

Pre-consultation business case: Proposals for the future location of very specialist cancer treatment services for children who live in south London and much of south east England

**Appendix 8: NHS England response to the recommendations of
the London and South East Clinical Senate Panel Review**





NHS England response to the recommendations of the London and South East Clinical Senate Panel Review

The role of the Clinical Senate is to provide independent strategic advice and leadership to assist statutory bodies in making the best decisions about health for the populations they serve. Their advice is impartial and is informed by the best available evidence. The London and South East Clinical Senates have jointly reviewed the proposal documentation and, in April 2023, convened a review panel, including national subject matter clinicians and co-chaired by the respective chairs of both Senates. The panel heard presentations from the NHS England Programme Team and then put questions to the team and representatives from the current Principal Treatment Centre and both potential future providers. The NHS England Programme Team has representatives from both the London and South East regions.

The Clinical Senates have examined the proposals to assess the following points.

- Is the case for change clear from a clinical perspective?
- Does the Equality and Health Inequalities Impact Assessment provide sufficient mitigation to possible health impacts, particularly travel times that might otherwise increase inequities?
- Is the clinical evidence set out in the pre-consultation business case clear about both proposals, following the evaluation of the proposals?
- Is there any further clinical evidence that NHS England should consider in making a final decision on the options?

The Joint Clinical Senate made recommendations for commissioners for further development of the pre-consultation business case. The recommendations of the panel are incorporated into the Clinical Senate's full report, ([link to website when available](#)). On receipt of the recommendations, the NHS England Programme Team held a workshop with representatives from the three providers to discuss how the advice can be addressed, particularly those relating to the Implementation Phase. In the table below is the NHS England Programme Team's full response to the Joint Clinical Senate's recommendations, using information collated at the workshop and from other documents provided by the three providers, setting out how we are taking into account their advice.

Senate Recommendation	Programme phase	NHS England Programme Team response
Executive Summary		
<p>R1. The NHS England Programme Team should support organisational development at the current PTC, involving the whole workforce which currently provides children’s cancer services. This should involve how the current Principal Treatment Centre (PTC) will work with the successful provider to provide the services in the future. Specific areas to work through and agree are likely to include:</p>		
<p>a) How organisational memory and key skills and competencies are preserved and transferred to the future provider.</p>	<p>Implementation</p>	<p>Staff recruitment and retention is a well-recognised risk of the implementation phase that will be closely monitored.</p> <p>As part of the options appraisal, both providers provided detailed and credible information on their provision of opportunities for staff education, training and support for staff wellbeing. This information is summarised in the PCBC section 5.4.3 Organisational support for staff</p> <p>High level implementation plans are set out within the PCBC, including proposals for involving and engaging with staff who will shape the future service. This includes a focus on workforce and organisational development to preserve and support the transfer of organisational memory, key skills and competencies. Organisational leadership will be an important enabler for this.</p> <p>Representatives from St George’s, Guy’s and St Thomas’ and The Royal Marsden have agreed to key principles that will underpin detailed work in the implementation phase after a decision has been made; this includes working in a professional and supportive manner, to ensure continuity of current services, the willingness to look for system wide solutions, and</p>



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		cherishing staff skills and ensuring a place for these to be used to the benefit of individual staff and patients going forwards.
b) How research is maintained, planned, and developed and where possible enhanced with the future provider. This will include how research and charitable income can be secured and protected, and the rationale for “wet research” remaining at The Royal Marsden, if that is to be the case.	Implementation	The NHS England Programme Team recognises ensuring continuity of research will need to be a key area of focus within the implementation phase and beyond. The paediatric clinical research team at The Royal Marsden works closely with the laboratory scientists based at The Institute of Cancer Research (ICR). There is a huge benefit from the critical mass of scientists working at the ICR and the interaction between those researching paediatric cancers and those researching adult tumours. There is no intention to move the science ‘wet lab’ research from the ICR site at The Royal Marsden site in Sutton. However, once paediatric cancer patients move to a different location for their clinical care, they will need to be recruited into research trials by staff at that Trust. Biological samples for research (blood, biopsies etc) will have to be taken by staff at that Trust and transported to the ICR labs. This is common practice for cutting edge research. It is the exception now for all labs to be co-located with the patients they research and indeed for global and pan-European studies of rare cancers, samples have to be transferred from all over the world. There will therefore need to be close engagement between the future PTC, the Institute of Cancer Research, The Royal Marsden and other stakeholders to support the development of a new clinical model and help ensure that risks associated with the change are mitigated. The PCBC outlines the risks associated with research and potential mitigation strategies have been identified to date. These include the protection of research grant income and ensuring access to research trials for children’s cancer. Work between stakeholders to understand and manage risks will be ongoing and a continued area of focus.

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<p>c) Work with patients / parents to design and develop the future service with the provider so it aspires to improvement beyond the PTC specification. To ensure holistic care it is essential that service users contributing their views span all geographies and demographic groups, including the 9 protected characteristics, as well as the type of cancer, stage of cancer, age of child and family circumstances.</p>	<p>Implementation</p>	<p>Information provided by both providers as part of the Programme's options appraisal process demonstrates that both have experience in delivering high quality patient engagement, including co-design processes with children, young people and their families. Both clearly set out the intention to use co-design methodologies to develop the PTC service and environment.</p> <p>Strong engagement with patients and families within the current service (at the time of implementation) will require close working with the current PTC Provider, drawing on their experience in this area.</p> <p>Feeding into this process would also be the wealth of information collected as part of the pre-consultation and consultation phase that could be used to improve service development plans. This process aims to engage with as many people as possible in the geography affected by the service change, prioritising engagement with groups that have protected characteristics as well as those that are known to experience adverse health inequalities.</p>
<p>d) Preserve the memories and legacies which have underpinned the services on the Sutton site so that, if possible, they can be incorporated in the new provision.</p>	<p>Implementation</p>	<p>The importance of the areas and facilities at The Royal Marsden, funded by parents in memory of their children, is fully acknowledged. As is the importance of a sensitive approach to considering how to preserve them. Both potential future providers expressed their wish to enable these legacies to be recognised and committed to work with families and The Royal Marsden to find a way to bring these across sensitively.</p>
<p>Section 1: Is the case for change clear from a clinical perspective?</p>		

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<p>R2. The successful site option must commit to not just working with their colleagues from the current PTC but commit to joint organisational development that gives opportunities for the incoming workforce and their patients / parents to co-design and develop the service not just transfer it.</p>	<p>Implementation</p>	<p>The intention to co-design and develop the future service with healthcare professionals from both future and current PTC providers, as well as patients and their families, is described in the PCBC and has been a feature of the options appraisal and other aspects of the programme so far. We would re-iterate the statements made for the implementation phase in recommendations 1a and 1c above.</p>
<p>R3. Develop the narrative on the case for change within the PCBC, to go beyond compliance with the technical aspects of the specification and demonstrating the improvements that the proposed change would bring for children across south east England and south London.</p>	<p>PCBC</p>	<p>Further work on the case for change narrative has taken place since the Clinical Senate panel review. The NHS England Programme Team have sought further input from colleagues across all three providers, through the Senate response workshop and other activities. As a result, the narrative within the PCBC has been strengthened to make the case for change clearer and describe the benefits that will arise. Please see Section 2 of the PCBC.</p>
<p>R4. Provide assurance that The Royal Marsden will work with the successful provider to bring a full understanding of the requirements of a paediatric oncology service to the</p>	<p>PCBC</p>	<p>The Royal Marsden have written to NHS England to confirm that they are working closely and constructively with the NHS England Programme Team, their patients, families and staff to contribute to the review process with the aim of ensuring the very best service is provided for children and families.</p>

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implementation of the future PTC.		In the context of the national service specification which mandates co-location of a PTC with a paediatric intensive care unit, The Royal Marsden Board has confirmed their commitment to work with NHS England and colleagues at Guy's and St Thomas' and St George's to arrive at the best outcome for children.
R5. Include clear quality measurements and metrics in the PCBC enabling progress to be measured and provide early warning of any destabilisation of the pathway to enable early mitigations.	PCBC/ Implementation	<p>Reference to the requirement for quality metrics that capture improvements and changes in outcomes, patient experience and organisational structures and processes (including workforce) have been included within the PCBC, within sections such as developing the clinical model, research, consultation and the approach to risk management.</p> <p>In addition to formal metrics, workshop attendees also agreed that it will be important to monitor the confidence levels in the transition process amongst different staff groups and patients and families. Use of "pulse" or "temperature check" type surveys could be utilised. Monitoring patient access in terms of modes of transport will also be important.</p>
R6. Consider whether the brand "The Royal Marsden" should be incorporated in the identity of the future service provision.	Implementation	The NHS England Programme Team agree that this is an option that should be considered jointly between The Royal Marsden and the future PTC provider (once known) during the implementation phase.
Section 2: Transitions - provision for children aged 0 to 15 years and moving the service		



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<p>R7. For transitions of care (post age 15), the review team felt the risk of providing the services on another site needs mitigation. The suggestions already made regarding flexibility and age (perhaps even extending to 18 or beyond), geographical location of the patient and tumour site, location will be important. It would be helpful to clarify current and future capacity to manage 16-18+ year old patients in appropriate facilities with appropriately trained workforce. Continuity of staffing support (e.g., nurse specialist) supporting patients and their families through transition may also help.</p>	<p>PCBC and Implementation</p>	<p>As described in the national service specification, the PTC provides services for children up to their 16th birthday. However, it is acknowledged in the specification that there will be some flexibility required in the age boundaries of services, to enable patients to access optimum disease and age-appropriate services. It may, therefore, be appropriate for a PTC to treat people up to their 19th birthday. It may also be appropriate for a teenagers and young adult cancer service to treat people aged 13 years and above.</p> <p>Therefore, the flexibility highlighted in the Clinical Senate recommendation is allowed for within the service specification. The PCBC sets out a summary of plans relating to transition best practice, service specification requirements and NICE Quality Standards.</p>
<p>R8. It will be important to ensure an active risk register to oversee the development and the first few years of practice.</p>	<p>Implementation</p>	<p>Risk management is recognised as an essential tool to deliver projects successfully and realise the intended benefits. As part of the options appraisal process, both providers have outlined key risks to delivery from a management perspective with their associated mitigating actions. During implementation these risk assessments will be developed into a comprehensive risk register, overseen by the Implementation Board. This will include the current PTC</p>



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<p>R9. The implementation is planned to be within 2.5 years. The team felt that it is important that once a decision is made the implementation is undertaken in a timely fashion to ensure safe transition that provides continuity of care and to relieve uncertainty amongst staff and patients.</p>	<p>Implementation</p>	<p>In their proposals, the two Trusts were asked to set out their implementation plans, including a high-level timeline, covering how the Principal Treatment Centre service and clinical model would be implemented. Both proposals included information on implementation, considerations related to risks that will need to be managed, and previous experience of major service change. These initial transition plans have been described in the Implementation section of the PCBC. Implementation is likely to take up to 2.5 years from that date as time will be needed for a number of reasons, including refurbishment of space within either hospital to create dedicated space within the estates for the children’s cancer service and for the Trust to secure JACIE accreditation for bone marrow transplants.</p> <p>Once a decision has been made on the location of the future PTC, it is proposed that the current Programme Board re-forms as an Implementation Board to ensure the programme stays on track, the benefits anticipated from this change are achieved and the risks of service change as fully mitigated as possible.</p> <p>Representatives from St George’s, Guy’s and St Thomas’ and The Royal Marsden have [previously] agreed to key principles that will underpin detailed work in the implementation phase after a decision has been made, including:</p> <ul style="list-style-type: none">• working in a professional and supportive manner• ensuring continuity of current services the willingness to look for system wide solutions.• cherishing staff skills and ensuring a place for these to be used to the benefit of individual staff and patients going forwards. <p>Workshop attendees re-iterated that this is a significant service reconfiguration programme that will require dedicated programme</p>



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		management expertise alongside strong clinical leadership to ensure a timely but safe transition. Integrated Care Boards, the clinical network (including Paediatric Oncology Shared Care Units (POSCUs)) and both NHS England London and South East regional teams will all need to be involved.
Section 2.4: Operational Delivery Network, Primary and Community Care		
R10. Whilst there are no changes to existing arrangements to pathways with primary care, GPs and community services we recommend that given the magnitude of the change specific attention is given to communications and engagement with these groups directly in addition to rather than through POSCU and Integrated Care Boards.	Consultation	Primary care and community care health professionals are recognised as stakeholders within the consultation plan. The NHS England Programme Team welcome this suggestion about consideration of further engagement and communication with these groups and plan to explore mechanisms for doing this.
Section 2.5: Diagnosis, Treatment and Management of Cancer		

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R11. Provide further assurance regarding theatre capacity; paediatric surgical resource; isolation cubicles; and paediatric competent 24/7 interventional radiology rotas at the Evelina London Children's Hospital, articulating how this capacity and resource can be flexed to demand if required.	PCBC	Further information on theatre capacity, surgical resource, interventional radiology and isolation facilities at the Evelina London Children's Hospital has been provided by Guy's and St Thomas' and/or reviewed by the Programme Team. They also provided proposals for ensuring ongoing sustainability of the specialist workforce required in these areas. The information provided has been reviewed by the NHS England Programme Team and reflected in the PCBC.
R12. To incorporate the learning from Covid 19, and current guidance around all emerging respiratory infections to inform the service model for this cohort of patients including managing transfers of patients in any future respiratory pandemic.	Implementation	<p>Both potential providers have submitted further information on their key learning and development as a consequence of the COVID-19 pandemic. This includes:</p> <ul style="list-style-type: none"> • importance of isolation facilities and enhance ventilation. • Measures to help protect theatre capacity. • Supporting staff to protect wellbeing and develop resilience. • Working collaboratively across the system • A proactive approach to ensuring the voices of children, young people and their families are part of service model development.

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<p>R13. Articulate in PCBC how end of life care would be supported 24/7 at home and how they would plan to work collaboratively with children’s hospices; this may refer to the information provided in the written response to the KLOE.</p>	<p>PCBC</p>	<p>Both potential providers have articulated how their End of Life and Palliative Care Services are integral to the paediatric oncology service, providing pathways for pain, symptom control, end of life care and bereavement support. The teams provide out of hours services and work closely with community teams, nursing teams, schools and local hospices.</p> <p>The information provided has been reviewed by the NHS England Programme Team and further clarification sought from the providers on how each service would plan to support end of life care at home 24/7. Further information on the management of this pathway has been provided and reflected in the PCBC.</p>
<p>R14. Further detail from the potential providers to describe their acute care pathways / their oncology triage service and how they will offer advice to carers and clinicians (including paramedics) assessing unwell children in the community on the need for admission to hospital (ED/POSCU/PTC) and in what time frame. A pathway example of a patient(s) journey may be helpful for clarity during consultation. The Providers may want to consider how they can support the carers of these</p>	<p>Consultation</p>	<p>As part of the consultation documentation, example clinical pathways will be provided to help consultees understand the typical journeys that children and their families may experience.</p> <p>It is important to note that current methods of communication and pathways between services in the community, POSCUs and the current PTC are already well established as part of the Children's Cancer Network.</p> <p>It was acknowledged that further development and transformation of the network is an important programme, to be aligned with the PTC service transfer, with opportunities to offer more care closer to home, better continuity of care from point of diagnosis, broader education and training opportunities and more outreach via Multi-Disciplinary Team working between PTC and POSCU.</p>

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R15. Clearly describe how up to date information to equip patients and parents with the tools and information required to co-manage their own health will be addressed, especially for more geographically remote patients. A pathway example of patient(s) journeys may be helpful for consultation.	Consultation	Please see response to R14 which references this aspect of care pathways and systems linking the child, family, PTC, POSCU and other community provision. example clinical pathways will be provided within the consultation documentation.
R16. Clarify how both providers would satisfy The Joint Accreditation Committee ISCT-Europe & EBMT (JACIE) for stem cell transplantation.	PCBC	<p>Both potential providers outlined in their proposals their intentions for timely JACIE accreditation. St. George's outline how they would use their experience of gaining accreditation for adult services. Evelina London Children's Hospital also outline plans to work closely with the current PTC provider to achieve accreditation within the specified time frame.</p> <p>Progressing JACIE accreditation for Paediatric Bone Marrow Transplants is recognised within the PCBC as a key focus of the Implementation Programme.</p>

Section 2.6: Survivorship, Mental Health, and Psychological Wellbeing

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<p>R17. The potential providers fully articulate the support they will provide to patients / parents and their primary care and community teams to provide safe and seamless care on a 24/7 basis. This should include longer term psychological support to patients and families where indicated or required.</p>	<p>PCBC</p>	<p>Please see response to R14 which includes reference to aspects of care pathways and systems linking the child, family, PTC, POSCU and other community provision.</p> <p>Proposals from both providers include the provision of psychosocial support throughout the clinical pathway.</p>
<p>Section 2.8: Clinical Engagement</p>		
<p>R18. Stakeholders have identified successful change requires strong clinical leadership. For successful implementation those clinical leaders from the current PTC and the future provider will need to be identified, developed and supported.</p>	<p>Implementation</p>	<p>The requirement for strong clinical leadership throughout the service change and beyond is recognised. This will include clinical leadership from all organisations concerned and potentially joint appointments between the future and current PTCs. Leadership development support may also need to be provided. In the near term, it has been proposed that a joint appointment for a senior nurse between The Royal Marsden and NHS England /future PTC be made to support the change process. It has been noted that allied health professionals, the clinical network and POSCUs all have an important role in supporting this leadership. Also highlighted is the need for adequate resourcing and capacity to provide the necessary focus on the transition at the same time as ensuring continuity of service provision.</p>
<p>Section 2.9: Workforce</p>		

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<p>R19. Retaining the specialist workforce across all staff groups both clinical and non-clinical needs to be a high priority and reflected in workforce plans.</p>	<p>PCBC and Implementation</p>	<p>Staff recruitment and retention is a recognised risk of the implementation phase that will be closely monitored. Please see our response to Recommendation 1 that details the intention of implementation plans to include processes focusing on the successful retention of specialist staff and the principles that all providers involved have agreed. This would also apply to staff involved in research. There is also opportunity to learn from recent experiences of retention and recruitment at the current PTC.</p>
<p>R20. Both proposals mention education and development. The team highlighted that opportunities for education and development of all staff can be vital components to a successful future service. Plans to deliver this pre and post transfer should be in the organisational development plans and include all workforce groups.</p>	<p>PCBC and Implementation</p>	<p>All participants in the Clinical Senate Response workshop emphasised the importance of supporting staff wellbeing, education, training, and other development opportunities across all professional groups.</p> <p>Provision of education and development was part of the options appraisal evaluation criteria and both providers provided detailed and credible information on their provision of opportunities for staff education, training and support for staff wellbeing. This information is summarised in the PCBC section 5.4.3 Organisational support for staff</p> <p>Please see our response to Recommendation 1 that details the intention of implementation plans to include processes focusing on the successful retention of specialist staff and the principles that all providers involved have agreed.</p>

Section 2.10: Environmental Sustainability



Senate Recommendation	Programme phase	NHS England Programme Team response
<p>R21. Ensure that resilience plans are developed to manage the impacts of climate change including working during extreme weather: IT systems, cooling and management of flooding.</p>	<p>DMBC/ Implementation</p>	<p>Under the Health and Care Act 2022, new duties were introduced which require NHS England to have regard to the wider effect of decisions it makes (s.13NA NHS Act), generally referred to as the triple aim duty, and to have regard to the need to contribute towards compliance with the UK net zero emissions target (s.13NC NHS Act). Currently, an assessment is being prepared for consideration during the decision-making process.</p> <p>In considering the proposals from both organisations, the environmental impact in relation to capital build and transport access has been initially assessed, including impacts of:</p> <ul style="list-style-type: none">• Models of care• Estates and facilities• Travel and transport• Environmental resilience <p>Both organisations have published environmental strategies which detail how they will support the national NHS commitment to delivering a 'Net Zero' Health Service.</p> <p>Both strategies outline plans to reduce emissions from all sources, contribute to improving local air quality, develop sustainable use of resources, and enhance green spaces.</p> <p>A detailed environmental impact assessment, including air quality and greenhouse gases, will need to be conducted as part of the planning and implementation phase. Ensuring sustainability and reducing carbon emissions will be a key part of the design process.</p>



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<p>R22. Demonstrate how efficient local working with POSCUs and maximising remote consultations, usage of bloods and samples transported by drone can provide the same or better standard of care to patients whilst reducing the patient need to travel and associated carbon impact.</p>	<p>Implementation</p>	<p>Please see response to R14 for details of maintaining and further developing excellent working relationships between PTCs and POSCU/wider community care.</p> <p>This will increase the opportunity for care closer to home (including, where appropriate, remote consultations), improving patient experience (by reducing travel requirements) and reduce transport emissions.</p> <p>This particular care model is also highlighted in the interim Equalities and Health Inequalities Impact Assessment (EHIA), noting that arrangements must allow for some families experiencing digital exclusion.</p>
<p>R23. Consider travel advisors to give advice on the cheapest and greenest routes, potentially offering travel cards for public transport if appropriate.</p>	<p>Implementation</p>	<p>Support for travel planning is part of the range of recommendations made in the EHIA to mitigate the impact of additional travel. This would typically be through the dedicated care coordinator/key worker who will help families to coordinate appointments and admissions for their treatment pathway. Also highlighted in the mitigation recommendations is that consideration should be given to the development of prospective funding systems, travel voucher schemes for example, to ease the financial burden of any additional travel required as a result of the service change. Whilst the primary objective of both of these proposals is that of supporting families in their travel planning and resourcing, an additional benefit could be reduction in journeys and associated environmental impact. It is recognised that the appropriateness, or not, of being in crowded areas (such as on public transport) at certain phases of treatment will differ from patient to patient and should be clinically assessed on a case-by-case basis.</p>

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<p>R24. Identify plans to increase active transport and decarbonise transport for staff. There is opportunity for units to further develop an emerging network of safe cycling/walking routes and plans with local authorities.</p>	<p>Implementation</p>	<p>Both organisations have developed Green (or Sustainability) Plans which cover conversion of fleet vehicles (including patient transport) to electric vehicles, supporting use of public transport patients (for those who are able) and active travel plans for staff. The links to these plans are shown below.</p> <p>The implementation and application of these wider plans to the particular staff group part of the service change will need to be incorporated into implementation planning.</p> <p>St George's University Hospitals</p> <p>NHS Foundation Trust: The Green Plan</p> <p>Guy's and St. Thomas' NHS Foundation Trust: Sustainability Strategy</p>
<p>Section 3.1: Population and Inequalities</p>		
<p>R25. Consider and articulate how the re provided service will meet Core20PLUS5 and the five strategic objectives for health inequalities in the NHS operating plan: Particular areas of focus on the pathway may be: identification of need; inclusive communication; remote appointments; care coordinators, and shared care, including support from primary</p>	<p>Implementation</p>	<p>An Interim Integrated Impact Assessment (which incorporates Equalities and Health Inequalities Impact Assessment) is in place and will be updated throughout the life of the programme.</p> <p>The IIA draws on a comprehensive description of the population of the PTC catchment area (i.e., identifying need) and uses travel time analysis to support an assessment of differential impacts on populations with protected characteristics or other vulnerabilities (i.e. the "CORE20Plus5" population).</p> <p>The EHIA sub-group has put forward a range of potential systems, processes or programmes that could serve to mitigate the adverse impacts outlined above (or enhance the positive impacts). All of the recommendations would benefit from patient, family and carer engagement to support their planning and delivery.</p>



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care, social care and other local stakeholders.		<p>The main themes include:</p> <ul style="list-style-type: none">• systems and processes aimed at helping patients and families plan their journeys to hospital, including provision of inclusive and accessible information and translation services.• systems and processes aimed at reducing the financial impact of travel, such as re-imbursements schemes for travel costs or supporting patients to access other financial support.• transport services provided directly to patients and their families (with clear eligibility criteria) and family accommodation.• high quality onsite accessibility arrangements, including parking and drop-off facilities.• other aspects of care planning including flexibility on appointment times, shared care closer to home, strong communication systems between different health and social care teams, and remote (non-face to face) appointments (taking into account digital exclusion)• an excellent implementation plan for the service change process, to support patients through the transfer period, with high quality continuity of care.
R26. Articulate how this future service could tackle the broader determinants of health and increase social value e.g., recruitment strategy (that may also help mitigate some service health inequalities) and its contribution to the broader goal	Implementation	<p>Both potential providers are rooted in their communities and have potential to contribute towards health and wellbeing through wider mechanisms than just direct care.</p> <p>They are also part of their respective Integrated Care Systems/Boards which offers further opportunities to take a place-based approach to reducing health inequalities through influencing the broader determinants of health.</p>



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of the Trust being an "anchor institution".		This recommendation about how the future PTC service can link with these system wide approaches to reducing health inequalities is welcomed and responding to it will form a key part of the implementation phase. Some of the ways the future PTC could contribute towards tackling the broader determinants of health includes widening access to quality work though being a good inclusive employer, paying people the real living wage and creating opportunities for local communities to develop skills and access jobs in health and care especially those experiencing inequalities ¹ .
R27. Demonstrate improved outcomes from the changes. Presumably the PTC will be recording a series of outcomes including patient reported outcomes and equalities data which can be used to compare and track performance and improvement.	Implementation	<p>An important element of the post-decision-making phase will be the development of quality metrics to ensure that good progress is being made against implementation plans. This will include the collection of baseline data.</p> <p>The national service specification includes a wide range of metrics on clinical care, patient experience and organisational structures and processes. We will be drawing on these mandatory measures of outcomes and standards of care, in addition to consideration of other monitoring sources, to define a set of quality metrics.</p> <p>Part of this process will include consideration of any unwarranted variation in clinical outcomes and quality (including patient experience) between different socio-demographic groups.</p>

¹ The NHS as an Anchor Institution: <https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/our-approach-to-reducing-healthcare-inequalities/anchors-and-social-value/>

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R28. Articulate how additional support for patients experiencing health inequalities will be provided (as it is likely to be required) during transition to the future service.	Implementation	Please see the response to Recommendation 25 for an outline of the recommendations for mitigation of impact (through additional support) on groups with protected characteristics or those known to experience health inequalities. Further detail is available in the EHIA section of the Integrated Impact Assessment.
R29. Articulate the mitigations proposed to help with travel times and access from the most disadvantaged communities including those who may be digitally excluded.	Implementation	Please see the response to Recommendation 25 for an outline of the recommendations for mitigation of impact (through additional support) on groups with protected characteristics or those known to experience health inequalities (including through the mechanism of digital exclusion). Further detail is available in the EHIA section of the Integrated Impact Assessment.
Section 3.2: Patient transport		
R30. Greater clarity on how the providers would work with NHS emergency ambulance services / 111 and with alternative patient transport services to support patients who deteriorate in the community with advice and if required transfer.	Implementation	<p>There are several aspects to patient travel that will be addressed during implementation planning:</p> <ul style="list-style-type: none"> • Patients travelling to appointments using their own resources (and potential financial re-imburement systems for this travel) • Non-emergency patient transport services (NEPTS): https://www.england.nhs.uk/publication/non-emergency-patient-transport-services-eligibility-criteria/ • The South Thames Retrieval Service • Standard NHS emergency ambulance services <p>It should be noted that there are already established processes for accessing emergency care. This includes 24/7 support from the PTC and POSCU; patient and family educational resources on recognising a deterioration in health status and what to do in that situation; established</p>



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		pathways between local emergency departments and the PTC/POSCU; and communication with the patient's primary care team.