Review

Assessing Canada's Health System Readiness for Complex Therapies - The Current and Future State of T-Cell Redirecting Therapies

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Assessing Canada's Health System Readiness for Complex Therapies - The Current and Future State of T-Cell Redirecting Therapies

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Simple Summary

Health care systems should anticipate increased pressure to adopt interventions where the impact on costs and patient health relies more heavily on a number of additional factors including expertise and skills required by those delivering and receiving the intervention; where care is delivered; and flexibility in approaches to care. These "complex" interventions will challenge traditional approaches to care delivery. Health systems that are not ready will be slower to adopt these interventions, which will in turn reduce potential benefits to patients. Through an evidence-informed discussion, we explored how health systems could ready themselves for the future of complex interventions.

Abstract

Background: Interventions are considered complex when a number of factors associated with their use contribute to their health system impact (i.e., costs and effectiveness). An emerging complex intervention is the use of T-cell redirecting therapy. These therapies change the behaviour of a patient's T-cells to modify (usually amplify) an immune response. Feasible approaches to care delivery, or initiatives that may support the safe delivery of these therapies given their real potential for expansion were identified. In doing so, the purpose of this report is to identify alternative feasible approaches to care delivery, or initiatives that may support the safe delivery and access to care of complex therapies in the Canadian and other health systems; Methods: readiness for complex therapies was explored using a mixed-methods approach. Information was sought using a conventional content approach and based on semi-structured interviews (30–60 min) and deliberation across key informants including patient representatives (n=2), healthcare system leaders/ administrators (n=2), and healthcare providers (n=11). (3); Results: This discussion revealed several insights for the future of complex therapies that will require attention including the need for: organizational change leadership and a change management function; specialized programs of care and implementation of navigational tools and educational strategies directed to providers and patients; transparent processes of evaluation that adhere to good practices in health technology

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assessment and implementation science; improving data collection to measure the cost and impact of new complex interventions; novel approaches to financing.

Keywords: complex interventions; biomedical research methods; humans; outcome assessment; health care methods; research design standards; primary health care organization & administration standards

1. Introduction

Interventions are considered complex when a number of factors associated with their use contribute to their health system impact (i.e., costs and effectiveness). A definition [1] developed by the UK Medical Research Council and National Institute of Health Research describes complex interventions as those whose impact depends on a number of interacting components required to deliver the intervention, "the range of behaviours targeted; expertise and skills required by those delivering and receiving the intervention; the number of groups, settings, or levels targeted; or the permitted level of flexibility" regarding how where and by whom the intervention or its components are targeted.

Complex interventions in healthcare, therefore, are highly context dependent and require a number of necessary conditions for their effective use. For example, an evaluation of robot-assisted surgery revealed successful adoption as dependent on delivering training to the entire team including those surgeons not performing robot- assisted operations, and ensuring that the operating theatre was adequately spacious for the equipment and workflow[1,2].

When health system policies or care delivery conditions require substantive changes to allow for the effective delivery of a complex intervention, it can create challenges for both innovators and healthcare system administrators. Innovators must define and maintain the core components of an intervention while also allowing for adaptation in a range of health care environments with differing organizational, social and cultural contexts.[3] Administrators must modify existing policies or care conditions and will in turn be hindered by "structural, political and cultural" factors.[4]

An emerging set of complex interventions are T-cell redirecting therapies. They are intended to change the behavior of a patient's T-cells to modify (usually amplify) an immune response. There are currently two types of T-cell redirecting therapies currently funded in Canada: chimeric antigen receptor T-cell (CAR-T) therapies (where T-cells are re-engineered to recognize specific surface antigens), and; bispecific T-cell engagers (BiTEs, which bring T-cells in proximity to another surface antigen). These therapies have led to more effective treatments for cancers with previously poor prognoses.[5] However, they have also led to the need for changes to health policy and care delivery including special monitoring and toxicity management requirements, heightened care coordination, focused educational strategies and protocols, and more sophisticated resource planning.[5]

While many health systems have begun to make the necessary changes to deliver these complex therapies, the use of T-cell redirecting therapies are expected to expand even further due to a variety of factors including: better experience with the interventions; introduction in earlier lines of therapy; reduced costs of delivery; and expansion into other therapeutic areas including outside of cancer. Given potential future challenges, it is in the best interests of both innovators of these new complex therapies, and the healthcare system administrators and payers who must implement them, to better understand alternative feasible approaches to care delivery, or recognize policies or initiatives that may support optimal access

The objective of this study is to identify alternative feasible approaches to care delivery, or initiatives that may support the safe delivery and access to care of T-cell redirecting therapies within the Canadian health system setting. While some solutions may be more specific to Canada or T-cell redirecting therapies, we believe there are also general lessons for other complex interventions in other health care settings.

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2. Materials and Methods

Preparedness for T-cell redirecting therapies was informed using a mixed- methods approach. First, a narrative review was undertaken. This involved a search of the literature conducted by a medical information specialist based on a purposive sample of the commercially published and grey literature including health ministry and healthcare system websites to identify Canadian-specific barriers and solutions.

In parallel, information was sought using a conventional content approach and based on semi-structured interviews (30–60 min) with key informants (n = 15). The interviews were performed from an approach of qualitative description [6]— a naturalistic inquiry where the interviews and resulting data present "a rich, straight description of an experience or event"[7].

All interviews were conducted by D.H. with a purposive sample of experts including patient representatives (n=2), healthcare system leaders/ administrators (n=2), and healthcare providers (n=11). Informants were chosen based on differing expertise and geographic location.

Interviews were conducted via a recorded video conference call with an audio recording feature and transcription capability. An interview guide (see Supplementary Appendix A.1) was developed and pilot tested. Data, including all audio recordings, transcripts, and digital field notes, were stored on a password-protected drive. Automated transcriptions were checked against the audio recording and subsequently corrected. Interviewees were asked to provide their perspectives from an organizational perspective without risk of personal injury; therefore, no ethics approval was obtained.

Information gathered from the interviews and literature search included the current state of healthcare delivery and opportunities identified to improve capacity for care and were presented at a virtual multistakeholder Roundtable held virtually on May 12, 2025. The purpose of the meeting was to discuss the capacity and readiness to deliver complex care in Canada to patients with cancer that require heightened monitoring and human resource requirements. Complex care included new T-cell based therapies, such as CAR-T and BiTEs, which were the focus of discussion.

The virtual meeting began with a presentation of findings and a discussion focused on characterizing unmet needs and priority actions for Canada. The agenda for the meeting can be found in the Supplementary Appendix B

In particular, participants were asked to provide input on questions including:

1. What are the most critical needs to address to optimize care for future patients?
2. What actions are most feasible? effective? cost-effective?

- What timing, format, and stakeholders are required to achieve these?
- Which have priority?

3. Results

3.1. Barriers and Solutions Identified from Interviews and Round Table Meeting

The literature review and interviews revealed a number of barriers to the optimal use of T-cell-redirecting therapies for patients, providers and health care system administrators. For patients, these barriers included limited access to apheresis programs and specialized treatment centres, the need for travel and lodging, wait times for cell therapy manufacturing, and burden on informal caregivers[8,9]. Provider barriers included the need for more logistics and coordination of care, education and training, guideline and protocols and collaboration across departments[10]. Barriers to healthcare administrators included the need for legal contracts and enhanced data collection, critical mass and human resource planning[11,12], expansion across clinical programs[13], the need for clearly defined referral pathways[14], and considerations for expenditure growth[15]. Potential solutions for these barriers were also identified and are provided in the Appendix C.

Through discussion of these barriers and potential solutions at the virtual round table, the main obstacles to delivering optimal care and solutions were identified (Table 1).

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Table 1.

Barrier /theme	Description	Potential solution(s)	Quote from interviews
Regulatory constraints	Locally developed cell therapies could increase number of uses and reduce costs but are expensive to approve under current commercial fees	1. Specialized regulatory pathways for non-commercially sponsored research.	"Health Canada [charges] more than $500,000 just to review your locally manufactured CAR-T product…"
Lack of anticipatory implementation planning	Need for care coordination, scheduling, human resource training, and infrastructure	1. Environmental scanning. 2. Advanced human resource and capacity planning. 3. Specialized implementation pathways. 4. Compassionate use and clinical trials / translational research.	"…people making the decisions don't have any clue about where medicine is going to be in 2030"
Inappropriate governance	Reliance on bone marrow transplant and pharmacy services is insufficient to allow for multidisciplinary care delivery across cancer and non-cancer applications.	1. Specialized programs of care dedicated to cell and gene therapy. 2. Intra- and interprovincial coordinating bodies.	"…the solid tumor doctors, you know, the people who deal with inflammatory conditions...their immediate reaction is really just to knock on my door and saying this is happening. Can you do this for us?"
Inadequate financing approaches	Financing of therapies needs to account for additional human resources, training, toxicity management, care navigation and coo dination, and associated patient travel and lodging expenses.	1. Financing that considers broader system costs including the need for specialized physician services and patient travel and accommodation. 2. Specialized programs of care as budget holders.	"…people who hold the money and make all the decisions, they really have no idea what a complex hematology patient is"
Lack of knowledge by care providers	Lack of experience and knowledge by providers can make care inefficient	1. Intra- and interprovincial collaboration and coordination - communities of practice. 2. Content and education / exchange for providers	"We don't have a sickle cell expert really in our province … …it would be … nice for some of our provinces that have that limited expertise to really leverage those you know across the country"
Inadequate models of service delivery	A hybrid approach between inpatient and outpatient care is needed.	1. Short stay units. 2. Tele-medicine and remote monitoring. 3. Novel approaches to scheduling and care coordination. 4. Intra and interprovincial coordination.	"…the Cancer Center doesn't want to actually see them because it's after hours. … And the health region really has new model… for how to deal with outpatient care"

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		5. Shared care and hub-and-spoke models.	
Uncertainty about value for money	Payer risk in terms of what the true costs and cost offsets associated with investment are.	1. Province-specific or pan-Canadian data collection based on consistent patient- and societal value-based metrics 2. Outcomes-based agreements based on these measures	"We're actually, in fact, …saving by not pursuing certain treatments and the system just doesn't have a really great way of tracking that, that kind of thing"
Lack of information and support for patients	Patients hesitate to receive therapy due to a lack of information or misinformation and the level of communication and support provided by health care systems and care providers.	1. Communication plans and standards 2. Patient support and navigation 3. Caregiver support and navigation 4. Patient and family health literacy initiatives	"…we really need to find a standardized way of describing [procedures] to patients"

When discussing the supports and their rating, Roundtable participants made the following general observations:

- There is generally a lack of preparedness across Canada for a future of T-cell redirecting therapy
1. Healthcare system leadership will need to better address the complexity of care delivery, and its associated need for personnel, and additional resources if capacity issues are to be avoided.
2. Solid tumour and non-oncologic applications will create challenges, as current service programs of care are based on hematologic programs.
3. Financing of therapies needs to account for additional human resources, training, toxicity management, care navigation and coordination, and associated patient travel and lodging expenses.
- Creating new dedicated programs of care and service delivery models for complex patients as well as improving inter- and intra-provincial coordination and knowledge sharing are important solutions.
- More cost-effective implementation will also be aided by creating special regulatory pathways for non-commercial sponsors and enhancing capacity to collect data tied to product listing agreements across Canada.

3.2. Priority Actions for Canada

Priority actions identified by the roundtable participants included:

1. Specialized regulatory pathways for non-commercially sponsored research – cost-effective and more decentralized solutions to manufacturing face substantial regulatory barriers which could lead to less costly products that are manufactured more rapidly;
2. Intra- and interprovincial coordinating bodies - reliance on hematopoietic cell transplantation and therapy programs and local knowledge could lead to unnecessary delays compared to a world where scheduling patients and sharing collective knowledge is facilitated by a coordinating body;
3. Specialized programs of care –hematopoietic cell transplantation and therapy programs will need to expand once solid tumor and non-oncologic indications are introduced;
4. Specialized implementation pathways and translational research – effective implementation requires "learning by doing";
5. Real-world data – improving data collection in a coordinated fashion across Canada could lead to more opportunities for improving financing, risk-sharing and managed entry approaches.

This discussion revealed several insights for the future of complex therapies that will require attention including the need for: organizational change leadership and a change management

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function; specialized programs of care and implementation of navigational tools and educational strategies directed to providers and patients; transparent processes of evaluation that adhere to good practices in health technology assessment and implementation science; improving data collection to measure the cost and impact of new complex interventions; novel approaches to financing.

4. Discussion

Insights from a purposive sample of 15 Canadian patients (n=2), healthcare system leaders/ administrators (n=2), and healthcare providers (n=11) suggests there is much more to do to ready Canada for a future that involves T-cell—redirecting therapies. Some solutions may be easier to implement, such as creating pan-Canadian coordination, while others, such as improving data collection and creating new cell and gene therapy programs, more difficult.

Some of the challenges and solutions identified have already been addressed by other jurisdictions internationally. The European Medicines Association (EMA), for example, introduced a pilot program in 2022 to aid not-for-profits and academic sponsors to develop medicines based on genes, tissues or cells (advanced therapy medicinal products) and explore what changes to regulation might be required[16]. They also created significant fee reductions for hospitals or EU small/medium enterprises (SMEs), including many academic spin-outs and not-for-profit developers; reductions include 100% for micro-enterprises and 50% for hospitals and small/medium enterprises on many human-medicines fees, with additional administrative charge waivers on withdrawals for SMEs[17]. The "hospital exemption rule" recognizes the need for these therapies to be accessible to patients in hospitals even when manufactured on a small scale or in non-industrial settings allowing for some flexibility while ensuring that such products still comply with quality and safety requirements.[18,19]

These European efforts have created the necessary conditions for the ready creation of CAR-T products as well as guidance and proposals for how this might be best implemented and improved given the experience of academic centres[20,21]. These efforts may have created a broader framework that could be adopted in Canada (or US) for the necessary fulfillment of regulatory and payer requirements once new therapies have been developed[22].

Round table participants also saw the need for enhanced coordination of care delivery. High functioning coordination and referral systems have already been developed in Australia and France.[23] In Australia, for example, a national referral system for CAR T-cell therapy has been developed, and includes weekly discussions across a panel of "clinicians and scientific and logistics staff" to prioritize and coordinate new and existing referrals. Consideration is given to "timely and equitable access, total system and regional capacity, patient/referrer awareness and geographical location limitations"[24]

In Canada, access challenges due to Canada's larger geography are amplified when patients have heightened travel, lodging and caregiver requirements. This leads to equity concerns, particularly for northern and rural communities, including Indigenous populations. Equitable deployment of complex therapies will require provincial harmonization of referral processes, standardized eligibility criteria, and mechanisms for remote toxicity monitoring to ensure that geography does not determine access or outcome. Coordination of care coupled with hybrid models —combining short-stay inpatient monitoring with virtual or hospital-at-home follow-up—to safely maintain outcomes when robust triage and rapid-response systems are in place. These programs mirror the earlier evolution of outpatient stem-cell transplantation and highlight the importance of standardized patient selection, home-based monitoring, and caregiver education to safely expand capacity beyond tertiary centres, expanding to other regions of Canada

Specialized programs of care as well as specialized translational research programs were also identified as a need for Canada. Recognition of the need to use "advanced therapies" as a whole have led to the development of similar programs in the UK as part of their Industrial Strategy Policy. This included a GBP 30 million from Innovate UK in 2018 made available "to create a national network of advanced therapy treatment centres (ATTC) with the aim of pioneering partnerships between NHS clinical centres, academia and the commercial sector to scale up activity and clinical delivery across

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the whole patient pathway "[25] While coordinated real-world data collection was also seen as a priority action, it is likely these efforts would be leveraged by the development of these networks of enhanced coordination and highly specialized programs for advanced therapies.

Although these discussions centered on T-cell redirecting therapies, the intent of the discussion was to provide insight into a future world of complex interventions that require changing service delivery models in healthcare. The first, practical insight from experts was that complex therapies will require healthcare system level oversight for organizational change to facilitate more rapid changes to governance and service delivery models for complex therapies. This includes creating organizational change functions and leaders focused on health system transformation, and innovation spread, scale, and sustainability[3,26]. The traditional model of reacting to disruptive technology (i.e., bottom-up approach) can be costly to patients. It was estimated that even a six month delay in implementing upcoming BiTEs and CAR-T therapies for diffuse large B-Cell lymphoma and relapsed/refractory multiple myeloma could equate with 1.3 years of life lost for every day of delay[27].

A second insight was that the future of cell, gene and other advanced therapies will require specialized programs of care delivery that go beyond focusing on single therapies such as CAR-Ts. Complex therapies will require programs of care that coordinate service delivery, plan for future resource use, and oversee the development and implementation of navigational tools and educational strategies directed to providers and patients. Along with these developments, awareness, education and navigation will become increasingly important, as the effectiveness and cost-effectiveness of therapy will greatly depend on their appropriate use and the knowledge of patients and providers[28].

Another aspect of health system readiness to deliver complex therapies will be the need for evaluation functions that align with good principles in health technology assessment (HTA)[29,30] and implementation science[26,31]. This will include HTA that addresses adoption decisions in a timely and transparent fashion and informed by a premarket (i.e., early scientific advice) function to ensure stakeholders are aligned on appropriate approaches to evaluation[32]. The HTA process should also have a post-market function that utilizes real-world data[33,34] to gauge real-world effectiveness largely driven by the care context and the learning curve associated with complex interventions[35] as well as ongoing capture of costs.

A final aspect of health system readiness for complex therapies revealed by T-cell- redirecting therapies was the need to revisit approaches to financing new technologies[36]. As the impact of complex therapies on health and healthcare costs may be uncertain, health care payers may need to adopt additional approaches to manage risk including translational research programs intended to manage the entry of new technologies, product listing (or managed entry) agreements that share risk between payers and producers, and the allocation of discretionary funding to support the development and validation of new interventions. Financing approaches across Canada varied widely. For example, associated costs of treatment (such as travel and lodging) being reimbursed in some jurisdictions (as traditionally seen in stem cell transplant programs) and not in others (as traditionally seen in drug reimbursement).

We believe our attempt to characterize barriers and solutions to the implementation of complex interventions is unique and we hope it will be able to inform future discussions on developing policy responses that will expedite patient access to valuable care. While the strength of our approach was adherence to good practices in qualitative research and a robust sample of Canadian clinicians, patients and policymakers, there are also limitations to the approach taken. Firstly, the insights in regards to complex interventions are drawn from a single example (T-cell redirecting therapies). It is possible complex interventions introduce additional challenges that have not been addressed here. The review undertaken to inform discussion was also not performed using a replicable search and selection strategy--- it is possible additional insights have been missed.

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Nonetheless, we believe complex interventions, including the use of cell and gene therapy as well as digital, telehealth and artificial intelligence applications, community-based and transitional care programs, and the increasing use of self-management programs will require further attention.

5. Conclusions

T-cell redirecting therapies provide insights into the future of complex interventions and the supports required to deliver them. Patients will most benefit from healthcare systems that are best able to anticipate and adapt to changes from disruptive and complex healthcare technology. As a starting point, healthcare system leaders should create organizational change functions. This will allow for the more rapid development of new programs of care and processes to ensure value. In a future of complex and disruptive technology, healthcare systems will also need to consider how to improve processes of data collection and how to introduce technology through programs of scale, spread, and sustainability.

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Informed Consent Statement: "Patient consent was waived as interviewees and round table participants were asked to provide their perspectives from an organizational perspective without risk of personal injury.

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Abbreviations

The following abbreviations are used in this manuscript:

BiTE	Bispecific T-cell Engager
CAR-T	Chimeric antigen receptor T-cell
HTA	Health Technology Assessment
SME	Small to medium enterprise

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Appendix A

Appendix A.1. Semi-Structured Interview Guide

The interview begins with the interviewer stating the purpose of the interview, the topics that he wants to explore and the depth of response expected[37]

Appendix A.1.1. Purpose

Interviewer: The purpose of today's interview is to better understand the capacity and readiness of the health system that you currently work in to deliver complex care to patients with cancer that require heightened monitoring and human resource requirements. These include new T-cell based therapies, such as CAR-T and Bispecific T-Cell Engagers, which we will focus on for the discussion.

I have been asked by a consortium of companies (Amgen, Pfizer, J&J, Roche) to investigate what the current and future state of readiness for advanced diagnostic testing in Canada is and might become in the future. This research is intended to help both these private life science companies as well as healthcare systems better plan for a future of complex therapies.

Appendix A.1.2. Topics

I would like to cover a few topics today. This includes the ability of health systems to expand and adapt to accommodate new therapies in the future, what barriers currently exist to adoption, what solutions have been considered or have been used to facilitate the introduction of these new therapies, and what was considered in developing these solutions.

Appendix A.1.3. Depth

In each case, I would like to explore your own knowledge and perceptions and will try to describe how much feedback is needed. However, I want to encourage you to speak freely in response to each question, even if you feel it doesn't directly address the question. We will have [time] for discussion.

Your contribution to this report will be acknowledged as a key informant, but there will be no comments specifically attributed to you. Notes from the interview will be shared with you after the call to ensure accuracy and to identify any areas of clarification required.

Appendix A.1.4. Background Information

- SLIDE 1 –
  Identified Challenges for Health System Implementation of T-Cell-based therapies
- Incremental human resources and critical mass planning crossing multiple disciplines
- Ongoing expertise, training requirements, referral protocols, monitoring and toxicity management
- Infrastructure needs for additional hospital beds and equipment
- Access for patients who reside in low population density, non-urban areas
- Significant 'net new' financial commitments
- Governance and collaboration across health system departments, nationally and provincially
- Slide 2-
  Potential utilization of CAR-T and BiTE therapies
- Only 1 T-cell-directed therapy was available up until 2021 (blinatumomab), with use in a small number (100-200) of predominantly pediatric Canadian patients with acute lymphoblastic leukemias
- In two years, the introduction of CAR-T therapies has led to up to 10 times this number of patients being eligible for treatment for a wider variety of diseases (large b-cell lymphoma, Mantle cell lymphoma, Follicular lymphoma)

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- In addition to 5 CAR-T therapies and 4 BiTEs that have already been considered there are dozens of new BiTEs in clinical trials currently. Use of current CAR-T and BiTEs will continue to evolve, with evidence of benefit in additional cancers and in earlier lines of therapies,

Appendix A.1.5. Questions

1. When thinking about the potential growth in use of these therapies, do you believe this will represent a significant challenge to the health system that you work in?
a. [If yes] When did you first become aware of this challenge?
b. [If no] Why not?
2. Do you think the barriers to implementation described on the slide represent all of those within your own healthcare system?
a. [If yes] Which are most important in your jurisdiction?
b. [If yes] Were any of these challenges unique to these therapies?
c. [If no], What barriers exist?
3. What strategies or initiatives have you considered to deal with these barriers?
a. Have these efforts been systematic or coordinated across your healthcare jurisdiction?
b. What strategies or initiatives have actually been implemented?
c. Are other strategies being considered?
d. Is planning ongoing?
4. What factors were considered when developing these strategies or initiatives?
a. What were the most important factors or considerations to address challenges to adoption?
i. Was equity a consideration?
ii. Was timeliness a consideration?
b. Is additional data collection (e.g., on patient utilization and outcomes) a consideration?
5. Are you aware of others who have insight into this issue?
a. Who is involved with this at a Ministry level?
6. Do you have any further thoughts about this issue?
7. Do we have permission to use your name?
a. Interviewee demographics

Appendix B

Appendix B.1. Agenda for Virtual Roundtable Meeting

May 12 – 2025 – 6:30pm – 8:45 ET

Link: https://us02web.zoom.us/j/86188155797?pwd=5lRLrBXl6GgxcaZYJHWdocaaW9LTif.1&jst=3

The purpose of the meeting will be to discuss the understand the capacity and readiness to deliver complex care to patients with cancer in Canada that require heightened monitoring and human resource requirements. Complex care includes new T-cell based therapies, such as CAR-T and Bispecific T-Cell Engagers, which we will focus on for the discussion.

The meeting will begin with a presentation of the current state of healthcare delivery and opportunities identified to improve capacity for care identified through interviews and in published literature. It is also expected members will have further insights and information to help inform discussion. The discussion will then focus on characterizing unmet need in Canada.

Detailed Outline.

Start	End	Activity
18:30	18:45	**Introductions and objectives of meeting**
18:45	19:00	**Background presentation** - Current state of care and opportunities to optimize care

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19:00	19:20	**Discussion of backgrounder, clarification, other important considerations** - Are there important pieces of information that have not been captured by the backgrounder or require clarification or correction?
19:20	19:50	**Characterizing magnitude of the problem** - Given the current state of clinical management and healthcare policy, what are the best and worst case scenarios for the future of T-cell based interventions? **Discussion of key unmet needs** - What are the most critical needs to address to optimize care for future patients?
19:50	20:00	**BREAK**
20:00	20:20	-
20:20	20:40	**Identifying priority actions and solutions:** - What actions are most feasible? effective? cost-effective? - What timing, format, and stakeholders are required to achieve these? - Which have priority?
20:40	20:45	**Final thoughts, and summary of next steps.**

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