

# Reconfiguration of Children's Cancer Principal Treatment Centre serving south London, Kent and Medway, most of Surrey, East Sussex, Brighton and Hove

Presentation to the South East London Joint Health Overview and Scrutiny Committee

6 July 2023

# Today we would like to

- Tell you more about plans for the service reconfiguration of the Principal Treatment Centre (PTC)
- Share an overview of our work to date including our plans for the forthcoming consultation
- Seek feedback on our plans and on how we work together going forward

# Structure of our presentation

## Agenda

1. Background and case for change
  2. Options development and evaluation
  3. Where are we now
  4. Equality and Health Inequality Impact Assessment
  5. Consultation plan and document, including stakeholder engagement
- Appendix – supporting slides

# 1. Background and case for change

# Caring for children with cancer

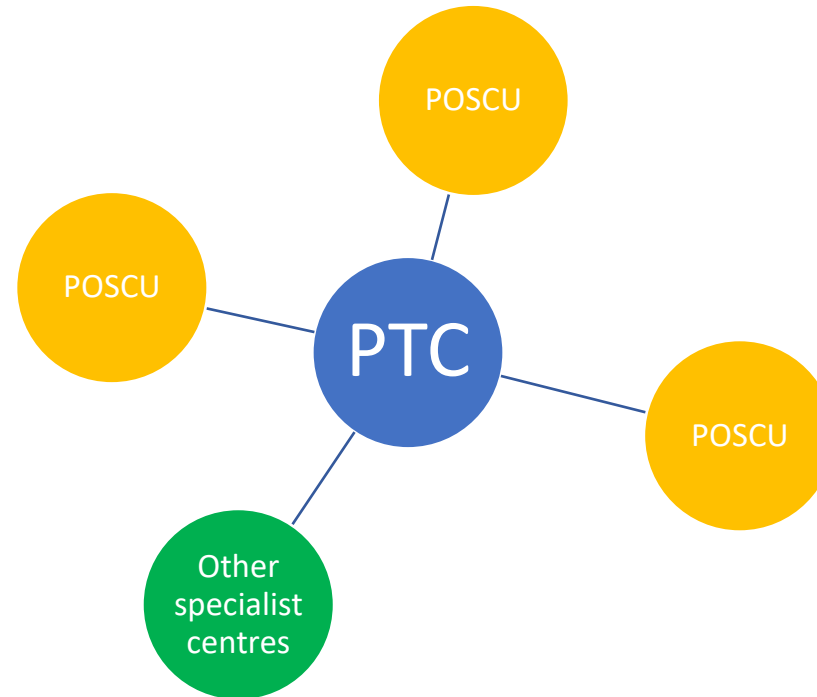
## Principal Treatment Centres

Children with cancer in England receive some of the best care in the world, at the forefront of cutting-edge treatments and technology.

Their care is coordinated and led by Principal Treatment Centres, which provide diagnosis, treatment plans, and highly specialised care for children aged 15 and under with cancer.

Principal Treatment Centres are responsible for making sure each child gets the specific expert care they need for their particular cancer, and for coordinating treatment by different hospitals, if needed. Treatments for cancer in children can be complex and intensive and are often delivered as part of a clinical trial. Children can become acutely ill during treatment, requiring a high level of medical support.

There are 13 Principal Treatment Centres across England.



## Shared care

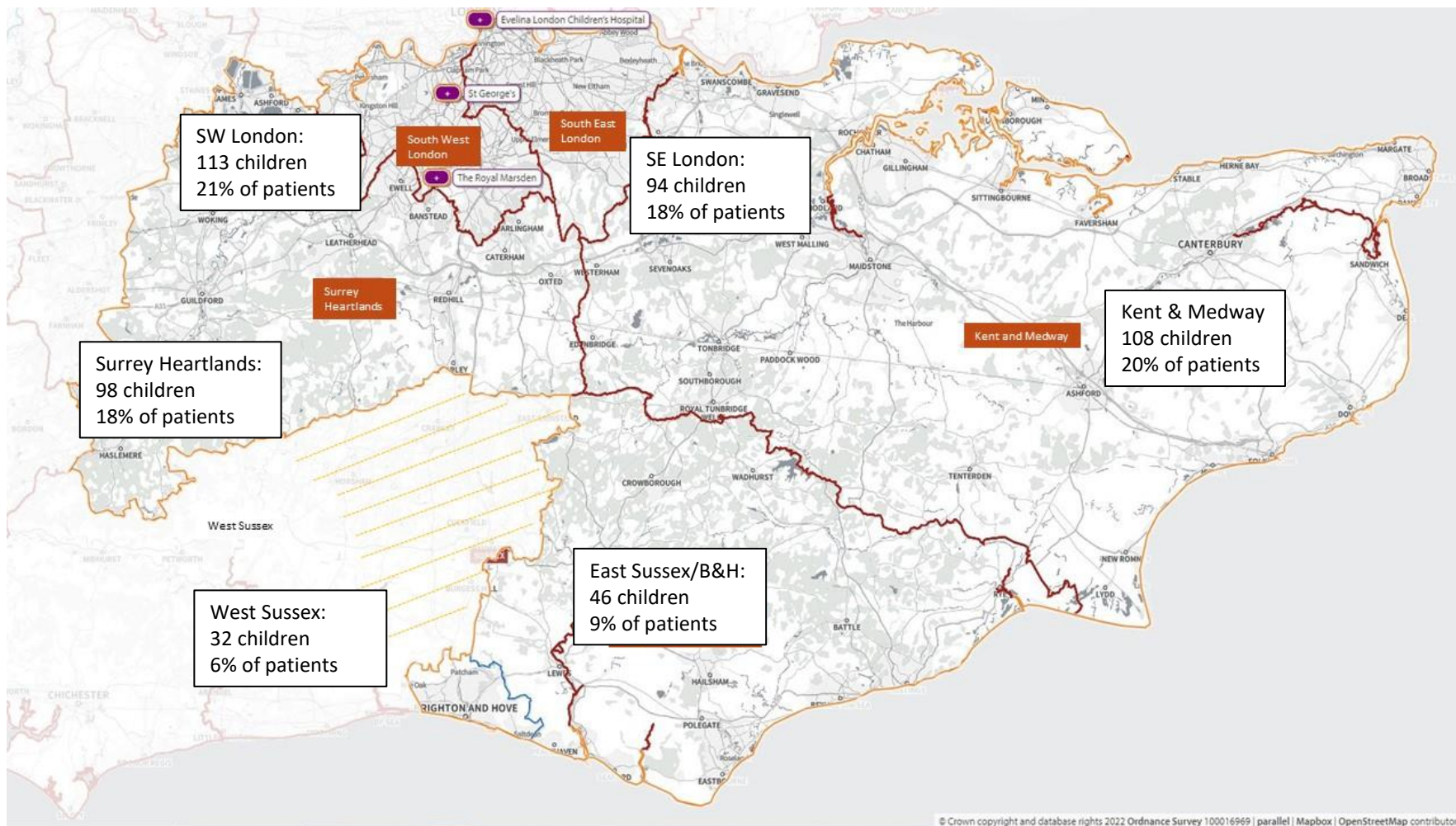
Principal Treatment Centres work in partnership with Paediatric Oncology Shared Care Units (POSCUs) at specified hospitals across their catchment areas, allowing care to be delivered closer to children's homes.

Many children with cancer also receive care in their homes. This can be from staff or 'outreach' services from the Principal Treatment Centre, POSCU or staff from children's community nursing teams.

Principal Treatment Centres also coordinate children's care with cancer services that are provided at other specialist centres (if not provided by the Principal Treatment Centre), and with national services to ensure children receive the right care at the right time and in the right place.

# The Principal Treatment Centre catchment area

**The catchment area of the Joint Principal Treatment Centre (The Royal Marsden and St George's)**  
(including number of children treated as inpatients at The Royal Marsden and St George's in 2019/20)



The Principal Treatment Centre (PTC) provides cancer care for children aged one to 15 who live in the area which covers south London, Kent, Medway, East Sussex, Brighton and Hove, and the majority of Surrey. It is acknowledged that children can access a PTC who live outside of a defined catchment area, and not all children resident within a defined PTC catchment area, diagnosed with cancer, choose to attend that particular PTC for their treatment

## Children newly diagnosed with cancer

While a diagnosis of cancer clearly has a huge impact on people's lives, it is relatively rare among children.

The rate of diagnosing new cancers among children in both South West London and Surrey is around **135 cases per million per year**. This means that around **1 child in every 7,400** are diagnosed with cancer each year.

On average, each year there are:

- 42 children diagnosed with cancer from South East London

## Children receiving cancer treatment

In total, the PTC treats around 1,400 children per year. Of these, in 2019/20:

- 252 children (18%) came from South East London

Nearly all children are seen as an outpatient (99%); 23% also had an inpatient stay.

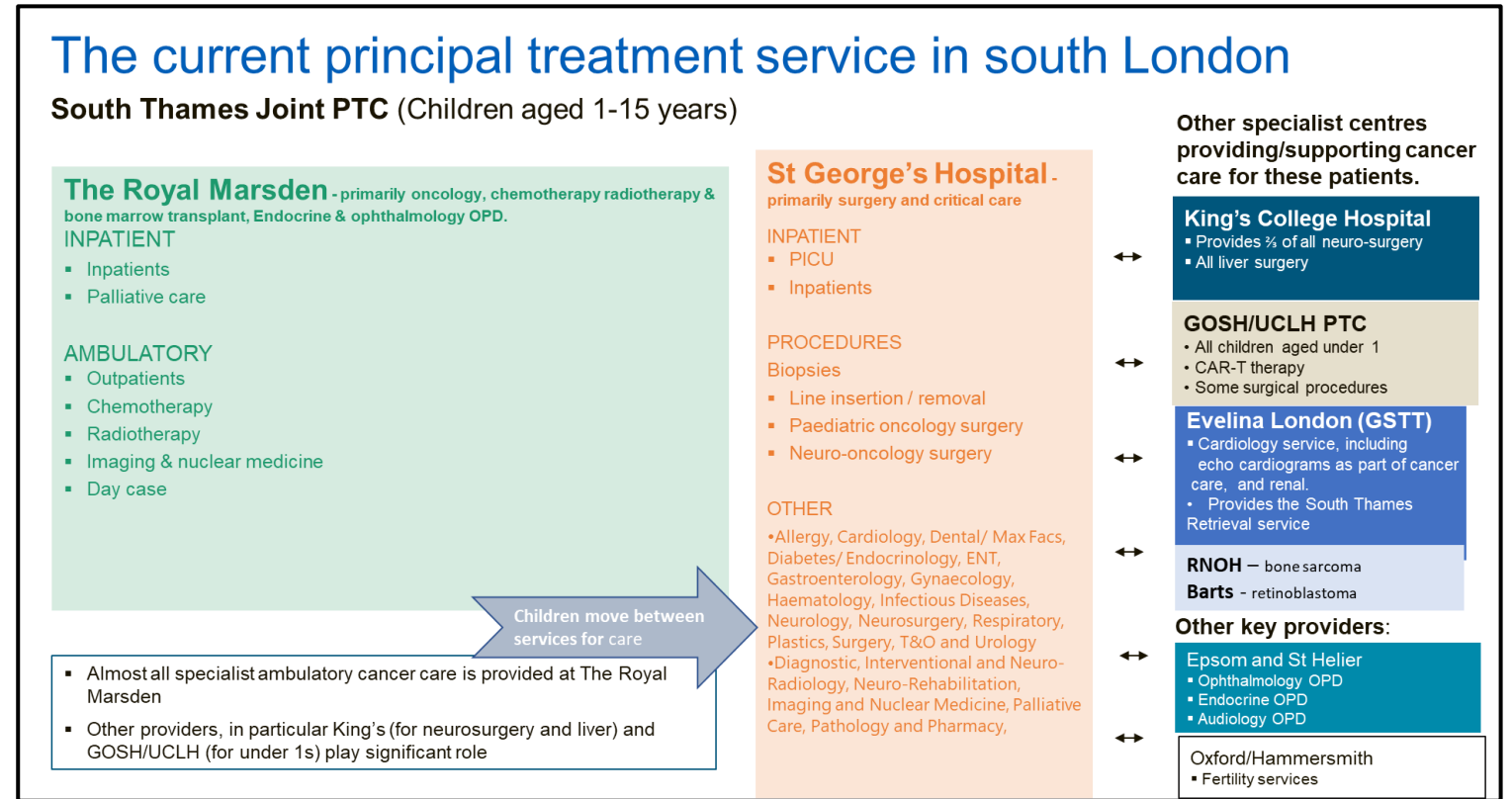
Due to data quality for patient postcodes, we are not able to show the actual split of all these patients between boroughs. However, below we indicate the likely distribution of patients, based on population size.

Borough	Approximate number of new cancer <b>diagnosed</b> per year
Lambeth	c.7
Lewisham	c.9
Southwark	c.8
Bexley	c.8
Brent	c.10
Bromley	c.10
Greenwich	c.9

Borough	Approximate number of patients <b>treated</b> per year
Lambeth	c.45
Lewisham	c.50
Southwark	c.45
Bexley	c.45
Brent	c.55
Bromley	c.60
Greenwich	c.50

# The current Principal Treatment Centre

- The Royal Marsden provides the majority of inpatient and outpatient care for children with cancer in the Principal Treatment Centre catchment area. Care is provided at its Sutton site.
- If children require surgery, critical care and some other specialist children's services they are treated at St George's Hospital in Tooting.
- The Royal Marsden works closely with the Institute of Cancer Research, which is based on its Sutton site, on world leading research into children's cancer care.



*Some children also travel to other London hospitals for care, this is because of the expertise these hospitals have in specialist areas. This will continue in the future too.*



Being on the **same site as a children's intensive care unit and cancer surgery** is now a national requirement for all Principal Treatment Centres in England, as set out in the [national specification](#) for Principal Treatment Centres published in November 2021.

Locating the future Principal Treatment Centre on the **same site as children's intensive care** will mean:

- ✓ no more hospital transfers for children who need intensive care: very sick children will not need to be transferred eight miles from Sutton to Tooting to receive intensive care. This happens safely but can be very stressful for children, parents, and the staff involved
- ✓ no more hospital transfers for children who the clinical team thinks may need admission to an intensive care unit: pre-emptive transfers to safely manage the inbuilt geographical risk will not be needed
- ✓ fewer admissions to intensive care: some can be avoided if intensive care doctors are able to visit the child on the ward and keep a close eye on progress.

Placing the future Principal Treatment Centre on the **same site as children's cancer surgery** will:

- ✓ improve patient experience as patients can get more of their care in a familiar place rather than having to find their way around different sites.

Other **benefits** of relocating specialist services for children with cancer include:

- ✓ the ability to provide a service that, in line with the other 12 Principal Treatment Centres in England, is equipped to give complex new treatments which require children's intensive care services to be on-site (such as CAR-T which uses a child's own treated immune cells to treat their cancer)
- ✓ the potential to further develop multidisciplinary team working and research.

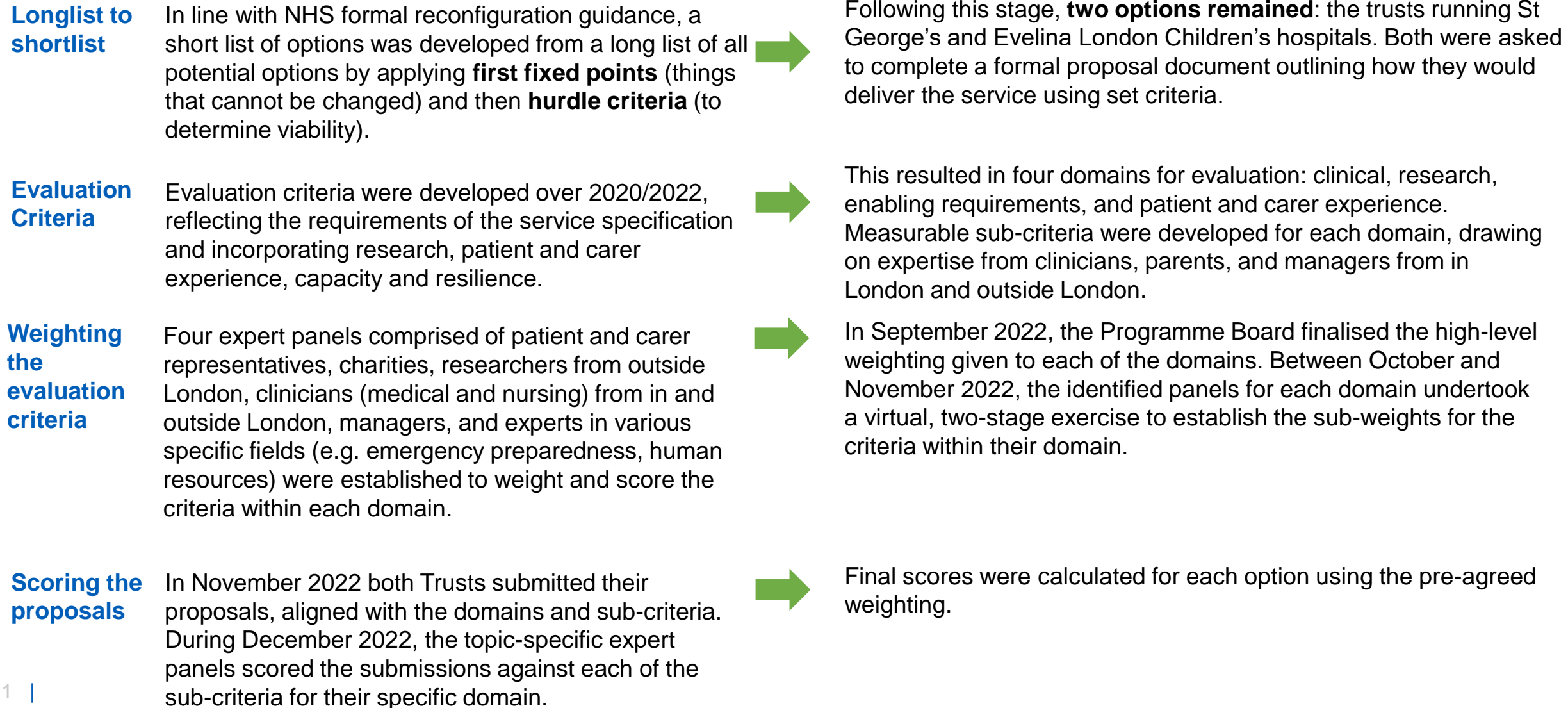
Transferring critically unwell patients is associated with a risk of physiological deterioration and adverse events<sup>(1)</sup> and the emotional and psychological stress for parents should not be underestimated<sup>(2)</sup>. Although specialist transport services have been shown to enhance safety and quality<sup>(3)</sup>, the 2008 "[Safe and Sustainable](#)" framework, produced by clinicians and endorsed by the relevant Medical Royal Colleges, states that paediatric oncology and paediatric intensive care have "absolute dependency, requiring co-location". It is this clinical advice, backed up by subsequent expert reviews<sup>(4)</sup> that underpins the national service specification requirement.

*See Appendix 1 for references*

## 2. Options development and evaluation

# Summary of options appraisal process

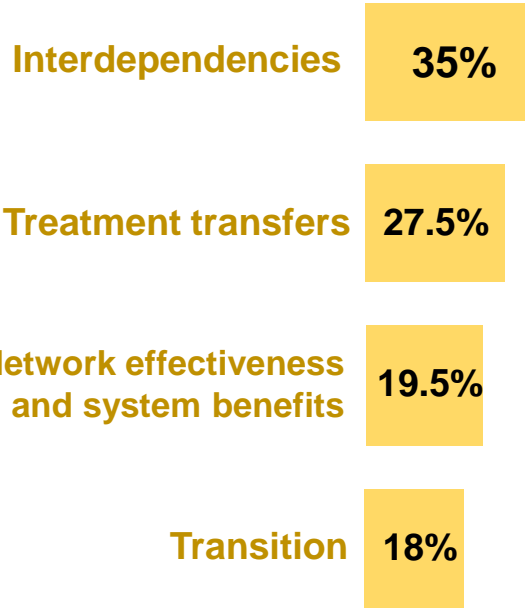
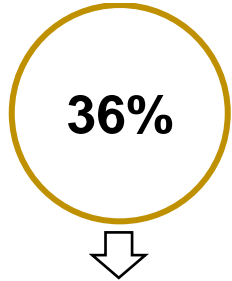
We have already run an option appraisal process – consisting of four elements:



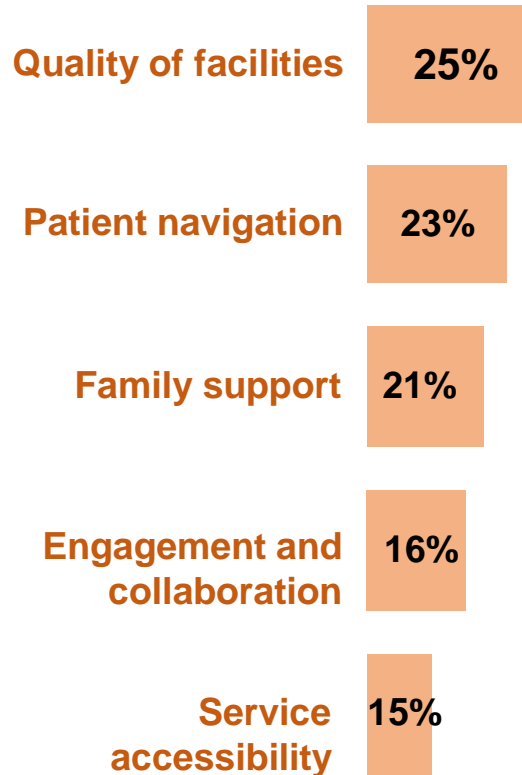
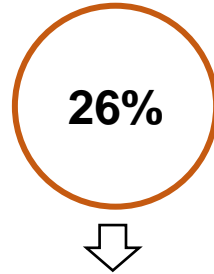
# Final weightings

Programme Board members set the domain weights and expert panels weighted the sub-criteria.

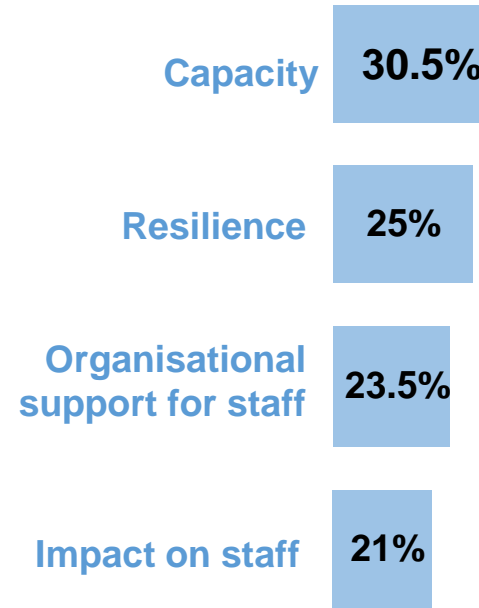
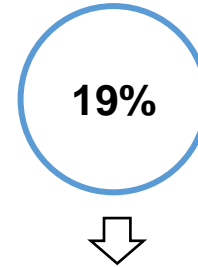
## Clinical domain



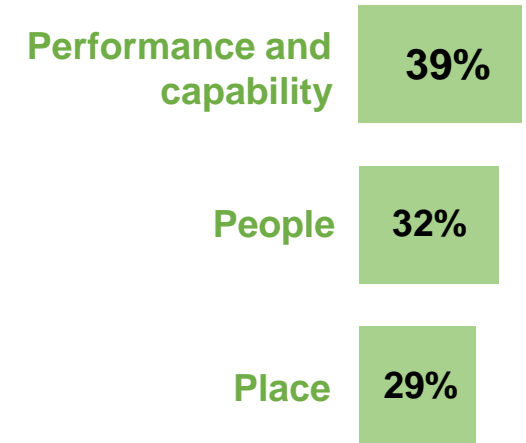
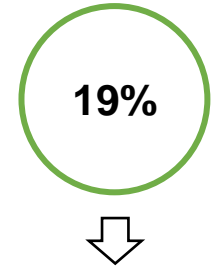
## Patient and carer experience domain



## Enabling domain



## Research domain



# There are two strong proposals for the relocated PTC

- Although the services which the **current Principal Treatment Centre** in south London provides are safe and high quality, they do not; and cannot comply with the national service specification. As a world-leading cancer hospital, not a children's hospital, The Royal Marsden does not have a children's intensive care unit or children's cancer surgery on-site. Children's intensive care units are always at hospitals that provide many other specialist children's services. In the context of the change in the service specification, the Royal Marsden is contributing actively to the review process to ensure the very best outcome is achieved for children.
- We are fortunate to have two strong options for relocating the Principal Treatment Centre which we will be consulting on:
  - Evelina London Children's Hospital, which is run by Guy's and St Thomas' NHS Foundation Trust and is based on the St Thomas' site in Lambeth
  - St George's Hospital, which is run by St George's University Hospitals NHS Foundation Trust (part of St George's, Epsom and St Helier Group) and is based in Tooting.
- In combination with the new specification for Paediatric Oncology Shared Care Units (POSCUs) this will enable NHS England London to implement the national vision for children's cancer services, driving continued improvement across the network with enhanced levels of care closer to where children live.

Our vision is that the future centre will lead coordinated children's cancer care of the highest standard across the catchment area. We are ambitious about what we can deliver for our patients by providing care in a specially designed environment that also supports the delivery of new treatments as they become available; continuation of ground-breaking research; and access to clinical trials. We know these things are very important to children with cancer, their families, and the staff who deliver the current service.

# Things to note:

In setting its clinical model, the Programme Board overseeing this reconfiguration made a number of key decisions including:

- No matter which option is chosen, children will need travel to other London hospitals for the care listed below. This is because of the expertise these hospitals have in these specialist areas – these services are not going to move as part of the reconfiguration
  - Royal London Hospital (RLH), Whitechapel – eye cancer
  - Royal National Orthopaedic Hospital (RNOH), Stanmore - bone cancer
  - Great Ormond Street Hospital for Children (GOSH), Bloomsbury – care of babies aged 0 to 12 months with cancer of any type
  - King’s College Hospital (KCH), Denmark Hill – liver cancer
  - St George’s Hospital, Tooting and King’s College Hospital, Denmark Hill – neurosurgery for cancer of the brain and central nervous system. See table below
  - University College London Hospitals’ Grafton Way building (UCL), near Euston - proton beam radiotherapy at one of only two proton beam machines in England.
  
- **Access** - the Principal Treatment Centre must be accessible for all service users in terms of journey time and should therefore be based within Greater London.
- **Timeliness** - once a decision has been made, the new service must ‘go live’ within a 2.5 year implementation timeline
- **Affordability** - so long as both options remain affordable, the cost will not influence the decision. Instead, the decision will focus how to create the best possible service for children with cancer.

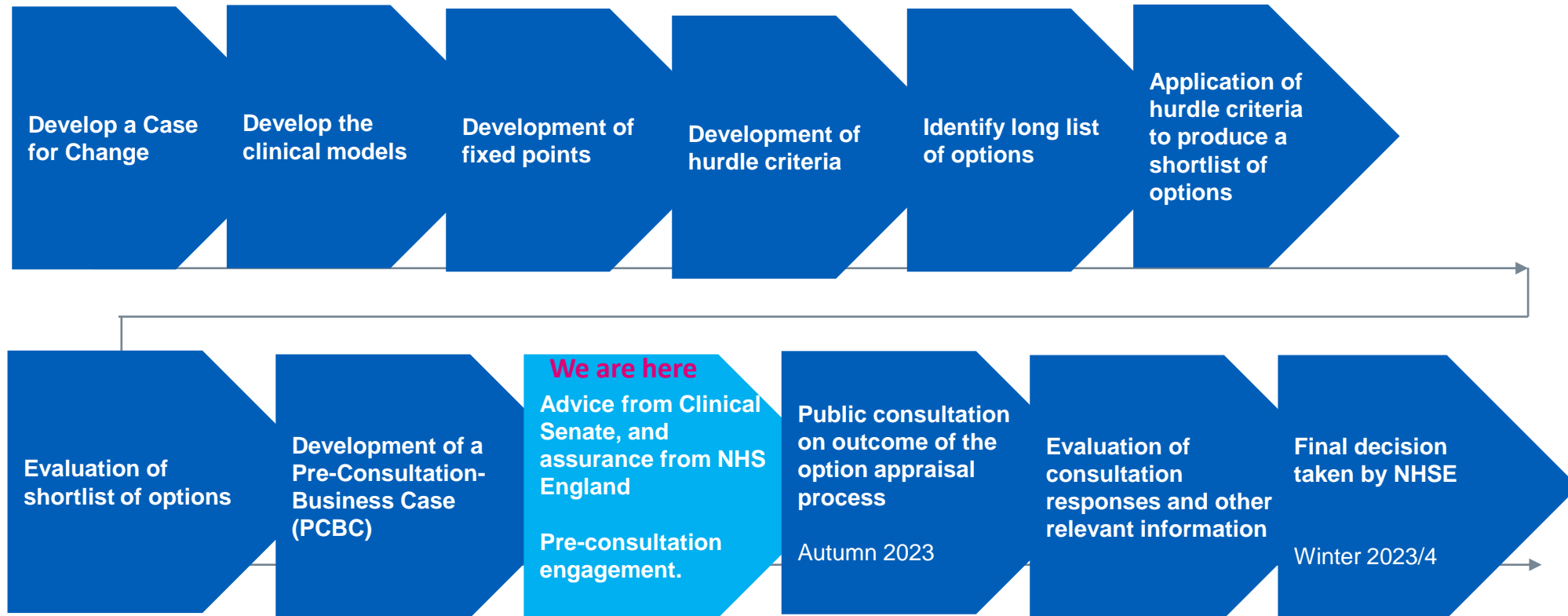
# Outcome of scoring

- The Evelina London Children's Hospital option received a higher overall score than the St George's option, scoring higher in three of the four key areas.
- Based on the evidence provided by the evaluation, Evelina London is NHS England London's preferred option at this stage in the process.
- Both options scored highly and are viable options for the location of the future centre. We are very much keeping an open mind.
- NHS England London will only make their final decision on the location of the future centre after hearing the views that come forward during the public consultation and taking account of all other relevant factors.

## 3. Where are we now



# Where we've been and where we are now



A formal reconfiguration process is required when moving a significant service from one site to another to ensure all stakeholders have the opportunity to review and comment on the case for change, clinical model and proposals.

*Consultation with SE London JHOSC will continue in forthcoming months; including during the decision-making phase.*

## 4. Equality and Health Inequality Impact Assessment

# Equality and Health Inequality Impact Assessment: Process

## Purpose of the EHIA

To support meeting legal duties including the Public Sector Equality Duty (Equality Act 2010) and the Health and Social Care Act (*to have regard to the need to reduce inequalities between persons in access to, and outcomes from healthcare services*)

## What changes are we assessing the impact of?

**A change in location of the current PTC and the implications of this change on patient travel arrangements including travel time, complexity of journey (including parking arrangements) and cost.**

### Additional considerations:

- the prospect of the service change process itself
- the prospect of a new environment and aspects of onsite accessibility
- other potential benefits

The EHIA takes a non-comparative, population-based approach.



Plus other groups who face health inequalities



## Which population groups were considered in terms of experiencing differential impacts?

Those with a protected characteristic as specified in the Equality Act 2010, or who typically face health inequalities, including those living in deprived areas or families on low incomes (EHIA document contains full list).

For each group, using the information referenced below, plus professional and personal experience, the sub-group assessed any potential differential impacts of the proposed changes in relation to both the Public Sector Equality Duty and inequalities in access to, and outcomes from the service.

## Sources of information used:

1. An equalities profile for the PTC catchment population
2. A travel time analysis report
3. Qualitative insight collected through patient engagement activities



## Impacts of travel time differences on health inequalities (access)

When comparing travel times to the current Principal Treatment Centre main site (The Royal Marsden) to either future PTC location, travel time analysis shows:

- there are differential positive impacts for children living in the most deprived areas and rural areas when travelling by public transport.
- there are differential negative impacts for children living outside London or in rural areas when driving.



**Other impacts** Several population groups (full list in EHIA) may experience a differential impact in terms of:

- complexity or cost of their journey
- uncertainty brought on by the prospect of the service change process itself
- on-site accessibility

For example, patients and/or families:

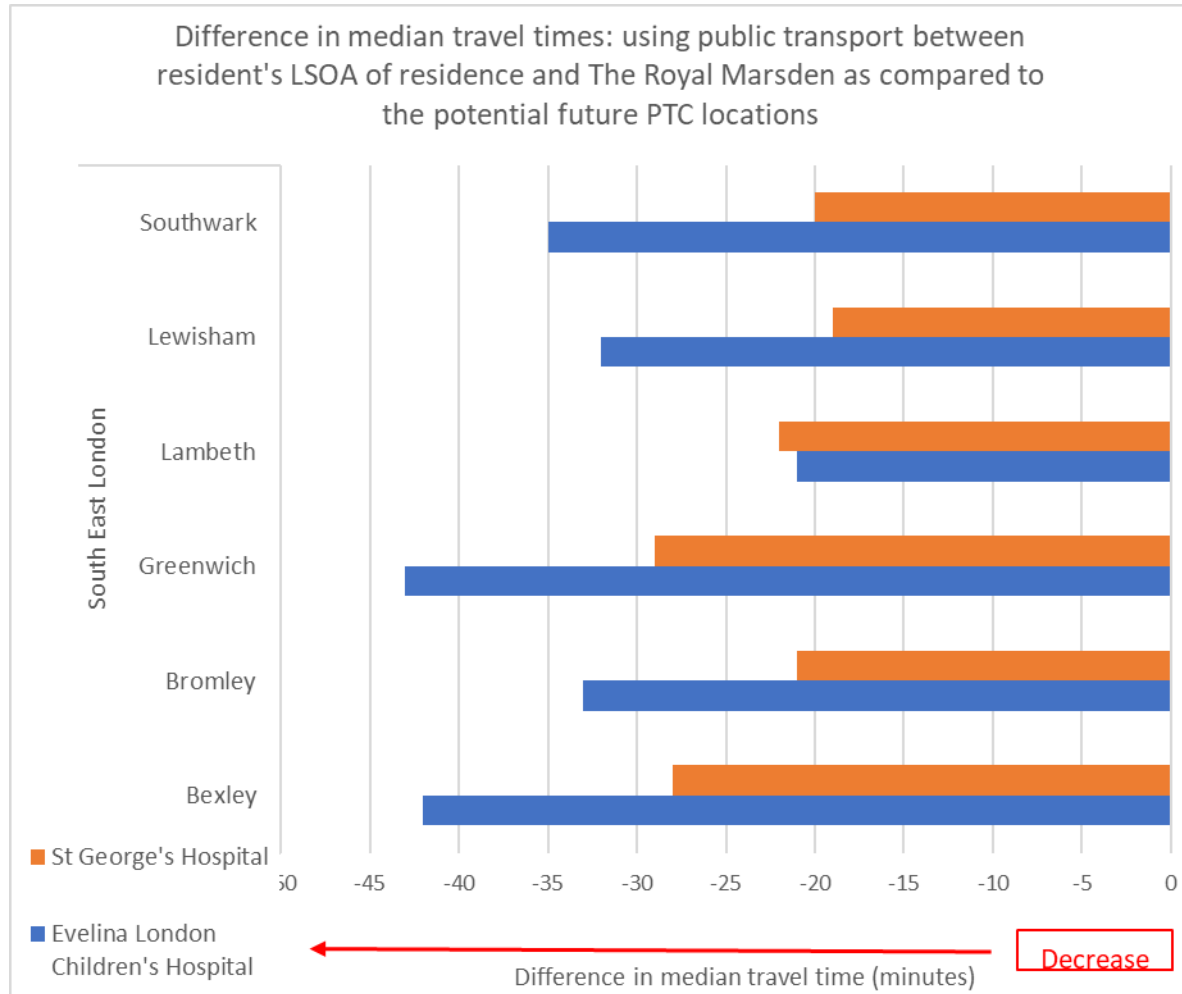
- where a family member is disabled (or has a spectrum disorder)
- who are on a low income/living in more deprived areas
- with poor literacy and/or language barriers
- who experience digital exclusion

The Equalities profile document includes an estimated quantification of the size of each population group within the PTC catchment area.

## Benefits for improving outcomes and reducing inequalities:

Compliance with the service specification will mean that healthcare related outcomes (in terms of patient experience and safety) are likely to be enhanced through receipt of co-ordinated, holistic care with a reduced requirement for treatment transfers at a time of crisis and the risk that certain types of transfers involve.

While this will benefit all children attending the PTC, the EHIA sub-group concluded that there may be a differential positive benefit for certain groups who may have a higher need for additional paediatric specialties (e.g. those with complex cancer care needs, co-morbidities, who are disabled or have or other conditions) or with communication difficulties (e.g. language barriers or poor literacy) where the reduced need for treatment transfers/multi-site appointments may be beneficial.



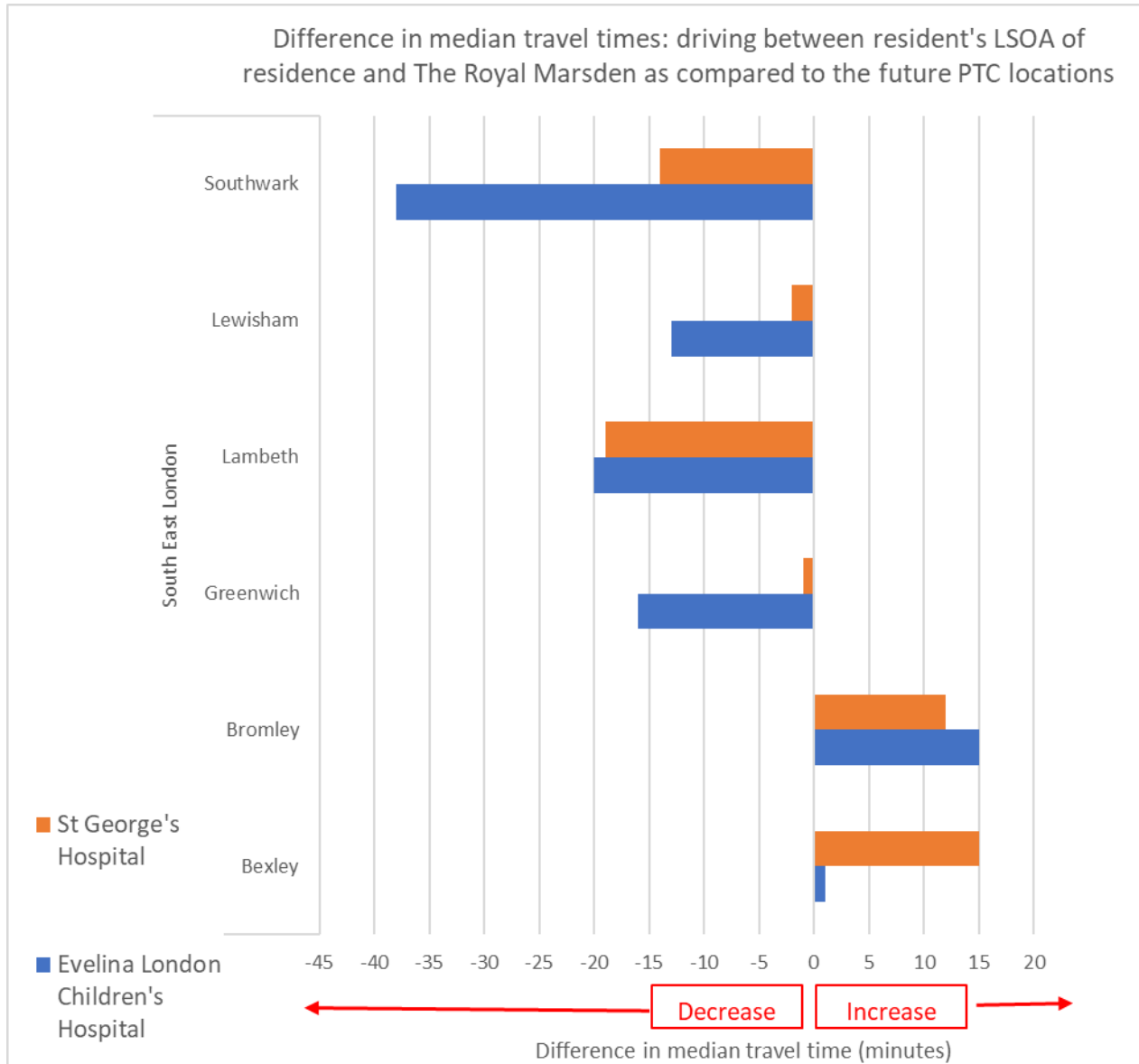
On average, the residents of all boroughs within South East London would see a reduction in travel time to either Evelina London or St George's via public transport, compared to travelling to The Royal Marsden.

Travel times to Evelina London would reduce by 34 minutes on average.

Travel times to St George's would reduce by 23 minutes on average.

For context, the estimated current public transport travel time to The Royal Marsden for South East London residents is on average 1 hour 24 minutes.

# Equality and Health Inequality Impact Assessment: driving



On average, the residents of most boroughs within South East London would see a decrease in travel time for driving.

However, this masks a difference within the area, with residents of Bromley likely to experience an increase in travel time of around 14 minutes on average to either potential future location.

Meanwhile, residents of Bexley would be likely to experience an increase of around 15 minutes travel time to St. George's.

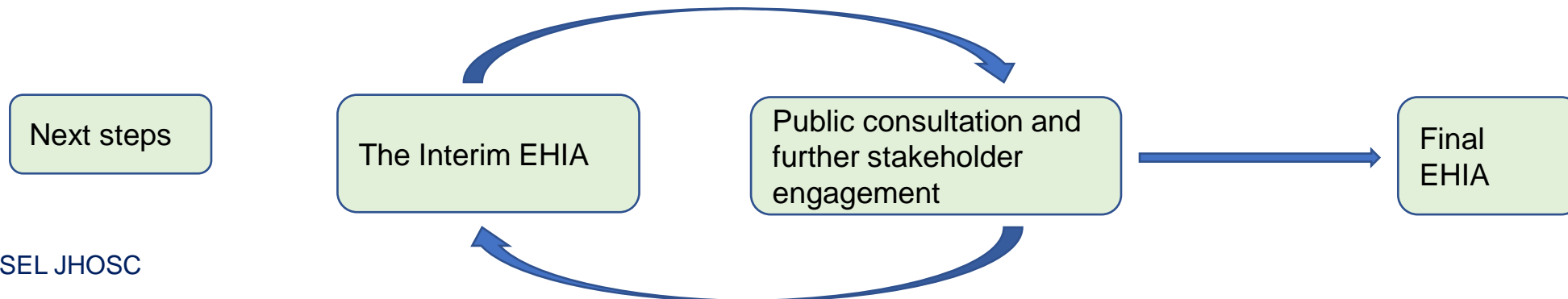
For context, the estimated current drive time to The Royal Marsden for South East London residents is on average 54 minutes.

# Equality and Health Inequality Impact Assessment: mitigation & next steps

It is important to note that the travel analysis can only capture impacts in terms of travel time. It is not possible to systematically quantify impact in terms of complexity of journey, reliability of transport services and costs. **The most important aspect of the EHIA is the recommendations for mitigation.** The EHIA sub-group has put forward a range of potential systems, processes or programmes that could serve to mitigate the adverse impacts of a longer, more complex, more costly journey.

The main themes include:

1. Systems and processes aimed at helping patients and families plan their journeys to hospital, including provision of inclusive and accessible information and translation services.
2. Systems and processes aimed at reducing the financial impact of travel, such as reimbursement schemes for travel costs (including Ultra Low Emission Zone - ULEZ charges) or supporting patients to access other financial support.
3. Transport services provided directly to patients and their families (with clear eligibility criteria) and family accommodation.
4. High quality onsite accessibility arrangements, including parking and drop-off facilities.
5. Other aspects of care planning including flexibility for appointment times, shared care closer to home, strong communication systems between different health and social care teams, and remote (non face to face) appointments (that take into account aspects of digital capability)
6. An excellent implementation plan for the service change process, to support patients through the transfer period, with high quality continuity of care. Implementation plans should consider meeting NHS duties around health inequalities and take a Core20Plus5 approach.



## Other impacts

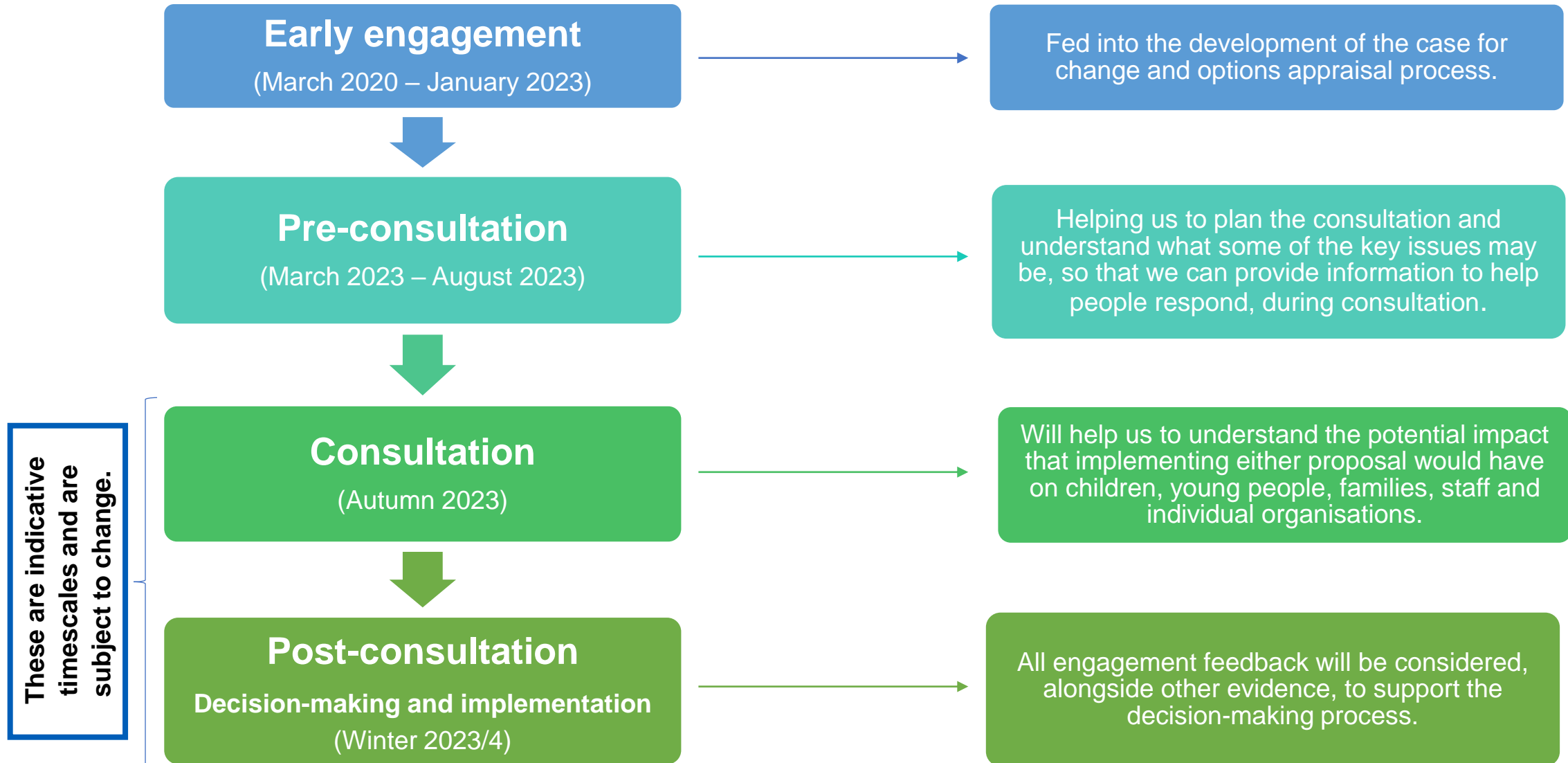
Alongside the duty to reduce inequalities of outcomes, NHS England – London, have, and will continue to give due regard to:

- The wider impact of the decision made
- The need to contribute towards compliance with the UK net zero emissions target (s. 13NC NHS Act)



## 5. Consultation plan and document, including stakeholder engagement

# Overview of engagement to date



# We seek to ensure an inclusive engagement approach

**Planned engagement** (during pre-consultation and consultation) is focussing on reaching professionals and different groups from across the region

## Professionals and groups include:

- **Current and recent service users and their families and carers**
- **Voluntary and community organisations** (those support children and young people and other communities, including Healthwatch)
- **Staff** (those working in these services and wider staff groups)
- **Health and care partners** (connected services and other nearby Trusts)
- **Children and young people from Black and minority ethnic communities**
- **Children with physical and/or learning disabilities or autism**
- **Scrutiny and assurance bodies** (Overview and Scrutiny Committees and both Clinical Senates across south London and south east region)
- **Focus on all geographic areas patients currently come from**
- **Focus on all age band between 0-15 years old**

## Our approach

- Working with **experts in the voluntary and community sector** to include a range of views.
- Commissioning specialist expert organisations to ensure we reach EIA groups and children and young people in an effective and appropriate way.
- Learning from Trust and ICB engagement colleagues to develop **relationships** with key stakeholders to be **inclusive of seldom heard, minority and deprived population groups**
- **Using intelligence** from the IIA to **inform engagement plans** to focus on those most affected and impacted groups
- Historic engagement (via both surveys undertaken) has reached a **range of ages, ethnicities and geographies**

# Pre-consultation activities – progress so far includes:

## Activity undertaken

- **Contacted over 300 organisations across south London, Kent, Medway, Surrey and Sussex**, to let them know about the project and to encourage feedback (detailed list in the appendix)
- **Attended The Royal Marsden teenage and young adult forum**
- **Session with POSCU staff across the catchment area**
- **Working with engagement leads from all three Trusts** to reach their patient groups, forums and volunteers
- **Visit to The Royal Marsden and Guy's and St Thomas' wards** to directly engage with children and young people and families
- **Staff engagement session** at The Royal Marsden
- **Stakeholder information session with VCS organisations across the catchment area**

## Upcoming activities

- **Further visits to wards at St George's** to directly engage with children and young people and families
- **Further work with Children with Cancer UK and Young Lives VS Cancer** to reach a broader range of families
- **Further sessions for staff at St George's and Guy's and St Thomas'**
- **Follow up communications to all groups we originally contacted**
- **Working with colleagues across the catchment area to understand further engagement opportunities** during the pre-consultation period

# Consultation: Aims

We have two strong options for the future PTC.

The consultation aims to inform NHS England – London on our decision on which option will offer the best service for children with cancer in the future.

The **purpose of the consultation** is to:

- engage with as many people as possible in the geography affected by this service change and hear their views on the proposals for the future location of the children's cancer PTC
- understand the impact of implementing either proposal and any mitigations or enhancements that could be put in place
- ensure NHS England - London, as decision-maker, is made aware of any information which may help to inform the options and the decision-making process.

Public consultation is not a vote or referendum, and we are asking stakeholders to consider each proposal in its own right.

Outside scope of consultation:

- Shared care units which provide cancer care to children in local hospitals are not affected by this consultation.
- Cancer services for teenagers and young adults (generally for 16 to 25-year-olds but with some flexibility around ages) will continue to be provided at The Royal Marsden.

# Consultation document

## Consultation document: proposed content includes

- How people can get involved (including hard copy questionnaire)
- What the consultation is about (and what services won't change)
- Why a change is needed and benefits
- Our proposals
- What the proposed changes would mean
- What children, parents and staff have told us about the impacts
- Developing and assessing our shortlist
- The options
- Other impacts (including travel and other services)
- Scoring outcome
- Our preferred option
- Timetable and next steps

## Appendices/other supporting documents include:

- Summary consultation document
- Easy read document
- Consultation questions
- Consultation plan
- Early engagement feedback report
- Animation
- Factsheets on development, summary and evaluation of the proposals, financial aspects including costs, getting to the two potential sites, transition offer to teenage and young adult service
- Initial Equalities and Health Inequality Impact Assessment (EHIA)
- Feedback from the Clinical Senate and programme actions

Our preparations for consultation remain ongoing, this includes ongoing review and assurance of our pre-consultation business case and associated consultation materials as part of NHS England's Stage Two assurance process. In parallel with this, we have received a lot of feedback during the pre-consultation phase, there remains ongoing work to review this and reflect it in our documentation.

# Consultation: Engagement methodology & key questions

## Engagement methodology

- **Writing to current and recent service users and their families/carers**
- **Online events**
- **Targeted sessions** with the **stakeholder group and other charities/ Voluntary and Community Sector (VCS) organisations** already closely involved with us
- **Community outreach to children and young people and their families with specific characteristics** identified in the equalities impact assessment
- **Creative activities on existing sites with children and young people currently accessing services** (through working with a play therapy organisation)
- **1:1 interviews/ survey completion on existing sites with parents/carers**
- **Attending existing meetings** in the community
- **Survey** (including an easy read version)
- **Wide use of simple animation** to raise awareness and encourage feedback
- **Sharing information through existing contacts and networks** including Facebook group for RM parents
- **Posters with QR codes** linking to online materials
- **Briefings**
- **Offering non-digital channels:** completion of surveys by post, interviews by phone, printed documents in wards/given out by Royal Marsden volunteers/in flats used by long-stay parents

## Consultation questions will focus on:

- Understanding of the case for change
- Views on key aspects of both proposals such as travel, access and research
- Ideas around how to mitigate or enhance impacts
- Understanding how we could make implementing the change easier for those currently in the service

## Appendix: Supporting slides

- Case for Change - references
- Travel time analysis – methodology
- Pre-consultation engagement – who we have contacted
- How stakeholder feedback is influencing our consultation plans and documents



Transferring critically unwell patients is associated with a risk of physiological deterioration and adverse events<sup>(1)</sup> and the emotional and psychological stress for parents should not be underestimated<sup>(2)</sup>. Although specialist transport services have been shown to enhance safety and quality<sup>(3)</sup>, the 2008 “[Safe and Sustainable](#)” framework, produced by clinicians and endorsed by the relevant Medical Royal Colleges, states that paediatric oncology and paediatric intensive care have “absolute dependency, requiring co-location”. It is this clinical advice, backed up by subsequent expert reviews<sup>(4)</sup> that underpins the national service specification requirement.

#### References:

1. Droogh, J.M., Smit, M., Absalom, A.R. *et al.* Transferring the critically ill patient: are we there yet?. *Crit Care* **19**, 62 (2015). <https://doi.org/10.1186/s13054-015-0749-4>
2. Harvey, Edmunds, Ghose. Transporting critically ill children. *Anaesthesia & Intensive Care Medicine* Volume 21, Issue 12, December 2020, Pages 641-648
3. Gilpin Hancock. Referral and transfer of the critically ill child. *BJA Education*, 16 (8): 253–257 (2016)
4. NHS England [board-meeting-item-9-update-on-specialised-services-c-appendix-2.pdf](#) ([england.nhs.uk](http://england.nhs.uk))

# Travel time analysis: methodology

Travel time modelling software was used to generate public transport and car journey travel times for all children (aged 15 and under) living in the PTC catchment to each of the three provider locations, from their “origin” (based on their Lower Super Output Area\* (LSOA) of residence). There are 4,000 LSOAs within the PTC catchment area.

Travel times are for the fastest trip departing from resident origin for arrival at midday on a Wednesday. Metrics used in the analysis are median and longest travel times (minutes) and the proportion of the population within a 60 minute journey time of each provider, by public transport and driving.

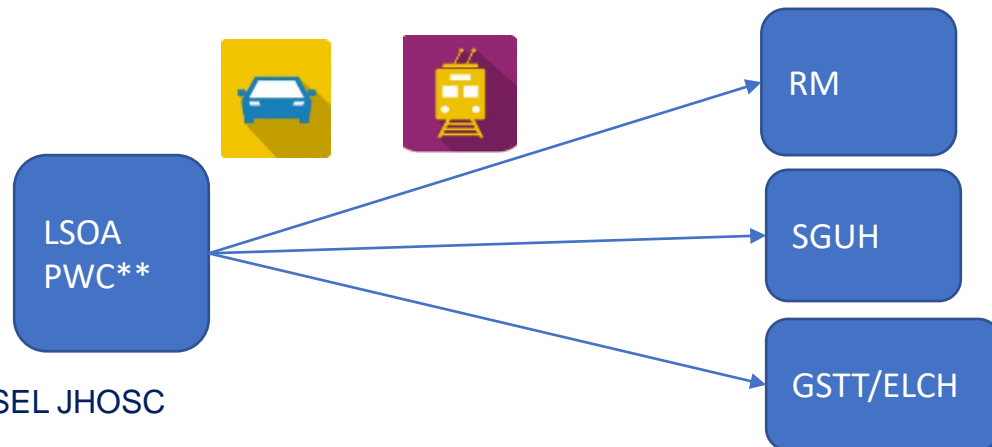
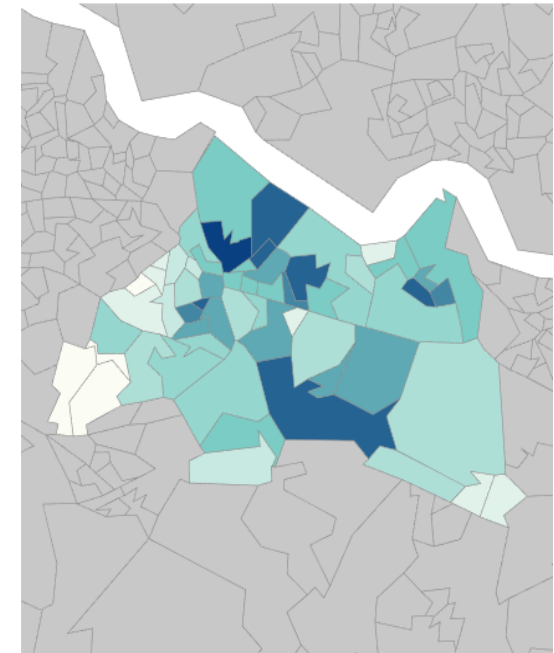
The modelling uses both road networks and timetabled transport networks. The potential combination of travel modes for each journey by public transport are national rail, tram, light rail, tube, bus, coach, ferry, and walking to and from stops and interchange, and walking alone if quicker. A public transport journey was only measured if a station or stop was reachable within an initial 20 minute walking time (only 0.2% of LSOAs did not meet this criteria).

The travel measures are intended to provide a typical indication of the quickest journey from origin to destination for people travelling with no additional requirements. Individual experiences may not completely align with the estimated times.

\* **Note: Lower Super Output Areas (LSOAs)** are a small area geography averaging approximately 1,500 people. Each LSOA has a PWC (population weighted centroid) which represents the centre of the distribution of residents across the LSOA.

Population estimates are available at LSOA level and each LSOA is assigned an [Index of Multiple Deprivation \(IMD\)](#) score and an [urban/rural classification](#). This allows for travel time analysis by these classifications. More information on the IMD is in [Appendix B](#)

Illustration of Lower Super Output Areas (Dartford)



**Below is a list of the different types of organisations we have contacted as part of our pre-consultation engagement:**

- Specialist Children & Young People (CYP) cancer charities/groups (including parent-led organisations)
- Youth Forums/Councils/ Parliaments
- Healthwatch organisations
- Maternity Voice Partnerships
- Mental health umbrella organisations
- Black and minority ethnic forums/ groups
- Pan-geography organisations supporting; refugees or asylum seekers, addiction and/or substance misuse issues, people involved in the criminal justice system, people experiencing homelessness and gypsies or travellers)
- Learning disability and autism groups
- Groups supporting people with physical impairments
- Carers (young and adult)
- Community groups in the most deprived areas within the catchment

# Stakeholder feedback is influencing our consultation plans and documents

## What we've heard through our pre-consultation engagement

- **How we engage during consultation** – taking a mixed approach to and offering different information in different format to suit everyone's information needs.
- **The information we need to provide during consultation** – short, engaging documents as well as more detailed information covering off topics like; the case for change, travel and access, costs involved, impacts on wider services and research.
- **A need to understand the impact on the service model** – what will this mean for The Royal Marsden, the range of supporting services that will be provided in future, whether the care will be of the same or improved quality.
- **Case for change** – identifying benefits and challenges
- **Impact of relocating services** – how transition to the new location will be managed, impact on travel times and access and wider challenges.
- **Process to date** – concerns over options appraisal process and stakeholder involvement
- **Decision-making process** – desire for transparency around how the final decision will be made
- **Important factors for a future service** – highlighting areas such as facilities and access requirements, as well as the availability of family support and workforce.

## How our plans have been influenced:

- **Adjusting our consultation plan**
  - to include surveying families in waiting rooms
  - offering visits to both sites so that people can find out more about the organisations and locations of services
  - adding new organisations to our database who are affected/interested
  - offering posters with QR codes so that people can respond online
  - recognising and reaching those who will be most affected – potentially those who are not aware of/ not currently using services. Focus on broad engagement with wide equalities groups and pregnancy and maternity groups.
- **Ensuring our materials are children, young people friendly**
  - testing our animation script with children and young people
  - looking at working with specialist children's cancer charities to develop social media content that may reach children and young people on a peer-to-peer level.
- **Ensuring our materials are accessible and easy to read**
  - Removing jargon in our documents and presenting information through diagrams
  - Slimming down the consultation document and signposting to other sources of more information, like our fact sheets, for more detail
  - Outlining the impact on individuals through patient stories
- **Creating new materials to respond to FAQs and early concerns**
  - Fact sheets about topics like finance and access will be produced.
- **Adding to our consultation questions**
  - Hearing clearly that travel and access are key concerns and adding questions on these to understand the impacts.