q2 2022 at 285, inflated to an assumed construction mid-point of Q2 2025 to anticipate contractors accounting for construction inflation on their tender price, given the duration of the construction period.
- Healthcare Premises Costs Guides (HPCG) benchmark rates.
- Fees at 15% as per standard NHS guidance.
- Planning contingency of 10% and inflation of 16% have been assumed.
- Optimism bias has been calculated using the Comprehensive Investment Appraisal (CIA) model at 24.5% on works costs, equipment costs, non-works costs and equipment costs.
- VAT at 20% on all costs excluding fees.

**St George's** - As this is a refurbishment of existing space, no planning permission is assumed by the Trust. The costs have been provided by specialist cost advisors. The costs are built up from:

- PUBSEC indices for Q3 2022 at 294 inflated to an assumed construction mid-point of Q2 2025 to anticipate contractors accounting for construction inflation on their tender price, given the duration of the construction period. Currently BCIS predict an index of 315 in Q4 and the Trust has assumed inflation continues at similar levels in 2025 with a further 1.3% increase to construction mid-point, May 2025. The Trust has added an additional 20% premium on top of this in recognition of current economic uncertainty.
- HPCG benchmark rates.

- Fees at 15% as per standard NHS guidance.
- Contingency of 10% and inflation of approximately 10% has been assumed on works costs, equipment costs, non-works costs and fees.
- Optimism bias has been calculated using the CIA model at 21% on works costs, equipment costs, non-works costs and fees.
- VAT at 20% on all costs excluding fees.

### Capital funding assumptions

**Guy's and St Thomas'** – The total capital cost of the scheme is £43.77 million with £20 million provided by national capital funding, £10 million from charitable sources and £13.77 million coming from Integrated Care System (ICS) operational capital envelopes. The revised capital cost is £570k less than the cost included in the pre-consultation business case. A letter of support from the charity for the £10 million contribution is available. No assumptions on impairment have been made by the Trust which is reasonable given the early stage of design/development. This would be revisited in the OBC if this option is chosen. See Table 54.

Table 54: Capital funding for Evelina London

CAPITAL EXPENDITURE PROFILE					
FUNDING SOURCE	2023/24	2024/25	2025/26	2026/27	TOTAL
	Total	Total	Total	Total	£'000
	£'000	£'000	£'000	£'000	£'000
DHSC Funded Capital	-	-	15,000	5,000	20,000
Charitable funding	-	-	5,000	5,000	10,000
Trust/ICS capital funding	235	3,809	6,536	3,189	13,769
<b>Total</b>	<b>235</b>	<b>3,809</b>	<b>26,536</b>	<b>13,189</b>	<b>43,769</b>

**St George's** – Funding for capital costs of £30.8 million consists of £20 million national capital funding with the balance of £10.8 million coming from Trust/ICS capital sources. This is phased from the end of the current year (2023/24) to the end of 2025/26. Key assumptions are that the capital build will be impaired in the year of completion (2025/26) by 15% of the

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total capital cost and that 20% of the VAT is recoverable in line with guidance for estate solutions of this nature. There will be no revenue impact of the impairment as the Trust has a sufficient revaluation reserve for Grosvenor Wing. See Table 55.

Table 55: Capital funding for St George's

<b>CAPITAL EXPENDITURE PROFILE</b>					
<b>FUNDING SOURCE</b>	<b>2023/24 Total</b>	<b>2024/25 Total</b>	<b>2025/26 Total</b>	<b>2026/27 Total</b>	<b>TOTAL</b>
	£'000	£'000	£'000	£'000	£'000
DHSC funded Capital	-	4,997	9,486	5,517	20,000
Trust/ICS Capital Funding	-	2,697	5,120	2,978	10,795
<b>Total</b>	-	<b>7,694</b>	<b>14,606</b>	<b>8,495</b>	<b>30,795</b>

### Capital costs – risks and mitigations

The Guy's and St Thomas' proposal has around 50% total contingency in for the capital costs at RIBA stage 2. The St George's proposal has just over 40% at RIBA stage 2. Both values are deemed prudent and acceptable at this stage. This includes planning contingency, optimism bias and inflation provision. Both proposals therefore currently include a significant level of risk contingency, and this would be expected to be applied at OBC and FBC stages. There is always a risk in capital projects that costs will overshoot. The mitigations that are in place to manage this are:

- use of professional cost consultants, benchmarked costs and up to date PUBSEC indices which have been employed by both proposals.
- detailed feasibility studies have already been done by each of the Trusts.
- proposals are refurbishment rather than new build and therefore should have a lower risk than new build of enabling costs discovering significant problems – a common risk in building projects.
- significant contingency in place in the costings submitted – 50% for Guy's and St Thomas's and 40% for St George's. Additional Guy's and St Thomas' contingencies partly reflect service decants included in their proposal.
- capital cost and funding risk will need to be managed within the ICS capital departmental expenditure limit (CDEL) envelope and would be phased over two to three years. NHS England (London and Southeast regions) will oversee this if required.

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## Due diligence

The Trust submissions were reviewed by the Regional Estates and Finance Teams. A set of assurance and clarification questions was submitted to each Trust requesting further information on elements of their proposals. The estates key lines of enquiry focused on the schedule of works, OB form detailed costings, planning issues, timelines and critical milestones, Private Finance Initiative (PFI) issues, net carbon zero, commercial and procurement strategy and so on. The financial key lines of enquiry focused on capital and revenue affordability as laid out in the detailed Value for Money templates and financial tables submitted alongside the short form business case. The due diligence process was necessarily conducted at a high level using the NHS England short form business case format used for national programme capital investments. The key tests in this process were that:

- The assumptions that each Trust used were reasonable.
- Trusts were able to explain how they had determined the assumptions they were using and providing supporting evidence on any which required review.

## Conclusion

Both proposals meet the capital affordability hurdle. In particular:

- Both proposals have satisfactorily demonstrated that the capital costs of their proposals are affordable at this early stage.
- Both Trusts have put forward proposals which involve the refurbishment of existing estate with standard asset lives of around 30 years.
- Both proposals include works costs assumptions which look reasonable. Professional cost advisors have been deployed to develop costs in the standard NHS OB costing format.
- The difference in works costs between the two proposals is explicable by the size difference between the proposals, the inclusion of an aseptic pharmacy in the Evelina proposal, location factors, slightly differing approaches to specifications, the number of clinical decants in the Guy's proposal, risk appetite including inflation and the different approaches each Trust has taken historically in delivering capital projects.
- Both Trusts have included assumptions on non-works costs in line with NHS assumptions for RIBA Stage 2. These includes fees, planning contingency, inflation, and optimism bias. Both Trusts have included substantial overall financial contingencies in their capital costings, 50% for Guy's and St Thomas' and 40% for St George's. Generally, an overall contingency of >40% would be considered reasonable



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at Stage 2. The Guy's and St Thomas' contingency level is quite high but that does not mean that the St George's figure is too low, rather that the Guy's and St Thomas' proposal reflects the Trust view of the risk of clinical decants into adjacent buildings and uncertainties over the concept designs which are still being explored at RIBA Stage 2. This will be tested at OBC stage, and the level of contingency may decrease to reflect the risk reduction from achieving RIBA Stage 3 designs.

- The £10 million charitable donation included in the funding for the Guy's and St Thomas' proposal makes the capital cost to the NHS of both schemes broadly similar within the range £31 million to £33.8 million. Charitable funding for capital developments is classed as external to the NHS in business cases.
- The focus on costs and affordability will continue as the future Principal Treatment Centre provider works up its proposal to outline business case and full business case stages.

### 8.8.3 Estates and commercial

#### Scheme description

Detailed descriptions of the facilities for each proposal are provided in Section 5.3.1 of the pre-consultation business case, with some developments described in Section 7.8 of this decision-making business case.

**Guy's and St Thomas'** – The Trust is proposing to refurbish existing space on the third floor of the Evelina Children's Hospital to provide a dedicated paediatric oncology ward for inpatients and co-location with interdependent children's services, including the paediatric intensive care unit (PICU) on the second floor. Day cases and outpatients are proposed to be elsewhere within the Evelina London footprint.

**St George's** – The Trust is proposing the conversion of Grosvenor Wing (ground and first floors) into a dedicated children's cancer centre (it is currently offices), co-locating a new paediatric oncology ward, day care unit, outpatients and range of educational, recreational and therapeutic spaces as well as research together, with opportunities to extend children's services further on the second floor.

#### Fit with estates strategies

**Guy's and St Thomas'** – The Trust proposal aligns with the Trust's estates strategy to co-locate high acuity care with existing children's facilities (including PICU) and to work with paediatric oncology shared care units (POSCUs) to deliver lower acuity care. Approvals were initially based on locating the service within the North Wing of St Thomas' Hospital, but

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subsequent Board approval to submit a revised SFBC for Evelina London was agreed at the Trust's Finance, Commercial and Investment Board on 12 April 2023.

**St George's** – The St George's estates strategy is to concentrate clinical activity on the main Tooting site, with ancillary requirements accommodated elsewhere or outside the perimeter road. This project would contribute to this aim, ensuring that the Grosvenor building is focused on clinical activity rather than administrative offices. The Grosvenor building is immediately adjacent to existing paediatric facilities and a new MRI facility. The Trust decant option, extending the existing Blackshaw Annex, situates administrative functions outside the perimeter road but close to the clinical base.

## Procurement

**Evelina London** – If it is chosen to be the future Principal Treatment Centre location, the Commercial and Procurement strategy will be ratified at RIBA stage 3, aligning with Guy's and St Thomas' procurement policies. The expectation is that the Procure 23 framework will be used. Design development is currently at RIBA Stage 2. The strategy will consider the following guiding principles: focusing on value for money through a competitive market process with a clearly defined brief; selecting the right commercial approach to achieve this; proactive market engagement; and allocating risk effectively through a contracting mechanism that will be managed through the lifecycle of the project.

**St George's** – If St George's Hospital is chosen to be the future Principal Treatment Centre location, the Trust's intention is to contract under the P23 framework. P23 is the NHS standard procurement framework for the design and construction of NHS capital projects so therefore includes all the potential suppliers to construct the building. Design development is at RIBA Stage 2 and in progress. The Trust's intention, following completion of Stage 3 design, would be to novate the design over to the appointed Principal Supply Chain Partner (PSCP) under the P23 framework to deliver detailed design development and building works.

## Timelines

The original project timelines for both Trusts were based on the decision-making business case being completed by late summer/autumn 2023. Both assumed that the new facilities would be fully open in 2025/26. Given that consideration of the decision-making business case is happening in spring 2024, the timelines given by each Trust have moved out. Both Trusts have resubmitted their timelines which show completion in September/October 2026. These dates may slip again if the programme is further delayed so are notional only at this point. Trusts will not want to commit significant resources to outline business case development until the decision-making business case decision is made. The Evelina London timeline with key milestones is shown in the table below.

Table 56: Evelina London high-level timeline

Task	End
NHS England decision	April 2024
RIBA stage 2	Complete
RIBA stage 3	August 2024
Outline business case	September 2024
Full business case	December 2024
Contractor procurement	January 2025
Main works complete	September 2026
Principal Treatment Centre operational	October 2026

The current St George's Hospital timeline with key milestones is shown in the table below.

Table 57: St George's Hospital high-level timeline

Task	End
NHS England decision	April 2024
RIBA stage 2	Complete
Principal Supply Chain Partner (PSCP) appointed	September 2024
Outline business case	August 2024
Full business case	November 2024
Main works commence	February 2025
Main works complete	August 2026
Principal Treatment Centre operational	October 2026

See Appendix 6 for further detail.

### Planning Consents

**Guy's and St Thomas'** – The Trust assumes the usual requirements relating to planning consent and building control approval would apply. Applications for each of these would be made once designs have been progressed. As this would be an internal refurbishment project where the Trust does not envisage either change of use or modifying the building facade, it does not foresee the requirement for any major planning consents for the design and construction works. However, how the new building services plant will be integrated will present a space challenge. Some minor planning consents may therefore be required for acoustic shielding and louvre screens. The Trust commits to ensure that any planning

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requirements would be met early in the project, allowing sufficient time in the programme for approvals and avoiding any delay to the construction works.

**St. George's** – The Trust assumes the usual requirements relating to planning consent and building control approval would apply. As this would be a refurbishment of existing space, no planning permissions are envisaged by the Trust.

### **Modern Methods of Construction**

Both Trusts' proposals refurbish existing buildings. Although Modern Methods of Construction (MMC) could be viewed as more focused on new builds, that is not to say that some of the key principles of MMC, such as standard repeatable room design and prefabricated components, could not be incorporated. MMC will be tested in greater detail at outline business case stage.

### **Private Finance Initiative (PFI) issues**

There are no PFI issues to note in either option.

### **Net zero and sustainability**

Section 8.7 sets out the overall environmental impact of the reconfiguration. Below net zero and sustainability plans for the estate are outlined.

**Guy's and St Thomas'** – The Trust has said it would work with contractors to take a whole-life carbon and costing approach to the project. The Trust proposal supports the delivery of the Trust Net Zero strategy by reducing transfers of care between hospitals and reducing travel by removing the need for multiple outpatient appointments at different hospitals. In addition, Evelina London is close to both Waterloo stations with mainline trains serving the south, south west and south east of England, as well as London Underground services at Westminster and Waterloo stations. Finally, repurposing existing space will be less carbon intensive than a new build option.

**St. George's** – The Trust's submission is a key part of the overall Trust Net Zero strategy. Of the options evaluated by the Trust for the location of the children's cancer service, the option selected has the lowest carbon footprint of all the options the Trust considered. It reduces transfers of care between hospitals and reduces travel by removing the need for multiple outpatient appointments at different hospitals. This option extends the lifespan of the building, helping to avoid the embodied carbon needed to replace the existing Grosvenor building with a new one. St George's Hospital is also close to Tooting Broadway underground station and Tooting station with mainline trains to London Blackfriars and Wimbledon and ongoing connections serving south, south west and south east England. As

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with the Evelina London proposal, repurposing existing space will be less carbon intensive than a new build option.

## **Conclusion**

Both Trusts have submitted clear proposals which fit with their respective estate strategies and have clear timelines based on a decision taken on the future location of the service in early 2024. There are no significant planning consent issues to flag. Both Trusts have submitted satisfactory content on modern methods of construction and net zero. Both Trusts provided satisfactory responses for assurance and clarification questions.

### **8.8.4 Economic case**

The economic case is not part of the financial hurdle on revenue and capital affordability. However, it is important that proposals deliver value for money in the economic analysis. Both Trusts submitted economic evaluations which compared two options.

- The 'Business As Usual' (BAU) option of not taking on Principal Treatment Centre services currently provided by The Royal Marsden – the Trust's own total costs without the Principal Treatment Centre plus the cost of the Principal Treatment Centre service as provided by The Royal Marsden and St George's.
- The 'Do Something' option of taking on the Principal Treatment Centre services at The Royal Marsden and St George's – the marginal cost impact on the Trust of taking on provision of those services.

Trusts used the standard NHS England programme VfM template. Both Trusts entered costs and benefits over a 30-year period (being the average lifecycle for a refurbishment project). Costs and benefits are consolidated over a 30-year period and then discounted to provide a VfM ratio. The VfM ratio compares the value of incremental benefits to incremental costs on a 'real' basis, i.e., discounted for inflation, to give a 'net present social value' (NPSV) of costs and benefits. Inflation, VAT, and capital charges are excluded from the economic analysis.

Discounting in the public sector allows costs and benefits with different time spans to be compared on a common "present value" basis. The public sector discount rate for use in UK government appraisal is set at 3.5% in real terms. The VfM ratio shows the relationship between a project's costs and benefits by expressing the ratio as a decimal. If the ratio is greater than 1, the benefits outweigh the costs. If the ratio is less than 1, the costs outweigh the benefits. In investment cases one would often look for a high VfM ratio. However, in the case of service transfers for clinical reasons there would not always be significant net economic benefits. Here, a VfM ratio of at least 1 could be deemed satisfactory particularly where significant capital investment is required.

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**Guy's and St Thomas'** – The economic case generates a VfM ratio of 1.5 compared to the BAU option, which is a modest net economic benefit. The Trust looked at a number of long-listed options for locating the children's cancer service within the Evelina London/St Thomas' Hospital site if chosen to be the future centre. The Trust then short-listed the options based on a series of criteria including:

- patient safety and clinical outcomes
- strategic fit
- patient and staff experience
- timescale and programme
- deliverability and future flexibility.

High level costings for the above shortlisted options were provided by the Trust cost advisors Lexica, and scoring criteria across clinical and non-clinical domains were developed. The options were scored by members of the working group, whose membership included Evelina London Directors, Clinical Directors, colleagues from Essentia (estates and engineering), site team, and Heads of Nursing.

**St George's** – St George's economic case also generates a VfM ratio of 1.5. This proposal therefore also generates a modest net economic benefit which is a satisfactory output.

The Trust considered and explored ten options before deciding was their preferred option for locating the children's cancer service within their estate if chosen to be the future centre. These options were reviewed in terms of various criteria to determine the options presented within the case. Key parameters for the appraisal are detailed below:

- clinical adjacency and impact on patient flow
- fit with overall Trust strategy as well as triangulated with the clinical, estates and research strategies
- minimal impact on existing services from space identified
- financial affordability (capital and revenue)
- best value
- position on site
- feedback from staff, patients, families and partners.

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## Sensitivity analysis

Baseline assumptions on income and efficiencies are outlined in Section 8.8.5. Sensitivity analysis on VfM ratios was completed at PCBC and is detailed below. Both Trusts demonstrate a VfM ratio of greater than 1 in the worst-case downside scenario, which is deemed satisfactory in the case of service transfers as there is no loss of economic benefits. The updated VfM ratios for DMBC are the same or greater than at pre-consultation business case for both providers and the conclusions from sensitivity analysis still stand. Further sensitivity analysis conducted at DMBC alongside mitigations can be found in Appendix 6.

**Guy's and St Thomas'** – The Trust has run three specific downside sensitivities:

- a 25% reduction in private patient income
- a 25% reduction in the level of overhead efficiencies achieved by the move
- a 10% reduction in the level of charitable funding received by the Trust.

The application of all three sensitivities generates a VfM ratio of 1.1, the Trust would seek to mitigate this by exploring further economies of scale across the entire Evelina London estate and service cost to tie into existing Trust productivity schemes. The Trust would need to generate an additional £1.5m of efficiencies to cover off this worst-case downside scenario. This is considered a reasonable assumption – set against the Trust turnover of around £2.5bn the additional efficiency amounts to 0.06% additional efficiency.

**St. George's Hospital** – The Trust has run three specific sensitivities to the analysis for other operating income. They are:

- a 15% reduction in private patient income
- a 15% reduction in the level of research and development (R&D) funding
- a 15% reduction in the level of charitable funding.

The application of all three sensitivities generates a VfM ratio of 1.25 and the Trust has a number of planned mitigations in the event of reduced income:

- St George's Hospital Charity has committed to providing an additional £500k per annum which currently has only been factored into the above model from 2028/29. However, this could be drawn down from 2026/27 to help mitigate the financial position. In the base income model, the charity is providing around £430k in 2026/27 increasing to around £1.1million by 2028/29. The charitable funding would therefore be rephased to pull more funding forward to mitigate the financial position in 2026/27 and 2027/28.



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- If R&D grant income failed to fully materialise once the service is fully bedded in, then non-core workforce models would be reviewed. This would not involve any posts considered under the protected core service.

## **Conclusion**

Both Trusts have done detailed option appraisals to shortlist viable options. NHS England would expect to see this outlined in greater detail in the economic case of the outline business case (OBC) for the successful option. Both Trusts have submitted proposals which meet a satisfactory economic value for money (VfM) ratio minimum of 1. This means that at the sum of relevant discounted economic benefits is at least equal to net discounted economic costs, so is not effectively an economic 'loss'. Conventionally with a significant capital investment, we would expect to see an economic VfM return significantly greater than 1. Service transfers of this nature would not necessarily be expected to generate large cost benefits; therefore this is a satisfactory output from both Trusts. Both Trusts have run sensitivity analysis in their downside scenarios and have reasonable proposed mitigations in place. This would need to be tested in greater detail at OBC level.

### **8.8.5 Revenue affordability**

#### **Statement of Comprehensive Net Income – SOCNI**

The SOCNI is the standard summary revenue financial statement used in NHS business cases. It summarises the overall revenue financial position of Trusts and the incremental impact of investments. Each Trust was required to submit a SOCNI showing the incremental financial impact of taking on the Principal Treatment Centre.

**Guy's and St Thomas'** – The financial modelling assumes the service goes live in October 2026, with six months of costs and income accounted for in the first year. The service reaches a steady state position in 2027/28 (the first full year after transfer). The incremental impact on the Trust financial position in 2027/28 is a deficit of circa £2.8 million, reducing to £1.88 million by 2030/31. Depreciation of £2.1 million annually is included within operating expenditure, which is driving the operating deficit position as presented. The remaining capital charges reflect £1 million in anticipated public dividend capital interest charges (PDC). Excluding incremental capital charges, the income and expenditure (I&E) impact on the Trust is a surplus of £0.4 million in 2027/28. Depreciation costs are deemed as being within the scope of the national funding mechanism. The Trust would need an additional efficiency of 0.05% per annum to mitigate the impact of capital charges after 2030/1, in the event that the national mechanism for funding additional depreciation costs does not apply and financial support tapers off. This is not deemed material and the Trust has agreed it would manage this. See Table 58 below for the summary SOCNI.



Table 58: SOCNI for Evelina London service transfer

<b>Statement of Comprehensive Net Income</b>					
<b>Incremental impact of Principal Treatment Centre on the income and expenditure of Guy's and St Thomas'</b>					
£'000	2026/27	2027/28	2028/29	2029/30	2030/31
Operating income from patient care activities	15,536	19,571	21,068	21,489	21,919
Other operating income	2,394	2,959	3,018	3,079	3,140
(Employee expenses)	-13,994	-16,439	-16,792	-17,128	-17,470
(Operating expenses excluding employee expenses)	-8,062	-10,819	-11,295	-11,507	-11,724
<b>Less cash releasing benefits</b>	3,000	3,060	3,121	3,184	3,247
<b>Operating surplus / (deficit)</b>	<b>-1,127</b>	<b>-1,667</b>	<b>-879</b>	<b>-883</b>	<b>-887</b>
(Public Dividend Capital Dividends Payable)	-1,027	-1,135	-1,087	-1,040	-993
<b>Adjusted financial performance retained surplus / (deficit)</b>	<b>-2,153</b>	<b>-2,802</b>	<b>-1,967</b>	<b>-1,923</b>	<b>-1,880</b>

**St. George's** – The financial modelling assumes the service goes live in October 2026. It is assumed that the service reaches a steady state position in 2027/28 (the first full year after transfer). The incremental impact on the Trust Operating surplus/deficit in 2026/27 is a deficit of circa £1.7 million, reducing to a minimal deficit by 2030/31. Capital charges of around £2 million annually are included within operating expenditure which is driving the operating deficit position as presented. Excluding incremental capital charges, the income and expenditure (I&E) impact on the Trust is a surplus of £278k in 2026/27. The Trust then shows an annual incremental improvement in the revenue financial position for the Principal Treatment Centre services. The capital charges of around £2 million per annum (split equally between depreciation and public dividend capital (PDC) interest) drive the Trust deficit to 2030/31. The cost of capital charges represents the indicative additional funding that would be required, to ensure that the services do not operate at a deficit. The Trust has indicated that it would mitigate the capital charges impact out by 2030/31 via cost efficiencies - shown in the SOCNI below.

See Table 59 for the summary SOCNI.

Table 59: SOCNI for St George's service transfer

<b>Statement of Comprehensive Net Income</b>					
<b>Incremental impact of Principal Treatment Centre on the income and expenditure of St George's</b>					
£'000	2026/27	2027/28	2028/29	2029/30	2030/31
Operating income from patient care activities <sup>82</sup>	22,305	22,710	23,115	23,520	23,926
Other operating income	1,537	1,780	2,547	2,992	3,131
(Employee expenses)	-16,619	-16,922	-17,224	-17,527	-17,830
(Operating expenses excluding employee expenses)	-8,902	-9,045	-9,187	-9,330	-9,472
<b>Less cash releasing benefits</b>	911	928	945	962	978
<b>Operating surplus / (deficit)</b>	-768	-549	196	617	733
(Public Dividend Capital Dividends Payable)	-898	-861	-825	-788	-751
<b>Adjusted financial performance retained surplus / (deficit)</b>	-1,666	-1,410	-629	-171	-18

## Financial assumptions

Both Trusts have submitted proposals with similar overall assumptions including:

- Commissioner funding is in line with that set out in NHS England's letter of 27 October 2022. Each outline reasonable assumptions of the level of R&D Income, charitable funding and private patient income which can be achieved.
- Staffing and non-staffing costs as detailed in the baseline financial and workforce information are a fair reflection of the resources required to deliver the service effectively.

<sup>82</sup> The inclusion of POSCU income for St George's is a point of difference in comparing the income assumptions of both Trusts.

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- Transitional funding is made available to cover both transfer costs, and a three year glide-path to achieve the required levels of non-NHS commissioner funding.
  - Funding is made available to cover increased capital charges arising from the capital costs involved in transferring the service.
  - Both Trust proposals mitigate out the current Royal Marsden deficit via a blend of overhead efficiencies, income growth for private patients and R&D, and pay/non-pay efficiencies.

### **Capital charges funding**

In the pre-consultation business case, NHS England committed to funding capital charges on a time limited basis and those costs were therefore excluded from the affordability assessment. Subsequent to the pre-consultation business case, the Government has agreed additional revenue resources for the NHS to support depreciation and amortisation expenditure, where the expenditure is within the scope of the technical ring-fence as defined in the HM Treasury Consolidated Budgeting Guidance. The purpose of this additional funding is to mitigate the risk that the capital costs adversely impact on the funding available for patient care and service delivery. This effectively updates the pre-consultation business case position on time limited funding for capital charges, the assumption now being that Principal Treatment Centre depreciation costs fall within this additional depreciation funding mechanism. This is consistent with national programme capital investments including elective recovery, diagnostics, digital, mental health, primary care and ambulance services. Should that not be the case, commissioners would revert to the agreement in principle for time-limited funding of capital charges, outlined in the pre-consultation business case, with the process, time limit and detail for funding to be discussed between NHS England and the successful Trust. The financial positions outlined by each Trust in the section above are therefore notional as they include capital charges. Funding of these would therefore eliminate the deficits summarised above. The decision-making business case does not give any warranties or guarantees on capital charges or funding assumptions included in proposal submissions. However, both Trusts have outlined the assumptions on which capital charge calculations are based and both are deemed reasonable at this stage.

### **Radiotherapy services**

Both Trusts assume that radiotherapy activity is to be delivered at University College Hospital under the proposed delivery model and commissioned directly for this activity.

### **Operating income from patient care activities**

**Guy's and St Thomas'** – Operating income from patient care activities of £19,571k in 2027/28 is comprised mainly of NHS specialised commissioning income reflecting R&D and

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grant funding, and private patient income. Specialised commissioning income reflects the service transfer income values in the letter from NHS England of 27 October 2022. These have been uplifted by the inflation rates provided by NHS England as set out in the NHS England VfM template. The patient care income assumption also includes around £1 million of private patient income. Private patient income is included within 'Other Operating Income' by St George's rather than under Operating income from patient care.

**St George's** – Operating income from patient care activities of £22,710k in 2027/28 is comprised mainly of NHS specialised commissioning income, R&D and Trust POSCU grant funding, and private patient income. The inclusion of POSCU income is a point of difference in comparing the income assumptions of both Trusts. St George's has modelled specialised income in line with the NHS England letter of 27 October 2022 and inflated in line with the NHS England VfM template uplift assumptions. The Trust also included an additional £2.7 million of POSCU income that is not strictly part of the Principal Treatment Centre portfolio and therefore would not transfer should St George's Hospital not be the chosen option, uplifted by inflation also. The Trust has included this because the POSCU is included in the 19/20 Trust costing system/PLICS and would be difficult to separate out, as the POSCU and Principal Treatment Centre is managed in an integrated way within the Trust. This is net neutral to Trust income assumptions as it is effectively netted out in the financial model. This has been discussed and agreed with the St George's finance team.

### **Other operating income**

**Guy's and St Thomas'** - Other operating income of £2.96 million in 2027/28 includes Trust charity funding of £800k, R&D funding of £1.4 million and £759k of Trust staff recharges. Trust charitable funding increases to around £1 million in 2027/28 and is available to offset charity funded staff costs.

**St. George's** - Other operating income of £1.78 million in 2027/28 includes Trust charity funding of £496k, R&D funding of £795k and private patient income of £489k. Trust charitable funding increases to £1.06 million in 2028/29 to be comparable with Guy's and St Thomas' and is available to offset charity funded staff costs.

Both Trusts have committed to the principle that growth in private patient income will not adversely impact access to services for NHS patients. Commissioners will ensure that is the case going forward, including ensuring 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 proposals have outlined sufficient capacity for physical space and workforce to meet NHS demand as per current demand and capacity analysis.

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## Pay costs

**Guy's and St Thomas'** – Staffing levels predominantly reflect the existing workforce structure. Staff have been costed at Agenda for Change mid-point, with inner London weighting and pay uplifts applied as per NHS England guidance.

**St George's** – Pay costings are aligned to the workforce templates submitted. Posts have been costed at mid-point Agenda for Change rates, with inner London weighting and inflated as per NHS England guidance over the appraisal period.

## Non-pay clinical costs

**Guy's and St Thomas'** – An incremental increase in overheads has been included at 5% of modelled direct and indirect costs. This recognises that some categories of overhead expenditure would increase because of the transfer, notably facilities and estates costs, but many would not. The assessment also assumes that where such costs are impacted, a marginal efficiency is achieved through economies of scale. This has been modelled as a monetizable benefit within the VfM and within 'cash releasing benefits' in the SOcNI above.

**St George's** – A review of overheads has been carried out to identify variable elements, for example facilities, Clinical Negligence Scheme for Trusts (CNST) and defence costs, which have been costed based on existing St George's costs proportionately increased for the incremental service size and estates solution.

## Transition Costs

**Guy's and St Thomas'** – costs of a transitional programme team have been included from 2025/26 until the year after transfer, 2026/27. These transitional costs also include time for staff training and phased recruitment to roles which are not expected to TUPE with the service transfer. Cumulatively these amount to £2.7 million from decision-making business case decision to Go-Live.

**St George's** – £1.7 million is included for TUPE risk, although much of this is expected to be managed through existing vacancies and turnover within the organisation. Additionally, a figure of £0.65 million has been allocated to manage the transition. An additional £0.27 million has been allocated to support the transition period across the two sites and mainly is for additional bank/agency nurses to support the short-term double running of the old and new wards. Total costs of around £2.6 million, therefore.

Transitional cost financial support would be considered by the task and finish group to be established after a decision is made. This group will make recommendations on the scope, value and duration of such costs and a formal governance process will be set up for this. by Both Trusts have also outlined that they would require tapered financial support over 3 -

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years to 'smooth' the ramp up of other operating income. This is in the range of £700k-£200k per annum over the 3-year period. This is included under the general heading of transitional costs.

### **Capital Costs**

**Guy's and St Thomas'** – Capital charges have been calculated on the capital cost with no impairment assumption. Should the asset be impaired, this may reduce the overall capital charge amount. Depreciation is calculated as a straight line over 30 years and public dividend capital (PDC) has been estimated as 3.5% of the average net book value in the year. The Trust has included around £3 million annually within revenue costs. The capital charges for the proposal are a challenge to the revenue affordability. As a result, the Trust has included an assumption that NHS England funds capital charges to meet the revenue affordability hurdle. The default position for the decision-making business case is that depreciation would be funded via the new national excess depreciation funding model – developed subsequent to the pre-consultation business case.

**St George's** – Capital charges have been calculated on the capital cost net of a 15% impairment. Depreciation is calculated as a straight line over 30 years and PDC has been estimated as 3.5% of the average net book value in the year. The Trust has included approximately £1.5 to £2 million annually within operating expenditure which is driving the operating deficit position as presented. The capital charges for the proposal are a challenge to the revenue affordability. As a result, the Trust has included an assumption that NHS England funds capital charges to meet the revenue affordability hurdle. The default position for the decision-making business case is that depreciation would be funded via the new national excess depreciation funding model – developed subsequent to the pre-consultation business case.

### **Cash releasing benefits**

**Guy's and St Thomas'** – The Trust's submission shows modest cash releasing benefits of around £3 million from 2027/28. This is driven by an increase in private patient income of £1.3 million per annum and an efficiency factor assumed on marginal overheads of £1.7 million per annum, transferring over where economies of scale and being on one site results in a lower level of marginal overheads in comparison to the baseline. The assumptions for additional private patient income growth here are based on expected available capacity (given fluctuations in demand). The Trust anticipates that this capacity can be freed up through:

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- Opportunities for reduced length of stay due to fewer transfers of care and greater availability of specialist services within the hospital, reducing waits for consults and providing more joined up care
  - The ability to make best use of the bed base of 260+ beds across the children's hospital, to ensure children are in the most appropriate place
  - Development of enhanced paediatric oncology shared care units (POSCUs) and improvements in the network model supporting more care closer to home for children where appropriate.

The assumption of additional private patient income as a cash releasing efficiency is a Trust risk and set against the Trust total paediatric bed base of 260+ beds rather than just beds for the Principal Treatment Centre. The commissioner view is that the Trust's private patient income ambitions here are separate to the Principal Treatment Centre and that NHS patients take priority for Principal Treatment Centre beds, which commissioners will ensure happens.

**St George's** – There are two cash releasing benefits. Firstly, pay efficiencies, generated by comparing the current total workforce across the two current sites at The Royal Marsden and St George's versus the total St George's model in the supporting workforce template, driving a £0.83 million per year benefit based on 2022/23 pricing. Secondly, the refurbishment of the area would lead to a more energy efficient building and is estimated to give a £8k per year saving in energy costs. There is also a further cost avoided in backlog maintenance reduction which has been calculated at £3.12 million and included as a non-cash releasing benefit within the VfM model.

### **Indicative values of stranded and transitional costs and governance Issues**

Currently, NHS England is the commissioner for Principal Treatment Centre services. Should services be delegated from NHS England to Integrated Care Boards (ICBs), responsibility for funding stranded and transitional costs would transfer to ICBs as the commissioner. The commissioner will consider the impact of both capital charges and transitional/stranded costs on Trusts. However, it is important to be clear that what is agreed in this decision-making business case is the funding principle only and no warranties are given in this decision-making business case to funding specific costs included in Trust proposals. Before the commissioner would consider specific financial support there would be an expectation that all parties would explore potential mitigations for those costs and the shortest possible period to manage such costs within Trust operational revenue baselines – no longer than three years. Post decision, NHS England would convene a task and finish group with Trusts and ICBs to develop transition and cut over plans which include stranded and transitional costs. It is envisaged that this work would include clinical, workforce, estates and financial subject matter experts. Financial support for transitional and stranded financial costs will be in the



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order of several million pounds, over a three-year period, and will be an additional financial call on NHS England Specialised Commissioning for such costs. This would be a pre-commitment on Specialised Commissioning budgets which may eventually be delegated to ICBs. It is therefore very important that relevant ICBs are both included in these discussions and sighted on potential values for financial support. The range of costs included in Trust proposals is given below.

**Fixed-term recurrent** – maximum capital charges funding of around £2 million to £3 million in any given year for a fixed term dependent on the successful trust and final capital cost details. Should the national depreciation mechanism fund these, the requirement for commissioners to provide depreciation cost support funding would cease.

**Non-recurrent** – Transitional costs for the successful proposal in the range of £3 million to £4 million phased over two to three years from decision-making business case decision to Go-Live.

**Non-recurrent other** – This includes transitional and stranded costs for The Royal Marsden, and for St George's should Evelina London be chosen. NHS England will discuss this further with The Royal Marsden (and St George's if needed) once a decision has been made. However, we would estimate these to be in the order of several million pounds.

### **Potential impact on The Royal Marsden**

The current service at The Royal Marsden has an estimated deficit of £6.7m<sup>83</sup> in FY2022/23; and has generated a deficit for the last five years. Contributing factors include the provision of a service without the wider paediatrics infrastructure of a specialist Trust, which does not enable efficiencies. The proposed service transfer would remove the headline deficit subject to the effective mitigation of stranded costs including overheads but would leave stranded and transitional costs in place. Additionally, there may be impacts on the Teenage and Young Adult Principal Treatment Centre also provided by The Royal Marsden at the Sutton site. NHS England will continue working with The Royal Marsden on how those costs can be mitigated and has indicated that it will in principle provide transitional funding, although the quantum and phasing of that is still to be agreed. Both Trust proposals mitigate out the current Royal Marsden deficit via a blend of overhead efficiencies, income growth for private patients and R&D, and pay/non-pay efficiencies. There is therefore a strategic opportunity for The Royal Marsden to eradicate a £6.7 million deficit working with commissioners.

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<sup>83</sup> An independent report found that the current service generates a recurrent deficit of £6.5m per annum.



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## **Potential impact on St George's**

St George's is concerned about the potential impact on some of its services should a decision to be made that the Principal Treatment Centre would be Evelina London.

St George's has also raised concerns about potential stranded costs that could result from this scenario. NHS England has been clear that stranded costs should be mitigated out over a maximum of three years. If St George's Hospital does not become the site of the future Principal Treatment Centre, commissioners would work with the Trust and the Integrated Care Board on a detailed decant and transition plan, ensuring that stranded costs are minimised and over as short a time period as possible. The Trust has shared initial broad estimates for these costs, but these are before mitigations are applied, rather than a definitive final position. Further work on these will be picked up by the task and finish group as described above.

## **Potential impact on University College London Hospitals NHS Foundation Trust**

Work is ongoing to secure further radiotherapy service capacity within University College London Hospitals via the provision of a fifth LINAC and associated revenue funding including a new 'complexity payment' to support current demand (including the transfer of children from Oxford). This work establishes helpful principles with respect to additional Principal Treatment Centres supported beyond the 'host Principal Treatment Centre' (University College Hospital /Great Ormond Street Hospital). It is expected that a similar arrangement could be put in place to support incremental costs as that associated with the Principal Treatment Centre transfer.

## **Conclusion**

Both Trusts have used the prescribed NHS England financial templates to develop their proposals. This includes default inflation uplift assumptions. Both Trusts have applied a consistent and reasonable set of assumptions in setting out their income and cost assumptions including both pay and non-pay. Transitional support costs have been included in both proposals. Both Trusts have applied appropriate capital charging methodology in their proposal submission. Both have included lifecycle costs in the financial model and in the calculation of capital charges. Both Trusts have submitted proposals which show that, net of capital charges, the proposed Principal Treatment Centre transfer delivers a modest operating surplus but that, including capital charges, both proposals have a deficit. Both proposals 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.

### 8.8.6 Estates and finance risks

Risk management is recognised as an essential tool to deliver projects successfully and realise the intended benefits. Both Trusts have outlined key risks to delivery from a management perspective with their associated mitigating actions. See the Table 60 and Table 61 below.

Table 60: Guy's and St Thomas' summary estates and finance risk assessment

Risk	Mitigation
Delays to decision-making of NHS England paediatric oncology programme and/or public consultation lead to significant programme delays, changed brief or cost increases.	<p>Ongoing communication with NHS England to understand programme status and close engagement with public consultation process.</p> <p>Robust project plan developed with clarity around gateways and key points for decision/escalation</p>
Engagement with The Royal Marsden team and other users following conclusion of NHS England-led process results in material change to the brief	<p>Analysis of NHS England-provided data lake has informed scope alongside current The Royal Marsden footprint. Robust process in place including a structured project initiation process to develop and iterate clear brief that meets user needs</p> <p>Work closely with design team to establish flexible design which is easily adaptable. This option already reflects feedback from The Royal Marsden and other colleagues so further changes are not anticipated.</p>
Design does not meet user needs	Early and ongoing structured engagement with clinical users and patients/families
Infrastructure upgrades more extensive requiring greater MEP replacement	Ensure full surveys are carried out in advance and loadings are determined to ensure power availability
Mechanical, electrical and plumbing (MEP) coordination between new and existing areas; risk of greater MEP upgrades; lack of as-built information; lack of power to support functions and lack of space to	<p>Engineering department input to advise on the existing systems.</p> <p>Detailed coordination with the design team</p>

support new MEP requirements, particularly with new plant room areas	Using an experienced MEP contractor who is familiar with Guy's and St Thomas'
Complexity of managing multiple projects across a number of construction sites (e.g., inpatient and day case facilities)	Employ experienced project managers (either internally within Guy's and St Thomas' and/or external consultants), coupled with a rigorous contract management system. Employ only experienced contractors who are adept at complex schemes
Contractor / consultant selection, procurement, performance, and staff turnover: risk that third parties don't have sufficient capacity or readily available management resources to deliver the project	Ensure robust and clear brief issued to consultants and contractor as well as selection criteria. Pro-actively monitor appointments / replacement individuals  Ensure that consultants are selected on the basis of a coordinated set of duties and deliverables
Material and labour shortages	Larger contractors have greater buying power; therefore materials can be purchased in advance or stockpiled, to prevent programming issues Ensure a detailed programme is maintained throughout the duration of the contract

Table 61: St George's summary risk assessment

Risk	Mitigation
Disruption to business continuity as the hospital's Atkinson Morley Wing will be temporarily designated as the hospital's main entrance.	Work areas to be screened off from all other operational areas
Construction access and logistics as main entrance and concourse to hospital (in Grosvenor Wing) will be closed and temporarily relocated.	Traffic management and delivery schedules to be controlled to suit hospital operations.
Delivery of the project is dependent on decant of existing services within	This can be mitigated and potentially eliminated through effective planning and

Grosvenor Wing, the majority of which is currently office space; there is therefore a risk of delay in gaining access to the site.	there is a robust plan to decant the existing offices within the capital figures.
Risk of inflationary impact being higher than anticipated due to the current instability of the economy, leading to incorrect cost estimates.	Costs have been calculated with a prudent assumption of 7.22% inflation, in line with current industry standards.
The financial case uses baseline data from The Royal Marsden based on the information available to St George's at the time of calculation; the current accuracy of which cannot be guaranteed by St George's.	If new or existing information becomes available this will need to be reviewed and reflected in updated workings.
Disruption of clinical services due to handover of services from Royal Marsden.	St George's is part of the current joint Principal Treatment Centre thus has expertise and positive relationships with clinical staff across the Principal Treatment Centre to manage risk appropriately.

### 8.8.7 Conclusions of financial impact assessment

The primary focus of this decision-making business case is the clinical aspects of the proposals. Capital and revenue affordability is a hurdle criterion which each proposal needs to demonstrate to be considered within the programme option scoring domains. Although financial considerations are not part of the option scoring process, both proposals demonstrate that they are affordable and deliver a small and positive value for money outcome. Because the proposal to relocate paediatric cancer services is based entirely on clinical considerations rather than financial, the financial test is therefore about the affordability of capital and revenue costs. That does not mean, however, that financial issues are not important. The impact of the findings of the financial impact assessment on decision making is summarised in Section 7.11.3.

The financial detail included in proposal submissions is high level. Proposals are at RIBA Stage 2. Neither proposal has been developed to outline business case (OBC) stage owing to the expense and time required to do this. Instead, proposals have been submitted using the national short form business case format. This means that the level of due diligence done on submissions is also at a robust, high level. As the detail of the successful proposal is developed to OBC stage, there will need to be a more detailed formal assurance process put in place between the successful Trust, NHS England regional and national teams, and Department of Health and Social Care (DHSC) colleagues. This will entail a full 5-case

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model process for both the OBC and full business case with an assurance report to the national NHS England/DHSC Joint Investment sub-committee – given the national capital contribution.

Both Trusts have submitted reasonable and consistent capital costing schedules to support their proposals although there is variation in capital costs. The Guy's and St Thomas' proposal is estimated to cost £43.8 million and St George's a lower cost of just under £31 million. The Guy's and St Thomas' proposal includes charitable funding donations of £10 million which reduces the net NHS capital cost of the proposal to £34 million. Both Trusts have satisfactorily demonstrated how capital costs have been worked up and how costs would be funded. Both Trusts therefore meet the capital affordability hurdle criterion subject to the national £20 million CDEL contribution being forthcoming and further cost detail, confirming the capital envelope, being worked up at OBC stage.

Both Trusts have applied consistent principles in their revenue costing submissions. Pay costs are based substantively on existing pay costs and non-pay costs follow a similar pattern. Income assumptions are based on the existing SLA with NHS England Specialised Commissioning with some local assumptions for private patient income, R&D and grant funding. These are deemed reasonable.

Both Trusts have submitted sensitivity analysis based on non-NHS income sources being less than planned. Both Trusts have shown, at a reasonable level, how this would be mitigated.

Both proposals meet the revenue financial hurdle criteria, subject to resolution of the impact of capital charges and show that the capital and revenue costs are affordable to both trusts. Both Trusts have outlined the assumptions on which capital charge calculations are based and capital cost estimates are deemed reasonable at this stage.

In the pre-consultation business case, NHS England outlined that the commissioner will consider the impact of both capital charges and transitional/stranded costs on Trusts. This is reconfirmed in this decision-making business case although there is an update to the capital charges funding issue in the light of the national funding mechanism being operated from 2024/25. The decision-making business case does not give any warranties or guarantees on capital charges, transitional costs or stranded costs, or funding assumptions included in proposal submissions.

NHS England will convene a task and finish group, after approval of the decision-making business case, to agree stranded and transitional costs for impacted parties, to be considered by commissioners for potential funding. Such costs are likely to be incurred both

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before and after service transition. NHS England would expect such costs to be mitigated out within three years of the service transfer and will work with both Trusts to ensure that such costs are minimised.

Any eventual non-recurrent funding requirement for stranded, transitional or capital costs (although the assumption is that the Principal Treatment Centre is within scope of the national depreciation and amortisation funding mechanism) would have to come from specialised commissioning budgets to be delegated in the future to Integrated Care Boards. Therefore, it is important to be clear that this would be a pre-commitment should specific funding be agreed after a decision is made.

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## 9. Further scrutiny and advice

Since the publication of the pre-consultation business case, we have continued to:

- engage with the Mayor of London and his team to support their review of our proposals against the mayoral six tests.
- have regard to recommendations arising from the London and South East Clinical Senates' review.
- consult and work closely with the Joint Health and Overview Scrutiny Committees which considered our proposals 'substantial', along with engagement with other Health and Overview Scrutiny Committees across the catchment area.

We welcome their ongoing input. An overview of their feedback and advice is set out below, including our consideration of it.

### 9.1 The Mayor of London's response

The Mayor of London has developed six tests to apply to major health and care transformation and reconfiguration programmes, looking at the impact on Londoners. During our public consultation the Mayor of London provided feedback on our proposals, including whether the changes were equitable, transparent and in the best interest of all Londoners. He did not take a position on either of the options.

The six tests cover:

- the impact of changes on health and healthcare inequalities
- the impact of changes on hospital beds
- the financial investment and savings that the changes involve
- the impact of changes on social care
- clinical support for the changes
- the quality of patient and public engagement carried out in developing the changes.

The Strategy Unit, an internal NHS consultancy, was commissioned by the Mayor of London to carry out an independent expert review of our proposed changes against the six tests. This analysis was used to inform The Mayor of London's position on the proposals as set out in public consultation documents, in particular the pre-consultation business case.

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Following publication of the independent consultation feedback report (on 31 January 2024) and of this decision-making business case, the Mayor of London will provide an updated position on the proposals.

### **9.1.1 The Mayor of London's responses and key recommendations**

#### **Test 1: Health and healthcare inequalities**

The Mayor of London made some recommendations for us relating to health and healthcare inequalities:

*“Set out greater analysis of existing inequalities within the current service in access to diagnosis and treatment, experience of care and outcomes from treatment. This baseline analysis is needed to show whether the proposed changes will reduce inequalities compared to the current service.”*

In the interim Integrated Impact Assessment (IIA), a demographic analysis of those diagnosed with childhood cancer (incidence) was presented in the equalities Appendix 2 of the pre-consultation business case. However, we have strengthened the final IIA with an analysis of the current patient cohort and comparison with both the Principal Treatment Centre catchment population and children who are diagnosed with cancer within it. This showed the patient cohort is broadly representative of those diagnosed with cancer and the child population in general, which indicates access is broadly representative of need (incidence).

The aim for our proposals would be to maintain this equity in access. All childhood diagnoses must be made by a Principal Treatment Centre, and the existing National Institute of Health and Care Excellence (NICE) guidelines on presentation, referral and diagnoses will apply to the future Principal Treatment Centre. This will be supported by ongoing development of the associated clinical network (which the future Principal Treatment Centre will host), helping to ensure that children get the right care in the right place, ensuring the same equity of service access.

Travel time analysis to the current service was already presented for demographic groups including age, sex, socio-economic status and those living in rural versus urban areas. We have now added analysis of travel time by ethnic group.

*“Commit to specific plans for how the future service will maximise opportunities to reduce health and healthcare inequalities, with clear targets and mechanisms for monitoring progress. This should be informed by analysis of existing inequalities, and engagement with patients, families and carers.”*



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Further work has been carried out to ensure we **appropriately measure and monitor access and service quality**. This will include monitoring clinical outcomes within the future Principal Treatment Centre service specification via the specialised services quality dashboard (SSQD), published on model hospital (see Appendix 4 for details) - from summer 2024. It will be the first time this service has been monitored in such a way. We will be making a recommendation for the new service to conduct regular health equity audits to monitor equity between socio-demographic groups.

These recommendations for future plans to improve equity are informed by the public consultation, and the Integrated Impact Assessment (IIA). The IIA is underpinned by the equalities profile (Appendix 2 of the pre-consultation business case) which contains analysis of existing inequalities within the Principal Treatment Centre catchment population.

The IIA contains information on:

- the socio-demographic profile of the Principal Treatment Centre catchment area, including groups with protected characteristics or other vulnerabilities
- the socio-demographic profile of children diagnosed with cancer (the 'incident population') as well as that of the current Principal Treatment Centre patient cohort.

Sections 5 and 6 of this decision-making business case give details of the consultation and engagement process and the feedback received from members of the public, patients, families and professionals.

*“Provide an analysis of travel costs and a strengthened analysis of travel times, with plans set out to mitigate any potential negative or inequitable impacts on patients and families. This should reflect the fact that a significant majority of patients and families travel to appointments by car.”*

We commissioned new travel time analysis to incorporate the impact on travel cost. This included an exploration of likely cumulative costs over an extended time period, for the whole patient population, and also for those who live in the most deprived areas. This has a focus on travel by car, as the preferred travel option (but also relates to the difficulties of producing 'average' public transport costs). The travel cost analysis is summarised in Section 8.4 and also available in Appendix 4.

The impacts on changes to travel time have already been presented for age, sex, socio-economic status and rural versus urban areas. We have now included analysis of travel time by ethnic group. The travel time analysis is available in Appendix 4 and also summarised in Sections 7.4.2 and 8.4 of this document.

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Overall, the proportionate impact of travel by car to the future Principal Treatment Centre will be lower for those from the most deprived areas of the catchment and for those from ethnic groups other than white. The increase in travel time was proportionately lower for these groups than the catchment population as a whole.

The additional travel cost analysis reveals that fuel costs (on average) incurred for driving to either potential Principal Treatment Centre location are likely to be slightly less than for driving to The Royal Marsden. The majority of the catchment population are likely to see little or no change. This finding is related to the density of the population who live closer to the future Principal Treatment Centre locations.

Despite the findings summarised above, it is fully acknowledged that some patients and their families from across the catchment area will face longer, more costly, journeys that need to be mitigated (see Appendix 4 for mitigations).

Recommendations for mitigation of equity impacts have already been described in the interim Integrated Impact Assessment. However, we have updated these recommendations with information collated as part of the public consultation on the service change (see Section 8.4). We will also ensure that these recommendations are included within future implementation plans once the future Principal Treatment Centre provider is known.

*“Commit to specific plans for how the future service will maximise opportunities to reduce health and healthcare inequalities, with clear targets and mechanisms for monitoring progress.”*

There are service specific opportunities to maintain or improve equity of access, via monitoring and putting in place support to facilitate easier travel and access for vulnerable groups. We also sought information from both potential providers of the future Principal Treatment Centre on their wider activities on reducing inequalities and how they will comply with the five priority areas for reducing health inequalities. Examples might include their development as an anchor institution, Core20PLUS5 approaches or proactive outreach work. This includes confirmation that they are committed to the London approach to tackling structural racism and also NHS Providers recommendations for reducing health inequalities faced by children and young people. The information has been summarised within the Integrated Impact Assessment.

## **Test 2: Hospital beds**

The Mayor of London welcomed that there would be no changes to bed capacity as a result of the proposals. He asked for sensitivity analysis around population growth and future required capacity.

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The most recent sub-national population projections<sup>84</sup> indicate that the child population of the Principal Treatment Centre catchment area is projected to decrease over the next decade. Population change is likely to be a primary driver of the numbers of children diagnosed with cancer. This means the projected decrease in the child population means that we do not anticipate an increase in incidence or associated pressures on capacity.

Both potential providers previously presented their modelling, reflecting their analysis of activity and resultant bed requirements. In the event there is an increase in demand, we have assurance from both providers that there is flexibility within their proposals to accommodate an increase in beds, should this be needed. See Section 7.8.1.

As part of any future business case development, providers will need to continue to assess demand and capacity assumptions, including any growth. This is to ensure that the needs of patients will be met, both when the future centre 'goes live' and subsequently. The latter reflects normal business and service development planning which is undertaken across the NHS.

### **Test 3: Financial investment and savings**

The Mayor of London found that capital funding is identified and appears affordable in the context of site consolidation and the efficiencies expected from this. He asked that revenue affordability should be further detailed in the decision-making business case. This work, in Section 8.8.5, shows that revenue affordability has not changed since the pre-consultation business case was published. Further work will be required as part of implementation to ensure that stranded costs are appropriately mitigated (see Section 8.8.5), and that revenue affordability continues to be tested as part of any future business cases.

The Mayor of London also asked that further assurance be provided that additional private patient activity will not impact NHS patient access. The capacity requirement set out by providers is modelled on the basis of NHS patient activity, therefore ensuring sufficient capacity is in place for these patients. Both providers have made assumptions about generating a degree of private patient income from the service. However, these ambitions are separate to commitments that they would make to meeting demand from NHS patients with cancer - which would take priority, first and foremost. Governance and oversight mechanisms will support adherence to this, including the regulatory framework.

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<sup>84</sup> Office for National Statistics 2018-based sub-national population projections.  
[Subnational population projections for England - Office for National Statistics](#)

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#### **Test 4: Social care impact**

The Mayor of London confirmed that there were no concerns related to the impact of the proposed changes on social care.

#### **Test 5: Clinical support**

*“Put forward a more detailed case for change that clearly sets out in more detail the expected benefits that the changes will generate for patients and families. This should set out expected improvements against a baseline analysis of existing access, quality and outcomes data for the current service.”*

As described in Section 1.4 and Section 7.10, the case for change for the proposal to locate the Principal Treatment Centre at either Evelina London or St George’s Hospital is firmly based in clinical evidence and received strong support from healthcare organisations, professional bodies and clinicians who commented on it as part of their responses to the consultation.

As described in Section **Error! Reference source not found.**, the proposed change will bring the cancer service in line with the national service specification. This will have the direct benefit that transfers of clinically high risk and very sick children from one part of the Principal Treatment Centre to the other for level 3 intensive care services that can give life support will cease. Although they are done as safely as possible, this will remove the avoidable underlying risks that under current arrangements can only ever be mitigated.

There is also a range of other benefits that are expected to be realised. These are summarised in Figure 7 and outlined in more detail in Section 2.4.

As described in Section 7.2.1, arrangements will be needed to ensure there is a baseline is needed to assure outcomes are maintained or improved, and against which the future provider can be held to account.

Additional information around the monitoring of benefits realisation is included in Section 11.2.2.

*“Set out detailed analysis of the potential impacts of the proposed changes on other services, particularly wider children’s inpatient services. This should consider and address potential knock-on effects in terms of service viability, access and outcomes, especially where these risk widening health and healthcare inequalities.”*

We have further considered the potential impacts of the proposed changes on other services, following the Mayor of London’s feedback and wider feedback from consultation,

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and have identified next steps and potential mitigations. This is further described in Section 8.6 and provides confidence that impacts on other services can be mitigated. If there are any unanticipated impacts of the service change that could lead to changes in patient flows, then subsequent proposals would be subject to a separate Integrated Impact Assessment.

*“There is a concern for the careful management of the transition services for children aged between 0-15 and 16-25 years as 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 if they need to move to this service.”*

As identified in Section 7.3.2 and reinforced through consultation feedback, the proposed configuration will have an impact on patients moving on to teenage and young adult services. Currently, when children who have treatment for cancer in childhood reach their 16<sup>th</sup> birthday (with flexibility on a case-by-case basis), management of their care moves from the paediatric to the teenage and young adult service within the Oak Centre for Children and Young People at Sutton. In the future, management of their care would move from the future Principal Treatment Centre to The Royal Marsden. This was identified during pre-consultation, with transition arrangements forming part of the pre-consultation options evaluation. Feedback from consultation has reinforced the importance of carefully managing this pathway in the future. Detailed planning, including pathway work will need to be undertaken between the future Principal Treatment Centre, The Royal Marsden, the wider network and other stakeholders to determine the best arrangements for this.

While both St George’s Hospital and Guy’s Hospital are designated units for teenage and young adult cancer services, children aged (approximately) 16 to 18 would still be looked after by the teenage and young adult (TYA) Principal Treatment Centre at The Royal Marsden. After they turn 19, many young adults can choose whether to have their care at The Royal Marsden or a designated unit for teenagers and young adults.

Both potential providers of the future Principal Treatment Centre and University College London Hospitals NHS Foundation Trust follow National Institute for Health and Care Excellence guidelines for transition from children’s services to TYA services. We would expect this process to be followed in future, regardless of the location of the future Principal Treatment Centre.

### **Test 6: Patient and public engagement**

The Mayor of London noted, at this stage, that he is pleased to see extensive pre-consultation activities were conducted and that these meaningfully informed the format and content of consultation materials. He also notes that, following the mid-point review of the

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consultation process, plans were developed to better reach groups that had been heard from less at that point. The Mayor of London's next letter will provide further comment against this test, taking into consideration the independent consultation feedback report.

Section 6 describes our consultation process, feedback received and how feedback has informed the decision-making business case.

Section 6 also refers to ongoing stakeholder engagement as the plans move into the implementation stage, if they are approved. There is no predetermination over what form this will take.

In Section 5.6 we have also discussed how the consultation met the four Gunning Principles:

- proposals are still at a formative stage
- there is sufficient information to give 'intelligent consideration'
- there is adequate time for consideration and response
- 'conscientious consideration' must be given to the consultation responses before a decision is made.

A detailed response to the Mayor of London and The Strategy Unit is included in Appendix 9. We will incorporate any further recommendations into future implementation planning.

## 9.2 London and South East Clinical Senates

As described in the pre-consultation business case, the London and South East Clinical Senates in their joint review found that the case for change is clear, with a sound evidence base, and that the plans meet the Principal Treatment Centre service specification. As part of their joint review, the Clinical Senates made 30 recommendations which related to NHS England's ongoing work, including the implementation phase of the programme. Responses to these were made as part of the pre-consultation business case (Appendix 1).

Since the pre-consultation business case, further updates to our response have been made to reflect consultation feedback and further evidence review – these are also reflected in Appendix 3. They include:

- How the current Principal Treatment Centre will work with the provider of the future centre to ensure a smooth transfer. Updates have been made to Trust plans including dedicated workforce retention plans such as buddying, reviews of previous organisational processes and culture, dedicated training plans (Section 7.5.1),

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additional mitigations around research risks (Section 7.9), and recommendations to work with families in the design of the new facilities.

- Further development and explanation of the case for change, as set out in Sections 1.4 and 7.10, with clear description of the evidence underpinning the national specification, expected benefits of the change and consultation feedback.
- More detailed consideration of how effective transition from children's services to teenage and young adult services will be managed has been further described within this decision-making business case, with commitments to work with The Royal Marsden and wider providers of care to ensure the patient pathway and transition processes are maintained.
- Sensitivity analyses of potential providers' capacity have been carried out, and aligned to expected population projections, to assess whether current and future capacity are aligned.
- Reduction of travel requirements – the Paediatric Oncology Shared Care Units Transformation Programme could have an influence on where care is provided. There is potential for more care to be provided closer to home. Our description of this programme has been further reviewed and clarified as part of this decision-making business case (Section 7.4.6).
- Inequalities – further work has been set out in the Integrated Impact Assessment around the impact of the changes on health inequalities, with a further analysis of travel costs and the impact on ethnic groups (Section 7.4.4).

NHS England will continue to consider recommendations from the London and South East Clinical Senates that are most pertinent to the transition phase; and monitor the implementation of recommendations through the governance and monitoring mechanisms set out in Section 8.

### 9.3 Feedback from Health Overview and Scrutiny Committees

As highlighted in Section 4.3, the programme liaised with all the Health Overview and Scrutiny Committees for local authorities across the catchment area before and during the consultation. The Joint Health Overview and Scrutiny Committees for south east London, and south west London and Surrey, viewed it as a substantial change for their populations. They were formally consulted with ahead of the consultation as well as at the mid-point, in accordance with statutory obligations (including the local authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013). The committees for the remaining



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local authorities across the catchment area requested frequent updates and were engaged with and kept informed.

At all points, we made it clear that the intention was to consult with scrutiny committees rather than to ascertain preferences for the options, and we were clear from the outset that a public consultation is not a referendum. However, some committees did express a preference.

An overview of interactions with the Joint Health Overview and Scrutiny Committees, including engagement, key points raised, and our responses to their queries is below.

### **9.3.1 South East London Joint Health Overview and Scrutiny Committee (JHOSC)**

The table below summarises the formal meetings held with South East London JHOSC, and the key points discussed at each meeting. Other engagement took place, including prior to this list, some of which is set out in Section 4.3.



Table 62: South East London Joint Health Overview and Scrutiny Committee engagement

Engagement	Date	Key points
Pre-consultation update	6 July 2023	The committee noted the difference in scoring between the two proposals. There was discussion about the Integrated Impact Assessment, impact on and mitigations for staff, and the urgency of meeting the 2.5 year implementation timeline. We noted the importance of hearing from current and potential future patients.
Mid-point review meeting	21 November 2023	We gave a recap on the case for change, process to date and proposed options. An NHS action plan to address the recommendations in the latter half of consultation was discussed.
Post-consultation meeting	1 February 2024	High level findings from the consultation feedback report were discussed including reach and feedback received. The decision-making process was outlined. Focused points of discussion included travel and access, accommodation, and workforce.

South East London JHOSC formally responded to the consultation on 9 February 2024. Their response addressed six key areas:

- travel and parking arrangements
- accommodation and other incidental costs
- workforce concerns
- local support officer
- delivery timeline
- public consultation feedback.

Appendix 7 provides a summary of the comments raised by the South East London Joint Health Overview and Scrutiny Committee and our response to these comments, aligned to the list of themes above.

In addition to the feedback in Appendix 7, the committee noted that the level of consultation response was positive and that there had been good reach to south east London and to staff

members. They also noted a high level of response from ethnic groups other than white in south east London.

The committee’s formal response indicated that their conclusion was non-unanimous in terms of the two options presented. However, by significant majority and based on the evidence presented and considered, Evelina London was their preferred option for the future location of the Principal Treatment Centre.

### 9.3.2 South West London and Surrey Joint Health Overview and Scrutiny Committee (JHOSC)

The table below summarises the formal meetings held with South West London and Surrey JHOSC, and the key points discussed at each meeting. Other engagement took place over this period, and prior to this list, some of which is set out in Section 4.3. In addition, we met with individual HOSCs and/or Chairs on request. This included the Sutton Scrutiny Committee (13 December 2023)

Table 63: South West London and Surrey Joint Health Overview and Scrutiny Committee engagement

Engagement	Date	Key points
South West London and Surrey JHOSC pre-consultation engagement	7 June 2023	NHS England reiterated the case for change and the process to date. We outlined findings of the interim Integrated Impact Assessment, shared updates on pre-consultation engagement and the preparation of consultation documentation, and on opportunities for the committee to give feedback.
NHS England London and the Chair and Vice Chair of South West London and Surrey JHOSC	5 July 2023	In response to several follow-up questions after the 7 June committee meeting, we held a meeting with the Chair and Vice Chair to present and discuss further detail on points that had been raised.
Mid-point review meeting [JHOSC sub-committee]	22 November 2023	We gave a summary of the case for change, process to date and the proposed options. The NHS action plan to address the recommendations in the latter half of consultation was discussed. The sub-committee also asked about the pre-consultation evaluation of the options, and

		the impact of the change on different population groups and other NHS services. At this meeting, both Trusts were invited to talk through their proposals and answer questions, and two parent representatives addressed the committee.
South West London and Surrey JHOSC post-consultation meeting	7 March 2024	High level findings from the consultation feedback report were discussed, including groups and people reached, and feedback received. The decision-making process was outlined. Areas of focus included: travel; workforce; accommodation; capacity; potential impacts on other services; case for change; service transition risks and how these would be managed. Feedback was ratified.

South West London and Surrey JHOSC responded to the public consultation and provided further feedback after considering the independent consultation feedback report. This was shared with us in February and formally ratified at the meeting on 7 March 2024.

Their response aligns to the following themes:

- our identification of a preferred option
- the options evaluation process, including a sense that the JHOSC should have had input into it, and membership of the expert panels
- travel and access
- staffing concerns
- funding
- impacts on patients of services not being on the same site, including radiotherapy.

Appendix 8 provides a summary of the comments raised by South West London and Surrey JHOSC and our response to these comments, aligned to the list of themes above.

The key concerns highlighted in the South West London and Surrey JHOSC response are in line with a formal response to the consultation received from the South West London and Surrey JHOSC sub-committee on 14 December 2023.

The unanimous view of the South West London and Surrey JHOSC sub-committee, in its formal consultation response, was that, should the service be required to move from The Royal Marsden, then St George’s would be the preferred future provider. The JHOSC agreed with this statement, stating that there was insufficient evidence to support Evelina London as the preferred option, whereas St George’s Hospital has demonstrated its ability to work with The Royal Marsden’s clinical teams.

It should also be noted that the leaders of those local authorities which form the South West London and Surrey JHOSC wrote to the Secretary of State for Health and Social Care on 30 January 2024, indicating they had “grave concerns about the proposal to move paediatric cancer services away from The Royal Marsden hospital in Sutton.” They indicated support for the service to transfer to St George’s Hospital and indicated if the decision was “in favour” of Evelina London they would “explore using [their] more formal call-in powers.”

### 9.3.3 Other Health Overview and Scrutiny Committees

The formal meetings held with other Health Overview and Scrutiny Committees (HOSCs) are outlined in the table below. East Sussex HOSC and West Sussex HOSC also submitted responses to the public consultation and Brighton and Hove submitted a response on 26 February 2024. Medway submitted a ‘nil return’.

Table 64: Engagement with other Health Overview and Scrutiny Committees

Engagement	Date	Key Points
Brighton & Hove HOSC meeting	15 March 2023	Brighton & Hove determined the proposed reconfiguration to be substantial for their area.
Brighton & Hove HOSC - pre-consultation meeting	12 July 2023	NHS England presented the background, case for change and the process to date alongside a planned timeline to decision-making, including discussion on public consultation timings. We also outlined the Integrated Impact Assessment. Discussion focused on incidence rates and the population impacted, travel and access, and elements of the options evaluation scoring.

		Brighton and Hove subsequently agreed it did not wish to undertake further formal scrutiny of our plans, but indicated its desire to be kept informed of their progress.
Brighton & Hove HOSC – post-consultation meeting	31 January 2024	High level findings of the independent consultation feedback report were discussed. The decision-making process was outlined. Focused points of discussion included continuity of care, communications with interested stakeholders, travel and accommodation support, and funding for the change.
Kent HOSC Meeting	29 February 2024	High level findings of the independent consultation feedback report were discussed including reach and feedback received including consideration around travel and access, estates, and the case for change. The decision-making process was outlined.
East Sussex HOSC Meeting	7 March 2024	High level findings of the independent consultation feedback report were discussed including reach and feedback received. The decision-making process was outlined. Areas of focus included travel and access, accommodation, workforce and plans for engagement during the service transition phase.

Their formal consultation responses are outlined below.

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## **Brighton & Hove Health Overview and Scrutiny Committee**

Brighton & Hove Health Overview and Scrutiny Committee's (HOSCs) response to the consultation commended NHS England for our approach to engaging with them, including contacting them at an early point in planning and responding swiftly to their requests for information. They described our approach as a model of how commissioners should engage with HOSCs on change programmes. They said the planning and delivery of stakeholder consultation on the change plans seemed to have been exemplary.

They set out their support for reconfiguration of the current Principal Treatment Centre, and for it to happen at pace, but did not express a preference for either option. They said both offer similar access challenges for Brighton and Hove families and the HOSC is not qualified to judge if one offers better clinical services than the other.

Areas of concern they reiterated for our attention were:

- travel including public transport costs, and the availability and cost of parking
- family accommodation for parents/carers
- continuity of care from clinicians.

## **East Sussex Health Overview and Scrutiny Committee**

East Sussex Health Overview and Scrutiny Committee's (HOSCs) formal response to our consultation highlighted travel and access support (including provision of information) for families as a particularly important consideration for the Principal Treatment Centre reconfiguration. This is because East Sussex has some areas of deprivation where families might not have access to a car. They also highlighted the longer journey to University College Hospital from East Sussex for radiotherapy and the support that would be needed for these journeys specifically.

They felt that Evelina London's lack of experience in paediatric cancer surgery would be a key challenge. For St George's Hospital, they were most concerned about potentially complex journeys by public transport from East Sussex, and the current staff turnover rates.

## **Kent Health Overview and Scrutiny Committee**

Kent Health Overview and Scrutiny Committee's formal response to our consultation described our approach to engagement with health scrutiny committees as exemplary.

They said they recognise the drivers for change and highlighted benefits of our proposals, including on-site specialist services and reduced need for transfers. Areas discussed by HOSC members at the HOSC meeting held on 29 February 2024 were:

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- the distance and ease of access to the future site
  - the cost of travel and the accessibility of reimbursements, and how more could be done to support and signpost parents to access financial support
  - future proofing and capacity of services at either of the potential locations
  - the impact on staff and what engagement with them had been undertaken.

They said they intend to write to Transport for London, Southeastern (trains company) and the Department for Transport about passes and concessions for parents transporting and visiting children receiving care.

Their response did not express a preference for either option but asked the clinical specialists to make an informed decision based on the facts and in the best interests of all stakeholders.

#### **Medway Children and Young People Overview and Scrutiny Committee (CYP OSC)**

This committee gave a “nil return” response to our consultation, saying they felt a formal response was not required.

#### **West Sussex Health and Adult Social Care Scrutiny Committee**

West Sussex Health and Adult Social Care Scrutiny Committee considered these proposals at its meeting on 8 March 2023 and felt that the proposals would improve clinical outcomes but was concerned that travel would be an issue for some families. The committee formally agreed that the proposals were not a substantial variation for West Sussex and requested to be part of the formal public consultation. The committee responded to the consultation to say it had no further comments to make.

### **9.4 Feedback from Local Authorities**

Responses to the consultation were received from six local authorities, all in London.

- London Borough of Bexley
- Lewisham Council
- London Borough of Merton
- London Borough of Sutton
- Southwark Council
- Wandsworth Council.

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All of them expressed support for one or other of the options, with the three local authorities in south east London expressing a preference for the future Principal Treatment Centre to be at Evelina London, and the three in south west London expressing a preference for it to be at St George's Hospital. The responses can be found in Section 13.8 of Appendix 2 (the independent consultation feedback report).



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## Decision making



## 10. Decision making

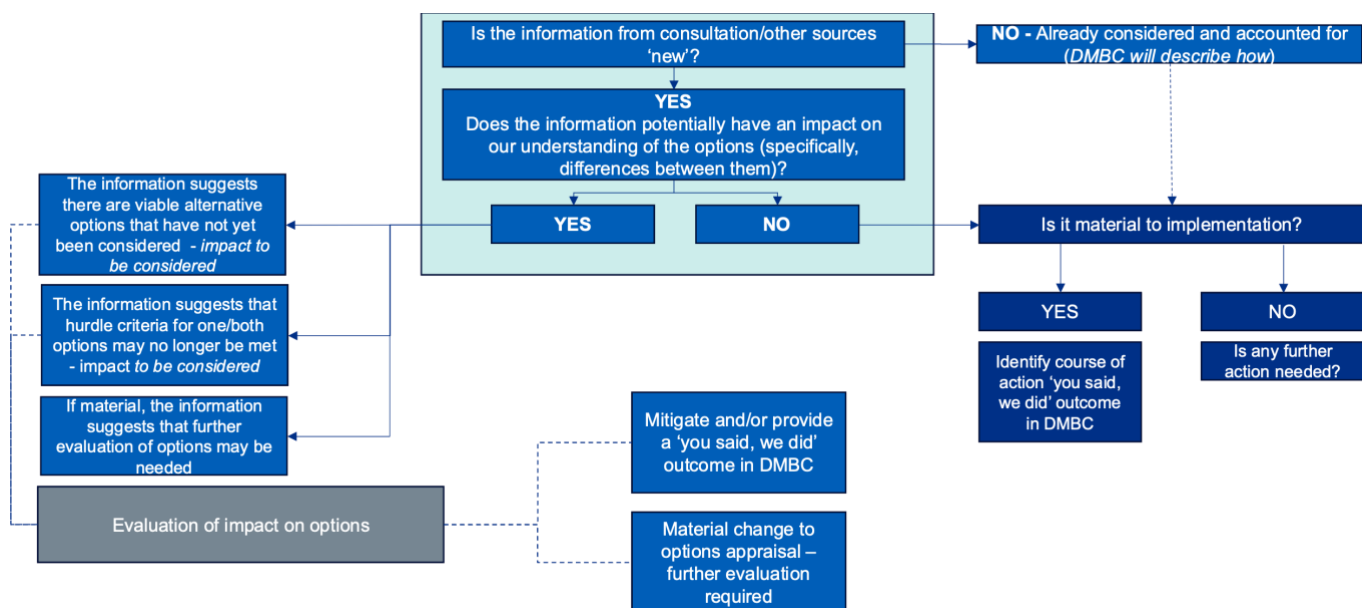
This decision-making business case has been written with the purpose of providing an evidence base to inform decision-making by NHS England (London and South East regions) on the future location for the Principal Treatment Centre for south London and much of south east England. In making their decision, decision-makers are to consider which option gives them the greatest confidence that it will deliver the best quality care for children with cancer in the future. In taking this decision, decision-makers are asked to look at all the evidence in the round, including information received from the public consultation, and have regard to the care for children from across the catchment area.

### 10.1 Decision-making process

As described in the pre-consultation business case (PCBC), based on the outcome of the options evaluation process outlined in the PCBC in which Guy's and St Thomas' proposal on behalf of Evelina London's received the higher overall score, Evelina London was our preferred option as we went into consultation. This outcome was based on what we, as commissioners, thought about the options based on the evidence we had at that point in time.

As part of this decision-making business case, we have been through a defined process to assess any new evidence or alternative options and its materiality, as set out in Section 7.1. This process is reflected in the diagram below. 'New' information is information that emerged after completion of the pre-consultation evaluation of the options.

Figure 8: Framework for review of information



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We have reviewed the consultation feedback using this framework. This process is described in Sections 6 and 7 and within this section, we will demonstrate how we've considered the impact of the consultation feedback and additional evidence on the options.

### **10.1.1 Impact of the consultation on the options**

Within Section 7, we have been through a process of reviewing the consultation feedback and the additional evidence that has arisen. We have used the framework to review information, consider this evidence and determine its impact on our understanding of the options.

The table below summarises the 'you said, we did' descriptions set out in Section 7.

Table 65: Consultation themes and actions to address

Theme	Subtheme	#	You said	We did
Clinical model	Evidence and benefits	1	Benefits should be articulated more clearly, with provision of metrics to monitor Principal Treatment Centre outcomes.	<p>Consultation feedback validated benefits reflected in consultation documentation and provided further evidence, allowing us to strengthen articulation of these, as summarised in Section 2.4.</p> <p>National metrics to monitor Principal Treatment Centre outcomes and performance will be in place from summer 2024 and these will provide a benchmark for future monitoring. Monitoring these metrics will sit alongside processes for ensuring patient safety (such as Serious Incident Review), evaluating equity of access to the service and other travel and access monitoring mechanisms. More detail is included in the IIA.</p>
	Mandatory services	2	Can the Trusts provide all the mandatory services, and associated interdependencies?	Both Trusts would meet the national specification mandatory requirements and could deliver the associated critical infrastructure. Planning and preparation will be needed to support this (including working in partnership with clinicians currently providing relevant oncology services). The adherence of the future Principal Treatment Centre

Theme	Subtheme	#	You said	We did
				to the national specification will be monitored through ongoing quality assurance.
	Interdependent services	3	The two potential providers provide different interdependent services. Evelina London provides specialist cardiology and nephrology services on site. It does not provide neurosurgery. St George's provides neurosurgery but does not provide specialist cardiology or nephrology.	Both providers have different strengths in particular service areas. We have reviewed these strengths as compared to the understanding in the pre-consultation business case. This process has confirmed that it will be important that robust plans are put in place by the future provider (working with partners) to develop their mitigations for those services which are not on site so that patients receive excellent care.
	Clinical expertise	4	There are differences in the respective expertise and experience of the potential providers in some key areas, and this should be clearly laid out and taken into account for decision making.	The experience of providers was considered as part of the pre-consultation evaluation of the options. Information about the experience of both providers was included in the pre-consultation business case and is in this document.

Theme	Subtheme	#	You said	We did
	Networked care provision	5	The future Principal Treatment Centre should have experience of networked care provision, managing care across the system.	We reviewed the networked care experience and arrangements for both providers noting that the future Principal Treatment Centre will have an important role ensuring the delivery of high-quality care across the Children's Cancer Operational Delivery Network.
Patient pathways	Patient transfers	6	Principal Treatment Centre reconfiguration doesn't solve the problem of patients requiring transfer.	Either option will result in more services being on the same site than now. However, movements of patients cannot be eliminated due to the configuration of services across London. While there will continue to be some transfers in the future, no children will be avoidably transferred for intensive care. University College London Hospitals clinicians have shared further detail on pathways for bone marrow transplant patients who need treatment at University College Hospital, including detail on transport arrangements.
	Moving on from children's services to teenage and young adult (TYA) services	7	Moving the Principal Treatment Centre may have a negative impact on patient experience, due to the need for patients to transition from a different site to	Both providers have also explained their current approach to transition to TYA services and adherence to National Institute of Clinical Excellence guidelines (we took this into account during the pre-consultation evaluation of the

Theme	Subtheme	#	You said	We did
			<p>The Royal Marsden which will remain the Principal Treatment Centre for TYA services.</p> <p>There would also be an impact on the existing TYA service which is provided from the Oak Centre for Children and Young People with some of the same staff who run the paediatric service. (This is covered in more detail in Section 7.3.2)</p>	<p>options). Detailed planning work would be needed in the service transition phase to design pathways and ensure these are well managed. There is precedent for this in other parts of the country. In 2019/20, there were 190 15-year-old patients being treated by the current Principal Treatment Centre. This provides an indication of how many patients may transition to TYA services per year.</p> <p>The Royal Marsden is currently developing an impact assessment of the relocation of the Children’s Cancer Principal Treatment Centre on its TYA service. The outputs of this will inform the work programme for the transition and implementation phases of the programme.</p>
Travel and access	Parking	8	<p>There needs to be sufficient parking provision at the future providers that is dedicated to the service and is comparable to the current provision at The Royal Marsden.</p>	<p>Both the potential providers have confirmed parking capacity would be available at the future Principal Treatment Centre. NHS England has made a recommendation around provision of parking and will monitor progress and feedback.</p>

Theme	Subtheme	#	You said	We did
	Travel time and cost	9	Travel time is an important and pressing issue, and increased costs associated with travelling to the future Principal Treatment Centre are a concern. Information needs to be provided about what help is available to support staff and patients.	The Integrated Impact Assessment incorporates refreshed travel time analysis and travel cost analysis as well and associated mitigations. We have also clarified the reimbursements and support that is available regarding travel costs. We have updated recommendations for the mitigation of the impact of increased travel time and cost, including the provision of information on what support is available.
	Non-emergency hospital transport	10	There needs to be adequate hospital transport provision. Hospital transport can often be unreliable, and eligibility criteria need to be reviewed.	Providers have clarified their hospital transport arrangements, and we have made a recommendation that the future provider should develop a family-centred strategy around non-emergency transport, including monitoring of performance.
	Impact on equality groups	11	Patients in deprived areas and ethnic minorities are likely to experience different impacts on travel time and cost compared to the rest of the population.	The EHIA describes mitigations around possible impact on health equity, including separate analysis for different ethnic groups, which shows that ethnic groups other than white have a lower travel time impact compared with the white population. Additionally, analysis shows that, on average, there would be decreased travel costs for patients from



Theme	Subtheme	#	You said	We did
				deprived areas, compared to travel to the current Principal Treatment Centre. <i>This does not negate the fact that some individual families will experience longer travel times or higher costs and that this impact needs to be mitigated as much as possible.</i>
	Providing care as close to home as possible	12	Ongoing communication and coordination of care between the Principal Treatment Centre reconfiguration and the paediatric oncology shared care unit (POSCU) Transformation Programme should be encouraged.	We have developed the description of the relationship between the Principal Treatment Centre reconfiguration and the POSCU Transformation Programme and articulated the enablers for shared care through Principal Treatment Centre reconfiguration.
	Safety of patients when travelling (via public transport)	13	Concern that travelling by public transport can present an infection risk for patients who are very unwell.	Mitigations have been developed to make alternatives to public transport (driving by vehicle and hospital transport) as easy as possible including through provision, improved processes and methods of reimbursement, recognising, however, that some patient's journey times by car will increase.

Theme	Subtheme	#	You said	We did
				It will also be important to ensure patients, families, staff and others are aware of the existing guidance on when public transport should be avoided so that people who choose/need to use it can do so with confidence.
Workforce sustainability	Workforce risks and mitigations	14	Risks associated with transition need to be appropriately managed, as some staff may not TUPE to either proposed site, or University College Hospital, in the future. Mitigations for expected staffing recruitment gaps should be considered and strengthened.	<p>The potential providers have provided further plans to bridge their workforce gaps and more detailed mitigations if staff in scope for TUPE decided not to transfer. Trusts have also provided further detail on key challenges and mitigations that may impact on the success of the future Principal Treatment Centre and their plans to mitigate against these risks.</p> <p>We recognise that the risks associated with transition (including the staffing gaps within the wider cancer workforce) are significant and need to be managed. Alongside trust mitigations, recommendations have been developed for regional oversight to monitor impact in real time, This would include the co-development of sustainable long-term workforce solutions.</p>

Theme	Subtheme	#	You said	We did
	Pay and benefits packages	15	<p>Consideration should be given to the benefits staff currently receive (such as on-site nursery care and training), and how that will be delivered in future. Staff should have financial assurance related to the impact of the Principal Treatment Centre reconfiguration on their net pay.</p>	<p>We understand the importance of staff being involved in the development of plans for the future Principal Treatment Centre. In particular, staff need to be able to advocate for key aspects of service change that may affect their roles and pay. Therefore, clear recommendations have been set out for the future provider, which will be monitored via the Implementation Oversight Board. Staff continue to be involved in the development of implementation plans and understand how their job and benefits will be affected.</p> <p>For further assurance we have reviewed the impact on net pay and recommended that the future provider should undertake a clear impact assessment on salary and benefits to inform their mitigations. Our workforce experts confirmed that additional spending on fares may be claimed via the travel policies of the future provider of the Principal Treatment Centre and University College London Hospitals on a case by case basis.</p>

Theme	Subtheme	#	You said	We did
Radiotherapy	Radiotherapy	16	If radiotherapy services are all provided at University College Hospital, this could lead to fragility and resilience risks, due to capacity and resourcing challenges.	University College London Hospitals has worked with us to develop mitigations for these concerns, including fragility and plans around enhancing capacity should this be required. An implementation plan has been shared by the Trust which incorporates these mitigations and sets out the overall transition period.
Impact on other services	Newly identified impacts	17	It is important to reconsider the impact of the Principal Treatment Centre reconfiguration on other services to ensure all potential impacts have been identified.	We further reviewed the impacts outlined in the pre-consultation business case to ensure that due consideration is given and risks and mitigations for each are clearly set out. We identified two additional potential impacts of reconfiguration (on recruitment and retention at Great Ormond Street Hospital and on mIBG therapy). We have outlined plans for addressing these additional impacts in Section 8.6 and continue to work with key organisations that would be impacted to further understand the implications of the Principal Treatment Centre reconfiguration.

Theme	Subtheme	#	You said	We did
Estates & Facilities	Ensuring appropriate physical capacity	18	Further assurance needed around capacity including for children's intensive care and inpatient beds.	<p>Comparative analysis of existing population growth analysis, to 2021 population forecasts, supports our expectations of 0% demand growth based on population growth and incidence forecasts.</p> <p>The Royal Marsden has advised that the service experiences surges in demand, we also recognise there could be changes in the model of care. We have therefore run a sensitivity analysis and both potential providers have provided assurances around their flexibility to provide further capacity if required.</p> <p>Critical care capacity across London needs to be actively managed with particular peaks over winter, but London is implementing changes to the delivery of paediatric critical care, enabling those who require lower levels of care to receive it locally.</p>
	Safe spaces / play areas (to ensure effective infection control)	19	Equivalent play, education and outdoor play spaces should be provided by the future Principal Treatment Centre.	We have asked the potential providers clarification questions to confirm their safe spaces and play area arrangements – both have confirmed this would be available.

Theme	Subtheme	#	You said	We did
				We have made recommendations around provision of this space and will monitor progress and feedback.
Research	Research	20	You have concerns about potential impacts on research and clinical trials if these are not carefully managed.	Both proposals were previously scored against the research domain evaluation criteria to inform an understanding of their respective strengths.  We reviewed 'new' research risks/mitigations. This emphasised the importance of close, collaborative working between stakeholders during the implementation phase. It has further informed our understanding of the risks which will be important during the next phase of the programme.
Strength of case for change	Alternative ideas/proposals	21	Several alternative proposals could be considered, including a risk-adapted solution, making use of the potential new hospital to be built at Sutton, or a suggested 3-stage solution involving adopting new technologies.	We have previously considered these alternative proposals, which unfortunately do not remove the underlying risks of the current arrangements whereby the very specialist cancer treatment services provided at The Royal Marsden are not on the same site as a level 3 children's intensive care unit that can give life support or associated

Theme	Subtheme	#	You said	We did
				children's services. Nor do they comply with the national service specification. The future Sutton hospital will not have a level 3 children's intensive care unit, as it would not be clinically sustainable.
	Single site solution	22	Throughout the consultation there were calls for a single site solution, with concerns related to radiotherapy not being available on-site in either of the proposed options.	University College Hospital is the only viable option with relevant scale and breadth of expertise to provide the future service. It would not be feasible for either Evelina London or St George's to build an equivalent radiotherapy service to that provided at University College Hospital which has benefited from significant investment and infrastructure, including the proton beam and a highly specialised workforce.
Deliverability	Timelines to deliver	23	Implementation should be undertaken in a timely fashion to ensure safe transition. Realistic timelines for this should be provided, and mitigations for implementation risks should be developed.	The providers have provided updated implementation timelines, with updated risks and supporting mitigations. We continue to assume a transition period of 2.5 years before the future Principal Treatment Centre transfers. Detailed plans for underlying workstreams will be developed after a decision is made. Delivery of plans will be monitored by the Implementation Oversight Board to ensure that the service transfer is safe and

Theme	Subtheme	#	You said	We did
				sustainable, conducted in a timely manner so that benefits of the change can be realised.
	Information sharing	24	Important to give clear, open communication about the timeline, key milestones and ways to get involved. Reassurance around staff retention and impact on care should be given on a regular basis.	The trusts have shared implementation plans with key milestones (included within this decision-making business case). Regular reporting will be required as part of implementation on delivery of the plans and recommendations, including comprehensive information sharing.
	Risks and mitigations for delivery	25	Recognise, and mitigate for, the fact that establishing a new service brings risks and may negatively impact the service as it transitions to the new site.	While there are risks to the delivery of the future Principal Treatment Centre, the case for change is strong. We will continue to monitor the risks and mitigations to them throughout implementation.
	Funding and financing	26	There is general concern around funding for the options (including research), and financial sustainability challenges for both of the options.	Both options are affordable from both a funding and financing perspective. As the future provider develops its outline business case and full business case, it will need to continue to demonstrate affordability with mitigations in place for associated risks.



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As per the framework for review of information, we have considered throughout this process the initial question of whether the information is new, and if so, whether it has a material impact on our understanding of the options and, specifically, the differences between them. 'New' information is information that emerged after completion of the pre-consultation evaluation of the options.

In the majority of cases, through this decision-making business case, the consultation feedback and additional evidence developed has clarified areas relevant to implementation, or provided further mitigations to consider. 'New' information, and therefore new evidence for the consideration of decision makers is summarised below:

### **Theme 1: Clinical model**

**Interdependent services:** new information has increased our understanding of mitigations for interdependent services that will not be on site, depending on the option that is chosen as the location of the future Principal Treatment Centre, particularly neurosurgery. Mitigations would be needed for neurosurgery if the future Principal Treatment Centre was at Evelina London, which does not provide neurosurgery. Interdependent services formed part of our pre-consultation options evaluation; the information does not differentiate further between our understanding of the options.

### **Theme 2: Patient pathways**

**Transition from children's services to teenage and young adult services:** Consultation feedback has strengthened our awareness of the risks of the reconfiguration to the process to support children moving on to teenage and young adult services. Feedback emphasised the importance of managing this during implementation. Impacts on The Royal Marsden's Teenage and Young Adult Principal Treatment Centre are likely to be similar regardless of which provider is selected as the future Children's Cancer Principal Treatment Centre. Our evaluation of the options looked at how both Evelina London and St George's Hospital currently support children and young people to move on to teenage and young adult services. This does not differentiate further between our understanding of the options.

### **Theme 3: Travel and access**

**Travel times and costs:** We understand that families are concerned about the costs of travel. We have analysed the costs of driving to both potential sites for the future Principal Treatment Centre and to University College Hospital. Travel costs analysis shows both options cost less to get to than The Royal Marsden by car, on average, with the average

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journey being £2 to £3 cheaper. Travel to University College Hospital is about the same. However, there is variation across patient journeys and some families would see travel costs increase, some substantially. The reduction in average driving costs is slightly greater for St George's Hospital. This does not impact on our understanding of the differences between the two options as we already understood from the pre-consultation options evaluation that travel by car was likely, on average, to be quicker to St George's Hospital and this finding is in line with that.

**Impact of reconfiguration on equality groups – travel times and costs:** We understand that people are concerned about the impact of travel and access on equality groups. New analysis has been undertaken of driving times and costs for socio-economic groups and ethnic groups. Analysis shows that although driving times increase on average for all groups for both options and to University College Hospital compared to current journeys, the increase is less on average for ethnic groups other than white than for white ethnic groups. Analysis of driving costs shows that although, like now, they remain higher for the most deprived population than the whole population, the reduction in cost to both options and University College Hospital is greater for people travelling from more deprived areas than for the area as a whole. This indicates that the change could improve ability to access services for these populations. The reduction in average driving costs for the most deprived population is slightly greater for St George's Hospital. This does not impact on our understanding of the differences between the two options as we already understood from the pre-consultation options evaluation that travel by car was likely, on average, to be quicker to St George's Hospital and this finding is in line with that.

**Sufficiency of on-site accommodation:** We understand that it is important for families to have access to accommodation close to the Principal Treatment Centre. We have received new information on the level of Ronald McDonald House provision at each site and arrangements for payment for family accommodation. While both options have Ronald McDonald capacity, St George's Hospital has a much smaller facility than Evelina London, although it is recognised that this benefit for Evelina London is likely to be offset by higher demand. Both potential providers have access to alternative accommodation which is used to support excess demand. This isn't differentiating on current information. Further consideration and development of accommodation plans and mitigations are reflected in our recommendations for implementation.

#### **Theme 4: Workforce sustainability**

No new information has been identified for workforce sustainability, however consultation reinforced our understanding that:

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- There will be a time and cost impact of the changes on staff – while a systematic public transport cost analysis across the entire staff cohort is not possible, illustrative journeys indicate that the costs of travel are likely to be greater for the majority of staff than their current travel costs. Under TUPE protections, relocated staff will be eligible to receive support for excess costs for up to four years (claims will be reviewed by the future provider on a case by case basis) and will also receive inner London high cost area supplement.
  - There will need to be robust retention, training and recruitment plans to ensure the wide range of skills and competencies required to provide high quality care for patients of the Principal Treatment Centre, both before and after service transition, are available.

We have detailed recommendations in place to address these and other concerns regarding workforce sustainability during implementation. This does not differentiate further between our understanding of the options.

### Theme 5: Radiotherapy

**Arrangements for radiotherapy:** We considered potential risks of the proposed relocation of conventional radiotherapy services before the public consultation; concerns raised in public consultation have prompted us to gather extra information from University College London Hospitals NHS Foundation Trust (University College London Hospitals) to provide further assurances over how these would be managed. Both potential providers propose that conventional radiotherapy is provided at University College Hospital and this information does not differentiate between the options. We acknowledge that there are some important travel impacts associated with our proposal that will need to be managed through the service transition and implementation phases. University College London Hospitals already provides proton beam and superspecialist radiotherapy for the current Principal Treatment Centre and conventional radiotherapy for others, it would provide the full range of radiotherapy treatments for the future centre with a range of associated benefits.

### Theme 6: Impact on other services

**Impact on mIBG (meta-iodobenzylguanidine) therapy:** arrangements for provision of this therapy (currently provided at The Royal Marsden) for a small number of children with cancer from across the country were raised through consultation. Like radiotherapy, considerations for mIBG therapy are needed irrespective of the location of the future centre. Besides The Royal Marsden, the only other centre in England which provides this service is University College Hospital.

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**Potential impact on Great Ormond Street Hospital:** Concerns were raised through consultation around recruitment and retention challenges at Great Ormond Street Hospital if the future Principal Treatment Centre is located closer, with a perception the impact could therefore be greater if the future centre was at Evelina London. Potential impacts on services at Great Ormond Street Hospital would be kept under review during the service transition and implementation phases. At this time the risk is not considered to be significant in the context of workforce mitigations identified. Great Ormond Street Hospital for Children NHS Foundation Trust is supportive of the case for change and of the development of a joined-up workforce strategy with the future Principal Treatment Centre. Given this risk is not significant, and clear mitigations are identified, this does not differentiate further between the options.

## Theme 7: Estates and facilities

**Ensuring appropriate physical capacity:** New information has been shared providing assurance that both potential providers could expand capacity should baseline assumptions change. Further work with University College London Hospitals has re-confirmed that there would be a range of options to meet demand arising from our proposals, which was a concern of the consultation. If a need is determined, we are assured that there would be a solution for additional LINAC capacity (LINACs are the machines that deliver radiotherapy). This would be agreed during the transition phase. This does not differentiate further between the options as both Evelina London and St George's Hospital have demonstrated adequate capacity, and in both options, radiotherapy will be provided at University College Hospital.

**Estates solution:** The proposed location for the Evelina London option was updated in April 2023, following the options evaluation, and was reflected in the pre-consultation business case. Evelina London's proposal is for the children's cancer ward to be on the third floor of the main children's hospital building. Benefits would be associated with the centre being within the Evelina London footprint. This space is currently being used by other clinical services with the impact that a series of four decants would be required. Guy's and St Thomas' NHS Foundation Trust has provided mitigations for this, including staggering of decants and construction work, alongside robust programme management. The capacity and facilities offered in the updated estates solution is the same as assessed at options evaluation. This information doesn't materially impact our understanding of the options.

St George's proposed option remains unchanged. In the future, St George's Hospital would have a new children's cancer centre in a converted wing of the hospital with its own entrance. The centre would include the inpatient ward, outpatient clinics and day case

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treatments. Consultation feedback highlighted benefits of these proposals and also considerations around the wider hospital environment.

In response to consultation feedback around the configuration of proposals for Evelina London's proposed cancer centre, the trust has developed plans to demonstrate it has flexibility on the configuration of ward space and also for outpatients accommodation. The final configuration would be confirmed during the service transition phase if Evelina London was the future Principal Treatment Centre.

### Theme 8: Research

**Research capability and capacity:** Concerns were raised about the potential impact of reconfiguration on research capacity and capability, echoing pre-consultation engagement. Both providers had previously set out their mitigations and we have also worked with The Royal Marden and the Institute of Cancer Research to consider these. New information about a potential merger between St George's, University of London and City, University of London was provided by St George's. We note this reflects potential opportunities for St George's to broaden its research platform (including in areas such as computer science and engineering, among others) but do not, at the moment, have evidence to suggest this would have a material impact on our understanding of the options.

### Theme 9: Strength of case for change

No new information was identified. We have set out consultation feedback about the case for change and responded to alternative solutions that were raised in consultation.

### Theme 10: Deliverability

The financial impact assessment confirmed that both options remain affordable in terms of revenue and capital. Both potential providers propose to refurbish existing space within their hospitals to create dedicated areas for children with cancer to be cared for. Work to develop the future Principal Treatment Centre would use £20 million national capital contribution from NHS England plus a contribution from their local health commissioners, of circa £11 million to £14 million. The Evelina London option would also use £10 million of grant funding from the Trust charity.

Both proposals for the future location of the Principal Treatment Centre have been costed and remain subject to robust financial scrutiny. Recurrent capital and revenue affordability have been tested and assured at an appropriate level within the pre-consultation business case. Both Trusts have provided reasonable sensitivity analyses showing how downside

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income and cost scenarios would be managed. This business case outlines a commitment to fund non-recurrent stranded and transitional costs.

## Summary of information review

As we have noted above, any new information has been considered specifically in the light of whether this differentiates the options as compared to previous assessments. As summarised above and set out in Section 7, while some information is new, it has not materially differentiated the options further than at the pre-consultation options evaluation. All the information set out above is material to implementation and will be very useful for the provider of the future Principal Treatment Centre.

## 10.2 Decision-making

On the balance of information reflected in this business case, decision-makers for NHS England London and South East regions are therefore asked to consider the following resolutions:

1. To agree that, if chosen and implemented as the future Principal Treatment Centre, either option under consideration could meet the national service specification for Children's Cancer Principal Treatment Centres, issued by NHS England in November 2021.
2. To agree that the future location for the Principal Treatment Centre should be Evelina London Children's Hospital.
3. To agree that conventional (photon) radiotherapy services for the future Principal Treatment Centre will be delivered by University College London Hospitals NHS Foundation Trust at University College Hospital.
4. To agree and adopt the recommendations (set out below) that will support the smooth transfer of services, enable continuity of care for patients and deliver the benefits of the clinical model.
5. To establish a London and South East Implementation Oversight Board (including patient and public voices, and independent representation) to oversee the service transition and monitor the delivery of the recommendations throughout implementation.

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## 10.3 Recommendations

As part of decision-making, leaders for NHS England (London and South East regions) have considered key recommendations for implementation that Evelina London Children's Hospital will be required to deliver.

These recommendations will be tracked and monitored according to the governance for implementation set out in Section 11.2.3.

These are summarised below.

Table 66: Recommendations for implementation

Theme	#	Subtheme	Recommendation
Clinical model	1	Benefits	Further development of plans for the future Principal Treatment Centre should focus on delivering and maximising benefits associated with the reconfiguration. Monitoring of benefits realisation and of clinical outcomes/service standards through resources such as the Specialised Services Quality Dashboard (SSQD) should form part of the oversight framework (described in Section 10.1). This should be owned by the future Principal Treatment Centre.
	2	Mandatory services	Future Principal Treatment Centre to ensure that, prior to the current services transferring, detailed planning and service development work is undertaken to deliver mandatory services to the standard set out in the National Service Specification as a minimum, with consideration for ‘future proofing’ services to meet changing demand. This is expected to be done in partnership with clinicians and experts currently providing these services as well as patients and families.
	3	Neurosurgery	Irrespective of the decision, further consideration of specific neurosurgery arrangements would be needed to optimise pathways for patients of the future Principal Treatment Centre and ensure good patient experience.



Theme	#	Subtheme	Recommendation
	4	Interdependent services - on site	Appropriate capacity and resilience needs to be in place for all aspects of care for interdependent services to support the delivery of care to future Principal Treatment Centre patients; more detailed service planning will need to be carried out by the future Principal Treatment Centre during the service transition phase.
	5	Interdependent services - off site	Clear patient pathways and targets for access to these services need to be set out prior to implementation, with appropriate mitigations in place for when patients need to be transferred. The future provider (supported by the wider system) should work collaboratively across the system to design patient pathways that minimise transfers.
	6	Networking	The future provider should focus on the development of effective networking arrangements with providers across the networks, most importantly paediatric oncology shared care units (POSCUs) across the Children's Cancer Operational Delivery Network. This will support continuity of care and the development of effective communication approaches as well as the transformation programme associated with the delivery of the national service specification for POSCUs. Where there are opportunities to align governance and deliver synergies through the two programmes of work, these should be explored.

Theme	#	Subtheme	Recommendation
Patient pathways	7	Teenage and young adults transition arrangements	Effective transition from the Children's Cancer Principal Treatment Centre to the Teenage and Young Adult Cancer Principal Treatment Centre must be considered during service planning. The future provider should work in close collaboration with The Royal Marsden and wider network, with input from patients, parents and carers, to agree how pathways can be optimised with a particular focus on the 16 to 18 age group. The Implementation Oversight Board should monitor progress and support any barriers to be addressed.
	8	Impact on teenage and young adults services	NHS England and Integrated Care Boards to continue to work with The Royal Marsden and other stakeholders to support ongoing sustainability of the teenage and young adult service at Sutton, including through the provision of stranded costs.
Travel and access	9	Parking	Parking possibilities must be available for patients and carers at the future provider and University College London Hospitals, and they must be easily accessible from the hospital. Processes around payment must be easy to understand and accessible (catering for families experiencing digital exclusion and available in inclusive formats).
	10	Hospital transport	Alternative methods of patient transport to and from hospital should be provided and its performance monitored (e.g., reliability of timing) by the

Theme	#	Subtheme	Recommendation
			provider of the future Principal Treatment Centre and University College London Hospitals.
	11	Equity of access	The provider of the future Principal Treatment Centre and University College London Hospitals should ensure that accessibility arrangements meet the needs of equality groups (for example, cost reimbursement for those experiencing financial difficulties, translation and inclusive communications for those that require it or reasonable adjustments for those with disabilities) and are regularly monitored against equality frameworks.
	12	Children's cancer shared care unit	The provider of the future Principal Treatment Centre should work with the Children's Cancer Network to support the development of plans and model of care within paediatric oncology shared care units so that all children and young people have the same experience of care, delivered close to home whenever this is possible.
	13	Travel and accommodation costs	The future provider and University College London Hospitals should further consider mechanisms to support families or staff who can't pay for travel costs or hotel accommodation, such as easier access to automatic reimbursement mechanisms or collaboration with local hotels if appropriate.

Theme	#	Subtheme	Recommendation
Workforce	14	Risks to current workforce	The Implementation Oversight Board should continue to develop mitigations and contingency plans for the potential changing profile of the existing workforce (for example, if fewer staff are retained than expected, fewer staff transfer or staff resign), monitoring resilience and support delivery of the current service. Where needed, identify mitigating actions to ensure that the services can continue to deliver high quality care.
	15	Supporting staff to transfer	As a high priority, the future provider should support retention of the current workforce, including through clear and timely communications, close engagement and providing assurance about future arrangements. Salary and benefits should also undergo a clear impact assessment, with financial mitigations provided where possible.
	16	Integration and organisational development	The future provider should work with The Royal Marsden (and St George's if applicable) to develop an organisational development strategy to preserve and support the transfer of organisational memory, key skills, and competencies and support integration of multiple teams. Ensure staff working in the future Principal Treatment Centre receive equivalent benefits, with appropriate onboarding processes, organisational culture and values integration, and buddying processes between staff.

Theme	#	Subtheme	Recommendation
	17	Workforce strategy	<p>A workforce strategy should be co-developed between organisations and collaboratively with support from the wider network, aligned to regional workforce strategies. This should be developed through the workforce workstream, with staff and HR representation, and should include detailed training and education plans (including engagement with relevant leads for training posts in service), as well as recruitment and retention plans.</p> <p>The Royal Marsden to work with the future provider to consider value of @Marsden model as a vehicle for continuity, collaboration and making best use of available skills and expertise.</p>
	18	Workforce planning	<p>The future provider should develop a detailed workforce modelling baseline and plan, against competencies required to deliver the Principal Treatment Centre and recruitment and retention gaps. They should also carry out a mapping exercise to determine any gaps or new roles that will be required to deliver the services with the appropriate workforce as part of transition planning.</p>
Radiotherapy	19	Radiotherapy	<p>The future provider should work closely with University College London Hospitals, The Royal Marsden, commissioners, and other stakeholders to develop detailed patient pathways, capacity and resourcing plans for</p>

Theme	#	Subtheme	Recommendation
			conventional radiotherapy services, drawing on the experience of providing care for patients from other Principal Treatment Centres.
Impact on other services	20	Working with organisations	The future provider, along with NHS England, Integrated Care Boards and other system partners should work with organisations/services which could be impacted by Principal Treatment Centre reconfiguration to ensure that risks are monitored so that mitigations can be identified in a timely way, including through collaborative working and existing networks.
Capacity	21	Sufficient capacity and resource	Sufficient capacity for beds, theatres, and clinical support services should be in place for Principal Treatment Centre, with potential for future capacity expansion should this be required. Ongoing review of capacity requirements for the future service should take place with associated demand/capacity planning and consideration of POSCU transformation, new treatments/therapies and other changes to models of care to enable this.
Estates	22	Estates solution	The estates solution for the future provider should continue to be developed during the service transition phase, with clinical, patient and carer input to the design.

Theme	#	Subtheme	Recommendation
	23	Accommodation and wider spaces	The future provider should develop detailed design work to ensure appropriate space is provided for accommodation, education, indoor and outdoor play space drawing on engagement with patients, carers, staff and wider stakeholders on their needs, in line with advice from the London and South East Clinical Senates.
Research	24	Research	<p>Work closely with the Institute of Cancer Research, The Royal Marsden and other key stakeholders to maintain and support the development of research and access to clinical trials for children and young people. We suggest that a dedicated work programme focused on enabling this through the management of risks is established with support from an Expert Advisory Board.</p> <p>The future provider should also work with The Royal Marsden to explore potential for a @Marsden model as a vehicle for supporting collaboration, continuity of research and clinical trials.</p>
Deliverability	25	Timely delivery to realise benefits	In order to realise benefits of the service change in a timely way it will be important that the future provider of the Principal Treatment Centre works proactively to enable the safe transition of the service in line with plans. Collaborative working with partners will be a key enabler to this and should support the development of more detailed plans and business

Theme	#	Subtheme	Recommendation
			cases informed by and co-designed with staff, patients, families and other stakeholders.
	26	Governance	Work with NHS England/Integrated Care Boards through the identified governance processes to ensure recommendations and mitigations are implemented with necessary support in place. This should include active management of risks including over the transition period and early implementation phase.
	27	Recommendations from the Integrated Impact Assessment	Establish a Travel and Access group with representatives across providers and commissioners to implement the recommendations set out within the Integrated Impact Assessment.
	28	Leadership	<p>Successful change requires strong clinical leadership. To enable successful implementation, clinical leaders from the current Principal Treatment Centre and future provider will need to be identified, developed and supported.</p> <p>Joint roles between organisations are also likely to be an important enabler to effective integration between teams and should be established to support the change process.</p>



Theme	#	Subtheme	Recommendation
	29	Support to families throughout transition	Consideration and plans developed to support families preserve memories and legacies, and support families throughout the transition and implementation period.
	30	Affordability	The future provider should demonstrate capital and revenue affordability of the scheme through development of the outline business case and full business case, with mitigations in place for associated risks.

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## 11. Implementation

### 11.1 Governance arrangements

#### 11.1.1 Overview

Once a decision has been made on the future provider of the Principal Treatment Centre, the Trust will work collaboratively with The Royal Marsden, St George's (if it is not the future provider), University College London Hospitals, other NHS partners, third sector and wider stakeholders to lead work on the service transfer. Along with the development and delivery of a detailed work programme for the service transition, this will also include a focus on recommendations agreed at the time of decision-making.

During the early part of this transition period, ownership for the delivery of programme will transfer from us to the future provider. We, along with relevant Integrated Care Boards will have a key role in implementation and will remain involved in the programme in a supportive capacity along with providing scrutiny, assurance, and decision-making input. A robust governance structure will be required to ensure joint decision-making and collaboration between the future provider, current Principal Treatment Centre providers (as applicable), NHS England, Integrated Care Boards and wider stakeholders.

The key considerations to ensure successful implementation of the plans include:

- Addressing the recommendations agreed at decision making, putting everything in place for a safe, smooth transfer of care.
- Ongoing engagement - partnership working will be invaluable in developing the design of the future service, maintaining the current levels of research activity and enabling the transition to happen as smoothly as possible, including the management of risks. Continued engagement with staff, patients and their families, and professional organisations will play an important part in this.
- A focus on supporting staff retention and recruitment to help ensure service sustainability.
- Review and development of clinical pathways including for conventional radiotherapy.
- Developing locally agreed mitigations/action plans for the areas identified in our Integrated Impact Assessment (Section 8.4) and particularly to address concerns around travel and access.

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- Development of a workforce strategy to address key gaps, ensuring the availability of the workforce to staff the current and future services with appropriate skill mix, training, and education.
  - A focus on capital plans, with development by the future provider of the required business cases, and timely delivery of the works required to refurbish existing space for the future centre.

### **11.1.2 Post decision governance arrangements**

Robust governance arrangements will be key to manage risks and dependencies across the system. The governance arrangements will build on the governance structures that were put in place for the development of the pre-consultation business case and decision-making business case, with future governance to be agreed.

It will be important that implementation is undertaken in a timely fashion to ensure the benefits associated with the service reconfiguration are realised; timelines will also need to be sufficient to ensure the safe and sustainable transfer of care, delivered in line with the national service specification. The needs of staff, patients and families will be central.

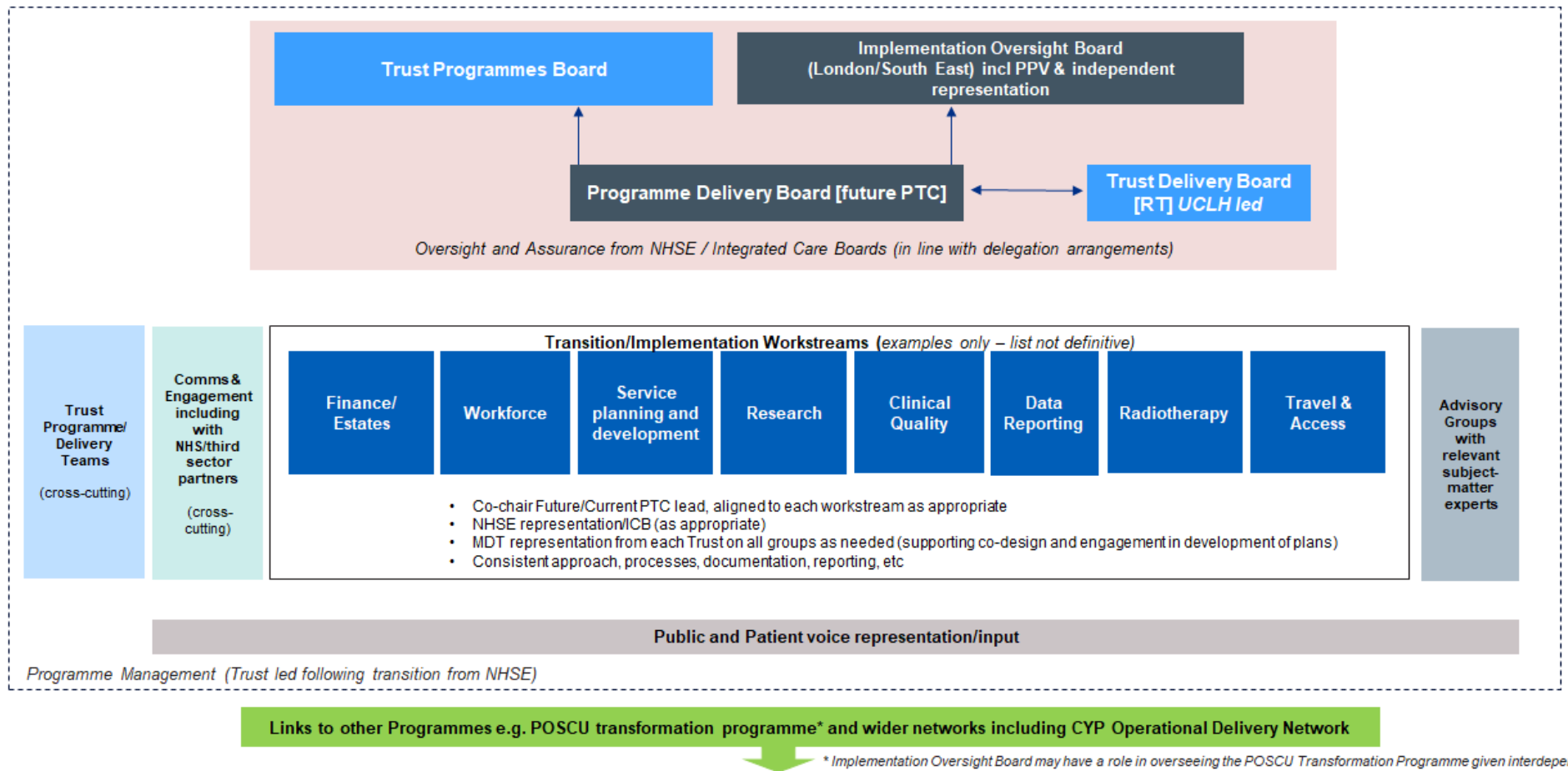
It is envisaged that an Implementation Oversight Board will be established to provide direction and oversight for the implementation of the future service, including to oversee delivery of recommendations, priorities, realisation of benefits, supporting collaboration between stakeholders, and ensuring risks related to the service transfer are managed and mitigated.

The proposed implementation governance is outlined in Figure 9.

Guy's and St Thomas' NHS Foundation Trust, St George's University Hospitals NHS Foundation Trust and University College London Hospitals have developed proposed governance arrangements and implementation timelines should they be chosen as the future provider of the Principal Treatment Centre/radiotherapy services. These are included in Appendix 12. Post decision, NHS England will work with the future providers of the Principal Treatment Centre and radiotherapy services to agree and establish the implementation governance.

Figure 9: Proposed implementation governance

# Proposed Implementation Governance



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The role of the Implementation Oversight Board will be to:

- Ensure the delivery of the benefits associated with the reconfiguration programme, including oversight of implementation of the recommendations proposed in this decision-making business case.
- Performance manage and monitor service quality and standards during the implementation phase.
- Ensure the programme delivers within its agreed parameters (for example, within the time period stated or reasonable other period agreed, management of costs).
- Oversight to ensure any potential impacts on other NHS services are identified in a timely way and mitigated.
- Resolve strategic and directional issues between workstreams, which need the input and agreement of senior stakeholders to ensure the progress of the work.
- Support the resolution of escalated risks and issues.
- Oversee any external dependencies of the programme.
- Provide formal approval in relation to deliverables and services produced by the programme.

Membership is envisaged to include Trust representatives from both the future and current service including those with a key enabling role (Great Ormond Street Hospital and King's College Hospital); commissioner representation; independent, and patient and public voice representation. This will be finalised through governance after a decision has been made.

Post decision, in addition to the governance structure for implementation outlined above, NHS England will also convene a task and finish group with Trusts and Integrated Care Boards to develop transition and cut over plans which include stranded and transitional costs. It is envisaged that this work would include clinical, workforce, estates and financial subject matter experts. The purpose of the financial element of this group will be to assess the value of stranded and transitional costs for impacted parties, and to make recommendations for the funding of those together with relevant timelines.

Proposed focuses and responsibilities for each of the workstreams is listed below. This is indicative and would be developed through detailed Roles and Responsibilities and Terms of Reference with the future provider.

Table 67: Workstream responsibilities

Workstream	Responsibilities
<p><b>Workforce</b></p>	<p>The workforce workstream oversight group will be responsible for developing the workforce model, recruitment strategy, training, and development. Other responsibilities will include:</p> <ul style="list-style-type: none"> <li>• Further analysis of workforce competencies required to deliver the Principal Treatment Centre and carrying out a mapping exercise to determine any gaps or new roles that will be required to deliver the services with the appropriate workforce.</li> <li>• Carrying out a more detailed workforce modelling baseline, against competencies and recruitment and retention gaps, and updating this on a frequent basis with a detailed transition plan and budget to mitigate against retention and recruitment challenges.</li> <li>• Developing mitigations and contingency plans for the potential changing profile of the existing workforce (for example, if fewer staff are retained than expected, fewer staff transfer or staff are on leave).</li> <li>• Working closely with the communications/staff engagement workstream particularly to engage the current Principal Treatment Centre workforce in workforce design and planning.</li> <li>• Ensuring current Principal Treatment Centre staff receive benefits that are equivalent to new staff benefits, with appropriate onboarding processes, organisational culture and values integration, and buddying processes with current staff.</li> <li>• Developing training plans, informed by national guidance, to ensure the appropriate staff and competencies are in place, and the Principal Treatment Centre is an attractive career prospect for staff.</li> </ul>

Workstream	Responsibilities
<p><b>Clinical Quality and Patient Experience</b></p>	<p>The clinical quality and patient experience workstream oversight group will be responsible for developing integrated clinical pathways and patient transition planning. This will include joined up working with the Children’s Cancer Network. Other responsibilities will include:</p> <ul style="list-style-type: none"> <li>• Ensuring that prior to the Principal Treatment Centre transferring, further work is undertaken to enable readiness to deliver mandatory services to the standard set out in the national service specification.</li> <li>• Ensuring appropriate capacity and resilience across all aspects of care for interdependent services to provide care to Principal Treatment Centre patients.</li> <li>• Setting out clear patient pathways and targets for access to these services prior to implementation, with appropriate mitigations in place for when patients need to be transferred. Working collaboratively across the system to design patient pathways that minimise transfers.</li> <li>• Working closely with the Children’s Cancer Network, children's hospice services and wider community services to design future pathways, identifying opportunities for improvement to ensure patients receive best quality care at right place, right time.</li> <li>• Further consideration of specific arrangements for interdependent services which are not on the same site so as to streamline pathways and ensure good patient experience, with potential transfers identified early in the patient's pathway.</li> <li>• Ensuring that the Principal Treatment Centre meets latest national guidance. Benefits monitoring of clinical outcomes/service standards through the outcomes framework, which is described in Section 11.2.2.</li> </ul>

Workstream	Responsibilities
	<ul style="list-style-type: none"> <li>• Developing plans and models of care to improve local hospital care (including POSCU transformation), alongside Principal Treatment Centre reconfiguration.</li> <li>• Developing the patient and family engagement plan, carrying out patient and family surveys and events, ensuring that service transition and planning is communicated clearly to all patients and their families, and they are engaged throughout.</li> </ul>
<b>Research</b>	<p>The research workstream oversight group will be responsible for developing the plans for research and implementing these plans. Membership is expected to include key partners such as the Institute of Cancer Research (ICR). Other responsibilities will include:</p> <ul style="list-style-type: none"> <li>• Working closely with ICR, The Royal Marsden and other key stakeholders to support the continued development of research and access to clinical trials for children and young people through creation of a dedicated work programme focused on managing risks to delivery of the future service with the proposal that an Advisory Board is stood up to provide support and guidance.</li> </ul>
<b>Communications/staff engagement</b>	<p>The communications/staff engagement workstream oversight group will be responsible for strategic and operational communications and engagement activity to ensure patients and families, staff, stakeholders and others are kept fully informed and are able to shape the future service and facility. Their other responsibilities include:</p> <ul style="list-style-type: none"> <li>• Defining key messages, selecting appropriate communications channels, and ensuring the transition and planning is communicated clearly to all staff across providers.</li> <li>• Developing the staff engagement plan, carrying out staff surveys and engagement activities. Analysing the</li> </ul>



Workstream	Responsibilities
	<p>feedback from staff, identifying concerns and proactively addressing them.</p> <ul style="list-style-type: none"> <li>• Ensuring regular and effective updates on key milestones. Providing clear messages on ways of working, change management.</li> <li>• Designing and implementing initiatives aimed at promoting cultural alignment including team building activities; equality, diversity and inclusion initiatives that reflect the organisation's values.</li> </ul>
<p><b>Finance (capital and estates)</b></p>	<ul style="list-style-type: none"> <li>• The finance (capital and estates) workstream will be responsible for further development of the estates design and commercial and procurement strategy. The group will have oversight of all aspects of the capital programme. A Programme Director will be appointed to lead the development of the scheme through outline business case and full business case following the RIBA stages and timescales set out in the Section 8.8.</li> <li>• Other responsibilities of the group may include:</li> <li>• Developing plans for estates and facilities upgrades, adhering to latest guidance such as Net Zero and Modern Methods of Construction.</li> <li>• Ongoing review of capacity requirements for the future service with associated demand/capacity planning and consideration of POSCU transformation, new treatments/therapies, and other changes to models of care to enable this.</li> <li>• Developing detailed design work to ensure appropriate space is provided for accommodation, dedicated education areas, indoor/outdoor play space, engaging with patients, carers, and wider stakeholders on their needs.</li> </ul>

Workstream	Responsibilities
	<ul style="list-style-type: none"> <li>Ensuring that resilience plans are developed to manage the impacts of climate change including working during extreme weather (for example, IT systems, cooling, and management of flooding).</li> </ul>
<b>Radiotherapy</b>	<p>The radiotherapy workstream oversight group will be responsible for overseeing the transition of the service from The Royal Marsden to the proposed future location at University College Hospital. This will include:</p> <ul style="list-style-type: none"> <li>Developing detailed patient pathways, physical capacity, and resourcing plans in collaboration with the future provider, drawing on experience of providing care for patients from other Principal Treatment Centres.</li> <li>Identifying and mitigating risks associated with the transition process. This involves conducting risk assessments, developing contingency plans, and implementing measures to minimise risk exposure.</li> <li>Engaging with key stakeholders to gather feedback, address concerns and build support for the transition.</li> </ul>
<b>Digital and data reporting</b>	<p>The digital and data reporting workstream oversight group will be responsible for ensuring the successful transition of data and IT systems, development of associated interoperability to support safe transfer, and visibility of patient records in line with information governance policies.</p> <p>The development of data dashboards to support service monitoring and management of risks will also be important.</p>
<b>Travel and access</b>	<p>The travel and access workstream oversight group (which should include patient and family representatives) will be responsible for alternative methods of transport, support for families for travel costs, hotel accommodation and accessible parking possibilities. Other responsibilities will include:</p>

Workstream	Responsibilities
	<ul style="list-style-type: none"> <li>• Ensuring parking possibilities are available to Principal Treatment Centre patients attending for care at the future provider and University College London Hospitals NHS Foundation Trust and are easily accessible from the hospital. Processes around payment must be easy to understand and accessible, catering for families experiencing digital exclusion and available in inclusive formats).</li> <li>• Developing a family-centre patient transport strategy and monitoring its performance (for example, reliability of timing).</li> <li>• Analysing future number of public transport users (through surveying/monitoring) and considering access and financial issues associated with this.</li> <li>• The future provider and University College London Hospitals should further consider mechanisms to support families or staff who can't pay for travel costs or hotel accommodation, such as easier access to automatic reimbursement mechanisms or collaboration with local hotels if appropriate.</li> <li>• Identifying patients/families requiring support as early as possible in their care pathway and ensure all families have a single point of contact for all aspects of travel and access planning.</li> <li>• Ensuring that accessibility arrangements meet the needs of equality groups (such as subsidisation for deprived communities, translation for those that require it) and are regularly monitored against equality frameworks.</li> </ul>
<b>Service planning and development</b>	<ul style="list-style-type: none"> <li>• The service planning and development workstream will be responsible for supporting the development of detailed plans for the future service including patient pathways,</li> </ul>

Workstream	Responsibilities
	<p>and for managing the organisational change programme, change management and ways of working.</p> <ul style="list-style-type: none"> <li>• It will also focus on managing any impacts of service change on other NHS services.</li> <li>• Other responsibilities will include:</li> <li>• Working collaboratively with existing and future staff to develop the culture for the future Principal Treatment Centre. Specific consideration should be given to preserving organisational memory, key skills and legacies as well as joint organisational development that gives opportunities for the incoming workforce and their patients to co-design and develop the service.</li> </ul>

## 11.2 Monitoring and management

### 11.2.1 Risk management

The reconfiguration of the Principal Treatment Centre brings risks which will need to be carefully managed throughout implementation and beyond. Risks are identified at all levels within the programme and are noted on a central risk register, held by the PMO. Risks are then rated based on their probability and impact. These are combined into an overall risk rating<sup>85</sup>.

During the service transition phase, the Implementation Oversight Board will take responsibility for managing risks supported by other groups who will regularly review risks to delivery. Risk management is recognised as an essential tool to deliver the programme successfully and realise the intended benefits. A system of risk management will be developed across the key workstreams using the risk register for real-time monitoring for effective programme management and delivery. The most significant risks for the programme have been outlined in the table below.

<sup>85</sup> Risks have been scored according to the NHSE Risk Management Process. Risks are rated using four categories: Low (green), Moderate (yellow), High (amber) and Extreme (red).

Table 68: Programme risks

Owner	Risk	Mitigation	Score
NHS England	There is a risk that during the service transition phase there may be instability of the current service, unsettling staff, patients, families, carers and other stakeholders, and increasing the risk profile. With support from the wider system the current Principal Treatment Centre needs to continue to offer and maintain a high quality service until the service transfers to the future provider.	<i>Recommendation #14: Risk to current workforce.</i>	H
NHS England	There is a risk the service change could impact teenage and young adult services at The Royal Marsden.	<i>Recommendation #20 Impact on other services.</i> NHS England is committed to working with The Royal Marsden to ensure appropriate support is provided for the delivery of services, including through provision of stranded costs.	M
NHS England	If the service moves to Evelina London there is a risk that the service change could impact sustainability of paediatric	<i>Recommendation #20 Impact on other services.</i> Commissioners and the wider system would continue to work closely with St	M

	surgery and pathology services at St George's Hospital.	George's to mitigate any impacts. This includes in principle, commitment to support with stranded costs.	
NHS England	There is a risk the service change would impact other services adversely, including Great Ormond Street Hospital, University Hospital Southampton.	<i>Recommendation #20 Impact on other services.</i>	L

Table 69: Delivery risks

Owner	Workstream	Risk	Mitigation	Score
Future Principal Treatment Centre provider	Workforce	There is a risk that staff from The Royal Marsden (and St George's Hospital if the Evelina London is the chosen option) do not choose to transfer to (or work cross-site at) the future provider leading to a loss of valuable skills, expertise and experience, and additional recruitment and training requirements for the future provider beyond expected levels.	<i>Recommendation #14 Risks to current workforce,</i> <i>Recommendation #15 Supporting staff to transfer, Recommendation #16 Integration and organisational development, Recommendation #17 Workforce strategy, Recommendation #18 Workforce planning.</i> Retention, training and recruitment strategies to be further developed and implemented, with input from The Royal Marsden and other stakeholders.	H

Owner	Workstream	Risk	Mitigation	Score
The Royal Marsden and the future Principal Treatment Centre	Research	There is a risk of attrition within the research workforce due to the reconfiguration and cross-site working, leading to loss of research capability and expertise and therefore loss of research and trials activity.	<i>Recommendation #15 Supporting staff to transfer.</i> Close working between The Royal Marsden, the future Principal Treatment Centre and the ICR to develop mitigations to support collaboration between clinical oncology teams at the Principal Treatment Centre and scientists at the ICR including: joint appointments, mutual honorary contracts, split site working, exploring funding opportunities to ensure continuity of funding for posts, and cross-site training including of cancer research nurses (and other professions)	H
Future Principal Treatment Centre provider	Research	There is a risk that research grant income is affected or withdrawn and therefore activity is lost, thereby significantly impacting on the scale and scope of children's cancer research due to the uncertainty created about future delivery of research for grant/research partners.	<i>Recommendation #24 Research</i> Close working between The Royal Marsden, the future Principal Treatment Centre and the ICR, supported by NHS England - including meeting with research funders (as appropriate) to encourage continued research funding, assuring them of the opportunities and future plans and	H

Owner	Workstream	Risk	Mitigation	Score
			giving them confidence in how the transition will be managed.	
Future Principal Treatment Centre provider	Research	There is a risk that access to research trials for children's cancer and TYA services is impacted through the reconfiguration of the Principal Treatment Centre. Furthermore, there is a risk that companies do not want to open trials in an environment where significant change (and transfer of services) will be taking place.	<i>Recommendation #24 Research</i>	H
Future Principal Treatment Centre	Workforce/ communications and engagement	There is a risk that staff are not involved and engaged in shaping the future service and do not have the information they need at every stage, for those who will and will not change employer, including third sector staff who also provide services to the Principal Treatment Centre. This could lead to attrition and poor staff experience as well as impacting the quality of the design of the future service.	<i>Recommendation #16 Integration and organisational development.</i>  A communication and engagement plan and organisational development plan will be developed post decision to support staff through the process and transition and enable co-design of the future service.	M



Owner	Workstream	Risk	Mitigation	Score
NHS England	n/a	There is a risk that the transfer of service will be impacted through lack of collaboration between the different Trusts involved	Parties to the reconfiguration have agreed a set of principles around collaborative working. Commissioners will continue to work with all organisations to support collaborative working.	M
Future Principal Treatment Centre provider	Travel and access	There is a risk the provider of the future centre does not put appropriate mitigations in place in time for the travel and access impacts. The results t would include poor patient experience, missed appointments, potential impacts on patient care	<i>Recommendations #9 – 13: Travel and access.</i> Travel and access workstream during the implementation phase to oversee and monitor the development and delivery of mitigations.	M
University College London Hospitals	Radiotherapy	There is risk that the development of radiotherapy services is not integrated in the overall programme with due focus on plans for capacity, pathways and suitable travel and access arrangements	<i>Recommendation #19 Radiotherapy</i>	M
NHS England, The Royal Marsden and future Principal Treatment	Programme management	There is a risk that strong leadership for the programme is not established, impacting vision and buy-in for the future Principal Treatment Centre	<i>Recommendation #28 Leadership</i> Development of arrangements for appointment of senior clinician whose main focus is to oversee successful transfer of clinical services is recommended quickly post decision, with joint	L

Owner	Workstream	Risk	Mitigation	Score
Centre provider			appointments between organisations to support collaborative working.	
Future Principal Treatment Centre provider	Communication and engagement	There is a risk that patients and families will feel uncertainty and that their views are not being taken into account for the development of the service.	<p><i>Recommendation #22 Estates solution, Recommendation #23 Accommodation and wider spaces</i></p> <p>The future provider should work with the current service to carry out robust stakeholder planning including patient and family engagement and representation in design of the service, facility, and travel and access arrangements. Regular communications will be needed to provide updates on programme progress and mitigations for impacts on patients and their families.</p>	L
Future Principal Treatment Centre provider	Finance and estates	There is a risk that further capital will be required moving into the outline business case and full business case phases due to incorrect assumptions or changing estates plans.	<p><i>Recommendation #30 Affordability</i></p> <p>Financial assumptions have been developed using professional cost advisors and benchmark costs, with appropriate contingency, inflation and optimism bias, reducing likelihood. Any additional capital costs will need to be met by</p>	L

Owner	Workstream	Risk	Mitigation	Score
			Integrated Care System operational capital envelopes.	
Future Principal Treatment Centre provider	Programme management	There is a risk of delay to opening of future Principal Treatment Centre due to complexity of build and/or delays to design and approvals process.	The future provider should implement a robust project plan developed with clarity around gateways and key points for decision/escalation, supported through its governance structure.	L
Future Principal Treatment Centre provider	Finance and estates	There is a risk that charitable funding for the future Principal Treatment Centre is lower than expected, impacting revenue affordability of the service.	<p><i>Recommendation #30 Affordability</i></p> <p>Downside scenarios are already modelled for these income assumptions. Broadly, both Trusts assume around £1 million direct charitable funding from 2028/29. While significant, this is not material to affordability and deficits would be picked up in wider Trust efficiency – adding a very small additional requirement. It is important to appreciate that the Principal Treatment Centre will not be a standalone service. Guy’s and St Thomas’ has an annual turnover of around £2.5 billion and St George’s of £1.1 billion.</p>	L

Owner	Workstream	Risk	Mitigation	Score
Future Principal Treatment Centre provider	Communication and engagement	This is a risk that the current and future Principal Treatment Centre's engagement with key stakeholders is disjointed and fragmented, this could impact on the current and future quality of service delivered to children and young people.	<p><i>Recommendation #26 Governance</i></p> <p>The future provider should carry out robust stakeholder management planning and ensure appropriate representation of stakeholders in governance.</p>	L

## 11.2.2 Benefits realisation and monitoring

The future provider of the Principal Treatment Centre will have overall accountability for the delivery of the benefits associated with the service change and will be responsible for overseeing the Benefits Realisation Plan, ensuring it is aligned with the business case. Its preparation will be managed through the Delivery Board and reported to the Implementation Oversight Board. A project team member will be appointed who will be responsible for the preparation of the Benefits Realisation Plan.

The benefits management process will include the following key steps and enable:

- Identification and agreement of benefits to be realised – building on those identified within Section 1.4 and 2.4.
- Development of agreed quantification and measures across benefit streams to ensure consistency and no double counting.
- Management of benefits through implementation.
- Communication of benefits progress and status reports to programme leadership including the escalation of any risks and issues associated with the development of these benefits.
- Post project evaluation and any lessons learned activities.

We have set out proposed metrics for the realisation and monitoring of the benefits identified through the reconfiguration to date, alongside their proposed owner. It is expected in the next stage of the programme that a baseline and target will be formally identified and agreed – this will likely require a detailed data audit of The Royal Marsden and St George’s data including activity, transfer data, clinical trials data and funding data.

Table 70: Benefits realisation

Benefit	Proposed measures/metric for measurement	Proposed owner
Elimination of inter-site transfers for intensive care	Number of transfers Patient outcomes data	Clinical Quality
Timely access to critical care review and expertise	Number of children admitted to intensive care	Clinical Quality

Benefit	Proposed measures/metric for measurement	Proposed owner
	<p>Clinical audit: time from referral to Paediatric Critical Care team, to bedside review on the ward.</p> <p>Patient experience surveys</p> <p>Patient outcomes data</p>	
Timely access to critical care treatment	<p>Number of children admitted to intensive care</p> <p>Clinical audit: time from referral to Paediatric Critical Care team, to admission to the unit</p> <p>Patient experience surveys</p> <p>Patient outcomes data</p>	Clinical Quality
Provide on-site access to more of the services that children with cancer need	<p>Number of interdependent services on site</p> <p>Number and type of inter-site transfers</p> <p>Fewer journeys for families to multiple sites for outpatient care – picked up through patient experience surveys</p>	Clinical Quality
Enable more children and their families – particularly those who need surgery - to get support and continuity of care from the start, from the team who will be leading	Patient experience surveys	Clinical Quality

Benefit	Proposed measures/metric for measurement	Proposed owner
their systemic cancer treatment and coordinating their care		
Ability to offer cutting-edge treatments that can only be delivered if a children's intensive care unit is on site	<p>Evidence of services meeting relevant national service specifications</p> <p>Evidence of services meeting relevant clinical standards</p>	Clinical Quality
Improved opportunities for close multidisciplinary and multi-professional working between cancer specialists and professionals in other specialties, allowing for consideration of all treatment options for patients	<p>Staff surveys</p> <p>Recruitment and retention</p> <p>Clinical audit e.g. MDTs</p> <p>Patient and family/cancer experience surveys</p>	<p>Workforce</p> <p>Clinical Quality</p>
Consolidation of expertise to enable doctors and other professionals delivering radiotherapy for children to work together in one place allowing them to develop greater expertise and specialist knowledge.	<p>Recruitment and retention</p> <p>Number of staff trained to deliver all radiotherapy treatments</p>	Radiotherapy
Develop clinical and lab-based research due to consolidation of radiotherapy	Number of research grants/publications related to radiotherapy	Radiotherapy Research
Children will have access to a wider range of radiotherapy treatments in one place with their treatment overseen by a single team of clinicians incorporating both proton and photon specialists	<p>Number and type of radiotherapy treatments offered on one site</p> <p>Workforce metrics</p> <p>Access metrics</p>	Radiotherapy

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### 11.2.3 Recommendation monitoring

Requirements for the future service, including recommendations agreed as part of decision-making, will be managed via NHS standard contract terms and conditions. During the implementation phase the service will be referenced in Schedule 5A (Documents Relied Upon) of the contract between NHS England/Integrated Care Boards and the receiving Trust.

Reporting requirements during implementation may differ from those expected after service commencement, these Key Reporting Indicators will be reviewed and ratified by the Implementation Oversight Board as part of the implementation governance structure. Consideration will be given to the reporting requirements to ensure that risks and recommendations are appropriately monitored with clear thresholds for escalation agreed.

Once the contract is awarded, the main Integrated Care Board contract for the provider will be amended to include a specific schedule for this new service, this will include any reporting requirements and Service Development Improvement Plans as set out and agreed between the commissioner and provider in line with regional and national standards.

### 11.2.4 Further monitoring

Alongside the approaches set out above, it will also be important to monitor other measures to ensure that the reconfiguration does not have an adverse impact including on patient groups. We have made the following recommendations for future monitoring of access and outcomes.

1. **Benchmark quality and outcome metrics against other Principal Treatment Centres and The Royal Marsden baseline.** Clinical outcomes within the new Children's Principal Treatment Centre service specification will be monitored via the SSQD, published on Model Hospital (see Appendix 4 for details). This data is not currently available and will be published summer 2024, enabling the establishment of a baseline for the current Principal Treatment Centre service. The new Children's Principal Treatment Centre should also ensure Serious Incident review is a core element of service monitoring.
2. **Conduct regular Health Equity Audit of access to the service.** A HEA is a tool used to examine whether resources are distributed fairly, relative to the health needs of different groups. The new service should assess whether the children being seen in the service reflect the structure of the catchment population and what is known about the risk of cancer between different groups. Further information on baseline equity data can be found in the Integrated Impact Assessment (Appendix 4).



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3. **Develop and implement a mechanism for monitoring uptake (by socio-economic group) of mitigating actions and processes.** The future Principal Treatment Centre should monitor travel cost reimbursement, family accommodation, hospital provided patient transport and referral to benefits advice services and/or third sector organisations for financial advice and support.
  4. **Use patient experience metrics to monitor experience between demographic groups.** Surveys include the [Under 16 Cancer Patient Experience Survey](#) and the [Children and Young People's Experience Survey](#). Further information on the findings of the Under 16 Cancer Patient Experience Survey can be found in Section 7.2.1 and in the Integrated Impact Assessment (Appendix 4).
  5. **Consider use of [Schedule 2N](#) within the NHS Standard Contract.**

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## 12. Conclusion and next steps

It is now a requirement for very specialist cancer treatment services for children to be on the same site as a children's intensive care unit and other specialist children's services. The current service does not and cannot meet this requirement.

As commissioners, we have run a robust process, including public consultation, to evaluate the options for the future Principal Treatment Centre with the aim of making a decision on the future location of children's cancer services that complies with the national service specification (2021).

In making a decision on the future location of the children's cancer service our ambition is to identify the option which gives us the greatest confidence that it will deliver the best quality care for children with cancer in the future taking all relevant information into account and with regard to the care for children across the catchment area.

Commissioners will continue to have a role in overseeing the programme through the service transition and implementation phases which will be key to the success of the future service. Programme governance will provide a mechanism to oversee this, which must also be underpinned by collaborative working between all stakeholders involved. With this, our ambition is to build on all the strengths of the existing service and create a future Principal Treatment Centre that can give best quality care and achieve world-class outcomes for children with cancer for decades to come.

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## Appendices list

Title
1. <a href="#">Pre-consultation Business Case</a>
2. <a href="#">Independent Consultation Report</a>
3. <a href="#">London and South East Clinical Senates' response</a>
4. <a href="#">Integrated Impact Assessment</a>
5. <a href="#">Key Organisational Responses</a>
6. <a href="#">Financial impact assessment</a> A) Economic Case Options Appraisal B) Sensitivity Analysis C) Schedule of Works D) OB Forms E) PUBSEC Indices F) Key Estates Information
7. <a href="#">Response to South East London Joint Health Overview and Scrutiny Committee</a>
8. <a href="#">Response to South West London and Surrey Joint Health Overview and Scrutiny Committee</a>
9. <a href="#">Mayoral Letter and Strategy Unit Response</a>
10. <a href="#">Response to Healthwatch Richmond and Healthwatch Merton</a>
11. <a href="#">Pre-consultation Engagement Report</a>
12. <a href="#">Implementation Plans for Potential Future Providers</a>