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Mount Vernon Cancer Centre public consultation January - March 2026

Findings report – V1.2

June 2026

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Executive summary

Introduction

Between 19 January and 29 March 2026, NHS England conducted a public consultation regarding the future of cancer services provided by Mount Vernon Cancer Centre. The consultation invited feedback on proposals to secure high quality, sustainable cancer care for adults in Hertfordshire, North London, East Berkshire and parts of Buckinghamshire.

The proposals included:

- Moving of cancer services provided by Mount Vernon Cancer Centre in Northwood to a new cancer centre adjacent to a planned rebuild for Watford General Hospital.
- Increasing the availability of chemotherapy at home for eligible patients and establishing a new chemotherapy unit at Hillingdon Hospital, alongside expanded capacity at Northwick Park Hospital.
- Providing a haematology (blood cancer) service for Hertfordshire and Bedfordshire residents at the new cancer centre instead of in Central London
- Increasing opportunities for patients to have diagnostic tests, blood tests and monitoring closer to where they live, where clinically appropriate.
- Providing an additional radiotherapy unit at either Lister Hospital (Stevenage) or Luton and Dunstable Hospital to reduce patient travel times in the north.

Mount Vernon Cancer Centre provides regional non-surgical specialist care for more than two million adult patients. However, its future has become a growing concern due to the lack of co-located support services (for example, Accident and Emergency and critical care) and significant infrastructure limitations. As highlighted in an independent clinical review; making no changes would inevitably lead to Mount Vernon Cancer Centre not being able to continue offering specialist cancer treatment.

The consultation provided an opportunity for people to share their views about the proposals and suggest alternatives for the Mount Vernon Cancer Centre programme team to consider or mitigations that might lessen any negative impact. The consultation is not a vote on proposal options but helps decision makers ensure the proposals provide the best possible option for the population.

Consultation governance, delivery and quality assurance

The consultation was led by NHS England, working with the six Integrated Care Boards with the largest number of Mount Vernon Cancer Centre patients and other partner NHS organisations across the catchment area.

The consultation was overseen by a small operational group of staff from NHS England, University College London Hospitals NHS Foundation Trust and East and North Hertfordshire Teaching NHS Trust supported by Olovus, a specialist public and patient consultation practitioner and Different Narrative, a creative marketing agency and working in partnership with local Integrated Care Boards.

The duty to take account of the outputs from the consultation in making the decision about Mount Vernon Cancer Centre sits with NHS England supported by NHS Central East, West North London and Thames Valley Integrated Care Boards.

The teams delivering the consultation held weekly progress review and strategic alignment meetings. The reviews led to specific actions modifying and extending plans to fill any perceived gaps.

The consultation was carried out in line with the statutory duties to involve the public and consult on substantial service changes, and the legal duties to address health inequalities. It followed the four Gunning principles; principles for public consultation which were established in 1985.

Analysis of all feedback was carried out and quality assured by Olovus' experienced team of research analysts.

Consultation activity

3,111 members of the public, patients, staff and other stakeholders participated in the consultation through attending an event or focus group, completing a survey or providing a formal response.

Roadshow activity and attendance at other meetings reached an additional 550+ individuals, however these individuals have not been included in final consultation number as it was not possible to reliably count the number of people engaged with. These activities provided an opportunity to raise awareness of the consultation and signpost individuals to the consultation survey.

Olovus' assessment of consultation delivery

As the specialist consultation and analysis partner for the programme, Olovus brings experience of NHS service change, public consultation, equality and health inequalities engagement, and consultation reporting. Olovus supported the delivery, monitoring and analysis of this consultation and is therefore able to provide a professional assessment of both the process followed and the strength of the evidence generated.

In Olovus' professional view, the consultation generated a substantial and usable evidence base for decision makers. It combined broad reach through the public survey, communications activity and partner promotion with deeper qualitative insight through microgrant funded community discussions, staff events, roadshows, stakeholder meetings and formal submissions.

The microgrant approach was a particular strength because it enabled discussions with communities who are often less likely to respond through mainstream NHS consultation routes. These discussions were held by trusted voluntary and community sector organisations in settings that were familiar and accessible to participants. This added depth to the consultation evidence and helped bring forward issues that may not have been identified through the public survey alone.

The consultation was also actively monitored during the live period, with activity adapted in response to emerging gaps in geography, participation and awareness. As with most

public consultations, the evidence should be read with appropriate limitations. These include the self-selected nature of the sample that responded to the survey and the fact that some views were based on anticipated future access rather than direct experience of the proposed new service model.

Taken as a whole, the consultation provides sufficient breadth, depth and consistency of evidence to inform the Decision Making Business Case.

Key findings

The consultation found divided public opinion on relocating the specialist cancer centre from Mount Vernon Cancer Centre to Watford General Hospital. However, views were not random. Across the consultation, support was more likely where people believed the proposals would improve access for them or their community, reduce travel, or bring services closer to home. Opposition was more likely where people believed the proposals would make access harder, particularly because of travel time, parking, public transport, patient transport, cost or reliance on others.

Public survey results show the relocation proposal was finely balanced: 48% supported moving the centre and 42% opposed it. Support was highest amongst individuals who refer people to Mount Vernon Cancer Centre (62%), those with no experience of the centre (61%) and Mount Vernon Cancer Centre staff (56%). Support was lowest amongst current Mount Vernon Cancer Centre patients (34%), those who have attended the centre with someone else (42%) and past patients (49%).

Clinician support was higher at 69%, with respondents from primary and secondary care across the Mount Vernon Cancer Centre catchment.

Perceptions of access were similarly divided: 37% of public respondents said Watford General Hospital would be easier to access, while 45% said it would be harder.

When asked about travelling to Watford for the most specialist treatment while receiving more routine care locally, 46% said they would travel, 38% would travel but would find it hard, and 12% said they would choose not to have specialist treatment if it meant travelling to Watford General Hospital.

This 12% response should be noted and explored further but interpreted with care because it was a hypothetical question about a proposed future service model. This group included people with different levels of direct experience of Mount Vernon Cancer Centre. Additionally, where this was discussed in the community discussions, some participants noted a preference to attend other hospitals. For example, some felt that accessing University College London Hospitals by train was easier than travelling to Watford General Hospital, while others in West London considered central London cancer services to be more accessible.

Across the public survey, clinician survey, staff events, community discussions and formal submissions, respondents identified a clear set of perceived benefits to relocation. These include:

- Co-location with acute services (including Accident and Emergency, critical care and diagnostics), which is seen as improving safety and pathways for complex or deteriorating patients.
- The opportunity for modern, purpose-built facilities and an improved patient experience compared with the limitations of the current Mount Vernon Cancer Centre estate.
- Improved access for some communities within the catchment where Watford General Hospital is closer.
- Alignment with a broader service direction of delivering more care closer to home (i.e., through expanded opportunities for local diagnostics and increased local chemotherapy, for example by providing more capacity in local hospitals and chemotherapy at home where clinically appropriate).
- Potential benefits for research, specialist expertise and workforce development, including the role of University College London Hospitals leadership and links to larger specialist centres.

The most prominent concern about the relocation relates to travel, transport and accessibility of Watford General Hospital. This includes concerns about increased journey times and costs, traffic congestion, parking availability and cost, public transport connectivity and availability and reliability of non-emergency patient transport. For many, their support for the relocation is dependent on mitigations being put in place to address these.

In addition to the primary concerns regarding access and transportation, respondents identified several other pertinent issues:

- The suitability of Watford General Hospital as an environment for cancer care - busy general hospital setting versus Mount Vernon Cancer Centre's calmer site, infection risk, space constraints and reputation/capacity concerns.
- Whether MVCC's quality and person-centred culture can be maintained.
- Uncertainty around timescales, deliverability and funding (including uncertainty about the wider redevelopment timetable, the implications of delivering cancer care alongside major construction, and what would happen if the new build does not proceed).
- The future of the Northwood site with concern about what happens to existing assets and previous fundraising/investment and potential service decline during any prolonged transition.

Another recurring theme, particularly in the south of the catchment, was trust in the process, with some perceiving that decisions may be pre-determined.

When considering options for the delivery of radiotherapy services, respondents who attended the community events and discussions generally favoured the options that reduce repeated travel and provide more local care options (i.e. Option B – an additional unit at Lister Hospital and Option C – an additional unit at Luton and Dunstable Hospital). This was also evident in the public survey where Option B and Option C were the most selected overall (both 29%), compared with 17% for Option A (all radiotherapy at WGH) (26% had no preference/weren't sure).

Clinicians responding to the clinician survey were cautiously supportive of a networked radiotherapy approach provided that safeguards are in place (57% felt a networked unit could deliver equivalent outcomes either fully - 10%, or with safeguards - 47%). Key clinician-identified risks raised in the survey and in staff discussions included staffing/recruitment, operational complexity, and maintaining quality assurance. Formal submissions from different organisations also emphasised the need to avoid a “two-tier” service and to ensure clear governance, equipment parity and coordinated pathways.

Equalities analysis suggests that some groups may be more negatively impacted by the proposals than others, particularly older people, disabled people, people with limited mobility, and lower-income groups. Additional barriers were also reported by other groups including minority ethnic, faith and migrant communities regarding language support, navigating the system and awareness of assistance.

The microgrant focus groups enabled individuals to discuss the concerns they have and offer suggestions as to what would help reduce impacts. These include the provision of reliable and high-quality patient transport services, the availability of accessible and affordable parking as well as drop-off points, and scheduling appointments at times that minimise travel risks, such as avoiding after-dark or early morning slots. There was strong advocacy for clearer communication and enhanced navigation support to help individuals understand and access services effectively. Importantly, individuals stressed the need for inclusive and accessible in-person options to be available alongside any digital or hybrid models of care, ensuring that no one is excluded by technology or circumstance.

The consultation enabled people to suggest alternatives for the Mount Vernon Cancer Centre programme team to consider. Alternative suggestions included redeveloping Mount Vernon Cancer Centre at Northwood, moving the centre to other hospitals, expanding radiotherapy networks (i.e. offering more than one satellite unit), considering a new site with better accessibility, and providing more local care options (i.e. using GP practices and other community settings).

With support among many being conditional on clear mitigations being put into place – a wide range of factors were identified for the programme team to consider. These include:

- A robust and equity-focused travel/transport/parking mitigation plan
- A calm, inclusive cancer care environment at Watford General Hospital
- Sustainable workforce arrangements
- Strong digital interoperability and communication across organisations
- Consistent and adequately resourced care closer to home capacity
- Clear governance, accountability and escalation pathways across partner trusts
- Credible transition planning, timelines and funding assurance
- Ongoing engagement and transparent decision-making to rebuild and maintain public confidence.

Next steps

The final report of the consultation will be published in early June 2026 and will then go through the programme's formal governance process. This will include review by the MVCC Strategic Review Programme Board and the MVCC Joint Health Overview and Scrutiny Committee.

The report will inform the Decision Making Business Case. The Decision Making Business Case will show how consultation feedback has been considered, how it has influenced the proposals, and how any agreed option would be implemented.

The Decision Making Business Case is expected to be reviewed by the end of September 2026.

1 Introduction

Between 19 January and 29 March NHS England conducted a public consultation regarding the future of cancer services provided by Mount Vernon Cancer Centre (MVCC). The consultation invited feedback on proposals to secure high quality, sustainable cancer care for adults in Hertfordshire, Bedfordshire, North London, East Berkshire and parts of Buckinghamshire.

To address these challenges, the consultation sought views on the following proposals:

- Moving of cancer services provided by Mount Vernon Cancer Centre (MVCC) in Northwood to a new cancer centre adjacent to Watford General Hospital.
- Increasing the availability of chemotherapy at home for eligible patients and establishing a new chemotherapy unit at Hillingdon Hospital, alongside expanded capacity at Northwick Park Hospital.
- Providing a haematology (blood cancer) service for Hertfordshire and Bedfordshire residents at the new cancer centre instead of in Central London.
- Increasing opportunities for patients to have diagnostic tests, blood tests and monitoring closer to where they live, where clinically appropriate.
- Providing an additional radiotherapy unit at either Lister Hospital (Stevenage) or Luton & Dunstable Hospital to reduce patient travel times in the north.

MVCC provides regional non-surgical specialist care for more than two million adult patients across Hertfordshire and parts of north London, Bedfordshire, Buckinghamshire and East Berkshire.

The main services the centre provides are radiotherapy, including brachytherapy, and chemotherapy and other anti-cancer drug treatments, including immunotherapy. These drug treatments are sometimes described clinically as systemic anti-cancer therapy, or SACT.

However, its future has become a growing concern due to the lack of co-located support services (for example, Accident and Emergency and critical care) and significant infrastructure limitations. As highlighted by the independent clinical review; making no changes would inevitably lead to MVCC not being able to continue offering specialist cancer treatment.

The consultation was an opportunity for people to share their views about the proposals and suggest alternatives the MVCC programme team might not have considered or mitigations that might lessen the impact. The consultation is not a vote on proposal options but points the team to important considerations in their decision-making, to ensure the proposals provide the best possible option for the population.

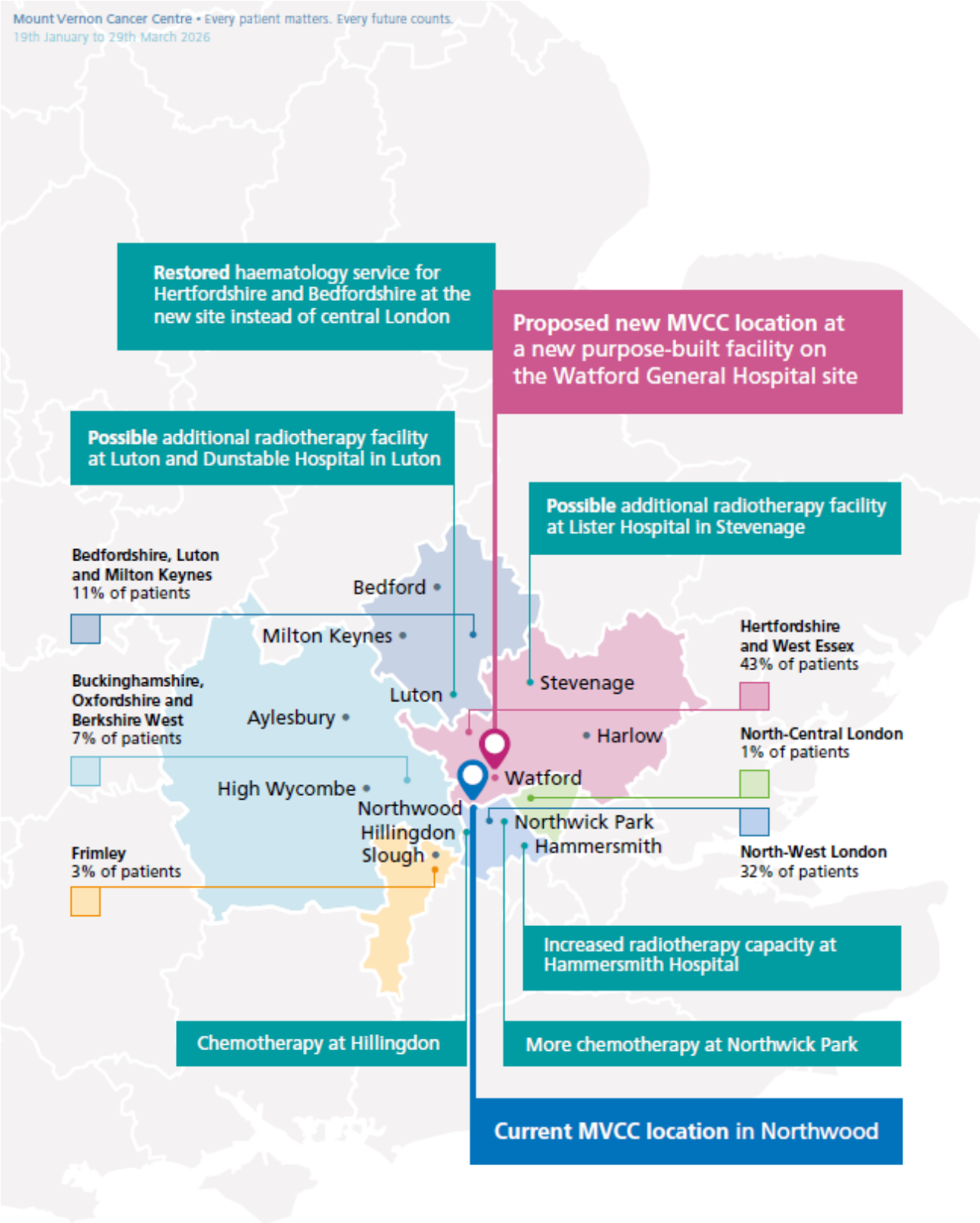

Figure 1 Map of current and proposed locations (from the Consultation document)

The consultation was led by NHS England, working with the six Integrated Care Boards with the largest number of MVCC patients and other partner NHS organisations across the catchment area.

The consultation was overseen by a small operational group of staff from NHS England, University College London Hospitals NHS Foundation Trust and East and North

Hertfordshire Teaching NHS Trust as well as representatives from Olovus, the independent specialist contractors appointed to support the consultation, with additional support from Different Narrative, a specialist marketing organisation.

This report analyses the feedback received during the consultation to inform those making the final decisions about the future of cancer services in this area.

2 Methodology

2.1 Consultation activity

To deliver the public consultation, the team used the Pre-Consultation Business Case (PCBC), equality impact analysis, and learnings from previous consultations to develop a Consultation Plan, Communications Plan, and Communications Toolkit. These set out the activities which would form the consultation in line with best practice. The consultation was launched on 19 January 2026 and closed on 29 March 2026.

The following consultation activities were undertaken:

2.1.1 Survey

A survey was available online between 19 January and 29 March 2026. Paper copies were available on request and consultation documents including paper copies of the surveys were available at in person events and roadshows, as well as GP surgeries, hospitals, libraries and local authorities.

The public consultation documents and survey questions are available in the Appendix report.

A table of the equality monitoring profile of all those who provided feedback via the survey is available in the Appendix report.

2,222 individuals responded to the online survey – this figure includes 20 paper copies received.

The analysis of the responses to the survey can be found in the section named Public survey analysis.

2.1.2 Consultation events - online, in-person and staff

Consultation events were held in person and online at different times, days of the week and locations across the area served by MVCC to enable as many people as possible to attend. As well as events open to all, a number of events were organised for staff.

There were 14 in person events, nine online events open to all, and six online staff events (see the Appendix report). People were asked to register in advance for the consultation events to ensure the events were well-staffed, however people were also able to turn up without booking.

The events were promoted on the public consultation's website, in the media and social media, through posters and pull-up banners, digital screen banners, web banners and email banners. Local partners including Integrated Care Boards (ICBs) and NHS Trusts had an important role to play helping to promote the events and the consultation in their areas.

2.1.3 Voluntary and community sector organisation (VCSO) 'microgrants' focus groups

In addition to the events organised by the consultation team, local voluntary and community sector organisations (VCSOs) in Hertfordshire, Bedfordshire, North West London, North Central London, and parts of Buckinghamshire and Berkshire were recruited to run focus groups of up to 10 people.

The aim was to hear from groups and communities that might otherwise face barriers to engagement including South Asian women, older African and Caribbean men, Muslim women, deaf British Sign Language (BSL) users, faith groups, gypsy and traveller communities and people with learning disabilities. These particular groups were identified following analysis of the Pre Consultation Business Case Impact Assessment and the 2021 Census and 2024/25 Local Authority estimates of areas of deprivation. The analysis also helped understand which geographical areas should particularly be targeted.

This was important to help ensure that the legal duty to address health inequalities in access and outcomes were met. In line with that duty, we approached representatives of all protected characteristic groups, including LGBTQIA+.

To ensure all participating VCSOs were fully prepared to facilitate focus groups, we hosted an introductory briefing webinar. This session provided a comprehensive overview of the consultation proposals and the microgrant programme, ensuring consistency across all engagement sessions. The webinar outlined the clinical proposals to ensure accurate representation during the sessions. Participants were briefed on the consultation toolkit, project timelines, and payment processes, and received a demonstration of the available resources, including how to integrate the consultation videos into their events. A dedicated Q&A session addressed all operational queries, ensuring partner organisations felt fully supported and equipped to deliver the engagement.

Out of 75 groups recruited, 50 groups ran sessions. Twelve of these ran two groups and three ran three groups, making a total of 68 sessions. Altogether there were 636 participants, representing a wide diversity of individuals, including the target groups and a range of people from areas of health inequality, and with other needs. In addition to receiving a microgrant for arranging and running the focus groups, the organisations were supported to provide interpreters and travel access funding as well as a small financial incentive for those who took part.

The full list of the groups who took part can be found in the Appendix document. The analysis of their feedback is in the section entitled Analysis of feedback from events, roadshows, community discussions and meetings.

2.1.4 Roadshows

15 roadshows were held at hospitals, including two at Mount Vernon Cancer Centre, and at shops and shopping centres (see the Appendix document). Facilitators recorded more than 430 direct interactions with the public, patients, and staff.

At the roadshows more than 400 leaflets and consultation documents were handed out to facilitate further feedback.

2.1.5 Additional meetings

The consultation organisers were invited by a number of organisations to attend existing meetings of community groups to discuss the proposals (see the Appendix report).

The feedback from these meetings, where available, is included as part of the section titled Analysis of feedback from events, roadshows, community discussions and meetings, and at all the meetings participants were supplied with written information and invited to complete the survey either online or on paper.

2.1.6 Written submissions

In addition to the survey, consultation discussion events, VCSO microgrant focus groups and other meetings, individuals and organisations were invited to submit a written response. This was possible by:

- Sending an email to the dedicated consultation email address
- Calling the involvement team, or
- Sending a letter.

The email address, phone number and postal address were all clearly signposted on the consultation documentation and website.

Responses were received from eight MPs, 11 NHS Trusts, 11 Local Authorities, three VCSO organisations, two Healthwatch organisations and four other organisations. There were also written responses from four individuals.

The analysis of these responses is available in the section Additional submissions.

2.2 Data protection

The consultation documentation stated that responses may be shared with colleagues in the consulting organisation, included in a published summary of responses, and referred to in this final published report. They may also be disclosed if someone requests it under freedom of information rules, unless a legal exemption applies.

The data provided has been processed only for the purposes of managing and reporting on the consultation. All data is held in line with the latest data protection regulations. Every effort has been taken to ensure that individuals cannot be identified in this report.

Participants were informed of how their data was being collected, used and stored in the data processing statement each time they provided information.

After the work is finished, Olovus will keep participants' data for no more than 6 months, then delete it. Under data protection law, NHS England East of England is responsible for the information. This means they are the data controller. Olovus collects, stores, and uses the information for the consultation. This makes them the data processor. Olovus may share the information given with NHS England East of England to help with this work and will be done lawfully in accordance with data protection legislation.

2.3 Publicity and promotion

A comprehensive communications plan was produced and partner organisations received communication toolkits to help with promoting the consultation and engagement activities. This included a plan of different communications activities and a range of designed communications assets" to publicise and promote the consultation. As the consultation covered such a wide area, the central team were able to call on local Integrated Care Boards and NHS Trusts to help with promotion in their areas. This included a network of 60 NHS communications and engagement professionals working within eight hospital trusts, six integrated care boards and three NHS regions.

2.3.1 Communications assets

Designed communications assets to promote the consultation, associated events and various consultation podcasts, recordings and geo-specific materials to encourage involvement included:

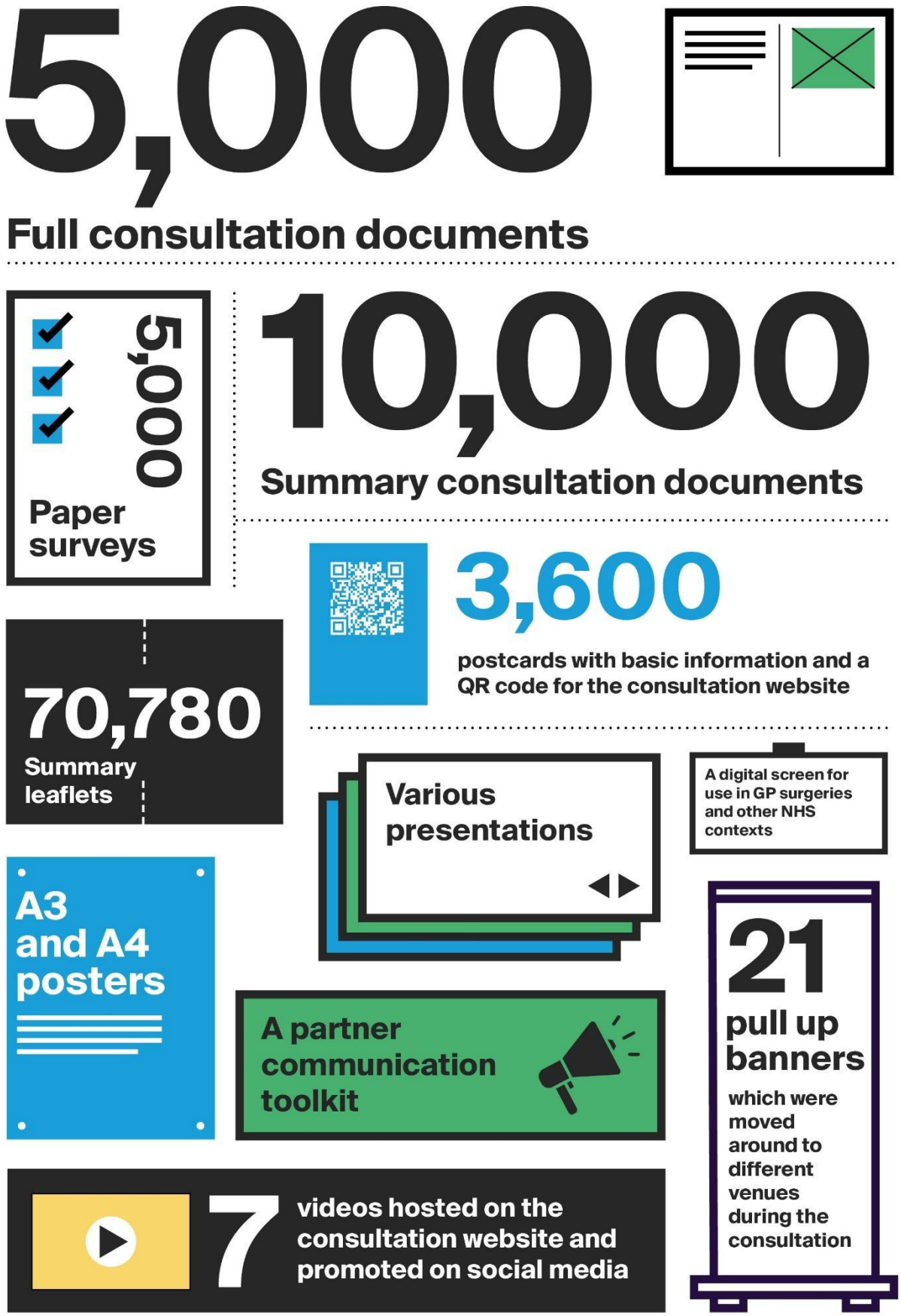

Figure 2 Summary of all consultation engagement

The documents were distributed widely to local hospitals, libraries, local authorities, Healthwatch organisations, voluntary sector bodies, Integrated Care Boards, MPs, NHS Chief Executives and Medical Directors.

The summaries and survey booklets were posted out to 529 GP practices.

2.3.2 Media

The marketing agency Different Narrative drafted and distributed five press releases and briefings to the media during the consultation period, in addition to a consultation launch press release distributed by the NHS before the consultation began.

In total 33 pieces of media coverage were published and broadcast during January-March 2026. Coverage was 94% positive. One radio interview took place on *BBC Three Counties Radio*'s breakfast show (12 March) with Dr Amy Guppy interviewed by presenter Andy Collins.

2.3.3 Social media

The agency Different Narrative created 15 'generic/launch' social media assets in various sizes and formats and 10 assets for specific events. Both sets were used for organic and paid socials then adapted and used for activity on the Next Door social media platform.

2.3.3.1 Social media organic activity

On the MVCC Review Facebook page, there were a total of 22 posts (including videos, reels and posts) throughout the consultation generating a total of 719,201 impressions.

2.3.3.2 Paid social media

A detailed report of the paid social media campaign is available on request. The key points from the paid social campaign report are:

The campaign delivered **2,570,000 impressions** across different regional and themed advertising sets. This means the adverts were shown more than 2.5 million times. The campaign generated **29,221 link clicks**, where people clicked through to the relevant web page or consultation information.

The campaign reached **706,559 individual users**. The average frequency was **3.65**, which means that, on average, each person reached by the campaign saw the adverts around **three to four times**. This does not mean every person saw the advert exactly 3.65 times. Some people will have seen it once, while others will have seen it more often. This level of repetition helped increase the chance that people noticed the consultation and had the opportunity to take part.

2.3.4 Media campaign report - combining paid social and traditional media

Full details of the combined media campaign are available on request. The key points are:

The combined campaign delivered more than **4.9 million impacts or impressions**. This means that consultation messages were shown or heard more than 4.9 million times across the different advertising and media channels used during the consultation.

The campaign generated more than **30,000 clicks** to relevant web pages, helping people access the consultation website, event information, videos and other supporting materials.

Activity on **Nextdoor** delivered **93,915 impressions** and **566 clicks** to the relevant web pages. These links took people to information such as the MVCC review website, event registration pages and consultation videos.

In addition, the MVCC consultation team developed **15 social media graphics** to support promotion of the consultation across different channels.

2.3.5 Videos

Seven videos were developed, including explanations and four videos of clinicians and a patient representative.

The majority of viewers accessed the videos through social media platforms, with only a limited number utilising the website. The video content generated considerable engagement, as evidenced by over 73,000 individuals who viewed the initial segment and more than 80,000 who watched at least 25% of the material. These figures reflect substantial public interest in the proposals. Specifically, there were 80,634 instances of viewers watching 25% of the video and 73,943 three-second views.

2.3.6 Consultation website

A dedicated consultation website was set up at mvccreview.nhs.uk. The website contained information about the consultation including why change is needed, the proposals, how to get involved, latest news and Frequently Asked Questions. There were links to the videos explaining the consultation.

A comprehensive downloadable document library included the Pre Consultation Business Case, documents central to the development of the proposals and access to all stakeholder updates over the years, the full consultation document and questionnaire, a leaflet, and a summary consultation document which was also available in an Easy Read version, and translated into Urdu, Polish, Bengali and Gujarati. The website also provided an accessible version of the summary document and the survey.

During the consultation news releases were published on the website. The events were publicised including weblinks to registration pages.

There were 18,500 visitors to the website during the consultation period.

2.3.7 Partner promotional activity

Across the partnership organisations, a comprehensive, multi-channel engagement programme was delivered to make sure staff, patients and the wider community were informed about the consultation and knew how to take part.

The activity included:

Internal staff engagement
Partner NHS organisations used internal communication channels to raise awareness of the consultation with staff and support local leaders to discuss the proposals with their teams. This included staff updates, intranet content, newsletters and local briefings. For example, University College London Hospitals reached 13,000 staff members through several electronic updates. East and North Hertfordshire Teaching NHS Trust also promoted the consultation through routes linked to Mount Vernon Cancer Centre and Lister Hospital, including staff communications and digital channels.

Patient and clinical communication
The consultation was promoted through existing clinical and patient communication routes. Information and links to the consultation website were included in more than 13,700 patient appointment letters. Partner organisations also helped promote the consultation through hospital sites, including roadshows at Lister Hospital, Watford Hospital, Mount Vernon Cancer Centre, Hemel Hempstead Hospital, Hillingdon Hospital, Luton and Dunstable Hospital and Wexham Park Hospital.

ICB, community and stakeholder networks
Integrated Care Boards and partner organisations helped cascade information through their local networks. These included patient participation groups, primary care networks, voluntary and community sector networks, Healthwatch organisations, local authority routes, faith and community networks, and local patient and community forums. This helped promote the consultation across the wider catchment, including communities less likely to respond through mainstream NHS channels.

Digital and social media outreach
Trust and partner digital channels were used to promote the consultation, events and supporting materials. For example, the Lister Hospital Facebook page, part of East and North Hertfordshire Teaching NHS Trust, recorded 71,000 views on a consultation post published on 23 January 2026, one of nine Facebook posts during the consultation.

Website and video promotion
Trusts and commissioners maintained website and intranet pages with links to the consultation website, consultation materials and clinician-led videos. These routes helped staff, patients and stakeholders access consistent information about the proposals and how to respond.

Direct stakeholder communication
The programme team and partners used existing stakeholder routes to share updates with MPs, local councillors, voluntary and community organisations, Healthwatch, patient groups and other local networks. The appendix also records engagement through existing forums and meetings, including Hillingdon Patient Engagement Forum, Herts and West Essex Patient Engagement Forum, North West London Residents' Forum, Harrow Health and Wellbeing Board, One Watford Board and Northwood and Ruislip United Synagogue.

2.4 Consultation governance and delivery

The consultation was managed and delivered by a small team from NHS England supported by Olovus, a specialist public and patient consultation practitioner and Different Narrative, a creative marketing agency working in partnership with local Integrated Care Boards (ICBs).

The original consultation plan was developed in March 2025 and set out the high-level consultation design, methods, audiences, materials, promotion routes, and intended governance and scrutiny arrangements.

A December 2025 delivery plan converted the consultation plan into a specific integrated supplier delivery model. It gave Olovus responsibility for consultation support, event logistics and promotional assets, stakeholder management through Tractivity (a stakeholder and consultation management platform), community microgrants, analysis and reporting. It gave Different Narrative responsibility for communications, website support, graphic design, social media and video production.

The Mount Vernon Project team, reporting to the Mount Vernon Cancer Centre Strategic Review Programme Board, held overall responsibility for the consultation, leading meetings, stakeholder relationships and programme governance. The programme board held responsibility for ensuring the consultation was conducted rigorously, transparently, and in accordance with statutory duties.

The duty to take account of the outputs from the consultation in making the decision about MVCC sits with NHS England supported by NHS Central East, West North London and Thames Valley Integrated Care Boards.

The teams delivering the consultation held weekly progress review and strategic alignment meetings at which they reviewed and discussed a dashboard of the consultation activity as follows:

- Reflections and a retrospective look
- Current status and decision log
- Risk and strategic horizon
- The forward plan

Following each meeting a record of the meeting was shared and the teams made any agreed adjustments to activities and confirmed their forward planning.

The reviews led to specific actions modifying and extending plans to fill any perceived gaps. These are discussed below in the section **Issues and learning opportunities**.

Three meetings were held between the Olovus analysis team and the NHS England team focusing on the analysis of feedback and the structure of the analysis report.

At these meetings the coding framework and the report structure were finalised. The NHS England team also reviewed Olovus' AI policy to ensure that it was in line with NHS England's own policy.

The consultation plan was formally approved by the MVCC Strategic Review Programme Board as part of its governance process. On 17 March, near the end of the consultation, the Board received an update paper. This paper compared what the original consultation plan, developed before the consultation and included in the business case and assurance documents, set out to achieve, with what was actually delivered during the consultation itself.

This paper evaluated the progress of the Mount Vernon consultation programme by comparing:

- The original consultation plan that was developed in March 2025, which set out the intended consultation architecture and broad programme activity.
- The operational delivery activity by the Mount Vernon programme team, supported by Olovus and Different Narrative, together with the delivery evidence currently available.

The aim was to support the Programme Board to understand where delivery was shown to be aligned, where activity was still in progress, and where there were evidence gaps that should be filled before any final assurance statement was made. The paper showed that on the evidence, the combined Mount Vernon programme team, supported by Olovus and Different Narrative, demonstrated good delivery of the live consultation support model that was formally set out in the delivery plan and the initial consultation plan from March 2025. The Programme Board was provided with assurance that where the plan had been varied, there was sound reasoning (i.e. made aware of what had changed and why) and was not material to the overall agreed plan

The strongest evidenced areas were survey delivery, website and digital content, communications activity, public meetings in progress, microgrant mobilisation and live monitoring, outreach, stakeholder correspondence, Tractivity assurance, and final reporting.

The Joint Health Overview and Scrutiny Committee had an important role in the consultation process. Before the consultation began, the committee considered the case for change, the proposed approach to consultation, the consultation plan and the consultation document. The committee's comments helped influence the final consultation materials, including some of the questions used to support demographic and equality monitoring.

During the consultation period, the programme team continued engagement with the Joint Health Overview and Scrutiny Committee. This included an update on the consultation process and a focused discussion on travel and access. Further engagement is planned, including discussion on care closer to home and formal consultation with the committee once the outputs from the public consultation are available.

This scrutiny route provided an important opportunity for elected members from across the catchment area to test the consultation approach, explore issues raised by residents and patients, and contribute to the development of the programme's understanding of key issues.

A JHOSC meeting was held on 13 March 2026, where the committee received an update on the consultation and a paper on transport and access. A further meeting is scheduled for 16 June 2026, at which the consultation report will be shared. The consultation report will also be shared with the MVCC Programme Board in early June.

2.5 Quality assurance

NHS Integrated Care Boards (ICBs) and NHS Trusts have statutory duties under the NHS Act 2006 (amended 2022) to involve the public and consult on "substantial" service changes. The Mount Vernon Cancer Centre Strategic Review Programme Board holds responsibility for ensuring the consultation is conducted rigorously, transparently, and in accordance with statutory duties. This report is in line with these duties. The duty to take account of the outputs from the consultation in making the decision about MVCC sits with NHS England supported by NHS Central East, West North London and Thames Valley Integrated Care Boards.

ICBs and NHS Trusts also have a specific legal duty to address health inequalities in access and outcomes, which should be central to consultation activities. They must also, according to the Equality Act 2010, Section 149 'advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it'. The consultation actively sought the views of those from the 'nine protected characteristics' defined in the equalities act and those from areas of health inequality. The section on equalities later in the report looks in more detail at how the consultation has worked to meet this duty.

The consultation was carried out in line with the four Gunning principles, principles for public consultation which were established in 1985. They stipulate that:

- **Gunning Principle 1**: Consultations must occur while proposals are still at a formative stage.
- **Gunning Principle 2:** Sufficient information needs to be supplied for the public to give the consultation 'intelligent consideration'.
- **Gunning Principle 3:** There needs to be an adequate time for the consultees to consider the proposal and respond**.**
- **Gunning Principle 4:** Conscientious consideration must be given to the consultation responses before decisions are made.

2.5.1 Transparency period

Following the drafting of this consultation report, the team ran a 'transparency period' of two weeks to allow those who took part in the consultation to review the draft report and provide feedback. The transparency period particularly supports the fourth Gunning principle, which requires decision makers to give conscientious consideration to consultation responses.

Publishing a draft consultation report and allowing stakeholders to review it provides additional assurance that:

- consultation responses have been carefully analysed
- the evidence gathered during consultation has been accurately reported
- stakeholder feedback has been taken seriously before decisions are made

This step strengthens transparency and helps demonstrate that the consultation process has been fair, robust and open.

Ten responses were received from individuals and organisations during the two week transparency period.

A number of additions were made to the document as a result. These included:

- More detail about the responses of specific groups including a group representing LGBTQIA+ people, a group of people seeking employment from deprived backgrounds, carers of people living with mental illness, a Patient Participation Group and a deaf support group all using British Sign Language
- Clarification on the relevance of ULEZ in people's responses
- Further clarification in the main report about whether the people responding to the consultation had used cancer services
- More detail from the responses in which people had said they would prefer existing London options to the option of going to Watford
- More detail about concerns about the wider redevelopment timetable, the implications of delivering cancer care alongside major construction, and whether an different site would offer a better alternative if the new build does not proceed
- A record of the fact that people were not clear why services could not be offered at a wider range of local hospitals, or why the specific options presented had been selected over other potential locations
- Specific feedback about the concerns of deaf people
- Specific feedback about carers
- More detail about language and other barriers

2.5.2 Assurance process

NHS England worked with NHS bodies across the wide geography served by Mount Vernon Cancer Centre to understand the impact people felt the proposed changes would have on them. Quality assurance was a systematic part of the consultation programme management. In their regulatory assurance role, NHS England reviewed and approved the Pre-Consultation Business Case, the draft consultation plan and the draft consultation document.

A key element of best practice management approach to public consultations is conducting regular progress reviews to identify, acknowledge and act upon issues that arose and to discuss and agree actions. Learnings from issues that arose and actions taken are reported in Issues and learning opportunities.

Analysis of the survey responses and feedback received was carried out and quality assured by Olovus' experienced, qualified research analyst, who is a member of the Market Research Society and Social Research Association.

Olovus' assessment is that the consultation was delivered substantially in line with the consultation plan and adapted appropriately in response to live monitoring. The strongest elements were the breadth of communications activity, the use of partner networks across a wide geography, the microgrant programme, the regular review of participation data and the use of multiple feedback routes.

The microgrant model added particular value by enabling trusted voluntary and community organisations to hold discussions in settings that were familiar and accessible to their communities. This produced insight that would have been difficult to gather through the public survey alone and strengthened the evidence on equalities, access barriers, community experience and practical mitigations.

There were also limitations. These included lower attendance at some public events, under-representation from some parts of the catchment and the fact that some responses reflected perceptions of future access to a proposed new service rather than direct experience. The public events also reflected different levels of understanding of the proposals, with some participants' views developing as they heard more about the case for change, the options and the issues raised by others.

These limitations do not undermine the consultation, but they should be taken into account when interpreting the findings and using them to inform the Decision Making Business Case.

2.6 Notes on analysis and limitations

Consultation evidence comes from multiple routes and should not be treated as a single additive headcount of unique individuals. For example, people attending meetings or an online/in-person event were also invited to complete the survey.

The report includes a summary of the key findings from:

- the public survey
- the clinician survey and staff discussion events
- the events, roadshows and community discussions and meetings
- additional submissions

Available in the Consultation Appendix report is a more in-depth analysis of the feedback from each consultation approach.

Quotes are used to illustrate points, not replace narrative. When using respondents' own text, these are provided verbatim, although spelling or grammar may be amended to make comments easier to read.

Public survey analysis

The sample was self-selecting, meaning that the survey was completed by those who chose to give their opinion, it is not a statistical representation of the catchment population.

The survey consisted of a mix of closed and open free text questions to understand views about the proposal.

To provide a quantitative representation of free text questions, coding frames were generated for each question. These were used to identify key themes and common perspectives. These were shared with the MVCC programme team, and wider, for comment and sign off, prior to the commencement of the analysis.

Prior to analysis, a robust quality check process was undertaken to ensure no duplicate entries or errors. At this point, five organisational responses were removed and presented as additional submissions. This was due to the depth of the insight provided.

To support decision making, closed survey questions and key free text questions were broken down by Integrated Care Board. Discussions with the MVCC programme team also noted that breakdown by Local Authority and Clinical Commissioning Group was necessary. Findings are excluded for any samples with 30 or fewer participants because the data's reliability is considered insufficient.

Comparisons were made between demographic groups and the overall sample to identify variation in responses; comparisons between groups were also considered to better understand differential impacts. Findings are indicative and not based on statistical significance testing.

An additional 20 paper surveys were received following closure of the survey. These were manually input into the survey link. These responses were considered and are presented within the public survey analysis section but are not included in calculated percentages.

Clinician survey analysis and staff discussion events

The survey sample was again self-selecting, representing the views of staff who wished to provide their opinion. It provides valuable professional insight into clinician perspectives; however, findings should be interpreted with appropriate caution, particularly where subgroup analysis is based on small numbers.

The section also provides an overview of the feedback from the staff events.

Analysis of feedback from events, roadshows, community discussions and meetings

This was a large qualitative exercise, with microgrant and roadshow activity targeted at geographies based on proportion of patients who currently access MVCC and on areas where survey responses were lower. The approach was dependent upon where the programme team were given permission to engage.

For VCSO run focus groups, discussion guides and recording templates were provided to ensure consistency in the data captured. For all other meetings, written transcripts and/or meeting notes were provided to the analysis team.

Thematic analysis was used to identify key themes and common perspectives across the events, focus groups and meetings. This technique does not allow for themes to be quantified, but the analysis team is able to understand the strength of feeling.

In line with NHS England's AI Acceptable Use Guidance, Microsoft Co-Pilot was used as a support tool by the research team at Olovus to summarise anonymised transcripts, highlight preliminary themes and organise qualitative insight for easier review. All AI-generated materials were reviewed, checked against the original data and refined by the team. The research team are responsible for all interpretations, findings and outputs.

Additional submissions

Formal submissions varied in length and detail; some were very technical and made specific recommendations, and some were brief. A brief overview of each is provided within the Appendix report.

3 Who responded

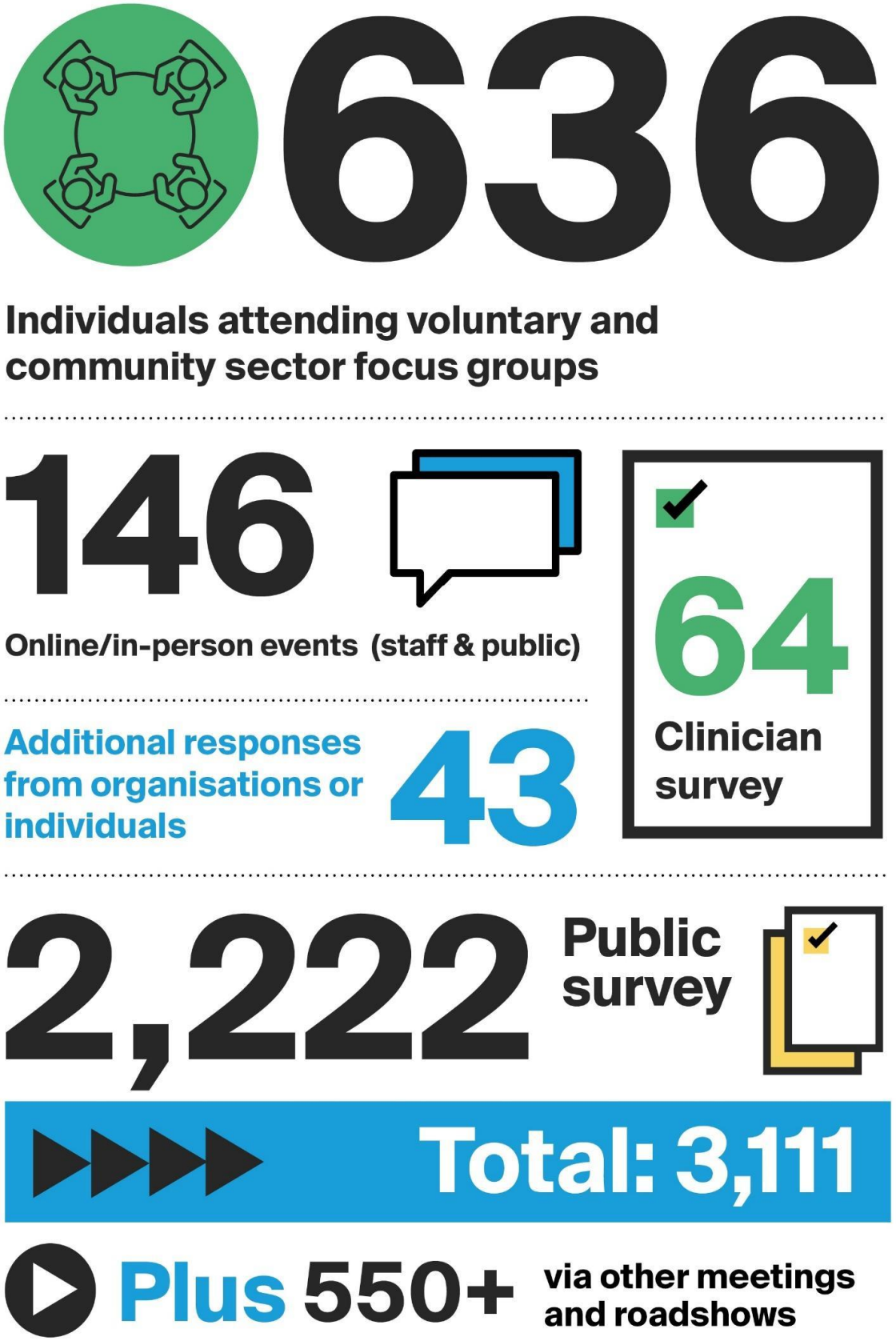

Figure 3 Summary infographic of who responded

A total of 3,111 members of the public, patients, staff and other stakeholders participated in the consultation through attending an event or focus group, completing a survey or providing an additional response.

Roadshow activity and attendance at other meetings reached an additional 550+ individuals, however these individuals have not been included in final consultation number as it was not possible to reliably count the number of people engaged with. These activities were an opportunity to signpost individuals to complete the consultation survey.

Consultation activity	Number engaged with
Online / in-person events (staff & public)	146
Public survey	2,222
Clinician survey	64
Individuals attending voluntary and community sector focus groups	636
Additional responses from organisations or individuals	43
Total	**3,111**
Other meetings and roadshows	*550+*

Table 1 Consultation activity and engagement numbers

3.1 Key demographics

The following are based on the 3,068 individuals who provided equality and monitoring information (data was not collected for those providing written submissions). A full breakdown is available in the Appendix report. (need to update infographic)

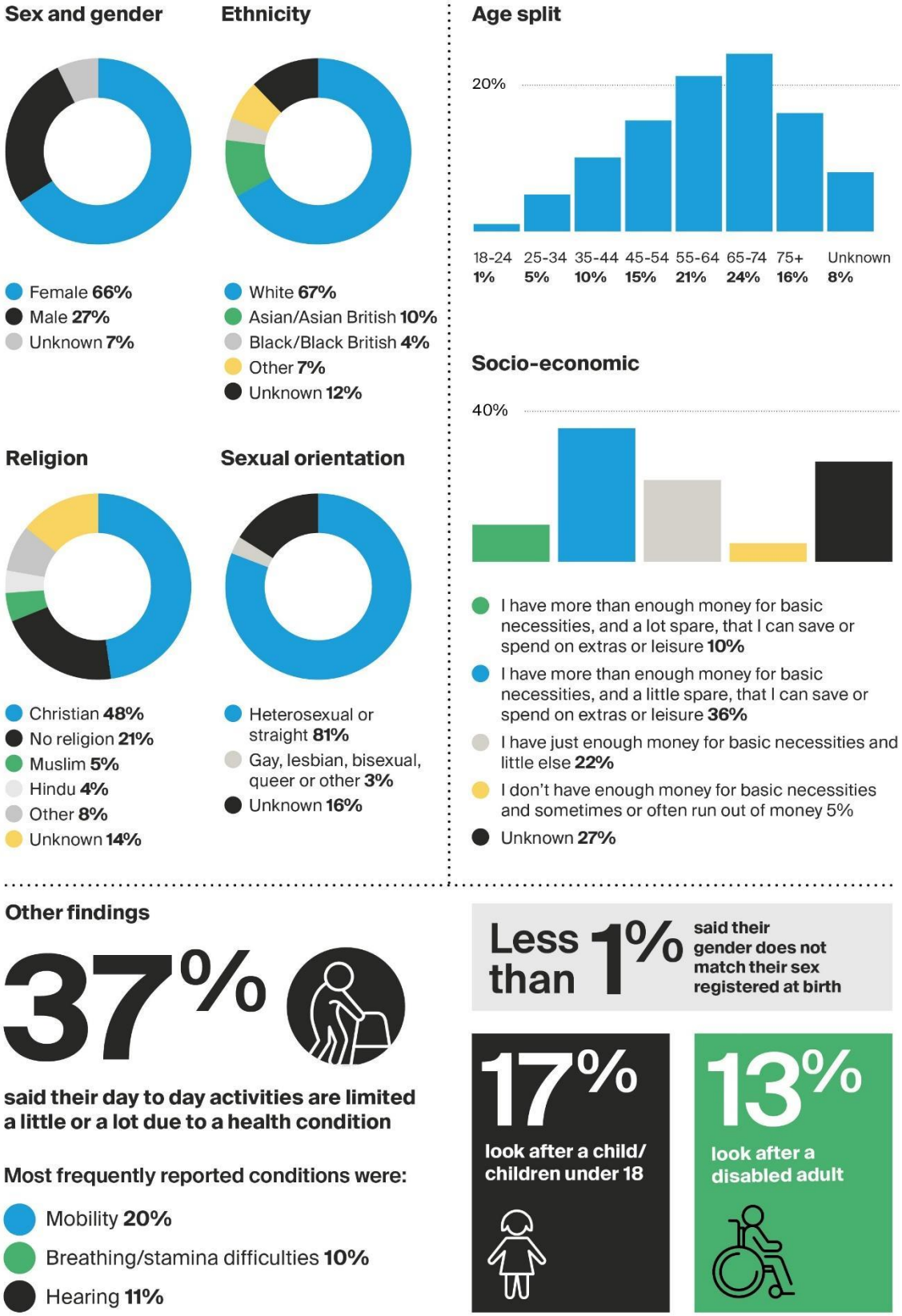

Figure 4 Summary of the demographic information of the consultation participants

Geography

The table below shows the distribution of respondents (those completing the survey and participating in the microgrant activity) compared to the percentages reported in Pre-Consultation Business Case in terms of MVCC catchment.

The largest proportions came from Hertfordshire and West Essex (47%), North West London (26%) and Bedfordshire, Luton and Milton Keynes (20%).

Area	Percentages reported in PCBC	Percentages of responses	Under / over represented
Hertfordshire and West Essex	42%	47%	Over (5%)
North West London	36%	25%	Under (10%)
Bedfordshire, Luton and Milton Keynes	11%	20%	Over (9%)
Buckinghamshire, Oxfordshire and Berkshire West	6%	3%	Under (3%)
Frimley	3%	2%	Under (1%)
North Central London	1%	1%	Balanced
Other / unknown	-	2%	-

Table 2 Geography of respondents compared to MVCC catchment

4 Issues and learning opportunities

To ensure a robust and inclusive consultation, the Programme Team conducted weekly reviews of engagement data. When these reviews identified challenges, strategies were put in place to ensure objectives and legal duties were met.

Attendance at public events

Issue: Early consultation data indicated that registration numbers for in-person and online events were lower than projected.

Action taken: In response, we initiated a two-pronged strategy:

- **Enhanced promotion** – we intensified the promotion of all events through paid social media and targeted press releases.
- **Strategic pivot**: We shifted resources toward 'roadshows' in high-footfall areas. By holding sessions in locations such as the Mount Vernon Cancer Centre, shopping centres, and markets, we met the public where they were rather than relying solely on pre-registered attendance.

Outcome: These actions successfully engaged more than 400 members of the public through roadshows, significantly increasing overall participation beyond the initial event attendance figures.

Voluntary and Community Sector (VCSO) recruitment

Issue: Initial recruitment of voluntary and community sector organisations to run focus groups for 'seldom-heard' communities was slower than anticipated, risking our goal to reach diverse populations.

Action taken: We identified this risk midway through the process and took the following steps:

- **Extended the deadline:** We extended the recruitment period by one week to allow for additional outreach.
- **Targeted Outreach:** We conducted a direct email campaign to specific, high-priority community organisations identified during the Pre-Consultation Business Case (PCBC) analysis.

Outcome: the target recruitment number of 75 was reached and ultimately 68 sessions were carried out.

5 Summary of findings

5.1 Views on the proposal to relocate the cancer centre

Views on relocating the specialist cancer centre from Mount Vernon Cancer Centre in Northwood to Watford General Hospital were divided, but not random. Across the consultation, support was more likely where people believed the proposals would improve access for them or their community, reduce travel, or bring more services closer to home. Opposition was more likely where people believed the proposals would make access harder for them or their community, particularly because of travel time, parking, public transport, patient transport, cost, disability, age, income or reliance on others.

Specifically, in the public survey (n=2,222), 48% supported the relocation (34% strongly; 14% slightly) whilst 42% opposed it (34% strongly; 8% slightly). Amongst those completing the public survey, the largest proportion had been to MVCC with someone else (35%), this was followed by 25% who had no experience of the centre. A quarter (24%) had been treated at MVCC in the past and 11% are currently being treated there.

Support for the relocation was higher amongst clinicians who completed the clinician survey (69% support). This included a range of professionals from primary and secondary care across MVCC's catchment; more specifically 29% work at MVCC, 48% refer patients to MVCC and 23% have no contact with the service.

It is important to note that respondents were commenting on a proposed future service model, including a new cancer centre next to a planned rebuild of Watford General Hospital. Some views were based on direct experience of Mount Vernon Cancer Centre, Watford General Hospital or other local hospitals. Others were based on expectations, assumptions or concerns about future travel, access and how the new model would work.

This is normal in a consultation about proposed service change. It means the findings should be interpreted as evidence of perceived impact, anticipated barriers and issues that may need mitigation, rather than as direct evidence of how the future service will operate in practice.

5.1.1 Benefits of the relocation

Across the consultation activities, key benefits of the proposals were discussed. These included:

- **Co-location with acute services** (e.g. Accident and Emergency, critical care and wider diagnostics), seen as improving safety and pathways for complex and deteriorating patients.
- **Modern, purpose-built facilities** and an opportunity to improve quality, patient experience and outcomes. Limitations of the current facility at MVCC were recognised.
- **Improved access for some parts of the catchment**, particularly where WGH is perceived to be closer and easier to access (37% of public survey respondents said

relocating the cancer centre to WGH would make access easier – 20% much easier and 17% slightly easier).

- **Care closer to home** (i.e., through expanded opportunities for local diagnostics and increased local chemotherapy, for example by providing more capacity in local hospitals and chemotherapy at home where clinically appropriate) which was widely viewed as beneficial for reducing travel burden and making the overall model more manageable.
- **Potential to support research, specialist expertise and workforce development**, including perceived benefits of University College London Hospitals (UCLH) NHS Foundation Trust leadership and links with larger specialist centres.

5.1.2 Concerns about the relocation

The most significant concern about the proposal to relocate the cancer centre was travel, transport and access to WGH. This was raised consistently in all consultation activities with concern that the proposal will disproportionately impact on people who do not drive, have limited mobility or disabilities, are older or frail, have lower incomes, or lack informal support.

The community events and microgrant focus groups enabled these concerns to be discussed in depth. Individuals talked about:

- extended travel times and increased costs
- traffic congestion and limited road capacity around WGH (particularly during peak hours and match days)
- poor public transport connectivity
- affordability and the availability, location and cost of parking - repeated comparison was made to the concessionary rates available to cancer patients at MVCC.

Many also expressed frustrations about the reliability, eligibility and long journey times associated with non-emergency patient transport.

In the clinician survey, travel and accessibility was the most significant practical concern - 59% reported some level of concern, including 35% who were very concerned.

Nearly half (45%) of those responding to the public survey said that accessing the cancer centre at WGH would be harder (34% much harder; 11% slightly harder). Furthermore, when asked how they felt about travelling to the main cancer centre at WGH for specialist treatment and using a local hospital for more routine treatment:

- 46% said they would travel for specialist treatment
- 38% would travel but would find it hard
- 12% said they would choose not to have specialist treatment if it meant travelling to WGH
- 4% were unsure.

The fact that some respondents (12%) said they would choose not to have specialist treatment if it meant travelling to WGH should be noted and explored further.

However, it should also be interpreted with care. This was a hypothetical question about a proposed future model, and the group included people with different levels of direct experience of Mount Vernon Cancer Centre. Of those who selected this response, 39% had accompanied someone to Mount Vernon Cancer Centre, 18% had no prior Mount Vernon Cancer Centre experience and 16% were former patients.

Additionally, where this was discussed in the community discussions, some participants noted a preference to attend other hospitals. For example, some felt that accessing University College London Hospitals via train was easier than travelling to Watford General Hospital, while others in West London considered central London cancer services to be more accessible.

Current Mount Vernon Cancer Centre patients made up a smaller proportion of this group, at 6%. By geography, this group included 28% from Hertfordshire and West Essex ICB and 25% from North West London ICB.

This finding points to the need for further consideration of who may face the greatest access barriers, how real or perceived those barriers are likely to be in practice, and what mitigations would be needed to support access to specialist treatment.

Other key concerns about the relocation of the cancer centre identified in the consultation activities, included:

- **Suitability of WGH as an environment for cancer care**, including concerns about a busier general hospital setting versus MVCC's calmer, more therapeutic site, increased infection risk, space constraints, and perceptions about WGH reputation and capacity.
- **Maintaining MVCC quality and culture**, with concern about continuity of specialist expertise, staff retention, and whether the person-centred 'culture' of MVCC can be replicated.
- **Timescales, deliverability, funding and dependency on the wider Watford redevelopment**, including uncertainty about the wider redevelopment timetable, the implications of delivering cancer care alongside major construction and what would happen if the new build does not proceed.
- **Future of the Northwood site and prior investment/fundraising**, including concerns about what happens to the existing site, equipment, and recent investment, alongside concern about further decline at MVCC during any transition period.
- **Trust in the process**, including a perception among some that the decision had already been made and that consultation feedback may have limited influence.

The community events and microgrant discussions provided individuals with the opportunity to discuss the concerns that they had about the proposals. It was noted that, in several of the community events, participants initially expressed concerns and frustration

regarding the proposal to relocate the cancer centre. However, after watching the consultation presentation and engaging with staff, a shift in sentiment was observed with some participants acknowledging the reasoning behind the proposal and some even offering constructive suggestions to address their apprehensions. There was also acknowledgement of the development of the proposal options, with realisation that making no change would inevitably lead to MVCC not being able to continue to offer specialist cancer treatment.

A further observation was that initial reactions tended to be based on the relocation of the cancer centre only without consideration of the additional changes to cancer services that are being proposed (i.e. more diagnostic appointments in local hospitals, more virtual appointments, more opportunities for chemotherapy at home), as well as more specific plans about the new cancer centre. As individuals gained an understanding of these changes, shifts in sentiment were observed.

For example, learning that the cancer centre will be in a building separate from the main hospital helped to alleviate some of the concerns that people had about the suitability of WGH and helped provide reassurance about being in a more protected environment, particularly in the in-person and online community events where discussions with event facilitators were undertaken.

5.2 Radiotherapy options

Consultation respondents were asked to discuss and indicate their preferred option for the location of radiotherapy services. The options were as follows:

- **Option A** – All radiotherapy services would be provided at the specialist centre at Watford General Hospital.
- **Option B** – As Option A, with an additional radiotherapy unit at the Lister Hospital in Stevenage
- **Option C** – As Option A, with an additional radiotherapy unit at Luton and Dunstable Hospital in Luton.

In the public survey, Option B and Option C were tied as the most popular, each receiving 29% of the total responses (n=634 and n=641, respectively) whilst Option A was selected by 17%. A further 26% had no preference or were not sure.

In community events and discussions, Options B and C were generally favoured over Option A because they were perceived to reduce the repeated travel burden for radiotherapy, with accessibility and equity emphasised as key factors for satellite locations. Participants additionally expressed a preference for services to be provided at their local hospitals and wanted more clarity as to why services could not be delivered through a wider range of local hospitals, or why the specific options presented had been selected over other potential locations.

Clinicians responding to the clinician survey were cautiously supportive of a networked radiotherapy model, while emphasising safeguards. From a clinical safety and quality perspective:

- 57% felt a networked unit could deliver equivalent outcomes either fully (10%) or with safeguards in place (47%)
- 15% felt equivalence was possible but had concerns
- 8% believed it would not be equivalent
- 21% were not sure.

Furthermore, overall support among clinicians for including a networked radiotherapy unit was 58% support, with 36% neutral and 7% unsupportive. The most identified risks were staffing and recruitment challenges, increased operational complexity and maintaining quality assurance.

Formal submissions received from different organisations raised a consistent set of concerns about the networked radiotherapy proposal. While some supported the aim of reducing travel for high-frequency treatment, they asked for reassurance that a multi-site model would not lead to variation in quality or a “two-tier” service.

Key concerns focused on how consistent clinical standards would be maintained across sites, whether there would be sufficient specialist workforce to staff multiple units sustainably, and how governance and accountability would work in practice. Submissions also highlighted the need for clarity on equipment parity and ongoing investment, and on how pathways would be coordinated to avoid fragmented journeys (for example, where planning and treatment might occur at different sites).

Consultation respondents were asked what else should be considered to support decision making (in the context of radiotherapy location criteria), the most frequent suggestion was accessibility, transport and equity. Other key considerations include:

- population need (including future demand and health inequalities);
- capacity and facilities aligned with demand
- the ability to deliver high-quality care and positive patient outcomes
- workforce factors such as staff availability, recruitment, and relocation impacts
- integration and interdependences with other clinical services
- reliable infrastructure and equipment
- overall financial viability and long-term sustainability.

5.3 Geographic variation

Analysis of public survey responses by geographic region enabled a deeper understanding of perspectives on relocating the cancer centre and radiotherapy services. Opinions differed across areas; with respondents predominantly favouring options that minimised travel requirements (see Table 3).

In Bedfordshire, Luton and Milton Keynes, a majority supported the relocation and anticipated easier access to WGH, with many valuing improved accessibility.

Conversely, Buckinghamshire, Oxfordshire and Berkshire West respondents were more inclined to oppose, citing travel difficulties and parking, although some saw benefits in better access to acute services.

In areas like Hertfordshire and West Essex, support was more balanced, with many favouring options based on location and travel convenience, while those opposed focused on challenges such as congestion and suitability of WGH.

In North West London, opposition dominated, driven by concerns about travel, transport, and preference for the existing MVCC site.

Overall, preferences for radiotherapy options reflected these regional differences: Option B was favoured for its accessibility in Hertfordshire and West Essex, Option C was overwhelmingly preferred in Bedfordshire, Luton and Milton Keynes, while in Buckinghamshire, Oxfordshire and Berkshire West, views were divided, with many feeling that services should remain at MVCC.

Findings from the community events and microgrant discussions largely reflect the geographical findings reported above. It was, however, apparent that views about the relocation of the cancer centre and the radiotherapy satellite site were dependent on personal experiences and individual circumstances (for example, having access to a car or being able to rely on someone else to support travel). This made drawing reliable conclusions about preferred options difficult.

A summary table of the overall support or opposition for the proposal, along with preferences for radiotherapy services is shown below.

Geographical location	Support or oppose relocation (majority)	Easier or harder access to WGH (majority)	Main reason for support of relocation	Main reason for opposition of relocation	Radiotherapy options
Hertfordshire and West Essex ICB	Support (56%)	Easier (48%)	WGH being closer / easier to access (23%)	Travel / access challenges (26%)	Option B - 47% Option C – 20% Option A – 15%
North West London ICB	Oppose (78%)	Harder (91%)	MVCC not fit for purpose (5%)	Travel / access challenges (49%)	Option A – 29% Option B & C – 6% *(No preference or unsure – 59%)*
Bedfordshire, Luton and Milton Keynes ICB	Support (63%)	Easier (55%)	WGH being closer / easier to access (33%)	Travel / access challenges (18%)	Option C - 85% Option B – 10% Option A – 1%
Buckinghamshire, Oxfordshire and Berkshire West ICB	Oppose (51%)	Harder (65%)	Access to acute and other services at WGH (18%)	Travel / access challenges (35%)	Option A - 31% Option C – 19% Option B – 8%

Table 3 Summary of public survey responses

5.4 Changes to cancer services and delivering care closer to home

Across the consultation, there was broad support for elements intended to reduce travel and provide more care closer to home, although this support was often conditional on safety, workforce capacity and coordination across organisations.

In the public survey;

- chemotherapy at home was supported by 63%
- relocation of haematology services received 46% support
- increased local provision of chemotherapy and other anti-cancer drug treatments, including immunotherapy, in North West London, through a new Hillingdon Hospital development and extended services at Northwick Park Hospital, was supported by 45%.

In the community events and discussions, ‘care closer to home’ was cautiously welcomed, with participants raising concerns about the capacity of local hospitals (including parking

and clinic space), and the need for seamless communication and shared records across NHS Trusts to avoid fragmented pathways.

Chemotherapy at home was seen as beneficial for eligible patients, but uncertainty was raised about practicalities, emergency response and whether it would remain a genuine choice; some discussions suggested cultural discomfort or lower trust for home administration among some minority ethnic and faith groups.

Virtual appointments were generally viewed as useful when offered as an option. In the public survey:

- 51% preferred a mix of face-to-face and virtual appointments
- 40% preferred all appointments face-to-face
- 7% would prefer all virtual appointments where possible.

Feedback across consultation channels noted that virtual options are not suitable for all patients or all stages of care, and that digital exclusion and language barriers need to be considered in implementation.

Clinicians emphasised similar conditions in the survey: the most selected 'closer to home' elements judged clinically valuable were:

- chemotherapy in local hospital units (66%),
- diagnostics (61%), and
- blood tests/monitoring (61%).

Chemotherapy at home was selected by 39% of clinicians and virtual appointments by 27%. For chemotherapy at home, comments focused on patient safety, governance and accountability, particularly how adverse reactions or emergencies would be managed without immediate specialist support and clear escalation pathways, with some noting that delivering chemo at home "will be challenging". For virtual appointments, concerns centred on equity and access, with a risk that older patients or those less confident with technology may struggle to engage effectively.

5.5 Equalities and inclusion

Minority ethnic, faith and migrant communities raised additional concerns about navigating the healthcare system, language/interpreter access, awareness of transport support, financial barriers, and experiences of discrimination.

There was also concern that the needs of deaf people, including British Sign Language users, should be considered, particularly in relation to how cancer services, including local hospital services and home-based treatment would be designed to provide accessible communication and appropriate support.

People with parental and/or caring responsibilities were more likely to prefer hybrid models, reflecting the need for flexibility. It was queried as to how carers will be supported to care for people during treatment and/or end-of-life (for example carer accommodation).

Feedback from LGBTQ+ participants and representatives highlighted the importance of inclusive, respectful and non-discriminatory cancer care. The consultation did not identify a

materially different impact for LGBTQ+ people in relation to the proposed relocation of specialist cancer services, compared with wider concerns raised about travel, access, dignity and continuity of care. However, feedback from Impactful Lives emphasised that future service design, staff training and implementation planning should recognise the experiences of LGBTQ+ patients and carers, including concerns about bias, confidence in services and being treated with respect. These points should be considered through the equality and health inequalities impact assessment and future implementation planning.

The microgrant focus groups enabled individuals to discuss the concerns they have and offer suggestions as to what would help reduce impacts. These include the provision of reliable and high-quality patient transport services, the availability of accessible and affordable parking as well as drop-off points, and scheduling appointments at times that minimise travel risks, such as avoiding after-dark or early morning slots. There was strong advocacy for clearer communication and enhanced navigation support to help individuals understand and access services effectively. Importantly, patient groups stressed the need for inclusive and accessible in-person options to be available alongside any digital or hybrid models of care, ensuring that no one is excluded by technology or circumstance.

These findings underline that decisions and implementation plans should be assessed not only for overall outcomes, but also for those who may experience reduced access without targeted support.

5.6 Alternative suggestions and considerations for decision makers

Support for relocating the cancer centre was often conditional on clear mitigations being put in place - particularly to address travel, transport and parking (including reliable public transport), alongside wider implementation requirements such as workforce capacity and sustainability, and digital integration.

The consultation provided an opportunity for people to share their views about the proposals and suggest alternatives the MVCC programme team might not have considered or mitigations that might lessen the impact.

Consultation respondents offered alternatives to the current proposal, often framed as ways to improve accessibility across the catchment area. Alternative suggestions clustered around:

- **Redeveloping or rebuilding MVCC at the existing Northwood site, and/or retaining some services there as a radiotherapy / outpatient satellite unit.**
- **Locating the main cancer centre at a different acute site** (commonly naming Hillingdon Hospital, Northwick Park Hospital, Harefield Hospital, Lister Hospital, Luton and Dunstable Hospital, Hemel Hempstead Hospital, Queen Elizabeth II Hospital, St Albans Hospital, and (less frequently) Wexham Park Hospital and Stoke Mandeville Hospital). Some also proposed two smaller centres attached to different hospitals to better balance access across a wide geography.
- **Strengthening the radiotherapy network** - some respondents suggested providing more than one satellite unit (e.g., units at both Lister Hospital and Luton &

Dunstable Hospital), or alternative satellite locations such as Hillingdon Hospital, Milton Keynes Hospital, Northwick Park Hospital, Queen Elizabeth II Hospital, and/or retaining MVCC as a satellite radiotherapy unit.

- A smaller set of suggestions proposed **a new 'greenfield/brownfield' site for the cancer centre** closer to major road / rail links.
- **Delivering more care closer to home** - respondents advocated for more outreach clinics, diagnostics and monitoring in local hospitals and community settings (including community diagnostic centres, GP/health centres and hospices) and use of mobile units.

Across all feedback sources, participants consistently identified considerations for the MVCC programme team to take into account. Many respondents and organisations indicated that their support for the proposals is contingent on these issues being addressed, particularly those relating to travel and access.

Travel, transport and access mitigations with a clear focus on those more likely to face access barriers
Including suggestions about sufficient and affordable patient parking, improved public transport links, shuttle/park-and-ride options, safe patient drop-off/pick-up areas, clear wayfinding, and improvements to patient transport services.

Creating a calm, inclusive and patient-centred environment at WGH that is appropriate for cancer patients
Across the consultation channels, respondents talked about the importance of the environment and replicating what is experienced at MVCC. They sought reassurance about cancer care being delivered in a dedicated space, away from the main general hospital.

Radiotherapy network model – location decisions, quality and governance
Ensure criteria for selecting satellite sites are transparent and equity-driven and that comprehensive governance structures, rigorous quality assurance measures, effective workforce strategies, and safeguards are in place to maintain consistent clinical standards across all locations.

Workforce, staff experience and retention
Deliverability was felt to depend on workforce capacity and retention, including impacts of travel/commuting, parking, and pay/terms. Considerations include early workforce planning, protecting specialist roles, managing organisational change, and maintaining morale and continuity of expertise during transition.

Digital interoperability and communication across organisations
A recurrent 'must get right' issue was shared patient records and smooth information flow across trusts and settings. Considerations include interoperability, test ordering/results visibility and clear communication routes.

Care closer to home - capacity, pathways and consistency

While there is broad support for delivering care closer to home strategies, clinicians and the public emphasised that these elements must be adequately resourced and consistently delivered. Considerations include local site capacity (clinic space, parking), clinical pathways and escalation routes and workforce capability across sites.

Governance and accountability across partner organisations
Clinicians requested clarity on clinical responsibility, escalation pathways and accountability between organisations (including UCLH as lead provider and host/partner Trusts), particularly if care is distributed across multiple sites.

Transition planning, timelines and funding assurance
There were repeat requests for clearer timelines (including dependencies with wider hospital developments) and confidence in long-term funding. Considerations include maintaining safe continuity of care during transition and addressing concerns about further decline at MVCC while changes are implemented.

Future of the Northwood site and existing assets
Consultation respondents raised the need for clarity on the future use of the Northwood site and what happens to existing assets and fundraised equipment, alongside requests to consider redevelopment/investment options and/or retaining some services on the site.

Ongoing engagement, communications and trust
A recurring concern (particularly in parts of the southern catchment) was whether decisions were perceived as pre-determined. Considerations include transparent decision-making criteria and tailored communications to different geographies and communities, alongside continued clinician/staff engagement through briefings, workshops and working groups.

5.7 Summary

The consultation shows divided public opinion on relocating the specialist cancer centre to Watford General Hospital. This division was not random. Across different consultation routes, views were strongly linked to whether people believed the proposals would improve or worsen access for them, their family or their community.

Support was more likely where respondents believed the proposals would improve access to specialist cancer care, reduce travel, provide more services closer to home, or strengthen clinical safety through co-location with acute services. Opposition was more likely where respondents believed the proposals would make access harder, particularly because of travel times, parking, public transport, patient transport, cost or reliance on others.

The same practical issues came through consistently across the public survey, clinician survey, staff events, community discussions and formal submissions. These were travel, transport, parking, patient transport, digital and pathway coordination, workforce, quality across sites, governance and the need for clear transition planning.

There was broad support for the direction of travel on care closer to home and for radiotherapy options that reduce repeated travel, provided that quality, safety, workforce and continuity can be maintained.

Support was often conditional. The issues most likely to influence whether the proposals can deliver their intended benefits are a robust access mitigation plan, sustainable workforce arrangements, interoperable digital systems, clear governance and escalation pathways, and practical transition planning.

Equalities findings reinforce the importance of targeted mitigations to support groups most at risk of reduced access, including older people, disabled people, people on lower incomes, people without access to private transport and people who rely on others to attend appointments.

6 Public survey analysis

6.1 Key findings

Below is a summary of the findings from the public consultation survey (2,222 responses).

The largest proportion have been to the MVCC with someone else (35%), this is followed by 25% who have no experience of the centre. Furthermore, 24% have been treated at MVCC in the past and 11% are currently being treated there.

A consistent set of cross-cutting themes emerges. Public opinion is divided overall, with views strongly shaped by geography and perceived ease of access to services. While there is support for aspects of the proposed model, particularly those that reduce travel and improve local access, concerns about travel, transport, and access are central to many responses.

Views on the proposed relocation

Public views on the proposed relocation were divided. Around 48% expressed support, while 42% expressed opposition, with a smaller proportion neutral or unsure. Support and opposition were closely linked to whether respondents believed the proposals would make access easier or harder for them, their family or their community.

Amongst those completing the public survey, the largest proportion had been to MVCC with someone else (35%), this was followed by 25% who had no experience of the centre. A quarter (24%) had been treated at MVCC in the past and 11% are currently being treated there.

Support is most associated with improved access to Watford General Hospital (WGH), the opportunity for modern facilities, and better integration with acute services.

Opposition is primarily driven by concerns about travel, accessibility, and the perceived impact of moving services away from the current Mount Vernon Cancer Centre (MVCC) site.

Responses indicate that views are closely linked to perceived changes in access, with support more common where access is expected to improve and opposition more common where access is expected to worsen.

For example, respondents in Hertfordshire and West Essex ICB and Bedfordshire, Luton and Milton Keynes ICB were more likely to express support for the proposals, whilst respondents in North West London ICB were more likely to express opposition and to report that access to WGH would be more difficult.

Travel and access

Travel and access are the most consistently raised issues across the survey and are closely linked to overall views on the proposal.

Opinion is divided on the impact on access, with 45% believing it would be harder and 37% believing it would be easier.

For those perceiving that access will be more difficult, key concerns related to:

- Increased travel times and cost
- traffic congestion and road infrastructure
- limited public transport options
- Poor and expensive parking (with repeated comparison made to the concessionary rates available to cancer patients at MVCC).

Travel and accessibility challenges were the most frequently cited negative impact (31%).

A total of 12% of respondents said they would choose not to have specialist treatment if it meant travelling to Watford General Hospital. This should be treated as an important potential access risk, but interpreted with care because it was a hypothetical question about a proposed future service model. Of those who selected this response, 39% had accompanied someone to Mount Vernon Cancer Centre, 18% had no prior Mount Vernon Cancer Centre experience and 16% were former patients. Current Mount Vernon Cancer Centre patients made up a smaller proportion of this group, at 6%. By geography, this group included 28% from Hertfordshire and West Essex ICB and 25% from North West London ICB.

This finding points to the need for further consideration of who may face the greatest access barriers, how real or perceived those barriers are likely to be in practice, and what mitigations would be needed to support access to specialist treatment.

Responses also indicate that travel challenges may disproportionately affect certain groups, including older people, disabled people, and those on lower incomes.

The most frequently suggested measures to support access were improved parking and reduced costs, alongside increased provision of care closer to home.

Care closer to home

There is broad support for elements of the proposal that deliver care closer to home and reduce the need for travel.

In particular:

- chemotherapy at home was supported by 63% of respondents (this included 42% of those from North West London ICB)
- relocation of haematology services received 46% support (this included 20% of those from North West London ICB)
- increased local provision of chemotherapy and other anti-cancer drug treatments, including immunotherapy, in North West London, through a new Hillingdon Hospital development and extended services at Northwick Park Hospital, was supported by 45%.

These findings indicate that proposals which reduce travel and provide more local access to care are generally viewed positively. However, this support is conditional on services being accessible, well-coordinated, and supported by appropriate staffing and infrastructure.

Networked radiotherapy

Views on the proposed networked radiotherapy model were divided, but generally more positive where it was seen to reduce travel.

Preferences were divided between options that included additional satellite units, with 29% supporting Option B (additional unit at Lister Hospital) and 29% supporting Option C (additional unit at Luton and Dunstable Hospital). This compares with 16% who selected Option A (no additional unit but with more radiotherapy at Hammersmith Hospital). A further 26% were neutral or unsure.

Respondents expressed a preference for options that provide more local access to radiotherapy and reduce the need for repeated long-distance travel.

At the same time, some respondents raised questions about consistency of care and the need to maintain high clinical standards across sites.

Overall conclusion

Across the survey, public opinion is divided, with views strongly shaped by geography and perceived access to services.

Support is strongest in areas where Watford or the additional radiotherapy unit are seen as more accessible, while opposition is strongest where travel to Watford is expected to be more difficult.

There is broad support for elements of the proposal that reduce travel and bring care closer to home. However, concerns about travel, parking, public transport, and the needs of groups facing greater barriers to access are consistently identified as key issues.

These factors will be central to any final decision and to the design of mitigation measures and are likely to be critical in determining whether the proposed changes improve or reduce access for different groups of patients.

7 Clinician survey analysis and staff discussion events

7.1 Key findings

This section summarises findings from a clinician survey (64 responses) and five staff discussion events (25 attendees). The clinician survey was completed by a range of professionals from primary and secondary care across MVCC catchment; this included 29% who work at MVCC, 48% who refer patients to MVCC and 23% who have no contact with the service.

Across both evidence sources, a consistent set of cross-cutting themes emerged, highlighting areas of broad support as well as key conditions required for successful implementation.

Awareness and understanding

Most clinicians reported being at least somewhat informed about the proposed relocation, and the majority understood the clinical rationale. Higher awareness was associated with greater confidence and support, suggesting that continued communication and engagement will be important in shaping clinician views.

Views on the proposed relocation

Clinicians broadly support the relocation of Mount Vernon Cancer Centre (MVCC) to Watford General Hospital (WGH), with around two-thirds expressing support. Co-location with acute services is widely seen as a key clinical benefit, particularly for improving pathways and access to urgent care.

However, support is not universal, and a proportion of clinicians remain neutral or uncertain, indicating a need for continued engagement and clarity.

Travel and access

Travel and access are the most significant concerns identified across both the survey and staff discussion events. Over half of survey respondents reported concerns, which were reinforced through staff discussions.

Key issues include congestion, parking, public transport, and patient transport reliability. These challenges are seen as particularly affecting vulnerable groups and those travelling longer distances.

Concerns about travel and access were also associated with lower levels of support for the relocation, and there are indications that levels of concern vary by geography.

Workforce and capacity

While improved facilities and links with University College London Hospital (UCLH) are seen as potential benefits, overall confidence depends on how workforce challenges are addressed.

There were also calls for clear governance and accountability arrangements across organisations, particularly in relation to clinical responsibility and escalation pathways.

Digital integration and communication

Clinicians identified digital interoperability and communication across services as critical enablers of the proposed model. Current systems are described as fragmented, with limited ability to share patient records and test results across organisations.

Both survey and event findings indicate that improvements in digital integration will be essential to support safe and coordinated care.

Care closer to home

There is general support for delivering more care closer to home, particularly for chemotherapy, diagnostics, and monitoring in local hospital settings.

However, clinicians emphasise that this depends on sufficient workforce capacity, clear clinical pathways, and appropriate infrastructure across sites.

Networked radiotherapy

Clinicians expressed cautious support for a networked radiotherapy model. Potential benefits include improved access and reduced travel burden for patients.

However, confidence depends on maintaining consistent clinical standards, ensuring adequate workforce and infrastructure, and having clear governance arrangements across sites.

Overall conclusion

Across both the clinician survey and staff discussion events, there is broad support for the proposed model and recognition of its clinical benefits.

However, this support is conditional. In particular, clinicians emphasise the importance of addressing travel and access, workforce capacity, digital integration, and system coordination.

There is a consistent view that outcomes will depend on how effectively the model is delivered in practice, rather than the model itself.

These factors will be critical in determining whether the proposed changes deliver the intended improvements in patient care and experience.

8 Analysis of feedback from events, roadshows, community discussions and meetings

8.1 Key findings

This section brings together feedback from the in-person and online events, which included events for staff, and the voluntary and community sector organisations (VCSO) focus groups as well as additional insight gathered during the roadshow events and meetings held by the MVCC programme team.

The in-person and online community events followed the same format, beginning with a presentation delivered by the MVCC programme team, followed by opportunities for attendees to ask questions and share their perspectives. It was noted that, in several sessions, participants initially expressed concerns and frustration regarding the proposal to relocate the cancer centre. However, after engaging with the presentation and staff, sentiment tended to shift with participants acknowledging the reasoning behind the proposal and some even offering constructive suggestions to address their apprehensions.

A further observation was that initial reactions tended to be based on the relocation of the cancer centre only without consideration of the additional changes to cancer services that are being proposed (i.e. more diagnostic appointments in local hospitals, more virtual appointments, more opportunities for chemotherapy at home). As individuals gained an understanding of these changes, shifts in sentiment were observed. There was also acknowledgement of the development of the proposal options, with realisation that making no change would inevitably lead to MVCC not being able to continue to offer specialist cancer treatment.

Participants attending the VCSO-led focus groups were shown a video explaining the consultation. Facilitators were then provided with a short set of questions and prompts to support discussion about the proposal and to understand what is important to individuals when accessing cancer care. Discussions featured a broad demographic, with marked diversity in VCSO-led groups.

For the roadshow events, those engaged with were signposted to complete the survey. More detailed discussion with individuals was captured by staff running the roadshow and fed back to the research team.

Moderate support for the proposal was evident, with individuals highlighting its clinical rationale, the prospect of modernised care, and the potential for treatment closer to home.

However, significant concerns were raised, particularly regarding travel and accessibility of WGH. Concerns related to increased travel times, traffic congestion around WGH, poor public transport options, poor parking facilities, increased costs and inconsistent and unreliable patient transport services. Concern was raised for some patient groups who will be disproportionately impacted, including individuals who do not drive, lack a support network, have lower incomes or reside in deprived areas, as well as older adults and those with limited mobility, frailty, disabilities, or long-term conditions.

WGH's suitability for the cancer centre was a cause of significant concern; concerns related to the location and setting at WGH being distinctly different from MVCC which is thought to provide a calm and therapeutic atmosphere with its open, green spaces and WGH's poor reputation stemming from past personal experiences and media reports. Concerns about clinical capability and service quality, as well as the condition of current estates were also raised.

Many highly valued MVCC's unique culture and person-centred care, with doubts about whether this will be the same at the new site.

Additional concerns included the timing of the new cancer centre build, certainty of long-term funding, and the future of the Northwood MVCC site. Some also felt the relocation decision was already made, viewing the consultation as a formality.

Support for the relocation was often conditional on mitigation measures. Improving access and environment at WGH was crucial, with suggestions for improved public transport, more affordable travel and accessible parking at concessionary rates. Calls were made for better patient transport services and free shuttle buses from local hospitals and Watford train station.

Alternative locations for the cancer centre were discussed, such as retaining MVCC, creating two smaller centres, or using other hospital sites in North West London, Hertfordshire, East Berkshire and Bedfordshire.

Seamless communication and data sharing across all services were deemed essential for the redesign of cancer services.

Regarding the proposed radiotherapy options, Options B and C were generally favoured over Option A, as they were seen to alleviate some of the travel burden. Accessibility and equity were seen as key factors in deciding satellite locations.

Care closer to home was cautiously welcomed, but there were concerns about local hospitals' capacity, parking, and digital integration. Virtual appointments were viewed as beneficial, provided they remained optional and sensitive to vulnerable groups.

Chemotherapy at home was met with uncertainty regarding practicalities, emergencies, and safety. Many felt it should be a patient option, subject to clinical suitability. Opposition was noted among some minority ethnic and faith groups, citing trust and cultural discomfort.

9 Additional submissions

9.1 Key findings

Most responses accepted the clinical rationale for relocating Mount Vernon Cancer Centre (MVCC) to a new, co-located cancer centre at Watford General Hospital (WGH). However, concerns consistently focused on access, feasibility, and wider system effects.

9.1.1 Benefits of relocating to Watford General Hospital

- **Improved clinical safety and sustainability** through co-location with acute, critical care and surgical services, addressing issues raised in the 2019 Independent Clinical Review.
- **A modern, purpose-built facility** enabling delivery of more innovative and up-to-date treatments, improved patient flow, privacy and experience, and better staff working conditions.
- **Workforce benefits**, including improved recruitment and retention of specialist staff and clearer governance/management (including support for University College London Hospital, UCLH, taking on management in some responses).
- **Enhanced access to research, innovation and clinical trials** through closer integration with specialist pathways and academic partners.
- **Potential for better system integration and resilience**, with more coherent links to diagnostics and acute specialties and opportunities to strengthen oncology pathways across the region.
- **Support for care being delivered closer to home** (e.g., chemotherapy closer to home, chemotherapy at home, virtual consultations and local diagnostics), to reduce unnecessary travel for some appointments.

9.1.2 Concerns, risks and mitigations requested

- **Travel, transport, and parking challenges** include longer or more complex journeys (especially via public transport), affordability issues, match-day disruptions and congestion at WGH; repeated calls for a robust travel impact assessment exploring parking concessions and practical travel support for regular visitors.
- **Equity and health inequalities:** concerns that additional access barriers could disproportionately affect deprived communities, older people, disabled people, people without car access, and some ethnic minority communities; repeated calls for a robust Equality and Health Inequalities Impact Assessment and for equity to be central to decision-making.
- **Deliverability and timelines**: scepticism about whether the WGH redevelopment and the new cancer centre can be delivered to time; requests for assurance that MVCC remains fully operational until the new facility is ready and that there will be a safe, phased transition with service continuity.

- **Capacity and system-wide impacts**: questions about assumptions on patient flows and patient choice (including potential displacement to neighbouring providers) and the knock-on effects for waiting times, workforce and financial viability across the wider regional cancer system.
- **Networked radiotherapy configuration**: mixed views on satellites; some supported additional radiotherapy units, while a significant concern was raised by Cambridge University Hospitals NHS Foundation Trust about how satellite arrangements would align with regional radiotherapy networks, research access and commissioning.
- **Workforce and staff terms**: uncertainty about organisational change (e.g., team mergers, office space, hot-desking, pay and Service Level Agreements, (SLAs)), with requests for clarity and early workforce planning.
- **Patient experience and the 'therapeutic environment'**: concern about losing aspects valued at MVCC (including calm surroundings and established support offers), and a request to ensure holistic support services are protected and well-integrated in the future model.
- **Governance and engagement**: calls for transparency about how feedback and data inform decisions, continued stakeholder engagement as plans develop, and clear communication about the final service model and mitigations.

10 Equalities and inclusion

10.1 Overview

Relocation of the cancer centre will disproportionately affect some groups more than others. This section looks at variance in the findings for different protected characteristic groups as well as people with parental and/or caring responsibilities and deprivation/income.

The data from the survey has helped to understand the viewpoint of those from the Equalities Act protected characteristics.

As it was recognised that the survey might not necessarily reach some groups, efforts were also made to hold in-person community events in areas of health inequality. In addition, Voluntary and Community Sector Organisations (VCSOs) were recruited to run focus groups, to try to ensure areas with the highest health inequalities and largest "seldom-heard" populations received a proportionate share of the engagement. Targeted groups were selected based on the 2021 Census and 2024/5 Local Authority estimates, alongside the Impact Assessment in the Pre Consultation Business Case (PCBC). Altogether 68 focus groups were held with a wide representation among the Equalities Act protected characteristics and people with health inequalities.

10.2 Analysis notes and limitations

The aim of the analysis is to understand the different barriers that people from different demographic profiles and backgrounds may face. Whilst it outlines trends and observations, it is important to remember that every individual's experiences and circumstance is different.

It draws together what we found in the public survey and what we heard in the community discussions, particularly the community and voluntary 'microgrant' focus groups which aimed to reach population groups who may face barriers to engaging in other ways.

10.3 Protected characteristic group - age

What we found in the survey…

Older respondents, particularly those aged 55 and over, expressed greater opposition to the relocation of the cancer centre. This is because they anticipated harder access, with increasing age correlating with a greater reliance on patient transport and volunteer transport schemes.

Older respondents have a stronger preference for face-to-face care, while younger and middle-aged groups are more likely to favour a hybrid model, indicating potential variation in preferences for digital healthcare delivery by age.

What we heard in the community discussions…

Older people had concerns about:

- Increased, difficult and costly travel by car and/or public transport, leading to greater reliance on family members, carers and patient transport services.
- Difficulty using shuttle services (i.e. from park and ride services).
- Cost of parking and parking incline at WGH.
- Walking lengthy distances.
- Living alone or having no one to support them with access.
- Travelling after dark.
- Accessing and using online systems.

The following were considered important when planning cancer services:

- Good, reliable patient transport services
- Dedicated parking facilities, within reasonable walking distance
- Patient drop-off areas, with wheelchair access
- The option to have someone with them at appointments
- Appointment times to consider travelling in dark hours.

10.4 Protected characteristic group - minority ethnic, faith and migrant groups

What we found in the survey…

Whilst some trends by ethnic group were observed, these should be interpreted with caution due to sample sizes.

Black / Black British respondents expressed the strongest support for the cancer centre relocation, with Mixed / Multiple ethnic groups also showing high support.

Black respondents were more likely to report that accessing the cancer centre would be easier.

Most ethnic groups prefer a hybrid care model - mixed groups favour face-to-face appointments, but Black / Black British respondents are least likely to prefer in-person visits.

What we heard in the community discussions…

People from minority ethnic, faith and migrant groups had concerns about:

- Challenges navigating the healthcare system and understanding cancer pathways – a particular concern for migrant communities, who cite difficulties, anxiety, and potential increases in waiting times.

- Limited awareness about available transport options - African Caribbean community members noted limited awareness, despite knowing such services exist.

- The financial burden of increased travel - with deprivation noted to have a great impact on African Caribbean communities and asylum seekers.
- Language barriers and the availability of interpreters – with concerns about privacy and confidentiality when relying on family members.
- Accessing and using online systems.
- Discrimination, including racial bias and changes in staff attitudes based on appearance or background.
- Recent alterations to home office hotels and asylum seeker accommodation have resulted in the discontinuation of taxi provision for hospital treatment. Requests for transportation funding must now be submitted in advance, and delays in receiving funds can hinder access to care.

The following were considered important when planning cancer services:

- Clear and accessible communication regarding service changes and ongoing engagement with community organisations.
- Continuity of care – not only did people from these groups want continuity of care from health professional teams, but some also valued having all care delivered at one location to support access and navigation of their care.
- Culturally competent services and staff -
- Consideration of cancer and death-related taboos
- Acknowledgement of diversity (including a variety of prosthetic colours and wigs)
- Respect for patient autonomy and cultural preferences, such as preferred gender of healthcare professionals
- Provision of complementary services that support and encourage cultural diversity
- Access to culturally appropriate food and refreshments.
- Provision of accessible, easy-to-read information translated into native languages (including Gujarati and Panjabi), with consideration for older generations who may have literacy challenges.
- Navigation support for individuals unfamiliar with the healthcare system (i.e. migrants and asylum seekers).
- Access to high-quality, medically trained interpreters, including those with expertise for patients with additional needs.

10.5 Protected characteristic group - disability

What we found in the survey…

Respondents with disabilities show slightly lower support and higher opposition to the relocation, with those most limited in day-to-day activities being especially opposed and reporting increased access difficulties.

Disabled respondents are less willing and able to travel for specialist treatment and face greater barriers accessing care. They are less likely to drive themselves and more reliant on hospital / patient transport and self-funded taxis.

There is a marked preference among disabled individuals for face-to-face care over hybrid models.

What we heard in the community discussions…

People with a disability and/or long-term conditions (including vision, hearing, neurodiversity) told us they had concerns about:

- Long-distance and complex journeys were described as difficult to manage and, in some cases, unsuitable. This increased reliance on family, carers, or patient transport, although not all patients have access to such support.
- Patient transport services were reported to be unreliable, with concerns about long journey times, limited coverage, and inadequate support for basic needs.
- Participants highlighted difficulties accessing public transport due to reliance on assistance, particularly in poor weather.
- Issues with parking included limited disabled spaces, misuse, steep gradients, and long distances to entrances.
- Appointment timing was identified as a barrier, with early morning appointments described as particularly difficult and stressful.
- Communication and accessibility issues were widely reported - participants noted barriers for people with dementia, anxiety, and learning disabilities, as well as difficulties using digital systems and accessing online or video appointments, particularly for those with visual impairments.
- Autistic people highlighted that negative past experiences could reduce willingness to access services.
- Deaf participants reported communication barriers, including reliance on telephone services, lack of interpreters, and inappropriate expectations to use family members for interpretation.

The following were considered important when planning cancer services:

- Preference for local and flexible care
- More local services to reduce travel time and stress (positive feedback on home-based care e.g. chemotherapy at home, and virtual appointments for individuals with autism).

- Information and communication
- Easy-to-read written information about care locations and what to expect, particularly important for individuals with autism
- Use of visual aids, videos, and clear consultation/treatment information
- Use of digital assistive technology (e.g. voice SMS).
- Patient transport and alternative options
- Need for high-quality, reliable patient transport services
- Availability of adapted taxis to meet individual needs.
- Access and infrastructure
- Accessible drop-off areas with wheelchair access
- Step-free / gradient-free access throughout facilities
- Sufficient disabled parking.
- Support and care coordination
- Greater awareness and use of hospital passports to highlight specific support needs
- Continuity of care
- Inclusion of carers in appointments to support patients
- Access to specialist support, particularly around diagnosis.
- Navigation and environment
- Improved navigation aids (e.g. large print signage, floor markings such as bumps or coloured lines)
- Consideration of sensory needs in the physical environment
- Engagement with patients to design appropriate environments.
- Accommodation
- Provision of accommodation options for patients travelling long distances.
- Support for deaf individuals
- Access to specialist BSL medical interpreters
- More staff trained in sign language.

10.6 Protected characteristic group - Lesbian, Gay, Bisexual, Transgender, Queer (or Questioning), Intersex, plus (LGBTQI+)

Feedback from LGBTQ+ participants and representatives highlighted the importance of inclusive, respectful and non-discriminatory cancer care. The consultation did not identify a materially different impact for LGBTQ+ people in relation to the proposed relocation of specialist cancer services, compared with wider concerns raised about travel, access, dignity and continuity of care. However, feedback from Impactful Lives emphasised that

future service design, staff training and implementation planning should recognise the experiences of LGBTQ+ patients and carers, including concerns about bias, confidence in services and being treated with respect. These points should be considered through the equality and health inequalities impact assessment and future implementation planning.

10.7 Equality - parental and caring responsibilities

What we found in the survey…

The findings suggest no meaningful difference between those with and without parental/caring responsibilities in terms of views on the proposal and ease of access.

However, parents and carers are more likely to prefer flexible, hybrid models of care, and less likely to prefer face-to-face appointments than those who are not carers, likely reflecting the need to balance caring responsibilities with attending appointments.

What we heard in the community discussions…

People with parental and/or caring responsibilities told us they had concerns about:

- Managing childcare and/or taking time off work to drive/transport patients
- Patient transport services not being available for carers / family members, leaving the patient unsupported.
- Anxiety of parking at WGH and getting the cared for person into hospital safely.
- Stress/anxiety of supporting a cared for person when appointments are cancelled/moved or patient transport services are running late.
- Cost issues when reliant on public transport.

The following were considered important when planning cancer services:

- The lived experience of carers to be considered
- Support services and facilities for family members / carers (e.g. accommodation) - it was noted that the emotional and logistical burden on those accompanying or caring for cancer patients during treatment and end-of-life is substantial and often not acknowledged.
- Carers to be empowered so they can help to provide better care.
- Travel passes.
- Patient / hospital transport services to provide transport for carers
- Childminder facilities.

10.8 Equality - deprivation and income

What we found in the survey…

Support for the relocation and proposal options shows a clear socioeconomic divide: more affluent respondents are the most supportive, while opposition grows among those with fewer financial resources. This disparity is also reflected in reported access, with more

affluent individuals being more likely to report easier access, and those with fewer resources anticipating that relocation would make access more difficult.

Lower-income respondents are less willing and able to travel for specialist care. They showed a greater reliance on public transport and assisted transport options such as taxis reimbursed by the NHS/hospital and patient transport arranged by the hospital.

Lower-income respondents are more likely to prefer face-to-face care and less likely to favour hybrid models, but travel access is a key barrier.

What we heard in the community discussions…

The microgrant activity targeted areas of greater deprivation. Among those who participated in these focus groups, 43% (n=276) told us they have just enough money for necessities or often run out of money. Regardless of income, a cancer diagnosis was noted to have a great impact on individuals.

People told us they had concerns about:

- Cost of travel and parking (some comments were made about congestion charges and the Ultra Low Emission Zone (ULEZ) charges system with concern about how individuals may be impacted, however ULEZ were not a key theme as the proposals actually benefitted some people with Watford being outside of London).
- Reliance on public transport (due to limited car access).
- Financial strain impacting ability to attend appointments and the take-up of treatment.

Concerns were also raised about individuals who are homeless/rough sleepers and others with chaotic lifestyles, and how they would access these services. These individuals are considered a "*very much forgotten group in society*".

The following were considered important when planning cancer services:

- Reimbursement of public transport costs.
- Free parking.
- Good, quality patient transport services.
- Financial assistance / benefit support for those unable to work.

10.9 Overall synthesis

The findings highlight that some patient groups may be affected by the proposals more than others, particularly older people, disabled people, and those on lower incomes. This is largely due to increased travel burden, higher dependence on public transport and patient transport, parking cost/availability, and challenges using digital systems.

Minority ethnic, faith and migrant communities raised additional concerns about navigating the healthcare system, language/interpreter access, awareness of transport support, financial barriers, and experiences of discrimination.

Parents and carers broadly echoed these perspectives but highlighted a particular preference for more flexible or hybrid care arrangements, reflecting the pressures of caring

responsibilities and work commitments. It was queried as to how carers will be supported to care for people during treatment and/or end-of-life (for example carer accommodation).

Across the different patient groups, various mitigations were suggested to reduce impacts that may be felt. These included the provision of reliable and high-quality patient transport services, the availability of accessible and affordable parking as well as drop-off points, and scheduling appointments at times that minimise travel risks, such as avoiding after-dark or early morning slots. There was strong advocacy for clearer communication and enhanced navigation support to help individuals understand and access services effectively. Importantly, patient groups stressed the need for inclusive and accessible in-person options to be available alongside any digital or hybrid models of care, ensuring that no one is excluded by technology or circumstance.

11 Next steps

The Mount Vernon Cancer Centre Strategic Review Programme Board holds responsibility for ensuring the consultation is conducted rigorously, transparently, and in accordance with statutory duties. The duty to take account of the outputs from the consultation in making the decision about MVCC sits with NHS England supported by NHS Central East, West North London and Thames Valley Integrated Care Boards.

Following the public consultation, the consultation report will be published in draft for two weeks (18 May to 1 June 2026). This allows participants to verify the accuracy of the report and to ensure all feedback has been captured.

The final report will be published in early June 2026 and then go through a formal governance process. This will include a review by:

- The MVCC Strategic Review Programme Board.
- The MVCC Joint Health Overview and Scrutiny Committee.

Commissioners of MVCC services, under the oversight of the Programme Board will develop the DMBC, in collaboration with key stakeholders.

The DMBC will outline:

- Consultation feedback
- The impact of this feedback on proposals
- An updated recommended option for the future of MVCC
- How the agreed option will be implemented.

The DMBC is expected to be reviewed by the end of September 2026.

As the programme transitions from decision-making to implementation, the full range of impacts will be assessed to ensure all legal duties are met. This includes:

- An update and review of the Equalities Health Impact Assessment and Integrated Impact Assessment including environmental and sustainability impacts of the proposals
- A refresh of the relevant activity modelling
- A review of travel times impact of proposals
- Greater detail on the workforce strategy for the new facility.