Thurrock: A place of opportunity, enterprise and excellence, where individuals, communities and businesses flourish

Health and Wellbeing Overview and Scrutiny Committee

The meeting will be held at **7.00 pm** on **15 September 2016**

Committee Room 1, Civic Offices, New Road, Grays, Essex, RM17 6SL

Membership:

Councillors Victoria Holloway (Chair), Graham Snell (Vice-Chair), Gary Collins, Tony Fish, Angela Sheridan and Aaron Watkins

Ian Evans (Thurrock Coalition Representative) and Kim James (Healthwatch Thurrock Representative)

Substitutes:

Councillors Tim Aker, Jan Baker, Terry Piccolo and Joycelyn Redsell

Agenda

Open to Public and Press

Page

1. Apologies for Absence

2. Minutes **5 - 14**

To approve as a correct record the minutes of the Health and Wellbeing Overview and Scrutiny Committee meeting held on 9 June 2016.

3. Urgent Items

To receive additional items that the Chair is of the opinion should be considered as a matter of urgency, in accordance with Section 100B (4) (b) of the Local Government Act 1972.

4. Declarations of Interests

5.	**Items Raised by HealthWatch** This item is reserved to discuss any issues raised by the HealthWatch co-opted member or designated representative.	
6.	**Positron Emission Tomography-Computed Tomography (PET CT) in South Essex**	**15 - 160**
7.	**Proposed Merger between NEP and SEPT**	**161 - 162**
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Queries regarding this Agenda or notification of apologies:

Please contact Jenny Shade, Senior Democratic Services Officer by sending an email to Direct.Democracy@thurrock.gov.uk

Agenda published on: **7 September 2016**

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DECLARING INTERESTS FLOWCHART – QUESTIONS TO ASK YOURSELF

Breaching those parts identified as a pecuniary interest is potentially a criminal offence

Helpful Reminders for Members

- *Is your register of interests up to date?*
- *In particular have you declared to the Monitoring Officer all disclosable pecuniary interests?*
- *Have you checked the register to ensure that they have been recorded correctly?*

When should you declare an interest *at a meeting?*

- **What matters are being discussed at the meeting?** (including Council, Cabinet, Committees, Subs, Joint Committees and Joint Subs); or
- If you are a Cabinet Member making decisions other than in Cabinet **what matter is before you for single member decision?**

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Does the business to be transacted at the meeting

- **relate to; or**
- **likely to affect**

any of your registered interests and in particular any of your Disclosable Pecuniary Interests?

Disclosable Pecuniary Interests shall include your interests or those of:

- your spouse or civil partner's
- a person you are living with as husband/ wife
- a person you are living with as if you were civil partners

where you are aware that this other person has the interest.

A detailed description of a disclosable pecuniary interest is included in the Members Code of Conduct at Chapter 7 of the Constitution. **Please seek advice from the Monitoring Officer about disclosable pecuniary interests.**

What is a Non-Pecuniary interest? – this is an interest which is not pecuniary (as defined) but is nonetheless so significant that a member of the public with knowledge of the relevant facts, would reasonably regard to be so significant that it would materially impact upon your judgement of the public interest.

Pecuniary

If the interest is not already in the register you must (unless the interest has been agreed by the Monitoring Officer to be sensitive) disclose the existence and nature of the interest to the meeting

If the Interest is not entered in the register and is not the subject of a pending notification you must within 28 days notify the Monitoring Officer of the interest for inclusion in the register

Unless you have received dispensation upon previous application from the Monitoring Officer, you must:

- **Not participate or participate further in any discussion of the matter at a meeting;**
- **Not participate in any vote or further vote taken at the meeting; and**
- **leave the room while the item is being considered/voted upon**

If you are a Cabinet Member you may make arrangements for the matter to be dealt with by a third person but take no further steps

Non- pecuniary

Declare the nature and extent of your interest including enough detail to allow a member of the public to understand its nature

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You may participate and vote in the usual way but you should seek advice on Predetermination and Bias from the Monitoring Officer.

Vision: Thurrock: A place of **opportunity**, **enterprise** and **excellence**, where **individuals**, **communities** and **businesses** flourish.

To achieve our vision, we have identified five strategic priorities:

1. Create a great place for learning and opportunity

- Ensure that every place of learning is rated “Good” or better
- Raise levels of aspiration and attainment so that residents can take advantage of local job opportunities
- Support families to give children the best possible start in life

2. Encourage and promote job creation and economic prosperity

- Promote Thurrock and encourage inward investment to enable and sustain growth
- Support business and develop the local skilled workforce they require
- Work with partners to secure improved infrastructure and built environment

3. Build pride, responsibility and respect

- Create welcoming, safe, and resilient communities which value fairness
- Work in partnership with communities to help them take responsibility for shaping their quality of life
- Empower residents through choice and independence to improve their health and well-being

4. Improve health and well-being

- Ensure people stay healthy longer, adding years to life and life to years
- Reduce inequalities in health and well-being and safeguard the most vulnerable people with timely intervention and care accessed closer to home
- Enhance quality of life through improved housing, employment and opportunity

5. Promote and protect our clean and green environment

- Enhance access to Thurrock's river frontage, cultural assets and leisure opportunities
- Promote Thurrock's natural environment and biodiversity
- Inspire high quality design and standards in our buildings and public space

Minutes of the Meeting of the Health and Wellbeing Overview and Scrutiny Committee held on 9 June 2016 at 7.00 pm

Present:	Councillors Victoria Holloway (Chair), Graham Snell (Vice-Chair), Gary Collins, Tony Fish, Angela Sheridan and Aaron Watkins Ian Evans, Thurrock Coalition Representative Kristina Jackson, Thurrock CVS
In attendance:	Councillor Halden, Cabinet Member for Education and Health Ruth Ashmore, Assistant Director of Specialised Commissioning, NHS England Midlands & East (East of England) Jessamy Kinghorn, NHS England Specialised Services (Midlands and East of England) Wendy Smith, Interim Communications Lead, Mid and South Essex Success Regime (arrived at 8.00pm) Roger Harris, Corporate Director of Adults, Housing and Health Tim Elwell-Sutton, Consultant in Public Health Catherine Wilson, Strategic Lead Commissioning and Procurement Funmi Worrell, Public Health Registrar Mandy Ansell, (Acting) Interim Accountable Officer, Thurrock NHS Clinical Commissioning Group Jenny Shade, Senior Democratic Services Officer Charlotte Raper, Senior Democratic Services Officer

Before the start of the Meeting, all present were advised that the meeting may be filmed and was being recorded, with the audio recording to be made available on the Council's website.

1. Minutes

The Minutes of the Health and Wellbeing Overview and Scrutiny Committee, held on the 16 February 2016, were approved as a correct record.

2. Urgent Items

There were no items of urgent business.

3. Declarations of Interests

No interests were declared.

4. Items Raised by HealthWatch

No items were raised by HealthWatch.

5. Specialised Commissioning - East of England Overview

Jessamy Kinghorn, Head of Communications and Engagement for NHS England Specialised Services and Ruth Ashmore, Assistant Director of Specialised Commissioning, NHS England Midlands & East (East of England) presented the report that provided Members with an overview of the specialised commissioning function within NHS England and their current priorities for 2016/17.

Ruth Ashmore briefly detailed that there were 140 specialised services commissioned by 10 specialised commissioning teams across 4 regions with 6 national programmes of care being internal medicine, cancer, mental health, trauma, women and children and blood and infection. Ruth Ashmore stated that specialised services tend to be for rarer conditions and those that were more costly to treat and briefly explained the challenges for specialised commissioning.

The top 10 services and the emerging priority for 2016/17 were briefly detailed to Members.

Councillor Collins asked if there had been a sufficient rise in Paediatric Burns. Ruth Ashmore stated that the numbers were tiny and that suitable services were available either at Great Ormond Street or Birmingham Hospitals if patients could not be dealt with at Basildon Hospital.

Councillor Collins noted that there were a small number of HIV services. Ruth Ashmore stated that the cost of drugs was a major element to this and discussions around prevention would need to take place.

Councillor Collins stated his surprise to see Gender Reassignment Services on the NHS. Ruth Ashmore stated this service was available for adults and children but there were insufficient providers that had resulted in long waiting lists.

Councillor Snell asked for an update on the PET(CT) scanner. Ruth Ashmore stated that the engagement process had been completed at the end of May, which had been received extremely well with roadshows, public, clinician and patient surveys and group meetings taken place and a decision will hopefully be made in July 2016 with an implementation date of December 2016.

Councillor Fish asked what next steps were in place for the engagement of patients, especially those of a younger age. Ruth Ashmore stated that a clear programme had been set out in transforming care for people with learning disabilities and working alongside other national partners.

The Chair thanked Ruth Ashmore and Jessamy Kinghorn for attending the Health and Wellbeing Overview and Scrutiny Committee and for their interesting and informative presentation.

RESOLVED

That the Health and Wellbeing Overview and Scrutiny Committee noted the overview of the specialised commissioning function within NHS England and the current priorities for 2016/17.

Jessamy Kinghorn left the Committee Room at 7.34pm.

6. Public Health Grant

The Officer presented the report which outlined the recommended course of action to ensure that when further planned cuts were made to the Public Grant in 2017/18, the best opportunities to ensure the financial balance within the public health but at the same time fulfilling all the statutory functions and improving the health and wellbeing of the people of Thurrock were undertaken. The report stated that there will be significant opportunities to deliver savings by transforming and integrating services between Public Health, other departments of the Council and with the CCG. Members were asked to endorse the measures taken by Officers to address this further reduction.

The Officer briefly outlined Table 4 of the report which identified the Services and Programmes with 2016/17 programmed spends and savings.

Councillor Snell asked Officers if the spend on Tobacco Control was money well spent. The Officer confirmed that the service will be moving inwards a more preventative model with open access to the Stop Smoking Service and will target patients with early onset smoking related ill-health.

Councillor Collins asked Officers what challenges had arisen as part of the mandatory Sexual Health Services. The Officer stated that this was a national agreement and providers outside of the borough would charge Thurrock for services received by residents of Thurrock. Currently in dispute with London Providers for cross charging.

The Officer agreed to report back to Members on findings on what was the biggest spend between Family Planning and Sexual Health Services.

All members agreed that the education of smoking and sexual health at an early age would have a significant impact on savings.

The Officer stated that effective work was being undertaken on prevention programmes for obesity within adults and children and how this could be influenced wider into the community.

The Chair thanked the Officer for an interesting report and stated that the transition of services be undertaken smoothly so existing users were not affected or services disrupted.

RESOLVED

That the Health and Wellbeing Overview and Scrutiny Committee noted the contents of the report and endorsed the measures being taken to address the reduction in the Public Health Grant.

7. Cancer Deep Dive (Health Needs Assessment) in Thurrock

The Officer presented the report and explained to Members that this report had been produced as part of the core Public Health offer to the National Health Service (NHS) Thurrock Clinical Commissioning Group (CCG) in recognition of the poor local performance standards that no patient with cancer waits longer than 62 days from an initial referral by their general practitioner. The report considered all elements of the cancer care pathway, from prevention, screening and the referral process through to diagnosis, treatment and survival.

Councillor Watkins asked Officers what level of screening was taking place with younger children and how could these be expanded to a wider audience, for example football clubs and as part of health checks in the work place. The Officer confirmed that a variety of programmes were being undertaken on the prevention of smoking and obesity and that the message of how important check-ups were.

Mandy Ansell stated that cervical screening was available at the weekend hubs in Thurrock undertaken by specialised nurses.

Councillor Watkins asked how General Practitioners were being monitored on the referral of patients. Mandy Ansell stated that General Practitioners were managed by NHS England but CCG had a dedicated team who looked at the range of indicators on the referral process and that they support practices to ensure they were performing and to monitor patient feedback.

Councillor Collins asked Officers what the cause of patients being diagnosed within Thurrock that generally survived for shorter periods of time compared to other locations. The Officer confirmed there were a variety of reasons but deprivation and early diagnosis impacted on the survival rates.

Councillor Collins questioned Officers on how the care pathway operated as part of the process. Mandy Ansell stated that the pathways spanned a number of hospitals and if there are bottlenecks in tests, for example, delays will occur. A group of CCGs including Thurrock were working together to understand what was happening as a wider issue and to look at the bottle-necking which was currently caused by an issue with workforce and general capacity and ensure that a seamless pathway was a high priority.

Councillor Collins asked if there was currently an organiser who could monitor these pathways. Mandy Ansell said processes were in place with multi-disciplinary teams and that nurses were able to track process but again it was down to workforce capacity for this to be done efficiently.

Councillor Snell stated that it appeared that some General Practitioners were below targets on under referring patients with suspected cancer in the two week wait pathway and questioned if it was the same general practitioners every time. Mandy Ansell stated that support mechanisms were in place and support for general practitioners was available.

Councillor Halden, Cabinet Member for Education and Health, stated existing General Practitioners must be held to account if under performing and in some cases, the need to name and shame.

The Chair thanked the Officer for an important report and asked what the Members of the Health and Wellbeing Overview and Scrutiny Committee can do to ensure that recommendations were moving forward and being changed as appropriate. The Officer stated that Members should keep asking difficult questions and keep on the Officer's case for updates.

RESOLVED

1. **That the Health and Wellbeing Overview and Scrutiny Committee noted the contents of the report.**

2. **That the Health and Wellbeing Overview and Scrutiny Committee will support the work done by Public Health, CCG colleagues and other partners to improve cancer services and outcomes in Thurrock.**

3. **That Members agreed that a further report be brought back to Health and Wellbeing Overview and Scrutiny Committee in November 2016.**

8. Domiciliary Care

The Officer presented the report that informed Members about the current local and national domiciliary care situation and the effects that our current difficulties were having on service delivery in Thurrock. The report outlined the responses made by the Council to fulfil the Local Authority's duty of care under the Care Act 2014 and detailed the reasons of a new direction of travel in developing a new service model to delivery support to individuals in their own homes and to communities. The new model being developed will be known as Living Well @ Home.

The Officer briefly outlined the proposed redesigned model of support which will take place in South Ockendon as a pilot from the summer of 2016 and will focus on 75-80 people who currently receive some form of care and support.

The Officer recommended that this item be returned to the Health and Wellbeing Overview and Scrutiny in September 2016 and provide Members with a detailed proposal about how the new model of service would be developed once the contract was due to finish in 2017.

Councillor Watkins asked how this pilot would be measured for success. Officers confirmed that standard metrics would be produced and reported on but the main indicator for success would be the feedback from service users.

Councillor Fish asked what the reasons were for the pilot to be undertaken in South Ockendon. The Officer stated that decisions had been made to undertake the pilot in South Ockendon as the Community Hub was already in place there and that positive works that had already been carried out in South Ockendon. The Officer also confirmed that there were discrete areas and places within South Ockendon that provided the opportunity to focus specifically on the pilot.

Councillor Snell stated that he believed the community spirit had never been a problem but had got lost over time but was keen and passionate about helping to bring this back into the communities.

Ian Evans asked Officers what plans were in place to involve individual service users in the design of the form and template and what questions will be asked to support their needs. The Officers confirmed that service users will be involved in the engagement process and this will be undertaken through meetings and engagement groups.

RESOLVED

1. **That Members noted the current situation as regards to domiciliary care in Thurrock and the measures being taken by the department to stabilise the situation.**

2. **That Members agreed that a further report be brought back to Health and Wellbeing Overview and Scrutiny in September with a detailed proposal about how a new model of service will be developed when the contract finishes in 2017.**

9. Success Regime Progress Update

Wendy Smith, Interim Communications Lead, Mid and South Essex Success Regime presented the report and stated that this was an ongoing project currently in the discussion stage. This stage will involve more input from service users to look how health and care can become more local and ways of truly knowing what people need and delivering this on a one-two-one basis. Also to look to join up services such as primary care, general practitioner services, community care, social care and mental health. The vision of the success regime will become more articulate in the sustainability and transformation plan, a draft will be available by the end of June 2016. It was stated that Thurrock was already ahead of these developments.

Wendy Smith briefly explained the challenges ahead and the main areas for change. It was hoped to have a draft proposal of the success regime to present to the Health and Wellbeing Board in March 2017.

The Chair thanked Wendy for the complex and interesting presentation and asked Mandy Ansell for comments.

Mandy Ansell commented that it would be useful for Members to bring this down to how the Success Regime would affect Thurrock and referred members to the New Model of Integrated Out of Hospital Care slide which cuts to the very core of what was already been achieved in Thurrock.

Mandy Ansell stated that Thurrock CCG were the cutting age of the community out of hospital strategy and as such will be leading the frailty pathway.

It was important for Members to understand the integration agenda currently being worked on with Officers and their teams through the better care fund to deliver a much more integrated model of delivery.

Mandy Ansell emphasised that Thurrock CCG is the only CCG in Essex that achieved the reduction in unplanned care which was a target in the BFC last year and as such has been able to re-invest £800,000 back into the community service to further keep people out of hospital.

In the wider context, consultation on the out of hospital strategy which had been led by HealthWatch had been undertaken with the public. The proposed model for Tilbury and Purfleet will also be used for the Thurrock Community Hospital and the new build in Corringham by NELFT. To look at the integrated services in a wider sense through voluntary and council services to address the lack of general practitioner capacity and to allow general practitioners to do what they have to do and other services will be picked up by other health professionals or social care partners.

Councillor Snell stated his concern over the Success Regime and that every effort to ensure that the one size fits all approach was avoided and should be tailored for each authority.

Councillor Watkins asked Officers what work would be undertaken with those practices that were under performing. Mandy Ansell stated that changes in practice profile, providing new providers and the re-siting of practices will be the way forward and change has already been achieved since the challenges in Tilbury in the summer of 2015.

Councillor Snell stated his concerns on how overspends or underspends would be addressed.

Councillor Halden restated that the Success Regime item will continue to be monitored.

Roger Harris stated that he had concerns with the proposed big changes to programmes and there were potential risks, therefore the Health and Wellbeing Board and the Health and Wellbeing Overview and Scrutiny

Committee will be watching this item closely and will support locally to ensure that it does not distract from what was already in place.

The Chair stated close scrutiny would be undertaken by all Members of the committee on this item and requested that this item be returned to the Health and Wellbeing Overview and Scrutiny Committee for further update in September 2016.

Wendy Smith asked the Chair to formally write to her with Thurrock Health and Wellbeing Overview and Scrutiny Members concerns and comments. The Chair and Members agreed this will be done.

RESOLVED

1. **That the Health and Wellbeing Overview and Scrutiny Committee noted the progress update report.**

2. **That the Chair would formally write to Wendy Smith to support the comments made by Members.**

3. **That Members agreed that a further report be brought back to Health and Wellbeing Overview and Scrutiny Committee in November.**

Wendy Smith and Ruth Ashmore left the Committee Room at 9.00pm.

10. Work Programme

The Chair asked Members if there were any items to be added or discussed for the work programme for this municipal year.

RESOLVED

1. **It was noted that the item Domiciliary Care be added to the work programme for 15 September 2016 committee.**

2. **It was noted that the item Shaping the Council – Budget Update be removed from the work programme for 15 September 2016 committee.**

3. **It was noted that the item Success Regime be added to the work programme for 10 November 2016 committee.**

4. **It was noted that the Cancer Deep Dive be added to the work programme for 10 November 2016 committee.**

The meeting finished at 9.03 pm

Approved as a true and correct record

CHAIR

DATE

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15 September 2016	ITEM: 6
Health & Wellbeing Overview and Scrutiny Committee	
Positron Emission Tomography-Computed Tomography (PET CT) in South Essex: Further Review August 2016	
Wards and communities affected: The service serves all of South Essex, although options are available in bordering areas. It is used by on average 0.18% of the population in Thurrock.	**Key Decision:** -
Report of: Ruth Ashmore, Assistant Director for the East of England, NHS England Specialised Commissioning Team, Midlands and East of England	
Accountable Head of Service: Ruth Ashmore, Assistant Director for the East of England, NHS England Specialised Commissioning Team, Midlands and East of England	
Accountable Director: Catherine O'Connell, Regional Director, NHS England Specialised Commissioning Team, Midlands and East of England	
This report is PUBLIC	

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Positron Emission Tomography - Computed Tomography (PET-CT) in South Essex

Further Review August 2016

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Positron Emission Tomography-Computed Tomography (PET-CT) in South Essex

Further Review

Version number: 1.0

First published: 30/06/16

Updated: 01/09/2016

Prepared by: Ruth Ashmore, Jessamy Kinghorn, Jane Hubert.

Classification: OFFICIAL

The NHS Commissioning Board (NHS CB) was established on 1 October 2012 as an executive non-departmental public body. Since 1 April 2013, the NHS Commissioning Board has used the name NHS England for operational purposes.

Contents

1 Executive Summary

1.1 The preferred Option for the Site of a Fixed Scanner for South Essex

In October 2015 we published our report outlining the options for locating a static PET-CT scanner at either Basildon University Hospital or Southend University Hospital sites. At that time our preferred option was Southend.

When we shared our report with stakeholders, including the Essex Overview and Scrutiny Committees, a number of concerns were raised. As a result of these concerns, we committed to undertake some extensive additional engagement and to look more closely at the impact on access for patients and the clinical evidence supporting each option. This report provides:

- detail of the outcome of our engagement with patients, the public and clinicians;
- additional information on the numbers of patients affected by the proposals and the impact on travel times, using the most recent data;
- the outcome of a review by East of England Clinical Senate of the clinical case for change.

What did the Public and Clinicians Say?

Section 6 summarises the responses we received from our engagement with patients and the public. There were consistent views about what was important when considering where a service should be located, however the views from the public were split when asked about travelling to either location. Equal numbers of patients told us they would find travelling to Basildon or Southend easier, with some concerns raised around accessibility. Clinicians were concerned about access for patients, but also thought that locating the services with radiotherapy and chemotherapy services had some advantages.

What did our analysis of travel times and the numbers of patients affected tell us?

Very small numbers of cancer patients require PET-CT scans. Contracted activity for 2015/16 was for 1,346 scans and for 2016/17 is 1,429 scans. By the end of the contract, the activity is expected to have risen to 3,062 scans during 2024/25. The number of patients attending the service is smaller than the number of scans as some patients require more than one scan.

The expected number of scans that can be managed by a fixed site scanner is between 2,500 and 4,800 per year. In 2015/16, around 68% (915 of 1,346) of South Essex scans took place at the Basildon scanner. Of the South Essex population requiring a scan, 32% used an alternative PET-CT location. Of the patients who underwent a scan at Basildon, 53%

(485/915) were patients from a Clinical Commissioning Group (CCG) area closer to Basildon, with 47% (430/915) closer to Southend. Our contract anticipates that there will be an increase in demand for PET-CT of around 12% per year, with growth expected to reach 3,062 scans in 2024/25. However, growth is exceeding this prediction with the rate of growth currently over 30% which means a second scanner may be required before the end of the ten year contract.

Analysis of travel times shows that travel to either location by public transport can be long and complex. Relocating the service to Southend would mean a longer journey for patients living in CCG areas closer to Basildon, however there would be an advantage in terms of travel for patients living closer to Southend.

It is important to note that many patients from those CCG areas that are closer to Basildon already have to travel to Southend for other elements of their cancer care including radiotherapy and chemotherapy.

Our patient survey revealed that the most important issues for patients are how quickly they can be seen and choice of appointment dates and times. Travelling times ranked near the bottom of priorities, although clear information on directions was considered important. The public survey drew similar conclusions, although those not currently using the service did not rate choice of appointment time as highly.

What did the East of England Clinical Senate Say?

The panel thought that the commissioners had “provided clear evidence and background information both for and against the proposed siting.” They agreed that although the difference between the two options over the course of the ten year contract was relatively marginal, the mobilisation of the Southend University Hospital (SUH) scanner was the preferable option, assuming a single site was the only option in the near future. They gave the following reasons:

1. the different mobilisation timescales, with the lost capacity of at least two additional days for at least 12 months (with subsequent lost appointments for patients) if SUH was not mobilised;
2. the benefit for radiotherapy planning purposes of having a co-located PET-CT (for a subgroup of patients);
3. there appeared to be no overall significant difference in the impact on overall travel times between the two sites;
4. there would be no advantage or additional benefit in terms of scanner specification of a new purpose built scanner on the Basildon and Thurrock University Hospital (BTUH) site.

Conclusion

In considering the outcome of the engagement exercise, the additional analysis of patient numbers and travel time, and the recommendation of the Clinical Senate, we recognise that the decision is finely balanced between the two sites.

In making our decision on a preferred location, we have therefore taken into account that patient numbers are increasing at a greater rate than expected, and that moving to a fixed site scanner as soon as possible will provide the NHS with greater capacity, flexibility and ensure people are offered appropriate diagnostics as part of their pathway of care. This, together with the emerging direction of travel of the Essex Success Regime to concentrate cancer services in Southend, would make the co-location of the PET-CT scanner on the same site advantageous to both patients and clinicians, is the basis for our continued recommendation of Southend for the location of the fixed PET-CT service.

2 Purpose of the Report

The purpose of the report is to provide further information following the Clinical Case for Change undertaken by NHS England Midlands and East in October 2015, sharing with stakeholders the questions and further issues and information identified through public, clinical and stakeholder engagement.

This document should be read in conjunction with the Clinical Case for Change document, published in October 2015 - Appendix 1, the East of England Clinical Senate Review July 2016 - Appendix 2, and the Patient and Public Engagement Report - Appendix 3.

The publication of the Clinical Case for Change document and presentation to the Essex Health Overview and Scrutiny Committees (HOSCs) in autumn 2015 brought about a number of concerns from stakeholders regarding the preferred location for the long term.

Despite the Clinical Case for Change document detailing a proposed communication and engagement plan and process, concern was raised by both Essex and Thurrock Health Scrutiny Committees and local patient and clinical stakeholders that there had been insufficient involvement and engagement with both patients and clinical stakeholders regarding the proposed change.

As a result, NHS England, Midlands and East Specialised Commissioning Team has undertaken a public and clinical engagement exercise and wider review of pathways and services that interact with PET-CT to further inform the clinical case for change and impact for patients of the proposals. The results are provided in this report, along with the recommendation and review by the East of England Clinical Senate which took place in July 2016.

3 Background

Positron Emission Tomography – Computed Tomography (PET-CT) is a diagnostic service that is currently primarily used to diagnose and stage cancers. About 5% of PET-CT scans are carried out for non-cancer reasons.

PET-CT is commissioned nationally by NHS England supported by clinical leadership through a PET-CT National Clinical Reference Group. Standards for providing the service and indications for use are covered by a National Service Specification.

In February 2015, a new provider was awarded a ten year national contract for the provision of PET-CT scanning to the North, Midlands and East, South and South West of England – about 50% of all PET-CT scans currently undertaken in England. As a result of this contract, the PET-CT service in South Essex has been identified to benefit from increased capacity and improved facilities through moving from a mobile unit to a fixed facility.

Following the award, the new provider, Alliance Medical Ltd (AML) asked commissioners to review the location of the PET-CT facility in South Essex. The contract award made provision for the delivery of PET-CT scans through a mobile unit at Basildon Hospital until December 2016 when a fixed site permanent facility would be installed at Basildon Hospital.

The recommendation of the Clinical Case for Change exercise was that in terms of strategic fit, future proofing and co-location of services, Southend Hospital (SUH) is the preferred long term location for the PET-CT service in South Essex. This was further supported by expert advice and by the East of England Clinical Senate Review in July 2016.

NHS England Midlands and East sought advice on the need to conduct a formal consultation process regarding the proposed change with reference to the NHS England Planning, Assuring and Delivering Service Change for Patients policy (October 2015), and received assurance that the appropriate course of action was to undertake a period of engagement with stakeholders.

There are no increased financial implications to NHS England irrespective of where the permanent service is located.

4 Options

The original Case for Change looked at two options Table 1:

Options	
1.	Status Quo – continue the mobile scanner and move to the fixed scanner at BTUH which will take 12 months to mobilise.
2.	Move the PET CT service to SUH following local engagement with patients, clinicians and stakeholders to maximise the benefits of a static service, colocation with radiotherapy and the opportunity for earlier increased capacity.

Table 1: Options in the Case for Change July 2015.

The preferred options were shared with a wide range of stakeholders and generated a large number of questions.

The current PET-CT service in South Essex is provided through a mobile facility two or three times a week at Basildon and Thurrock University Hospitals NHS Foundation Trust (BTUH), although recently efforts have been made to secure additional attendances of the scanner to meet increased demand. Under the terms of the contract, the provider (AML) is required to provide a fixed site permanent facility at BTUH. Alternatively, as recommended by the Case for Change, PET-CT services could be provided through an existing modular build facility based at Southend University Hospital NHS Foundation Trust (SUH) which is owned by AML. The facility at SUH is a modular build specifically designed for PET-CT scanning that can be relocated if required.

A fixed site facility at BTUH would take between nine months and a year to become available. The originally anticipated commencement date was December 2016; should the outcome of the decision making process conclude that BTUH is the preferred option the original commencement date will be delayed due to the time taken to undertake the engagement process and clinical review. The fixed site facility at SUH would take less than 3 months to commission and become active.

5 Current Activity and Patient Flows

The specialised commissioning team has looked at the current and future demand for this service, where patients are coming from and their primary reason for the scan. As the primary reason for scans being requested is cancer we have looked at the projected growth in cancer for the population of the CCGs.

5.1 Where can we Expect Patients to come from?

Population Profile of South Essex

Current population figures for the six Clinical Commissioning Groups (CCGs) in South Essex that use the service have been considered, noting that the contract to provide PET-CT scanning to South Essex is in place for 10 years, until 2025.

	Population in thousands			
Area Name	2015	2025	Growth	Growth by %
Basildon and Brentwood	255	273	18	7
Castle Point, Rayleigh and Rochford	174	183	9	5
Mid Essex	387	415	28	7
Southend	178	192	14	8
Thurrock	164	182	17	10
West Essex	295	330	35	12

Table 2. Source: Office of National Statistics released August 2013

The data indicates that the highest growth area for the duration of the contract will be West Essex CCG whose patients access services outside the centres that come under the national contract, as well at the BTUH site. The next highest growth area is Thurrock CCG followed by Southend CCG. Mid Essex will remain the most highly populated area (Mid Essex CCG patients currently access PET-CT services at both BTUH and Colchester); the second highest populated area is, and will remain, Basildon and Brentwood.

This does not take into account the Thames Gateway Development (TGD) which is expected to realise growth in all areas in South Essex in population, commerce, industry, transport, infrastructure and housing. The information on time periods for these developments differs but will certainly be ongoing for the duration of the PET-CT contract. The TGD could be expected to realise a growth of 45,000 homes and 52,000 jobs to South Essex. *Source: South East LEP growth deal and strategic economic plan. 2014*

PET-CT activity in NHS England has a projected growth rate of approximately 12% per annum; this is incorporated into the contract with the provider. Given the contract is currently over-performing, in time a further increase in capacity of PET-CT to South Essex may be required to accommodate growing demand. Commissioners will keep demand under review and commission additional capacity as required.

5.2 Cancer Diagnosis and Treatment Pathways for South Essex

PET-CT is used predominantly in the diagnosis, and staging of cancer to assist in determining treatment pathways for the patient.

The predominant users of the PET-CT scanner at the BTUH site are from Basildon and Brentwood, Castle Point, Rayleigh and Rochford, Mid Essex, Southend, and Thurrock CCGs. For the year 2013, the following numbers of new cancers were diagnosed in the five South Essex CCGs.

CCG Population	Cancer Diagnosis 2013	Per 100,000 Population
Basildon and Brentwood	1329	579
Castle Point, Rayleigh and Rochford	1018	544
Mid Essex	2053	559
Southend	957	582
Thurrock	737	625

Table 3. Data Source: Public Health England's National Cancer Intelligence Network and Macmillan Cancer Support

The highest number of new cancers diagnosed in South Essex in 2013 was from Mid Essex CCG followed by Basildon and Brentwood CCG. The highest number per 100,000 population was from Thurrock CCG followed by Southend CCG. A snapshot of actual PET-CT scan data between Aug 2015 and Jan 2016 shows that 157 patients attended the BTUH site for a PET-CT scan from Thurrock CCG with 146 from Southend CCG during the same time period.

A change in location of the PET-CT service will not affect cancer diagnosis in South Essex or change the clinical indications for a PET-CT scan.

Patients will still be referred to their local hospital for suspected cancer within two weeks of their GP appointment. A number of diagnostic options are available to hospital consultants, including PET-CT for appropriate patients (it is not the appropriate option for all patients). Following their PET-CT scan and diagnosis, they would then be referred for treatment at their local hospital or to a specialist cancer or surgical service if needed.

For lung cancer patients, other than those requiring PET-CT and for surgery, diagnostic and other elements of care for lung cancer are provided by all of the hospitals in South Essex. More patients are diagnosed with lung cancer at Southend Hospital, but Basildon is the specialist centre for lung cancer patients requiring surgery and treats approximately 12% of Southend's lung cancer patients. A move of service would impact on surgical patients should they require further PET-CT scans.

Cancer diagnosis data obtained from “cancerstats” for 2015 shows cancer diagnosis for BTUH and SUH below, indicating that more cancer diagnosis is undertaken by SUH. This suggests that SUH is supporting more cancer patients. As BTUH is the lead hospital for lung cancer surgery in Essex, around 12% of Southend’s lung cancer patients are transferred to BTUH for surgery, after their diagnosis. Southend provides radiotherapy services for South Essex and there are no plans to move or increase radiotherapy provision in the near future.

CANCER	BTUH	SUH
Lung	321	349
Haematology	122	121
Head & Neck	36	85
Colorectal	240	318
Upper GI (oesophagogastic)	81	141
Total	**800**	**1014**

Table 4: Source Cancer Diagnosis by Trust 2015.

5.3 PET-CT Activity

Contracted activity for 2013/14 was for 930 scans at the Basildon mobile scanner, with the actual number for the year at 986, an over-performance of 6%. Contracted activity for 2014/15 was for 1,096 scans, with the actual number at 1,196, an over-performance of 9%. Contracted activity for 2015/16 was for 1,346 scans and for 2016/17 is 1,429 scans.

By the end of the contract, the activity is expected to have risen to 3,062 scans during 2024/25. The number of patients attending the service is smaller than the number of scans as some patients require more than one scan.

The expected number of scans that can be managed by a fixed site scanner is between 2,500 and 4,800 per year.

In 2015/16, around 68% (915 of 1,346) of South Essex scans took place at the Basildon scanner. Of the South Essex population requiring a scan, 32% used an alternative PET-CT location. Of the patients who underwent a scan at Basildon, 53% (485/915) were patients from a Clinical Commissioning Group (CCG) area closer to Basildon, with 47% (430/915) closer to Southend.

Our contract anticipates that there will be an increase in demand for PET-CT of around 12% per year, with growth expected to reach 3,062 scans in 2024/25. However, growth is exceeding this prediction with the rate of growth currently over 30% which means a second scanner may be required before the end of the ten year contract. The table below gives a detailed snapshot of data from August 2015 to January 2016.

Total scans undertaken Basildon site for the period Aug 15 – Jan 16	South Essex Scans undertaken Non Basildon site for the period. Aug 15 – Jan 16	Total
832	379	1211

CCG	Total	Basildon	Non Basildon
NHS Basildon and Brentwood CCG	225	219	6
NHS Thurrock	164	157	1
NHS Southend CCG	149	146	3
NHS Castle Point and Rochford CCG	156	149	7
NHS Mid Essex CCG	206	100	106
NHS West Essex CCG	92	49	43
NHS North East Essex CCG	219	6	213
Totals	1211	663	379

Table 5: PET –CT Contract Monitoring

The South Essex PET-CT service is used most commonly in the diagnosis of lung cancer, followed by lymphoma. This is consistent with the rest of the country. Those patients going on to require lung cancer surgery are treated at BTUH, with most currently receiving chemotherapy at Southend and smaller numbers requiring radiotherapy also receiving that element of their care at Southend. A snapshot of scan activity by cancer diagnosis is below.

Totals Aug 15 – Jan 16. Basildon Site	Lung	Lymph	H&N	Upper GI	Colorectal
NHS Basildon and Brentwood CCG	102	58	4	16	5
NHS Castle Point and Rochford CCG	71	28	0	12	10
NHS Mid Essex CCG	45	18	3	9	9
NHS North East Essex CCG	1	1	1	1	0
NHS Southend CCG	61	36	7	9	10
NHS Thurrock CCG	81	49	10	12	11
NHS West Essex CCG	4	23	6	5	11
Total	**365**	**213**	**31**	**64**	**56**
Totals Aug 15 – Jan 16. Total Contract	**Lung**	**Lymph**	**H&N**	**Upper GI**	**Colorectal**
NHS Basildon and Brentwood CCG	104	61	4	16	5
NHS Castle Point and Rochford CCG	72	29	0	13	11
NHS Mid Essex CCG	86	41	6	21	19
NHS North East Essex CCG	85	52	16	26	19
NHS Southend CCG	62	37	8	9	11
NHS Thurrock CCG	81	50	10	12	11
NHS West Essex CCG	8	35	11	11	13
Total	**498**	**305**	**55**	**108**	**89**

Table 6. PET CT Activity by Tumour Site (H&N – Head and Neck)

5.4 Population Use

Very small numbers of people have a PET-CT scan. Some may require more than one scan during their treatment. The following percentages apply in terms of the numbers of people having a PET-CT scan in relation to the whole CCG populations.

CCG	% Pop
NHS Basildon and Brentwood CCG	0.16
NHS Thurrock CCG	0.18
NHS Castle Point and Rochford CCG	0.16
NHS Southend CCG	0.14
NHS Mid Essex CCG	0.05
NHS West Essex CCG	0.03

Table 7.

A change in location would affect on average approximately 0.17% of the total population of around 1.4 million.

6 Patient and Public Engagement

NHS England, Midlands and East have undertaken further analysis of local factors including patient pathways and flow, travel and patient, clinician and user views. These are contained within Appendix 2 and summarised below.

6.1 Patient and Public Involvement Executive Summary

What did the community say?

The engagement process was carried out over a period of just over four months from January 2016 to mid-May 2016.

A wide range of stakeholders was engaged which included patients using the service, the public, members of community and patient groups, clinical referrers, clinical reporters, medical directors and other key stakeholders i.e. Councillors and Healthwatch.

To give as many people as possible the opportunity to respond, a wide range of communication channels were used which included surveys developed specifically for patients who use the service, and for the public and clinicians. 268 responses were received from the three surveys. Alongside the surveys a wide range of face-to-face activity was held which included a series of roadshows and meetings with community groups, patient groups and clinicians. Views were also provided through letters, emails and by telephone. A detailed feedback report is attached at Appendix 3.

6.2 A summary of the feedback

Patients: there were 40 responses to the patient survey and over half of these were from either Southend or the immediate surrounding area. The key points that were raised included:

- There was a mixed response to whether their journey would be more difficult if the scanner was at Southend. Some felt it would be easier; however others felt it would be more difficult because of travel time, congestion and parking.
- The factors most important to patients (in order of priority) when choosing where they are treated were:
    - To be seen quickly;
    - Difference it might make on the outcome of their treatment; and
    - How good car parking is.
- The factors that were most important when asked where the services are located were:
    - Should put the scanner on the site where there is the larger amount of inpatients; and
    - Put on the site with other services the scanner needs to work with.
- Equal numbers of patients said the journey to Southend would either be easier or more difficult (exactly 50% for each). Of those who explained why they held that view, the majority thought Basildon Hospital was more accessible.

The public: there were 209 responses to the general survey and half of these responses were from people who lived nearer Southend. Over half said that either they or a relative had undergone a scan but some were not sure what type of scan they had. The key points that were raised through this survey included:

- The factors most important to the public when choosing where they are treated in order of preference included:
    - How quickly they can be seen (over half the responses – 138);
    - The difference it might make on the outcome of the treatment; and
    - Being treated in the same place as other treatments.
- The factors most important when asked where the services should be located are:
    - The scanner should be put on the site near to other services it needs to work with now;
    - The scanner should be put on the site near to other services it needs to work with in the future; and
    - Where the largest number of inpatients who use the service are.
- The key themes that were raised in the general feedback included:
    - Travel and parking was a key issue;
    - Some concern around lower income families having to travel to Southend if the scanner was moved;
    - It should be put in the same place as specialist clinicians (cancer centres);

- People wanted it in the hospital that has the best outcomes;
- The decision makers should listen to clinicians when making their final decision about the location.

Face to face roadshows and community/patient group meetings: A series of roadshows were held across South Essex and over 35 community/patient groups were given the opportunity to meet face to face with the engagement team to give their feedback. In addition to the roadshows there was attendance at four patient group meetings. In the main attendees completed the survey and where views were given there was no clear consensus of opinion. However some of the key themes were:

- Concern that the scanner at Southend should be put to use as soon as possible;
- People should have access to a local service and that travel and access for patients should not change or become more difficult;
- That the decision should be made on the immediate use of the service not the future;
- Speed of access to aid diagnosis was important, no changes should be made that slow access or change the speed of diagnosis;
- Strong concern from one member of the public who attended some meetings and put forward their concerns in writing that the recommendation for the use of PET-CT for radiotherapy planning was invalid, unfounded and outside the current service requirement and therefore co-location with radiotherapy is not required.

Clinicians Survey: There were 19 responses to the Clinicians survey and the majority were from Clinicians based at Basildon Hospital. The following key themes were raised:

- Concern that moving the service would impact on the lung cancer pathway;
- Travel, access and location of Basildon more central and easier for patients to travel to;
- Concerns about the delay in the pathway should the service move.

Face to face meetings with Clinicians: One meeting was held with GPs from the Mid Essex Primary Care Forum and the further three with Clinicians from Basildon, Mid Essex and Southend. The key points that were raised:

- Three of the four meetings felt that co-location of the scanner with radiotherapy planning would be an advantage;
- Important that there is access to a fixed site scanner as soon as possible;
- Both Basildon and Southend would prefer the location to be locally based and see advantages to it being on site; Basildon clinicians felt particularly strongly about benefits of co-location with their lung surgery and lymphoma services, whilst Southend clinicians felt that they also provide lung cancer services that don't require surgery and that a number of patients already have to travel for elements of cancer care that are only provided at Southend;

- Concern that the decision had become political rather than based on clinical outcomes;
- There should be some alignment with the Success Regime however recognition of different timescales.

6.3 Travel and Access

As noted in the Clinical Case for Change commissioners and clinical experts agree that consideration needs to be given to population access to the service. The scanner should be sited where local people will not be disadvantaged and where optimum access for most patients would be served.

Geography

Clearly, the time taken to travel to either location will differ depending on exactly where in a CCG area the patient lives. However, for the purposes of this analysis, we have used the CCG office locations as a starting geography. In terms of the distance in miles, the following applies:

CCG	Scans Aug 15 – Jan 16	Closest Location
NHS Basildon and Brentwood CCG	219	BTUH
NHS Thurrock	157	BTUH
NHS Southend CCG	146	SUH
NHS Castle Point and Rochford CCG	149	SUH
NHS Mid Essex CCG	100	SUH
NHS West Essex CCG	49	BTUH

Table 8.

Based on the snapshot above, if the location of the service were to change from BTUH to SUH, approximately 30 people undergoing a scan out of a total number of 663 scans undertaken between August 2015 and January 2016, i.e. 5% would have needed to travel further in distance.

For the full year, 53% (485) of patients attending are from a CCG closest to BTUH and 47% (430) from a CCG closet to SUH, which would mean 46 people undergoing a scan would need to travel further in distance.

Travel by car

These results apply when looking at travel times by car to either site, although travel to either site may be affected by traffic density at the time of travel.

Public Transport

Public transport services in Essex are complex. Some residents are best served by both bus and train depending upon where they are travelling from.

- **Train Travel**

BTUH is a 21 minute walk from the nearest train station or a 13 minute journey by bus. SUH is served by Southend Victoria and Southend Central train stations both of which are a 9 -16 minute bus journey to the hospital and a walk of 17 minutes from Southend Victoria or 23 minutes from Southend Central.

Therefore there is minimal difference in accessing either hospital from local train stations.

- **Bus Travel**

Analysis of travelling times by bus was completed at three separate times: 11:30 on a Monday morning, 9am on a Wednesday morning and 3pm on a Thursday afternoon. The six CCG offices were used as starting points to enable consistent analysis.

The results (available at appendix 4), show that a change in location of the scanner would have some impact on patients travelling from the BTUH area if travelling by bus, however in this context, bus travel, irrespective of location of the service or time of the day, is often lengthy and difficult particularly for those in poor health.

Approximately 5% of PET-CT patients told us they travel by bus (according to our patient survey), 0.006% of the total population or around 71 patients (based on contracted activity for 2016/17, although the increased demand we have seen so far this year could mean this number rises to around 92 patients if the trend continues).

Consequently, at the slowest time of day for travelling to Southend, 0.0038% of the local population (approximately 53 people each year) would be affected by longer travelling times if the service were to move. Conversely, 0.0032% (approximately 45 people per year) would benefit from shorter travelling times.

6.4 Consistency with current and prospective need for patient choice

Current services in South Essex

PET-CT is predominately used to assist in the diagnosis and staging of cancer. There is no single hospital in Essex that has been designated as a cancer centre, with each hospital taking the lead for a different cancer. BTUH is the lead for lung cancer surgery, Mid Essex Hospital NHS Foundation Trust (MEHT) the lead for head and neck cancer and upper GI cancer surgery, SUH and Colchester Hospital University NHS Foundation Trust provide radiotherapy. Lymphoma is treated locally for level 1/2a services (Level 1 only at MEHT),

and level 2b and 3 are referred on to London Hospitals, although this may change with the development of haematological services at BTUH from MEHT. Colorectal surgery is treated locally with the exception of anal cancer which is referred to Addenbrooke's in Cambridge or to London.

In the East of England, Essex is the only area not to have a designated cancer centre and the South Essex service is the only PET-CT service that is not co-located with radiotherapy services.

Currently patients who require a PET-CT scan are offered a number of sites for appointments. In addition to the service at BTUH there is also provision to Essex at Colchester Hospital University NHS Trust and elsewhere in the East of England through the same contract at Cambridge University Hospitals NHS Foundation Trust and Norfolk and Norwich University Hospital NHS Foundation Trust, as well as London options. A change to the location of the PET-CT service in South Essex will not change the opportunity for patients to access PET-CT or alter existing clinical pathways of care.

7 Clear, Clinical Evidence base

A Clinical Case for Change was initiated by NHS England Midlands and East Specialised Commissioning Team. In building the case for change advice was sought from, among others, the Royal College of Radiologists and its Clinical Oncology Subcommittee for Nuclear Medicine, the Institute of Physics and Engineering in Medicine, key clinical leads and from expert patients. All clinical experts agreed that a fixed site scanner was preferable over a mobile PET-CT service and that co-location with radiotherapy would be desirable for the future. For the purpose of this report these are summarised in the Case for Change October 2015 and the Clinical Senate Report of August 2016.

7.1 The East of England Clinical Senate Review

At the request of the specialised commissioning team the East of England Clinical Senate reviewed the Clinical Case for Change. It was agreed that the role of clinical senate was not to endorse, or otherwise, the proposal to site PET-CT services for South Essex from SUH, but to consider whether the proposals have "the potential to deliver real benefits to patients. The panel should also identify any significant risks to patient care in these proposals".

The East of England Clinical Senate considered this question on the 21st July 2016, reviewing all available evidence, including responses received through the engagement exercise from clinicians and Basildon and Southend, other stakeholders and interested parties, and members of the public as well as presentations from a two-day international PET-CT event. The panel's recommendations were ratified by the full Senate Council on the

16th August 2016. The full report can be found at Appendix 2. This was received by the specialised commissioning team on the 16th August 2016.

The panel agreed that although the difference between the two options over the course of the 10 year contract was relatively marginal, the mobilisation of the SUH scanner was the preferable option, assuming a single site was the only option in the near future, for the following reasons:

1. the different mobilisation timescales, with the lost capacity of at least two additional days for at least 12 months (with subsequent lost appointments for patients) if SUH was not mobilised;
2. the benefit for radiotherapy planning purposes of having a co-located PET-CT (for a subgroup of patients);
3. there appeared to be no overall significant difference in the impact on overall travel times between the two sites; and
4. there would be no advantage or additional benefit in terms of scanner specification of a new purpose build scanner on the BTUH site.

The Senate has also suggested that the fixed site scanner would increase the ability for patients to be entered into research trials which could improve outcomes.

It also made three recommendations which we will take into consideration when we are planning the move.

ARSAC

PET-CT requires the oversight and support of an approved Administration of Radioactive Substances Committee (ARSAC) certificate holder. Certificates are held by two consultant radiologists in South Essex, one based at BTUH and one based at SUH. A change in the location of the service will still require an ARSAC certificate holder and can be accommodated by the accredited radiologist based at SUH. Referral processes and arrangements for patients would not alter if the location of the service were changed.

Radiotherapy

PET-CT is directly commissioned by NHS England. A change in location of the PET-CT scanner in South Essex has no bearing on current or future commissioning of radiotherapy. The Clinical Case for Change exercise identified that a change of location of the scanner to SUH could extend its use into radiotherapy planning. Clinical advice sought for the Case of Change noted that the co-location of PET-CT with radiotherapy services would be an advantage to allow radiotherapy planning using PET-CT, in line with the recommendation of the national cancer strategy, although not yet widely available. SUH provides radiotherapy in South Essex as noted on the following page:

By CCG	Radical	Palliative	Total
Basildon and Brentwood	277	159	436
Barking and Dagenham	1	0	1
Castle Point and Rochford	213	151	364
Havering	5	1	6
Horsham and Mid Sussex	0	1	1
Ipswich	1	1	2
Kent	1	3	4
Mid Essex	21	17	38
Northumberland	1	0	1
Southend	151	140	291
Southwark	0	1	1
Thurrock	172	124	296
Total	**843**	**598**	**1441**

Table 9

The highest users of both radical and palliative radiotherapy delivered at SUH in 2015 were Basildon and Brentwood and Castle Point and Rochford CCGs. Basildon and Brentwood CCG is more closely located to BTUH. The data indicates that more patients from the BTUH area are already travelling to SUH to access radiotherapy than patients from the SUH area; however there is no prospect of radiotherapy moving or provision increasing. Data is not yet collected to indicate the numbers of patients who have a PET-CT scan that progress onto radiotherapy, or to show those patients that have a PET- CT scan but do not undergo radiotherapy as part of their treatment pathway.

Radiotherapy planning

The Clinical Case for Change exercise identified that there is an increasing role for PET-CT for radiotherapy planning, particularly for head and neck cancer, lung tumours, lymphoma, gastrointestinal tract tumours, brain tumours and gynaecological malignancy. Radiotherapy planning is currently conducted using CT scanning and is commissioned as part of the radiotherapy pathway of care. Radiotherapy Planning using PET-CT is not currently commissioned although it is being reviewed by NHS England and expert advice suggests that this will become the norm as part of future developments in cancer care. PET-CT is a standalone service that could be sited anywhere and reported remotely. However, PET-CT in radiotherapy planning requires the attendance of a radiotherapy team and could only realistically and safely be delivered if co-located. Failure to co-locate PET-CT with the radiotherapy services means it would be difficult to implement a fully integrated PET-CT planning function and may become a non-viable option that is unlikely to be used.

Chemotherapy

Advice gained for the Clinical Case for Change exercise noted that, wherever possible, scans should take place in a facility close to other cancer diagnostic and treatment services. Chemotherapy plays an important part of the care pathway for some cancer patients. Data relating to patients seen by a specialist under the 31 and 62 day drug treatments monitoring, obtained from the Strategic Clinical Network – Cancer, for the calendar year 2015, indicates that SUH is the main provider of chemotherapy care in South Essex.

Hospital	31 days. Patients	62 days. Patients	Total
BTUH	279	264	543
SUH	622	358	980

Table 10

The numbers of patients experiencing chemotherapy at BTUH may expand due to plans to centralise some haematology services at BTUH from MEHT, but is unlikely to overtake the numbers at SUH. MEHT is expected to retain some chemotherapy provision. In terms of PET-CT this relates to those patients suffering from lymphoma who often experience more than one and up to four PET-CT scans. Currently patients access PET-CT at either Colchester or BTUH. Should the location change to SUH, patients will access PET-CT at either Colchester or SUH. Chemotherapy for these patients will be delivered either at BTUH, MEHT, Colchester or Southend.

Current clinical pathways of care do not allow for the PET-CT to be conducted on the same day as the chemotherapy. PET-CT is used in the diagnosis and staging of haematological cancers and follow up scans are undertaken to monitor treatment response to chemotherapy. A change in location of the PET-CT scanner would not change pathways of care but mean that patients would travel to SUH for the scan and where relevant to BTUH for chemotherapy.

Lung Cancer

Lung cancer was raised as a key issue, with concerns about fragmenting the pathway from diagnosis to treatment. Currently the largest use of PET-CT for cancer diagnosis is for lung cancer patients. A PET-CT scan is one element of the patient pathway and occurs relatively early in the diagnostic journey. Improving access to early diagnosis is a priority for NHS England in improving long term outcomes for patients.

Lung cancer diagnosis and treatment is currently provided at both Basildon and Southend hospitals, with Basildon providing the specialist surgical element where it is required and Southend providing radiotherapy and chemotherapy elements where required. Data on patient numbers is not matched to PET-CT scans at this time so access to precise information on numbers is not currently available. Southend diagnoses larger numbers of

lung cancer, of which approximately 12% require surgery at Basildon. The percentage of lung cancer patients at Basildon requiring surgery is expected to be higher.

The Clinical Senate advised that overall, the percentage of patients having PET-CT who would go on to receive radiotherapy was currently in the order of 30-35% but would almost certainly change as treatment protocols develop. Patients are required to attend hospital for radiotherapy more frequently than for surgery.

Chemotherapy use is higher than radiotherapy, and whilst Basildon is developing future chemotherapy capacity, Southend will remain the larger provider of chemotherapy services for the South Essex population.

In-patients
The provider does not separate data on outpatient and inpatient PET-CT attendances so precise numbers have been difficult to obtain. However, Clinical Senate Panel members agreed that in their experience this was likely to be a small percentage and should not be a relevant factor in determining the option chosen.

Non-Cancer
Currently PET-CT for non-cancer applications is approximately 5% of the total scans undertaken in England. Those non cancer indications include vascular disease, pyrexia of unknown origin, cardiac perfusion and neurological conditions. It is not expected that the use of PET-CT in these areas will increase significantly. Possible exceptions to that in the future are its use in neurological conditions such as Alzheimer's dementia and cardiac perfusion. This is not currently commissioned by NHS England.

7.2 Support for proposals from commissioners

NHS England, Midlands and East Commission PET-CT in South Essex and conducted the Clinical Case for Change in October 2015, which recommended that the permanent PET-CT service be provided at SUH.

Views from local commissioners have been sought and identified that the decision is equally poised with the recognition that either site would support the pathway of care.

The Essex Success Regime aims to help create the conditions for success in challenged areas. Its purpose will be to protect and promote services for patients in local health and care systems that are struggling with financial or quality problems and seek rapid improvement against agreed quality, performance and financial metrics. Essex has been selected as one area to take part in the Success Regime. The Success Regime will see all partners working together across South Essex.

The Success Regime has come into being since the original PET-CT case for change was prepared and it is important to ensure that plans for PET-CT fit within the emerging direction of travel for the Regime.

It is expected that there will be key service changes across the health sector in South Essex, including acute services, as part of the work of the Regime. The detail of these proposals identified to date is that cancer services in South Essex will be led by SUH which is being considered a fixed point for radiotherapy and cancer specialisms in the current discussion about configuration.

8 Summary

- A permanent PET-CT scanner will be provided by NHS England in South Essex irrespective of the location.
- There are no financial implications or considerations for NHS England in regards to the permanent location of the PET-CT scanner and no additional funding is required.
- A period of thorough clinical, patient and public engagement has occurred since the publication of the Clinical Case for Change document in October 2015, and concluded in May 2016.
- Differing views on the preferred location of the permanent PET-CT scanner have been expressed by a range of stakeholders with no clear preferred option from the whole clinical or patient/user population identified.
- Further analysis has been undertaken of the factors noted as important to stakeholders during the process, these have included concerns such as travel, access, co-location with other key services, expected population changes, timeliness of service, the opportunity to have a view, and possible long term developments of the use of PET-CT both nationally and locally, with reference to the recommendations made in the Clinical Case for Change document, and seeking expert clinical advice, during the process.
- A change to the location of the PET-CT scanner in South Essex will not alter other aspects of clinical services for cancer or other disease, or clinical pathways of care.
- A key advantage as highlighted in the Clinical Case for Change is the opportunity to realise increased capacity, access and choice in appointments more quickly through the facility at SUH.
- A secondary advantage of locating the service at SUH remains the opportunity to fully utilise PET-CT in radiotherapy planning, an opportunity that at best could be only partially utilised if the service were to remain at BTUH, due to the complex technical requirements and expertise required to conduct full radiotherapy planning using PET-CT.
- The Clinical Case for Change document recommended due to strategic fit, future proofing and co-location of services, SUH is the preferred location for the permanent PET-CT service. Radiotherapy and Oncology co-location provide strong reasons for

providing the service from SUH. The direction of travel of the Essex Success Regime and findings of the Clinical Senate reinforce that view.

- It considered the advantages for providing the service at BTUH relating to the volume of lung and lymphoma patients who currently receive treatment at BTUH but noted there are also large numbers of lung cancer patients at Southend (it is specialised surgery that is performed at Basildon) and a number of these patients already travel to SUH for radiotherapy.
- These considerations were supported by the Clinical Senate Review who on balance, subject to some recommendations, agreed with the decision.

9 Conclusion

The process and analysis undertaken during the engagement process has been valuable in gaining further information, data and views in the consideration of the best permanent location for the PET-CT service in South Essex.

The view of NHS England, Midlands and East, as expressed in the Clinical Case for Change document (October 2015) that the preferred long term permanent location for the PET-CT service in South Essex is SUH, has not been altered by information received during the process and is unchanged. However we will take note of the recommendations of the Clinical Senate in the mobilisation of the fixed site scanner at SUH, and the views of the Senate and local people in doing what we can to mitigate any adverse impact for patients.

10 Mitigation

In reaching this conclusion, it is acknowledged that there would be an impact on some patients. Whilst the numbers form a very small proportion of the local population, NHS England recognises the need to mitigate this impact and proposes the following:

- Regularly review growth assumptions and commit to any further future expansion of the service (mobile or fixed) being undertaken at Basildon Hospital;
- Develop a robust plan for the transition and clear information for patients, including travel, car parking, public transport and information on assistance with travel costs and qualification for hospital transport if necessary;
- Undertake a more comprehensive Equality Impact Assessment with respect to patients with a Learning Disability and those with mobility issues, and provide information or assistance as is considered appropriate;
- Instruct the provider to establish a patient information group to review information and ensure patients are given adequate support;
- Monitor the impact of travel and access through patient surveys;

- Require the provider to offer a selection of appointment times to ensure those traveling furthest can avoid busy times of day;
- Undertake a piece of work to look at offering multi-clinic appointments;
- Research and develop a case to become a test site for PET-CT in radiotherapy planning.

11 Next Steps

Date	Action
15th September 2016	Further engagement with Essex, Southend and Thurrock HOSCs
20th September 2016	Regional Executive requested to endorse the decision to site the permanent PET-CT service at SUH.
September 2016	Provider formally advised of decision and mobilisation plan agreed with firm timelines for delivery.
September 2016	All stakeholders formally advised of decision mitigating actions agreed with all stakeholders.
October – December 2016	Mobilisation of Scanner Provider commence commissioning of facility at SUH;
December 2016	Go live of service at SUH

12 Recommendations

Health Overview and Scrutiny Committees are asked to:

1. Note the further work that has been done since the Clinical Case for Change was presented.
2. Note the conclusions of the East of England Clinical Senate and subsequently of the NHS England regional specialised commissioning team.
3. Comment on the patient and public engagement carried out as part of this exercise.
4. Advise on any considerations or factors NHS England should consider before making a final recommendation to the Regional Executive, particularly in relation to implementation and mitigating actions.

13 Appendices

1. Clinical Case for Change October 2015
2. East of England Clinical Senate Review August 2016
3. Analysis of Patient Engagement Activity June 2016
4. Patient Travel by Bus Analysis June 2016

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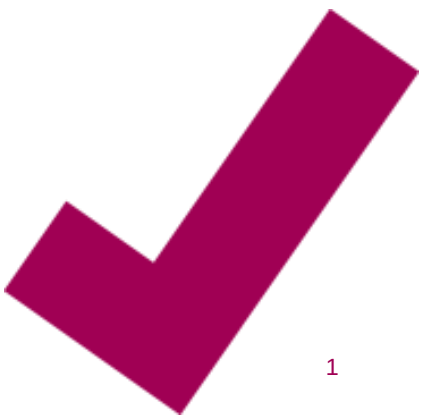
Positron Emission Tomography- Computed Tomography (PET-CT) in South Essex

The Clinical Case for Change

September 2015



Positron Emission Tomography- Computed Tomography (PET-CT) in South Essex the Clinical Case for Change

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Contents

1 Introduction

Positron Emission Tomography – Computed Tomography (PET-CT) is a diagnostic service that is currently primarily used to help diagnose cancers. About 5% of PET-CT scans are carried out for non-cancer reasons. Both the national cancer strategy (Achieving World-Class Cancer Outcomes, A Strategy for England 2015-2020, July 2015) and NHS England Specialised Services 5 year strategy note that there is a need to use PET-CT in radiotherapy planning. PET-CT is commissioned nationally by NHS England supported by strong clinical leadership through a dedicated PET-CT National Clinical Reference Group.

In February 2015, a new provider was awarded a ten year national contract for the provision of PET-CT scanning to the North, Midlands and East, South and South West of England – about 50% of all PET-CT scans undertaken in England.

Amongst other benefits, the contract includes increased investment to install new scanners and improve the current infrastructure, increased access to services and a commitment to move away from mobile PET-CT scanning services towards fixed sites.

As a result of this contract, the PET-CT service in South Essex has been identified to benefit from increased capacity and improved facilities through moving from a two-day per week mobile unit to a fixed facility that will function five days per week. The new provider has asked commissioners to review the location of this unit.

Two clear options have emerged: siting the unit at Basildon and Thurrock University Hospitals NHS Foundation Trust (BTUH), or at Southend University Hospitals NHS Foundation Trust (SUH).

There is currently a fixed scanner in a purpose built facility at SUH that is not being used. If we do not make this decision now, there are other parts of the country that need additional PET-CT capacity and we have been asked to move the unused scanner so that cancer patients elsewhere in England can benefit. If the long term decision is BTUH, the timetable will be the same as the BTUH option in this paper but if the long term decision is then SUH, South Essex patients would have missed out on 12 months of additional capacity to diagnose cancer sooner.

The purpose of the report is to seek the support of the Health Overview and Scrutiny Committees in Essex, specifically for:

- The recommended option for the location of the fixed unit and timetable for implementation.
- NHS England's plans to engage patients, local people and other stakeholders.

This report only deals with the PET-CT diagnostic component of the patient pathway for those who have a suspected cancer, not the whole pathway which is commissioned separately by local Clinical Commissioning Groups.

2 Background

2.1 What is PET- CT?

PET-CT is a diagnostic service that primarily provides scans to help diagnose cancers. A small amount of a radioactive tracer is normally injected into a patient's vein. The most commonly used radioactive tracer is a radioactive form of glucose called Fluorodeoxyglucose. The scan then shows how the body breaks down and uses glucose. Cancer cells use glucose differently and this will show up on the scan. The PET-CT technique also uses X-rays to produce images of the body.

Approximately 70,000 PET-CT scans are carried out in England each year. More than 95% of these are for cancer patients, but as new radioactive isotope tracers are developed it is anticipated this technique will have an increasing role in other conditions.

PET-CT is one of the most powerful imaging tools available to clinicians today in the diagnosis and staging of cancer. It also has an increasingly important role in radiotherapy planning. Its use in early diagnosis and treatment is known to have a positive impact on clinical outcomes for cancer patients.

There has been a steady increase in the requirement for PET-CT over the last decade which has resulted in the need to commission additional capacity. A significant amount of current capacity is provided from mobile scanners whilst clinicians now recommend that wherever possible, scans should take place in a static facility and should be close to other cancer diagnostic and treatment services.

The services are delivered by a variety of providers including NHS trusts, the independent sector, research institutes and charitable organisations.

2.2 Commissioning of PET-CT

NHS England commissions PET-CT services. The previous contracts expired in March 2015 and July 2015, leading to a national procurement exercise during 2014/15.

The new contract moves away from the mobile service provision and will deliver improvements in infrastructure, equipment, and radiotracer supply across the country, closing the gap in access to PET-CT so that more patients will benefit from easily accessible quality diagnostics. It contains a number of factors that are designed to improve patient access to services:

- Increased investment, across thirty different sites in England to install new scanners and improve the current infrastructure
- Increased patient access to services, including new locations where there is no current provision at all
- A commitment to move away from mobile PET-CT scanning services towards a greater number of sustainable, high quality static PET-CT sites
- Faster production of reports, meaning the referring clinician receives the scan results more quickly thereby enabling the planning of subsequent

treatment and care to the patient sooner, reducing the stress of waiting, and allowing treatment to start earlier
- Greater value for money, with the cost of scans reduced significantly to commissioners
- Substantial number of scans at no additional cost to support research and clinical trials within cancer and other new applications, to improve the evidence that will allow enhanced outcomes for patients
- Provide a funded managed clinical network to drive improvements in cancer outcomes.

Where current mobile sites were operational it is intended that these will change over time to fixed site facilities. In the majority of cases, the location of the service will not change as a result of this procurement. Only one site has moved as a result of the new contract, with services being stopped at Bournemouth and only provided at Poole since April 2015. This decision was a result of the local reconfiguration of cancer services.

2.3 Current services in South Essex

In most parts of the country, many cancer services have been consolidated into single specialist cancer centres to increase the expertise of the clinicians and improve the outcomes for people with cancer.

However, there is no single hospital within Essex that has been designated as a cancer centre, with each hospital taking the lead for a different cancer. Basildon and Thurrock University Hospitals NHS Foundation Trust (BTUH) is the lead for lung cancer, Mid Essex Hospital NHS Foundation Trust the lead for head and neck cancer and Southend University Hospital NHS Foundation Trust and Colchester Hospital University NHS Foundation Trust provide radiotherapy.

In the East of England, Essex is the only area not to have a designated cancer centre and the South Essex service is the only PET-CT service that is not co-located with radiotherapy services.

Currently patients who require a scan are offered a number of sites for appointments. There is a secure centralised referral system that supports clinicians to refer a patient quickly and efficiently without the scanner being located with the referring clinical team.

The existing service in South Essex is provided from a mobile scanner that is situated on the BTUH Hospital site two to three days per week. Between 800 and 1,200 scans a year are provided from the mobile site at BTUH to the south Essex population. Almost all the scans performed are for patients registered to BTUH and Brentwood CCG, Castle Point, Rayleigh and Rochford CCG, SUH CCG and Thurrock CCG, with small numbers of ‘out of area’ patients attending from areas elsewhere in Essex (during 2014-15 there were 83 patients from Mid Essex CCG, 18 from North East Essex CCG and 15 from West Essex CCGsuch as Colchester and Mid-Essex), as well as other parts of the East of England, London and Kent (42 in total during 2014-15).

People living in North Essex are served by a PET-CT scanner at Colchester University Hospital NHS Foundation Trust with some patients from West Essex choosing to use services provided at Cambridge University Hospital Foundation Trust or London providers.

Table 1 below sets out the PET-CT activity for South Essex CCGs over the last two contract years, identifying the centre to which the patients travelled for their scan, where that centre was within the East of England. Please note that it does not include the data for patients who travel to sites within London for their scan.

Table 1 PET-CT SOUTH ESSEX CCGs ONLY	**2013-14**		**2014-15**	
	Scans	**Percentage**	**Scans**	**Percentage**
BTUH PET-CT Service	871	92%	1196	94%
Cambridge PET-CT Service	2	0%	5	0%
Canterbury PET-CT Service	0	0%	2	0%
Colchester PET-CT Service	46	5%	66	5%
Maidstone PET-CT Service	1	0%	1	0%
Northampton PET-CT Service	1	0%	0	0%
Norwich PET-CT Service	1	0%	2	0%
Sawbridgeworth PET-CT Service	26	3%	N/A	
TOTALS	**948**	**100%**	**1272**	**100%**

Table 2 demonstrates the breakdown of the BTUH PET-CT service by South Essex CCGs. The breakdown shows an equal distribution over two years between CCGs in the West and the East.

Table 2 BTUH PET-CT Service South Essex CCGs Only	**2013-2014**		**2014-2015**	
	Scans	**Percentage %**	**Scans**	**Percentage %**
BTUH and Brentwood CCG	173	20%	413	35%
Castle Point, Rayleigh & Rochford CCG	293	34%	268	20%
SUH CCG	152	17%	255	19%
Thurrock CCG	253	29%	260	20%
TOTALS	**871**	**100%**	**1196**	**94%**

The service at Basildon was mobilised on the 1st August 2015 under the new contract with Alliance Medical Ltd (AML) and continues the same level of service as previously provided to South Essex patients – two to three days a week from a mobile site.

During the mobilisation period of the new contract, AML requested that commissioners review the existing provision and consider increasing capacity

through the use of a fixed scanner and re-locating the service to SUH, where there is already a new static unit that is not currently being used.

2.4 Options for the future configuration of the PET-CT Service

Options		Timescale
1.	Status Quo – continue the mobile scanner and develop plans for a fixed scanner at BTUH	Approx 12 months from decision
2.	Move the PET-CT service to the existing fixed scanner at Southend	Approx 1 month from decision

Engagement and consultation is underway with clinicians, stakeholders, patients and the public.

3 Clinical Case for Change

NHS England has undertaken a clinical sense check and impact assessment of the options. Advice has been sought from key clinical leads to provide us with an opinion on the requirement for co-location with other services. We have also considered the benefits of both options for patients and the impact of the mobilisation timescales for the proposed options.

The Regional Specialised Commissioning Team sought advice from the Royal College of Radiologists, particularly their Clinical Oncology Subcommittee, the chair of the PET-CT Clinical Reference Group, Intercollegiate Standing Committee for Nuclear Medicine (a combined committee of the Royal College of Radiologists and Royal College of Physicians), Institute of Physics and Engineering in Medicine, Strategic Clinical Network Clinical Director, Regional Medical Director, Clinical Commissioning Groups in South Essex and also sought an Expert Patient view.

3.1 Why does the service need to change?

One of the key objectives of the NHS Mandate is for better early diagnosis and treatment of conditions such as cancer. Increasing capacity for PET-CT will help achieve that objective in South Essex.

Cancer patients in the UK are typically diagnosed with cancer at a later stage with an increased cost to treat and five year survival rates at 54%, substantially lower than the 67% average in many developed European health systems.

There are no immediate safety or quality concerns with the current service in South Essex. However, there is room for improvement in the speed of diagnosing cancer in South Essex which will improve clinical outcomes for patients.

Patients in Essex have less choice of appointment time for PET-CT than they should, with just 58% reporting that they were given a choice between April and June this year compared to the national target of 70%. As well as earlier diagnosis and treatment, greater capacity to carry out more scans on more days would mean a greater choice of appointment time.

South Essex are currently exceeding 62 day cancer waiting time targets, and the 31 day diagnosis to treatment target is, almost always, achieved by all providers in all quarters. This suggests that the time from diagnosis to treatment for lung cancer patients is extremely quick but there is room for improvement in the speed of the diagnostic part of the pathway. Increasing access to PET-CT should improve diagnostic waiting times, contributing to improving outcomes.

The use of standardised evidence based pathways of care across all the sites is a benefit wherever the site is based. The new capacity and national infrastructure provides additional capacity for research at local and national level.

3.2 Mobile or fixed site location

PET-CT is at present a predominately oncology based diagnostic tool (95% of the total use). All of the clinical experts agreed that a fixed site scanner is preferred over a mobile PET-CT service.

3.3 Population Access and Patient Experience

The existing mobile service is well thought of by patients, with over 95.3% rating their overall service as good or better in the first quarter of 2015.

Commissioners and clinical experts agree that consideration needs to be given to population access to the service. The scanner should be sited where local people will not be disadvantaged and where optimum access for the most patients would be served.

Patients do not have significant contact with PET-CT services beyond one or two appointments so any change in location will affect new patients rather than existing patients.

Over the most recent two year period, broadly equal numbers of patients have travelled to BTUH from the east and west of the area (see table 2 above). That means that as many patients travel from the East to Basildon as would travel from the West to Southend if Southend were selected as the preferred option. The number of patients using the service from other areas is small and usually due to capacity issues at other trusts. Any change is unlikely to significantly affect the distance they already choose to travel.

3.4 PET-CT Use

3.4.1 Patient access

It is widely acknowledged that the majority of PET-CT scans for cancer and suspected cancer are undertaken to support the diagnostic phase of the patient journey in determining the extent of spread of disease and for detecting hidden cancers. There is justification for the PET-CT scanner being located in close proximity to the centre that use the most diagnostic PET-CT, therefore co-location of

the PET-CT scanner to the centre which leads in the care of lung cancer and lymphoma, assuming that the remainder of the patient pathway is conducted at the same location. Such a situation allows the highest numbers of patients to benefit from all services delivered as part of their pathway of care to be located at one site. BTUH is the lead centre for both lung cancer and lymphoma. Notwithstanding agreed protocols, this model can also be seen to have the advantage of facilitating rapid transfer of images to clinicians for reporting and reviewing, assuming those clinical reporters are located at the same site as the lead cancer organisation. However, the rapid transfer of images across organisations is a normal part of PET-CT scan delivery.

3.4.2 Multi-Disciplinary Team access

A further considered advantage is for the reporting clinician to attend the relevant Multi-Disciplinary Team (MDT) meeting, enabling direct discussion with colleagues regarding the findings of the scan and the planned pathway of care for the patient, the emphasis to this point is not where the PET-CT scanner is located but that the reporting clinician attends the MDT.

3.4.3 Radiotherapy planning

The largest growth area in PET-CT use in the next few years is likely to be PET-CT fusion for radiotherapy planning.

There is an increasing role for PET-CT for radiotherapy planning, particularly for head and neck cancer, lung tumours, lymphoma, gastrointestinal tract tumours, brain tumours and gynaecological malignancy. The PET-CT Clinical Reference Group considered the possible future developments of PET-CT as part of the work undertaken to form the NHS England Specialised Services Five Year Strategy in 2014. The absence of PET-CT radiotherapy planning was cited as a weakness in the current configuration of services to NHS England and identified an opportunity to develop an infrastructure that supported improved technology and scanning techniques to improve patient pathways, experience, outcomes and radiotherapy planning.

The 'Achieving World-Class Cancer Outcomes – A Strategy for England 2015-2020' issued in July 2015, noted that as part of the national radiotherapy capital fund, NHS England should support the provision of dedicated ME and PET imaging facilities for radiotherapy planning in major treatment centres.

For PET-CT radiotherapy it is important if possible to have the PET-CT scanner co-located with the centre delivering radiotherapy for a number of reasons. Firstly, many clinical oncologists favour attendance of radiographers with specialised expertise in radiotherapy planning with the PET-CT is carried out to ensure the PET-CT scans are optimal for radiotherapy planning. This includes accurate positioning the patient, mimicking the radiotherapy position and ensuring optimal use of immobilisation devices. It is also considered an advantage to have physicists available on site to support the radiotherapy planning process. If the PET-CT scanner is not in the radiotherapy centre, staff will need to be deployed to the hospital where the PET-CT scanner is located with implications for the service and staffing resource.

Secondly, PET-CT scanning for radiotherapy planning requires patients to be scanned using immobilisation devices, which have been specifically made for the patient. For some patients such as head and neck cancer patients this will mean transferring the immobilisation device personally to the PET-CT centre if this is not located at the radiotherapy centre. Damage and loss may occur and remodelling of the immobilisation device will be required. This could impact on the patient journey and treatment times as well as negatively impact on the patient experience. In other patients such as lung cancer patients, generic immobilisation devices are required. These are expensive and the PET-CT centre will have to acquire these pieces of equipment as cancer centres are generally reluctant to lend them out.

Thirdly, data transfer for radiotherapy planning scans is less straightforward than that for diagnostic scans, meaning that although not insurmountable the complex nature of the radiotherapy planning process using PET-CT does not lend itself to the planning PET-CT being constructed remotely to the radiotherapy centre.

The colocation of PET-CT and radiotherapy allows for future developments. Preliminary research has shown that there is a possibility that an approach of combined diagnostic and planning scans can be undertaken, reducing patient journey times, improving the patient experience and speeding up the patient pathway.

Radiotherapy is provided at Southend Hospital, there is no radiotherapy provision at Basildon NHS Trust. All the other sites that provide PET-CT within the East of England are currently located with radiotherapy (table 3).

Table 3 Trust	Radiotherapy	PET-CT	Cancer Centre
Colchester Hospital University NHS Foundation Trust	Yes	Yes	
Cambridge University Hospitals NHS Foundation Trust	Yes	Yes	Yes
East and North Hertfordshire NHS Trust (Mount Vernon Cancer Centre)	Yes	Yes	Yes
Norfolk & Norwich University Hospitals NHS Foundation Trust	Yes	Yes	Yes
BTUH &Thurrock University Hospitals NHS Foundation Trust		Yes	

3.4.4 Chemotherapy

There is a generally accepted clinical view that PET-CT located in close proximity to where the majority of chemotherapy is carried out. PET-CT scans are frequently booked and organised to support chemotherapy regimens, although the location of the scanner does not affect the chemotherapy delivery plan. It should be noted however that reduction in patient visits can occur if the PET-CT is located where the

chemotherapy is delivered by organising scanning on the same day as the chemotherapy care. Although expert advice indicates that there is an increasing desire to deliver more chemotherapy in the community.

3.4.5 Non Cancer

With regard to current non cancer PET-CT applications, PET-CT scanning is used as a diagnostic test; therefore similar arguments apply as for diagnostic PET-CT for cancer.

PET-CT is currently used for cardiac patients at only two centres in England – UCLH in London and The Christie in Manchester. BTUH is the regional cardiac centre but it is not envisaged there will be an expansion to deliver PET-CT for cardiac patients at other sites in the UK in the near future. Only small numbers of patients per year would experience a PET-CT scan for cardiac perfusion to those experiencing a PET-CT scan for cancer.

3.5 Deliverability

Either option is deliverable. However, the greatest positive clinical impact is the reduced time it would take to mobilise the scanner at Southend, which could take as little as one month from the decision. By rapidly moving to the fixed site at SUH there would be immediate benefits to patients with mobility issues and the scanner site also has facilities for patients, relatives and carers. The extra 50% capacity would be delivered at least twelve months sooner. Overall costs to the system would be reduced and services to patients improved within a shorter timescale.

3.6 Clinical Commissioning View

We asked the CCGs in South Essex about the location of the PET-CT. Their view was that what matters most is the timely access to scanning and reporting to support the cancer journey. The location of the scanner is not a significant factor, although the volumes of cancer activity at each site in relation to the highest users of PET-CT may need to be considered. If there is a decision to relocate the service from BTUH to SUH it is unlikely that there will be objections from the CCGs with regards to the location decision.

4 Impact Assessment

A duty on public bodies to promote race equality was introduced in 2001. A duty to promote equality for disabled people came into effect in December 2006, and this was followed by a duty to promote gender equality in April 2007. The Equality Act 2010 introduced protected characteristics: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex (gender) or sexual orientation. Public organisations are required to conduct an assessment of the impact of their current or intended policies, programmes and service delivery for any disadvantageous experiences or outcomes and take action to remove inequalities.

A period of engagement will take place to assess the impact of the proposed changes on patients against the protected characteristics, along with wider engagement with patients, the public, support groups and other stakeholders.

The primary drivers for change are to improve diagnostic and clinical outcomes through increasing capacity and reducing waiting times as soon as possible. Co-location with radiotherapy presents further clinical benefits to patients.

An initial assessment suggests that there is unlikely to be any inequality with regard to the impact of either option on people due to their gender reassignment, marriage and civil partnership, pregnancy and maternity, sex (gender) or sexual orientation, although further work will need to be done to be certain. Both hospital sites provide multi-faith facilities for worship and contemplation and it is not anticipated there will be any differences in the impact of either option due to issues of religion or belief.

The most significant factors are clinical effectiveness, environment, travelling times and information and these are most likely to (either positively or negatively) disproportionately impact people due to their disability, age or race.

Consequently, particular effort will be made to engage these groups in order to influence the on-going impact assessment of the options. Patient satisfaction with the current service model is in built to the contract with AML with at least 10% of patients given a Patient Satisfaction Survey (PSS) to complete on the day of their appointment. All clinicians have the opportunity to access Clinician Satisfaction Survey (CSS) which will feed into the quality assurance process.

The clinical impact is that we will have a fixed site scanner within a shorter time frame and it will have improved capacity and the waiting time will be reduced for patients. There are added benefits in that collocation with radiotherapy services will bring for the longer term. Overall the positive clinical impact would suggest that operating the fixed site scanner at SUH is the preferred option, with minimal impact.

5 Recommendation

Against the criteria of clinical outcomes and patient experience, both options mark an improvement on the current service, although this could be delivered 12 months earlier at Southend University Hospital NHS Foundation Trust.

The strongest advantages for providing the service at Basildon relate to the volume of lung and lymphoma patients who currently receive treatment at BTUH but travel to SUH when they need radiotherapy planning.

However, in terms of strategic fit, future proofing and co-location of services, Southend is the preferred location. Radiotherapy and Oncology co-location provide strong reasons for providing the service from SUH, even with consideration of the volume of lung and lymphoma patients.

A summary of the advantages for each site can be found at Appendix One.

6 Public, Patient and Community Engagement

Engagement over the intended change has already commenced with stakeholders and clinicians over the last couple of months and will shortly begin with patients and patient groups. It is proposed to complete a 30 day period of consultation following the HOSC presentations. This will entail thorough and fast paced engagement with patients, patient and community groups, clinicians and stakeholders such as Healthwatch in order to move swiftly to a decision to maximise the clinical benefits. An outline engagement plan is provided at Appendix Two. The timeline for decision making and engagement is set out below.

6.1 Timeline for Engagement

Action	RO	Completed By
Discussion with Stakeholders	Midlands and East Specialised Commissioning Team	July – October 2015
Discussion with HOSC	Midlands and East Specialised Commissioning Team	October 2015
Rapid Engagement	Midlands and East Specialised Commissioning Team	October – November 2015
Mobilisation	AML	December 2015 (SUH) or December 2016 to March 2017 depending on procurement (BTUH)

7 Next Steps and Timetable for Decision

The findings of the clinical review and assessment by NHS England lead to the conclusion that SUH is the site that offers the best long term benefits for patients and for the future of the PET-CT service. Following patient, public, clinical and stakeholder engagement, a final decision will be made in November. Mobilisation of the available fixed site scanner would then take place in December 2015.

Appendix One: Summary of Options

	Option One: Basildon (BTUH)	Option Two: Southend (SUH)
Travelling times for patients from the West	There would be no change	Travelling times would be longer. However, patients attending Basildon for PET-CT are already required to attend Southend for radiotherapy planning and treatment. Providing PET-CT and radiotherapy on one site could reduce the number of appointments they need
Travelling times for patients from the centre	There would be no change	There would be no change
Travelling times for patients from the East	There would be no change	Travelling times would be shorter
Patient access	Lung cancer is the largest user of PET-CT and is based at Basildon	Lung cancer patients and other PET-CT users who require radiotherapy already travel to Southend
Multi disciplinary Teams	No change – PET-CT readers could attend MDTs at BTUH without leaving the site.	Would benefit from easy access to discuss radiotherapy planning.
Access to radiotherapy	Access would stay the same – patients would still have to travel to Southend for part of their treatment	Access would improve – PET-CT and radiotherapy would be carried out in one place. Clinical experts agree it is ideal to locate the services on the same site.
Image sharing	This would be as it is now for diagnostic and staging PET-CT scans. data transfer for radiotherapy planning scans is less straightforward than that for diagnostic scans, meaning that although not insurmountable the complex nature of the radiotherapy planning process using PET-CT does not lend itself to the planning PET-CT being constructed remotely to the radiotherapy centre.	This would be as it is now for diagnostic and staging PET-CT scans. This would improve with co-located radiotherapy and PET-CT teams for those patients undergoing PET-CT for radiotherapy planning
Faster diagnostic times	This would improve with increased capacity from around 12 months	This would improve with improved capacity from around 1 month
Increased capacity and number of scans	This would improve with increased capacity from around 12 months	This would improve from around 1 month and offers greater potential for future use
Future growth	If cardiac PET-CT is commissioned in future (there are currently no plans for this), the cardiothoracic service is at BTUH	The largest growth area for PET-CT use in the next few years is likely to be PET-CT fusion for radiotherapy planning which ideally requires co-location with the service at SUH
Patient pathway	Waiting times will reduce because of increased capacity and choice of appointment times will increase	Waiting times will reduce because of increased capacity and choice of appointment times will increase. In addition pathways can be further shortened and a one stop shop for diagnosis and treatment planning can be provided which will save the patients time.
Clinical Oncology	The relationship with clinical	Co-location with oncology services would

/Chemotherapy	oncology would not change	maximise the use and interaction of oncology expertise across many disciplines and enable one-stop shops to be established, reducing the number of hospital appointments. Currently Southend delivers five times the amount of chemotherapy as Basildon. Oncology clinicians at Basildon are provided by the Southend team.
Improved facilities	This would improve	This would improve but much sooner at Southend

Appendix Two: Engagement Plan

Stakeholder group	Method of communication	Timescale
Community groups and patient support groups, for example: • Southend Lung Cancer and Mesothelioma Information and Support Group • Carers Trust • DIAL Basildon and South Essex, and Southend • BASIL • Castle Point, Basildon and Thurrock Lung Cancer and Mesothelioma Support group • Lymphoma Support for you • The Phoenix Club • Basildon, Billericay & Wickford CVS • Gay Essex Men's Social Club • Churches Together	• Letter and booklet • Attendance at existing meetings where requested	• Commencing within two weeks
	• Letter summarising decision and responding to feedback for those who engage	• Upon mobilisation of service at SUH
	• Letter to those who engage summarising benefits delivered three to six months after mobilisation	• Three to six months after mobilisation of service at SUH
Community groups identified through the impact assessment process, i.e. • Age UK Essex • Age Matters Basildon • Age Concern Southend • Basildon MIND • Reason • The Friday Club • Trinity Disability Club • South Essex 50+ Club • Livability • Essex Coalition of Disabled People • Contact the Elderly • Thurrock Over 50s Forum • Essex Multicultural Activities Network CIC • Minority Ethnic Network Eastern Region	• Letter and booklet • Involvement in focus groups • Attendance at existing meetings / specially arranged meetings as requested	• Commencing within two weeks
	• Letter summarising decision and responding to feedback for those who engage	• Upon mobilisation of service at SUH
	• Letter to those who engage summarising benefits delivered three to six months after mobilisation	• Three to six months after mobilisation of service at SUH
Public / patients	• Media briefings • Info in public places, i.e.	• Commencing within two

	libraries, website • Attendance at meetings where requested • Focus group x 2 (Basildon and Southend)	weeks
	• Letter summarising decision and responding to feedback for those who engage	• Upon mobilisation of service at SUH
	• Letter to those who engage summarising benefits delivered three to six months after mobilisation	• Three to six months after mobilisation of service at SUH
Clinicians (including acute and primary care clinicians), Chair of Clinical Reference Group, key clinical stakeholder group, referring doctors – acute and primary care	• Email, telephone calls and face to face meetings where necessary • Engage through CCG communication tools	• Commencing within two weeks
	• Update responding to feedback	• Upon mobilisation of service at SUH
	• Update summarising benefits delivered three to six months after mobilisation	• Three to six months after mobilisation of service at SUH
Local MPs	• Letter and booklet • Follow up meetings as required	• Commencing within two weeks
	• Update responding to feedback	• Upon mobilisation of service at SUH
	• Update summarising benefits delivered three to six months after mobilisation	• Three to six months after mobilisation of service at SUH
Other stakeholders (HOSCs, Health and Wellbeing Boards, Healthwatch)	• Regular meetings / briefings as appropriate • Presentation • Letter / report	• Commencing within two weeks
	• Update responding to feedback	• Upon mobilisation of service at SUH
	• Update summarising benefits delivered three to six months after mobilisation	• Three to six months after mobilisation of service at SUH

East of England Clinical Senate

NHS England, Midlands & East Specialised Commissioning on Siting of Positron Emission Tomography – computed Tomography in South Essex

Report of the Independent Clinical Senate Review Panel

england.eoeclinicalsenate@nhs.net

21 July 2016 final draft

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1. FOREWORD BY CLINICAL SENATE CHAIRMAN

Clinical Senates have a unique and critically important role in providing independent clinical and patient focussed advice. This clinical panel review was requested by Specialised Commissioning to provide advice regarding the location of PET-CT scanning services for south Essex.

A fundamental element of delivering safe, quality services for patients is, of course, a skilled workforce. The panel was aware that matters of workforce and training were a key part of the wider Mid and South Essex Success Regime programme and so were not included as a specific part of this review. It would be crucial though to ensure that the workforce planning for the PET-CT and cancer services across mid and south Essex are linked.

The future location of clinical services understandably often engenders strong views from the public, patients, staff, senior managers and politicians. Clinical Senate panels are always carefully selected aiming to avoid conflicts of interest and where this isn't possible they are declared, carefully considered and appropriately managed. Panels are also selected to ensure an appropriate balance of experts along with generalists and patient representatives.

I am confident that the evidence presented was considered carefully and in a non-biased manner. The panel all contributed to a detailed discussion and I thank them all for their expertise, knowledge and honest open discussion.

Our aim in this review was to provide advice and constructive recommendations to enable the Specialised Commissioning team to make a decision regarding the way forward and to work together with Alliance Medical, the Acute Trusts, the Essex Success Regime and other stake holders to enhance the services for patients.

I believe the panel has answered the specific question put to it and has given some additional advice surrounding this recommendation.

Dr Bernard Brett

Review Panel Chair and Chair of East of England Clinical Senate

2. BACKGROUND & ADVICE REQUEST

2.1 Following a national procurement process by NHS England, in February 2015, a new provider, Alliance Medical was awarded a ten year national contract for the provision of Positron Emission Tomography- Computed Tomography (PET-CT) a diagnostic service that is currently primarily used to help diagnose and stage cancers. The new provider was contracted to provide PET-CT scanning to the North, Midlands and East and South and South West regions of England accounting for around 50 per cent of all PET-CT scans undertaken in England.

2.2 The new national contract moves away from mobile service provision and is intended to deliver improvements in infrastructure, equipment and radiotracer supply across the country. It aims to close the gap in access to PET-CT so that more patients will benefit from easily accessible diagnostics rather than having to travel to large tertiary centres out of their locality.

2.3 At the time of the contract award, PET-CT services in South Essex were provided three days a week from a mobile unit located at Basildon & Thurrock University Hospitals NHS Foundation Trust (BTUH). Patients were also able to choose to travel to Colchester Hospital, the Norfolk & Norwich Hospital, or to Addenbrooke's Hospital in Cambridge, if they wished.

2.4 The former provider of PET-CT services (Inhealth) had installed a fixed modular scanner in a new purpose built facility at Southend University Hospitals NHS Foundation Trust (SUH). The decision to build and install this had been taken by that provider in conjunction with the Trust prior to the award of the new contract to AML. That unit and scanner have never been mobilised.

2.5 In July 2015, following their purchase of the scanner at SUH from Inhealth, Alliance Medical made a formal request to Specialised Commissioning to utilise the scanner at SUH in preference to the mobile scanner at BTUH, which could then be used elsewhere.

2.6 A clinical case for change was initiated by NHS England Midlands and East Specialised Commissioning Team. In building the case for change advice was sought from, among others, the Royal College of Radiologists and its Clinical Oncology Subcommittee for Nuclear Medicine, the Institute of Physics and Engineering in Medicine, key clinical leads and in addition advice was sought from expert patients. All clinical experts agreed that a fixed site scanner was preferable over a mobile PET-CT service.

2.7 The preferred, and recommended, option in the clinical case for change was for the fixed site located at SUH. This created some tension among clinicians, the public and politicians and an extensive series of engagement events were held to explain the case for change and allay fears.

2.8 The two hospital sites in Southend and Basildon are part of the wider Mid and South Essex Success Regime which is looking at provision of all services across SUH, BTUH and Broomfield Hospital run by Mid Essex Hospital Services NHS Trust. No single hospital in Essex has been designated as a cancer centre; each hospital takes a lead for different cancers. BTUH is the designated cardiac centre and the lead for lung cancer (although all three hospitals provide lung cancer care), Mid Essex Hospital the lead for head and neck cancer (and designated burns and plastic surgery unit) and Southend Hospital provides radiotherapy and Chemotherapy. Colchester University Hospital NHS Foundation Trust provides radiotherapy but is not in the Essex Success Regime. Essex is the only area in the East of England not to have a designated cancer centre and South Essex PET-CT is one of only a very few PET-CT services in England that is not co-located with the radiotherapy service.

2.9 Almost all scans performed at the BTUH site were for patients registered in the South Essex area respective Clinical Commissioning Groups. A small number of out of area patients attended from elsewhere in Essex (during 2014-15 there were 83 from Mid Essex CCG, 18 from North East Essex CCG and 15 from West Essex CCGs) and 42 from other parts of East of England, London and Kent.

2.10 Following the consideration of the clinical case for change, the engagement events and discussion by the Health Overview and Scrutiny Committee, and the proposal to site the PET-CT scanner at SUH, Specialised Commissioning requested the East of England Clinical Senate to review the evidence and

proposals and provide an independent expert clinical opinion and any recommendations on the proposed siting of the PET-CT services in South Essex.

2.11 It was agreed that the role of clinical senate was not to endorse, or otherwise, the proposal to site PET-CT services for South Essex from SUH, but to consider whether the proposals have ***"the potential to deliver real benefits to patients. The panel should also identify any significant risks to patient care in these proposals".***

2.12 The approach and clarification of the scope of the request was developed and formalised in Terms of Reference (Appendix1) and a clinical review panel date set for 21st July 2016.

2.13 Given that the majority of panel members were from outside of the East of England area, it was agreed that the panel would be held by teleconference.

3. METHODOLOGY & GOVERNANCE

3.1 The scope of the review was discussed with NHS England Midlands & East Specialised Commissioning PET-CT Contract Manager and Assistant Director, to identify the most appropriate expertise for the review panel and also the approach to be taken (as per section two above).

3.2 It was agreed that a combination of a desktop review of the evidence and an independent review panel by teleconference was the most appropriate approach. It was agreed that site visits would not add any additional value or information to the evidence provided.

3.3 Terms of reference for the review were drafted with NHS England Midlands & East Specialised Commissioning, and agreed and signed by Ruth Ashmore, Assistant Director of Specialised Commissioning and Dr Bernard Brett, Chair of East of England Clinical Senate and appointed Chairman of this review panel.

3.4 Senate council support team identified clinical review panel members (Appendix 2) from the East of England clinical senate council and assembly members, and a list of clinical experts in this field provided by Specialised Commissioning, none of whom had had any previous involvement in this work. Two experts by experience (patient representatives) from Clinical Senate Assembly were also identified. Once the potential panel members had been invited, accepted and had made declarations of interest and signed a confidentiality agreement, they were sent by e-mail the evidence provided by Specialised Commissioning for the panel review (Appendix 5).

3.5 From that set of evidence, panel members were asked to identify any key areas of concern or enquiry for the review. Only one point was raised and this was answered by Specialised Commissioning by return (detailed in Appendix 5) – all panel members were provided with that information (18 July 2016). Other expert opinion was also sought on an informal basis from an expert in the field who had been invited to be a panel member but was unable to attend the actual panel. The information sought related to recent research of PET-CT use for radiotherapy planning. His response was that research was still very limited and as such inconclusive. This response had no material impact on the evidence and was not

provided, however during the presentation on the current state of play, Ruth Ashmore, Assistant Director NHS England Midlands and East Specialised Commissioning, did advise of the same.

3.6 No other points were raised by panel members prior to the panel review.

3.7 The clinical review panel took place by teleconference between 15.00 hours and 17.15 hours on Thursday 21 July 2016.

3.8 Some supporting information on contracted activity was provided post the panel and provided to panel members on 25 July 2016. Although this information would not have any material impact on the recommendations agreed by the panel, it was provided to panel members on 22 July 2016 and included in the evidence summary at Appendix 5.

3.9 A draft report was circulated on 3 August 2016 to panel members and the Specialised Commissioning team for matters of accuracy.

3.10 This, final report, was submitted to a specially convened meeting of the East of England clinical senate council on 16 August 2016 for it to ensure that the clinical review panel met and fulfilled the Terms of Reference for the review.

3.11 This report is then submitted to the sponsoring organisation, NHS England Midlands and East Specialised Commissioning.

3.12 East of England Clinical Senate will publish this report on its website as agreed with the sponsoring organisation in the review Terms of Reference.

4. KEY FINDINGS AND RECOMMENDATIONS

4.1 Key findings:

4.1.1 The panel welcomed the presentation from Ruth Ashmore, Assistant Director of Specialised Commissioning for NHS England Midlands and East. The team had provided clear evidence and background information both for and against the proposed siting, with the case for change and proposals.

4.1.2 The review panel heard that the previous provider of PET-CT services (Inhealth) had installed the fixed unit at SUH on the basis that it was confident it would be preferred bidder for the new contract in the national procurement process. The scanner installed in the fixed unit was understood to be one of the very latest high specification models. The panel agreed that a further new build at BTUH would not provide any additional benefit from a scanner specification perspective. In response to a question from the panel on the specification of the fixed scanner installed at SUH, as the details were not available at the time, Specialised Commissioning later provided the following detail by email which was duly forwarded to all panel members:

"The specifications of the equipment installed in the facility at Southend Hospital not only meets the minimum requirements but is Siemens latest generation PET CT scanner in terms of 64 Slice CT scan capability, PET detectors and electronic switching to provide high resolution imaging with low patient and operator dose.

The unit is comparable to the latest generation GE units which have been deployed on the new mobiles in last year and all of these are the latest technology available. This equipment well exceeds the minimum specification identified within the contract reflecting the developments in technology. The imaging components for both CT and PET are the same as the recent Siemens units installed in 2 fixed sites, as such is the unit could be relocated in the NHS England contract area".

4.1.3 In response to panel questions on capacity and predicted growth in demand, the panel was advised that NHS England had built a threefold increase (around 12% year on year) into the ten-year contract. (See Appendix 5 for detail of contracted activity information – as mentioned at para 3.8 above). Expert members of the panel agreed that the predicted growth was somewhat conservative and in their experience and opinion likely to be more in the region of 20% year on year.

4.1.4 The panel was advised that the fixed site scanner could reasonably accommodate 20 patients a day – assuming 240 days a year operational activity that would be circa 4,800 patients a year. The panel was later informed by Specialised Commissioning that the fixed scanner had the capacity to provide around 3000 scans a year, although it was not clear if that took into account any downtime for maintenance.

4.1.5 The panel was advised that the purpose built fixed unit at SUH had four uptake bays, the mobile had two uptake bays in standard use – an attached trailer could provide additional two uptake bays. Being a purpose built, ground level unit, access to the fixed scanner at SUH was fully enabled with allocated car parking (the panel was advised that SUH had plans to build a new multi-storey car park to cope with general demand at the site). Access to a mobile unit required the use of some steps into the unit, which could prove difficult for some patients.

4.1.6 One panel member advised that recent (local) research had shown that the scans from a fixed unit were more reliable than from a mobile unit as there was no physical movement. Although this had not been tested and was a small sample, the panel agreed that there was less volatility to scan with a fixed scanner than a mobile one.

4.1.7 The panel was advised that all scan data went immediately to a central server, irrespective of where the scan had been carried out. The data was transferred back to the respective multi-disciplinary team and so the panel was advised that data transfer from either site was not an issue. The panel therefore did not feel this should impact on their recommendations.

4.1.8 The panel heard from its experts that there was a benefit of having a PET-CT scanner co-located with radiotherapy. Whilst pure diagnostic teams provided excellent diagnostic scans and information, there was added benefit in having a radiotherapy pre-treatment team present during the diagnostic scan. This enabled the patient to be positioned in exactly the same manner as for radiotherapy treatment. In addition there was no need to move patient specific positioning equipment to the site of a diagnostic service with the potential for loss or damage. The panel heard that there was an additional benefit of co-locating the PET-CT scanner with the radiotherapy unit in so much as PET-CT could be used to conduct the radiotherapy planning scan as opposed to the current CT which is

considered by some clinicians to be more specific and targeted to the specific care of radiotherapy treatment than CT.

4.1.9 In response to the panel's question on whether the option to have both sites available had been considered, it was advised that had indeed been tested out. However the provider was clear it wanted to have a single site and preferred that to be a fixed site with greater capacity. The panel sought clarification whether the drive to move to a single fixed site came from Alliance Medical or NHS England. It was advised that whilst there may be a longer-term commercial benefit to the provider in moving to a single site, the proposal was in line with the NHS England contract and desire to move to fixed sites in order to provide better outcomes for patients. In addition, if not used at BTUH for the current three days a week, the mobile unit would be released for use elsewhere thus providing much needed additional capacity for the NHS.

4.1.10 The panel was advised that it had been difficult to obtain the data and information regarding how many patients that had had a PET-CT then went on to have radiotherapy. Some of this was due to the fact that patients may have had their PET-CT scan in the area but, with patient choice, may have chosen to have radiotherapy treatment out of area (e.g. London hospitals). The panel advised that this would vary between patients groups with head and neck, prostate and breast cancer patients currently most likely to benefit from PET-CT assisted targeted radiotherapy. Overall the panel felt that the percentage of patients having PET-CT who would go on to receive radiotherapy was currently of the order of 30 to 35% but this would almost certainly change as treatment protocols develop.

4.1.11 Data on the number of in-patients that had had PET-CT scans was also not readily available, however panel members agreed, in their experience, that this was likely to be a small percentage. This was therefore unlikely to be a relevant factor in determining the option chosen going forward.

4.1.12 The panel heard that while the proposal had initially created some tension with the two hospitals, in recent months as part of the Mid and South Essex Success Regime, the Trusts were working more collaboratively and had built relationships.

4.1.13 The populations of Southend and Basildon were very different and, understandably, each wanted to have the PET-CT service provided at its respective local hospital. Significant numbers of communication events had been laid on to explain the proposal but it remained a contentious issue.

4.1.14 The panel discussed the proposal to build a new fixed site at BTUH. It agreed that although some of the evidence suggested a shorter timescale, from various panel members' experience it was more likely to take 12months or more from agreement to mobilisation, possibly up to 24 months.

4.1.15 The panel agreed that although the difference between the two options over the course of the 10 year contract was relatively marginal, the mobilisation of the SUH scanner was the preferable option, assuming a single site was the only option in the near future, for the following reasons:

i. the different mobilisation timescales, with the lost capacity of at least two additional days for at least 12 months (with subsequent lost appointments for patients) if SUH was not mobilised;
ii. the benefit for radiotherapy planning purposes of having a co-located PET-CT (for a subgroup of patients);
iii. there appeared to be no overall significant difference in the impact on overall travel times between the two sites; and
iv. there would be no advantage or additional benefit in terms of scanner specification of a new purpose build scanner on the BTUH site.

4.1.16 The panel considered that the case for change could be strengthened by the inclusion of mention of how a fixed-site PET-CT scanner could enable more recruitment of patients for research studies. Research studies are known to enhance the quality of service for patients, provide a potential additional funding stream for NHS services, assist in attracting and retaining a valuable skilled workforce as well as help answer important research questions for the benefit of patients. Panel members advised that although research studies had been carried out on mobile units in the past, usually they were carried out on fixed sites which had less movement and were more reliable.

4.1.17 The panel acknowledged that if the service was moved to a single site, whichever that would be would require travel for some patients. The panel noted the detailed evidence within the documents regarding travel times including, for those using public transport, at different times of the day. There was no clear overall benefit in terms of travel times for either site. Clearly if the SUH site were chosen this would have a negative impact on some patients in relation to the current location. The panel agreed that the overall improved outcome to all patients from the increased capacity would result in shorter waiting times. In addition running a service five days a week would provide more choice regarding appointment times, would be more likely to improve the reliability and quality of service, and together those benefits were greater than the unfortunate dis-benefit to a minority of patients who would have to travel to use the service, wherever that was.

4.2 RECOMMENDATIONS

4.2.1 Recommendation 1

The panel supported in principle the proposal to provide the PET-CT service for South Essex from the fixed unit at Southend University Hospital. However, the panel had some concern that with the probable currently unplanned growth in volume over and above the contracted activity, and potential downtime for scanner maintenance, there might not be sufficient capacity in the fixed site alone for the entire contract lifetime. The panel therefore recommended that Specialised Commissioning review the data against actual capacity of the fixed unit and give consideration to providing additional residual diagnostic provision on a much more limited basis than currently, from the mobile scanner at Basildon & Thurrock University Hospital

4.2.2 Recommendation 2

The panel recommended that in preparation for the transfer of services, the Specialised Commissioning Team develop and agree with the provider and respective Trusts, a clearly planned out programme for transition of the provision from Basildon & Thurrock University Hospital to Southend Hospital. This should

include appropriate testing of the PET-CT scanner for mobilisation, a stepped down programme for services from Basildon & Thurrock University Hospital and step up programme for Southend University Hospital.

4.2.3 Recommendation 3

The panel recommended that a more in-depth Equality Impact Analysis be developed for travel to a fixed unit for learning disability patients and patients with mobility issues in particular.

4.2.4 Recommendation 4

The panel recommended that further work is done to ensure those with difficulty in traveling to the proposed site are given adequate assistance and support.

End.

APPENDIX 1: Terms of Reference for the review

East of England Clinical Senate
Independent clinical review panel for

NHS England, Midlands and East Specialised Commissioning on

Siting of Positron Emission Tomography – computed Tomography in South Essex

21 July 2016

Terms of Reference



CLINICAL REVIEW: TERMS OF REFERENCE

Title: Siting of Positron Emission Tomography – Computed Tomography (PET-CT) in South Essex

Sponsoring Organisation: NHS England, Midlands & East Specialised Commissioning

Clinical Senate: East of England

Terms of reference agreed by: Dr Bernard Brett

on behalf of East of England Clinical Senate and

Ruth Ashmore, Assistant Director – Commercial, Specialised Commissioning on behalf of sponsoring organisation: NHS England, Midlands & East Specialised Commissioning

Date: 19 July 2016

Clinical Review Team Members

Panel members	
Dr Bernard Brett	Chairman of Review Panel Chairman east of England clinical senate council Deputy Responsible Officer and Consultant Gastroenterologist James Paget Hospital NHS Trust
Dr Nick Ashford	Consultant Radiologist Western Sussex NHS Foundation Trust, Chichester
Sue Barham	Lead Cancer Nurse Peterborough & Stamford NHS Foundation Trust
Dr Andrew Bateman	Senate Council member Clinical manager and Director of Research Oliver Zangwill Centre for Neuropsychology Rehabilitation
Dr Jamshed Bomanji	Head of Clinical Department Institute of Nuclear Medicine, UCLH NHS Foundation Trust
Claire French	Expert by Experience
Jonathan Gifford	CRG Patient/User representative. Former Operations Manager, Inhealth Molecular Imaging (PET CT South). Radiographer
Professor Peter Hoskin	Consultant Clinical Oncologist, Mount Vernon
Caroline Smith	Expert by Experience
In attendance	
Sue Edwards	Head of Clinical Senate, East of England
Ruth Ashmore	Assistant Director – Commercial, Specialised Commissioning NHS England, Midlands & East

Aims and objectives of the clinical review

The review will specifically look at the proposal for the siting of Positron Emission Tomography – Computed Tomography (PET – CT) in South Essex.

Scope of the review

The East of England Clinical Senate is asked to review the documentation provided as evidence and consider:

> ***"whether the proposal outlined in the case for change for the location of the PET CT service makes clinical sense for the delivery of diagnostic and other cancer services in South Essex, going forward?"***

When reviewing the case for change and options appraisal the clinical review panel (the panel) should **consider whether these proposals have the potential to deliver real benefits to patients. The panel should also identify any significant risks to patient care in these proposals.** The panel should consider benefits and risks in terms of:

- Clinical effectiveness
- Patient Safety and management of risks
- Patient experience, including access to services
- Patient reported outcomes.

The clinical review panel is not expected to advise or make comment upon any issues other than clinical (e.g. financial elements of risk in the proposals, patient engagement, GP support or the approach to consultation). However, if the panel felt that there was an overriding risk this should be highlighted in the panel report.

Questions that may help the panel in assessing the benefit and risk of the proposals include (but are not limited to):

- Is there evidence that the proposals will improve the quality, safety and sustainability of care? (e.g., sustainability of cover, clinical expertise)
- Do the proposals set out an appropriate plan for the service to be able to meet national specifications and standards
- Do the proposals reflect up to date clinical guidelines and national and international best practice e.g. Royal College reports?
- Will the proposals reflect further the delivery of the NHS Outcomes Framework?

- Do the proposals uphold and enhance the rights and pledges in the NHS Constitution?
- Will these proposals meet the current and future healthcare needs of their patients within the given timeframe of the planning framework (i.e. five years)?
- Is there an analysis of the clinical risks in the proposals, and is there an adequate plan to mitigate identified risks?
- Do the proposals demonstrate good alignment with the development of other health and care services, including national policy and planning guidance?
- Do the proposals support better integration of services from the patient perspective?
- Do the proposals consider issues of patient access and transport? Is a potential increase in travel times for patients outweighed by the clinical benefits?
- Will the proposals help to reduce health inequalities?
- Does the options appraisal consider a networked approach - cooperation and collaboration with other sites and/or organisations?

The clinical review panel should assess the strength of the currently proposed evidence base of the case for change and proposed models.

Timeline

The review panel will be held on 21 July 2016. This will be conducted by teleconference.

Reporting arrangements

The clinical review team will report to the clinical senate council which will ensure the report meets the agreed terms of reference, agree the report and be accountable for the advice contained in the final report.

Methodology

The review will be undertaken by a combination of desk top review of documentation and a review panel which will be held by teleconference.

Report

A draft report will be made to the sponsoring organisation within six working days of the clinical review panel for fact checking prior to publication.

Comments/ correction must be received from the sponsoring organisation within **five working days**.

Final report will be submitted to clinical senate council to ensure it has met the agreed terms of reference and to agree the report.

The final report will be submitted to the sponsoring organisation no later than 20th August 2016.

Communication and media handling

Communications will be managed by the sponsoring organisation. Clinical senate will publish the report once the service change proposal has completed the full NHS England process. This will be agreed with the sponsoring organisation.

Resources

The East of England clinical senate will provide administrative support to the review team, including setting up the meetings and other duties as appropriate.

The clinical review team may request any additional existing documentary evidence from the sponsoring organisation. Any requests will be appropriate to the review, reasonable and manageable.

Accountability and Governance

The clinical review team is part of the east of England clinical senate accountability and governance structure.

The East of England clinical senate is a non-statutory advisory body and will submit the report to the sponsoring organisation.

The sponsoring organisation remains accountable for decision making but the review report may wish to draw attention to any risks that the sponsoring organisation may wish to fully consider and address before progressing their proposals.

Functions, responsibilities and roles

The **sponsoring organisation** will

i. provide the clinical review panel with the case for change, options appraisal and relevant background and current information, identifying relevant best practice and guidance. Background information may include, but is not limited to:
    - relevant public health data including population projections, health inequalities, specific health needs
    - activity date (current and planned)
    - internal and external reviews and audits,
    - relevant impact assessments (e.g. equality, time assessments),
    - relevant workforce information (current and planned)
    - evidence of alignment with national, regional and local strategies and guidance (e.g. NHS Constitution and outcomes framework, Joint Strategic Needs Assessments, CCG two and five year plans and commissioning intentions).

The sponsoring organisation will provide any other additional background information requested by the clinical review team.

ii. respond within the agreed timescale to the draft report on matter of factual inaccuracy.

iii. undertake not to attempt to unduly influence any members of the clinical review team during the review.

Clinical senate council and the sponsoring organisation will:

i. agree the terms of reference for the clinical review, including scope, timelines, methodology and reporting arrangements.

Clinical senate council will:

i. appoint a clinical review team, this may be formed by members of the senate, external experts, and / or others with relevant expertise. It will appoint a chair or lead member.

ii. endorse the terms of reference, timetable and methodology for the review

iii. consider the review recommendations and report (and may wish to make further recommendations)
iv. provide suitable support to the team and
v. submit the final report to the sponsoring organisation

Clinical review team will:

i. undertake its review in line with the methodology agreed in the terms of reference
ii. follow the report template and provide the sponsoring organisation with a draft report to check for factual inaccuracies.
iii. submit the draft report to clinical senate council for comments and will consider any such comments and incorporate relevant amendments to the report. The team will subsequently submit final draft of the report to the clinical senate Council.
iv. keep accurate notes of meetings.

Clinical review team members will undertake to:

i. Declare any conflicts of interest and sign a confidentiality agreement prior to having sight of the full evidence and information
ii. commit fully to the review and attend all briefings, meetings, interviews, panels etc that are part of the review (as defined in methodology).
iii. contribute fully to the process and review report
iv. ensure that the report accurately represents the consensus of opinion of the clinical review team
v. comply with a confidentiality agreement and not discuss the scope of the review nor the content of the draft or final report with anyone not immediately involved in it. Additionally they will declare, to the chair or lead member of the clinical review team and the clinical senate manager, any conflict of interest that may materialise during the review.

SUMMARY OF PROCESS

APPENDIX 2: Membership of the review panel

Chairman of review panel:

Dr Bernard Brett
Deputy Responsible Officer and Consultant Gastroenterologist
James Paget University Hospitals NHS Foundation Trust
Dr Bernard Brett is a consultant in Gastroenterology and General Internal Medicine based at the James Paget University Hospitals NHS Foundation Trust.

His clinical interests include Bowel Cancer Screening (he has been an accredited bowel cancer screening colonoscopist for the last 7 years), Therapeutic Endoscopy and ERCP. Bernard has held several senior management posts including that of Medical Director, Responsible Officer, Deputy Medical Director, Divisional Director, Director of Patient Flow and Appraisal lead.

Panel Members:

Dr Nick Ashford is a Consultant radiologist at Western Sussex NHS Foundation Trust Chichester. Trained in radiology in Cambridge and London and New York re PET-CT, Nick has an extensive background and experience in PET CT, Radionuclide radiologist ARSAC Nuclear medicine and PET-CT.

A Treasurer and Officer of Royal College of Radiographers from 2010-2014, Nick is a previous member intercollegiate standing committee of nuclear medicine and Founding member of Council for the Faculty of Medical Leadership and Management. Nick has been a National PET-CT reporter since 2008 and previous national PET-CT mentor.

Sue Barham has been Lead Cancer Nurse at Peterborough and Stamford NHS Trust since December 2013. Sue qualified as a Registered Nurse in 2002 and after starting her career on the oncology/haematology ward as a junior staff nurse, was promoted to senior staff nurse and deputy ward sister within 5 years, whilst studying for her BA (Hons) Degree. Using experience gained in complex palliative management, Sue undertook an MSc in Advanced Nursing, giving her the title of Advanced Nurse Practitioner. In her current role, Sue is involved in service development, leading on the national PEER review process, responsible for the oncology ward and chemotherapy day unit, cancer trials team, oncology nurse specialist's team and acute oncology team, plus numerous projects to improve patient care.

Dr Andrew Bateman qualified as a Chartered Physiotherapist in 1990, completed a PhD in Neuropsychology in 1997 (Birmingham) and has worked in research and clinical rehabilitation. Andrew has been leading the Oliver Zangwill Centre for Neuropsychological Rehabilitation (Ely, UK) since 2002 and is especially interested in rehabilitation research – specifically outcome research & assistive technology. In the field of neuropsychology Andrew has specialised in areas of executive functioning, dyspraxia & visual perception. Andrew has recently been appointed a member of the East of England Clinical Senate council

Dr Jamshed Bomanji graduated in 1980 and undertook his post-graduation at St Bartholomew's Hospital where he completed his Masters and PhD in Nuclear Medicine in 1987. He was appointed as Consultant in Nuclear Medicine at St Bartholomew's Hospital in 1990 and then moved to The Middlesex Hospital in 1993. Currently, he is the Clinical Lead and Head of Department at the Institute of Nuclear Medicine largest single site department in UK.

Jonathan Gifford is a registered Radiographer who has worked in the NHS, Industry and the Independent sector. He was operationally in charge of PET CT South between 2008-2012 and was heavily involved with the commissioning, setup and service performance.

In 2011 Jonathan became a PET CT patient during treatment for NHL and as such has seen the service from both patient and provider perspective. He continues to work in diagnostic imaging but is no longer directly involved with the provision of PET CT by the NHS or the Independent Sector. Since 2012 Jonathan has been a Patient Representative on the PET CT CRG.

Claire French is an Expert by Experience who has worked with the NHS, locally, regionally and nationally as an expert patient for fifteen years. Claire gained a Health and Social studies degree and Disability Equality practitioner post graduate certificate. Currently, she is involved with NHS Citizen and as the East of England Clinical Networks co-chair for Mental Health, Dementia, Neurological Conditions, Learning Disability and Autism steering group; and chairs her General Practice Patient Participation Group.

Professor Peter Hoskin trained in clinical oncology at the Royal Marsden Hospital London and has been consultant in clinical oncology at Mount Vernon Cancer Centre, Northwood UK since 1992. He is also Professor in Clinical Oncology at University College London

Caroline Smith is an Expert by Experience. Caroline worked as a registered dietitian in the NHS for 23 years before retiring on the grounds of ill-health. Caroline is a lay member of the MS Trust Forward View Project and a member of the East of England Citizens' Senate and the Bedfordshire neurological network.

Also attending the panel review teleconference:

Ruth Ashmore, Assistant Director – Commercial, Specialised Commissioning NHS England, Midlands & East Specialised Commissioning (from 15.10 hours until 16.25 hours only)

Clinical Senate Support Team:

Sue Edwards, East of England Head of Clinical Senate, NHS England.

APPENDIX 3: Declarations of Interest

Name	Personal pecuniary interest	Personal family interest	Non-personal pecuniary interest	Personal non-pecuniary interest

Dr Bernard Brett	None	None	None	None
Dr Nick Ashford	None	None	None	None
Sue Barham	None	None	None	None
Dr Andrew Bateman	None	None	None	None
Dr Jamshed Bomanji	None	None	None	None
Claire French	None	None	None	None
Jonathan Gifford	None	None	None	None
Professor Peter Hoskin	None	None	None	None
Caroline Smith	None	None	None	None

APPENDIX 4: Review Panel Agenda

INDEPENDENT CLINICAL REVIEW PANEL

Siting of Positron Emission Tomography – computed Tomography (PET CT) in South Essex.

Review of proposal for sponsoring body NHS England Midlands and East, Specialised Commissioning

A G E N D A

Thursday 21st July 2016 commencing at 15.000hrs

By teleconference

Free phone dial in: 0800 9171950 (if using mobile please use 0203 463 9697) followed by participant Code: 75148821#

Chaired by Dr Bernard Brett, Chair of East of England Clinical Senate

The review will specifically look at the proposal for the siting of siting of Positron Emission Tomography – Computed Tomography (PET – CT) in South Essex.

Scope of the review

The East of England Clinical Senate is asked to review the documentation provided as evidence and consider:

> ***"whether the proposal outlined in the case for change for the location of the PET CT service makes clinical sense for the delivery of diagnostic and other cancer services in South Essex, going forward?"***

Time	Item
15.00 -15.15	Introductions, welcome and outline of panel procedure from Clinical Review Panel Chairman Dr Bernard Brett
15.15 – 15.35 **20 mins**	**Specialised commissioning team: Context setting** .
15.35 – 16.05 **30 mins**	**Questions from panel members to Specialised Commissioning Team** .
16.05	**Sponsoring organisation members to leave call –** **Panel members only to remain for discussions**
16.05 -16.55 **50 mins**	Panel discussion
16.55 – 17.15 **20 mins**	Final comments from panel & Summary from chair
17.15	Next steps & chair to close

APPENDIX 5: Summary of documents provided as evidence for the panel

Document A	Case for change
Document B	A draft update Case for Change (an early, unfinished, draft the draft of a report to go to the Health and Scrutiny overview Committee)
Document C	'Achieving World-Class Cancer Outcomes: Taking the strategy forward' NHS England May 2016
Document D	An analysis of the public engagement undertaken
Document E&F	Letters from a member of the public
Documents G	Letter from Southend University Hospital NHS Foundation Trust CEO
Documents H	Letter from Basildon & Thurrock University Hospitals NHS Foundation Trust CEO
Documents J	Letter from Basildon & Thurrock University Hospitals NHS Foundation Trust clinical team
Document K	A report of the Annual PET/CT meeting held at the Royal College of Medicine on 14th and 15th March 2016 from a lay perspective

Documents A-K above were emailed to panel members on 18 July 2016
NB No Document I

By email 18 July 2016	In response to a question from a panel member, all panel members were provided with the following update to the evidence "*the provider (Charles Neihaus, AML) has confirmed that the scanner (at Southend) has the capability to undertake radiotherapy planning and any upgrades required will be undertaken".*
By email 25 July	Alliance Medical document 'Comparison of AML's PET/CT facility types (February 2016) V1.2' Details from Specialised commissioning (passed to panel members by email 25th July) of annual contracted activity from 2015-16 to 2024-25 2015-16: 1,346 ; 2016-17: 1,429; 2017-18: 1,572; 2018-19: 1,729; 2019-20: 1,902; 2020-21: 2,092; 2021-22: 2,301; 2022-23: 2,532; 2023-24: 2,785 & 2024-25: 3,063

NHS England

APPENDIX 3

PET-CT Scanner Location

Feedback from Engagement activity

June 2016

Contents

Introduction

NHS England is committed to ensuring decisions regarding changes to NHS services are influenced by feedback from patients, the public, clinicians and all other key stakeholders.

- NHS England is seeking views on two options for the permanent location of the PET-CT service in South Essex
- The new service will be provided through a fixed site, permanent facility and will be available to operate 5 days per week
- A mobile service is currently delivered at Basildon Hospital
- Approximately 1200 PET-CT scans were conducted in 2014-15. Demand has grown in 2015-16.
- Funding to open a permanent scanner has already been set aside and therefore cost doesn't influence decision
- Decision will be based on clinical benefits to patients on the location and feedback received from the engagement activity

Engagement Process

The engagement process was continually shaped through feedback from Clinicians, patients, the public and other key stakeholders including Councilor's and included the following activity:

- A range of communication channels were deployed to provide information on the proposals for change, advertise the engagement process and encourage feedback

- The following audiences were given the opportunity to complete surveys developed specifically to meet their needs:
  - Patients
  - Public
  - Clinicians

- Face to face activity was held with:
  - Patient
  - Public
  - Clinicians
  - Key stakeholders i.e. Councillors

A breakdown of the activity by audience is included within the next three slides

Engagement Methodology

To ensure the best response to the engagement activity the following communications have been taken forward to promote and encourage feedback:

- Press releases
- Posters advertising the Road Shows
- Letters/emails/telephone calls to patient and community groups with the offer of attending to discuss face to face
- Information circulated through NHS and CCG communication channels
- Healthwatch given the opportunity to circulate information through their communications channels

Engagement Methodology

Patients and the public:

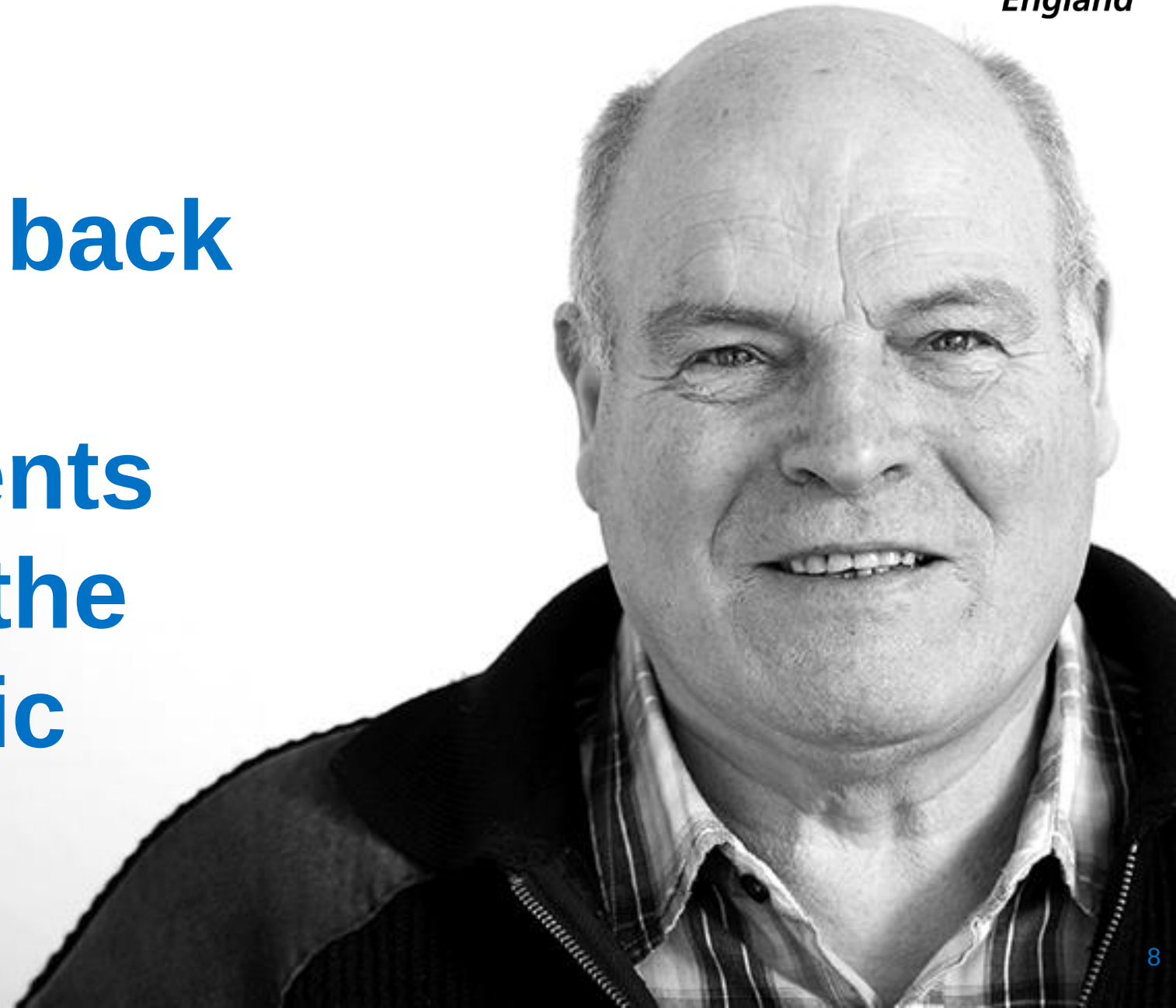
- PET-CT patients currently using the service have been given the opportunity to complete a patient survey whilst waiting at the scanner for their appointments (staff from NHS England have been available on site to support this activity)
- General public survey distributed through various communication channels
- Roadshows were held across South Essex where face to face discussions could be held and opportunity provided for survey to be completed
- Patient and Community groups given the opportunity to give their views face to face and complete surveys

Engagement Methodology

Clinicians:

- National experts in the field of cancer diagnosis and treatment have been given the opportunity to give their view
- Medical Directors from three main referring Trusts given the opportunity to advise on how best to engage Clinicians and to share their views
- An online survey for clinicians was made available to three main referring Trusts and to the Essex Strategic Clinical Network (Cancer)
- Face to face meetings held with Clinicians from the three main referring Trusts

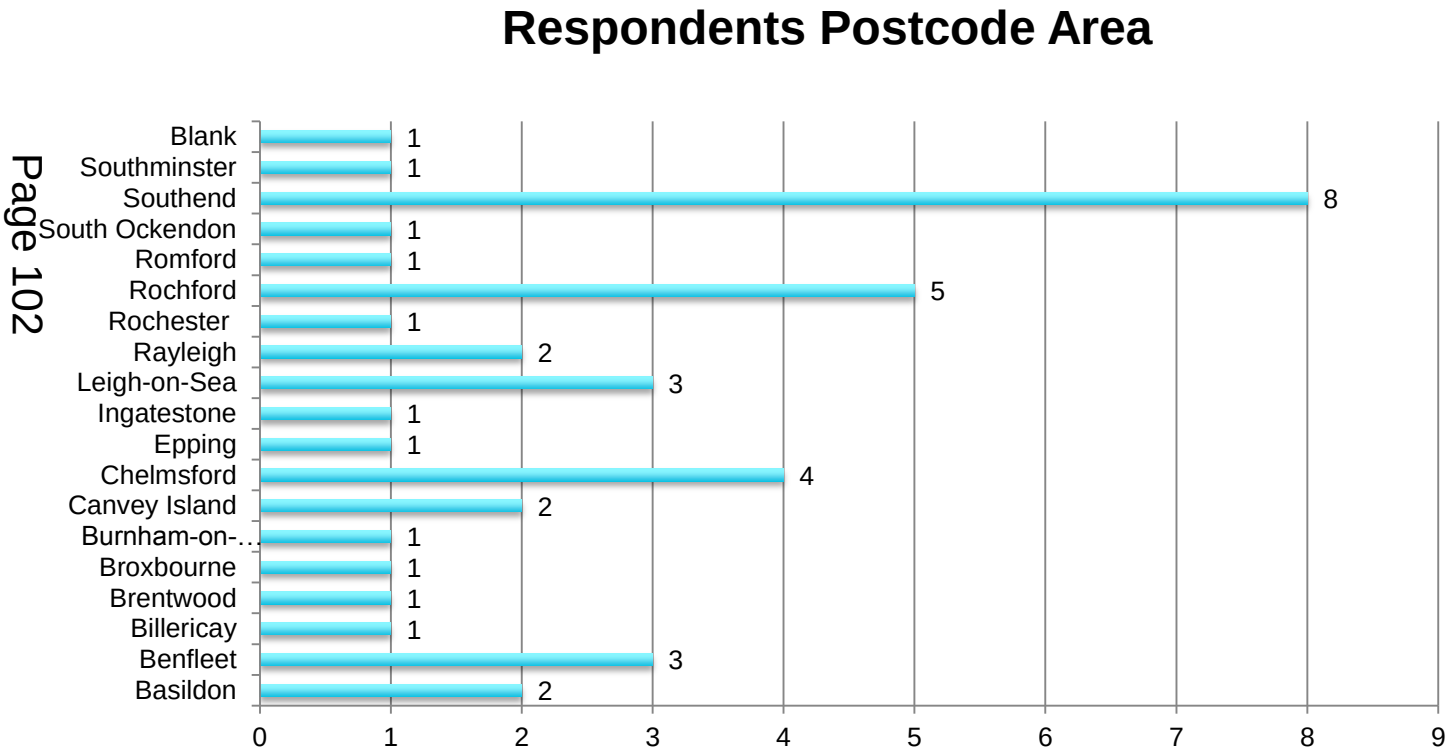
Feedback from patients and the public



PET-CT Patient Survey

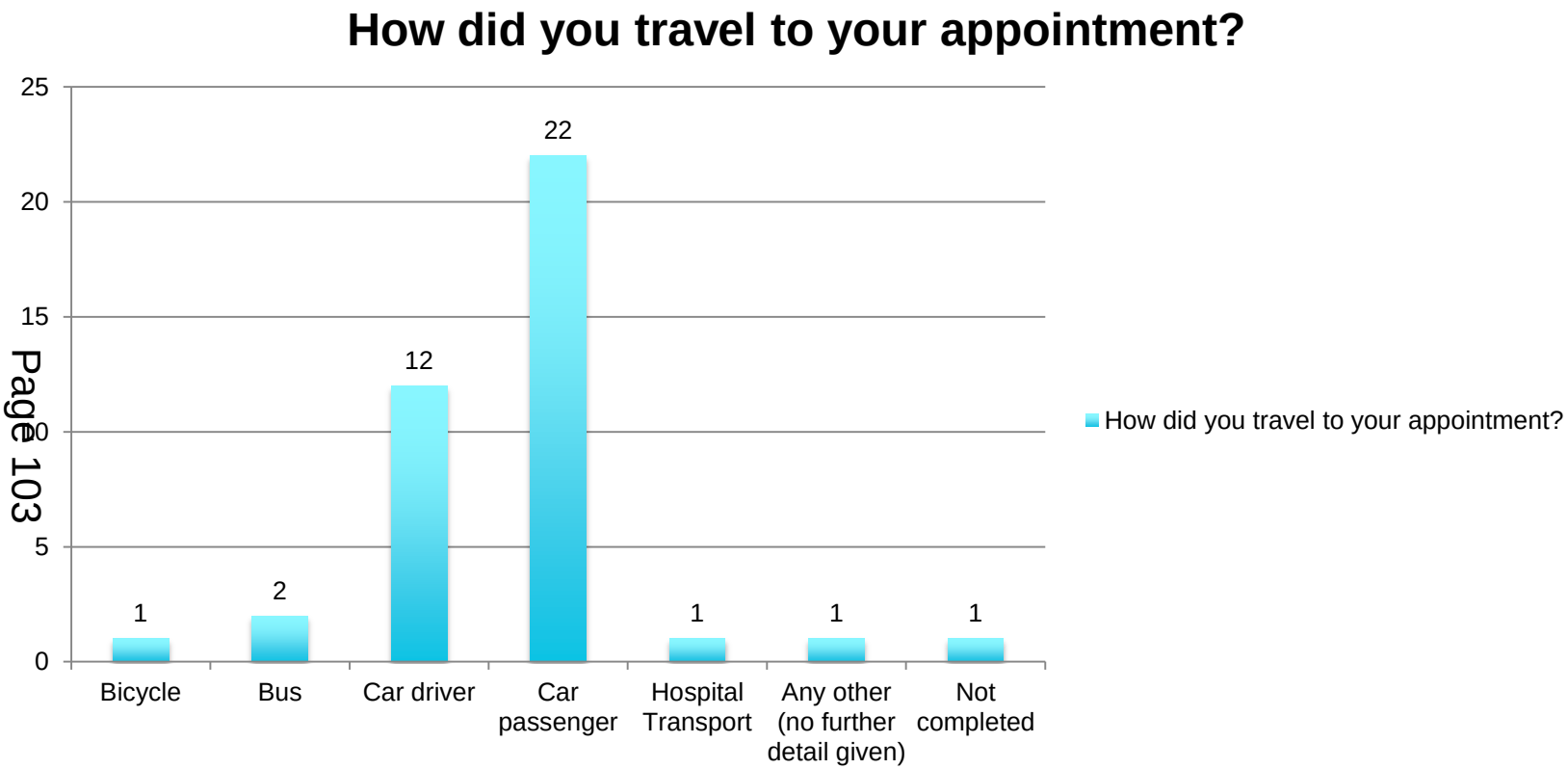
- Patient survey developed to:
  - Provide information on the two options for the long term location of the implementation of the scanner
  - Help to provide an understanding of the impact to patients and users if location changed
  - Seek views on what influences patient choice and preference when selecting a NHS service
- Patient survey on site for patients to complete when attending for scans
- NHS England staff attended site to respond to questions and encourage completion
- Survey available until May 1st
- 40 responses received in total

Patient Survey Responses



40 responses in total

Patient Survey Responses



NB. Hospital Transport was included as an option at a later stage as requested by patient

Patient Survey Responses

- 37 respondents stated that their journey on the day of the appointment was easy

- The 3 respondents that stated their journey was difficult on the day of their appointment were all either driving or a car passenger – One patient stated the traffic was bad and one stated that it was difficult because of where they live (Burnham on Crouch)

It would be more difficult to travel to Southend:	It would be easier to travel to Southend:
18 respondents advised their journey would be more difficult if they had to travel to Southend. These respondents lived in a range of postcode areas including 5 from a Southend postcode. Where reasons were given they included: ▪ Cost of travel ▪ Travel congestion and parking/particularly at school times ▪ Increased journey time – major roads and very busy area ▪ Volume of traffic ▪ Not on bus route	18 respondents advised their journey would be easy if they had to travel to Southend. These respondents lived in a range of areas. Where reasons were given they included: ▪ It would be a bit longer with more traffic but still ok ▪ Live in Leigh on Sea very easy to drive or bus ▪ Does depend on traffic

Patient Survey Responses

NHS England

"Where You Are Treated"

Factors	Ranking ((With responses ranked in order of importance – 1 as 'most important' and 8 as 'least important')									
	1	2	3	4	5	6	7	8	No Rank	Ticked
How quickly I can be seen	25	9	1	1	0	2	0	0	1	1
The amount of choice I have of appointment dates and times	4	4	8	7	9	4	1	1	1	1
Having all of my treatment at the same hospital, even if on different days	4	4	4	13	3	1	6	3	2	0
How close the hospital is to where I live or work	4	5	5	7	5	5	5	2	2	0
How good the public transport links are to the hospital	4	4	2	2	1	5	3	17	2	0
How good the car parking is at the hospital	8	1	5	2	2	6	8	6	1	1
The reputation of the hospital	4	5	5	4	4	7	6	2	3	0
The difference it might help to have on the outcome of my treatment	11	7	4	2	8	1	3	1	3	0

N.B: - Several respondents may have ranked more than one factor equally, not given rankings to all/any factors or ticked boxes rather than give rankings

Patient Survey Responses

"Where Services Are?"

Factors	Ranking (with responses in order or importance – 1 as 'most important' and 9 as 'least important'										
	1	2	3	4	5	6	7	8	9	Not Ranked	Ticked
You should put the scanner on the site which has the larger number of inpatients who use the service	14	7	5	1	2	1	2	5	0	1	2
You should put the scanner on the site that has the shortest average journey times	6	6	2	6	6	4	6	1	0	3	0
You should put the scanner on the site near other services it needs to work closely with now	6	9	10	2	2	5	2	1	0	3	0
You should put the scanner on the site near other services it may need to work closely with in the future to develop the latest techniques and treatments	14	5	7	5	2	2	2	0	0	1	2
You should make sure that all journey times are under one hour	2	2	2	8	7	9	2	4	0	4	0
You should make sure that all journey times are under 30 minutes	4	2	2	5	5	6	3	5	4	4	0
You should provide clear information for patients who need the scan	9	2	5	6	5	0	9	2	0	1	1
You should work with public transport to improve transport links	2	4	6	2	4	4	2	11	1	3	1
Other	0	0	0	0	0	0	0	1	9	30	0

N.B: - Several respondents may have ranked more than one factor equally, not given rankings to all/any factors or ticked boxes rather than giving rankings

Patient Survey Responses

Patients were asked whether there was anything else they thought NHS England should consider in deciding on the location of the PET-CT service in South Essex and they were also invited to give additional comments. Their responses have been themed as follows:

- Location and travel 
- Clinical 
- Other 

Patient Survey Responses

I live near Southend and obviously hospital of choice due to breathing difficulties

Basildon is a huge town and not many people in these areas around Basildon are able to travel to Southend due to expense or distance

Needs to be as near as possible to majority of people

Basildon much easier to get to

Basildon more central – Southend is out of the way x 3

Money raised to purchase the scanner was for Southend Hospital

Southend is limited – it is only Southend patients

Should stay at Basildon

Basildon more accessible to the whole of the County

Should be centralised at Basildon as it has a lot of surrounding areas that use it x 2

Southend for most of the day is gridlocked and the university campus is already tired and overcrowded

Southend Hospital harder to get to than Basildon

Basildon has easy access via M25, A13, A127 Southend is in the backstreets and has a lot of congestion

Basildon is my location plus there are more surrounding areas which are nearer to Basildon which patients can access

Should be at Chelmsford

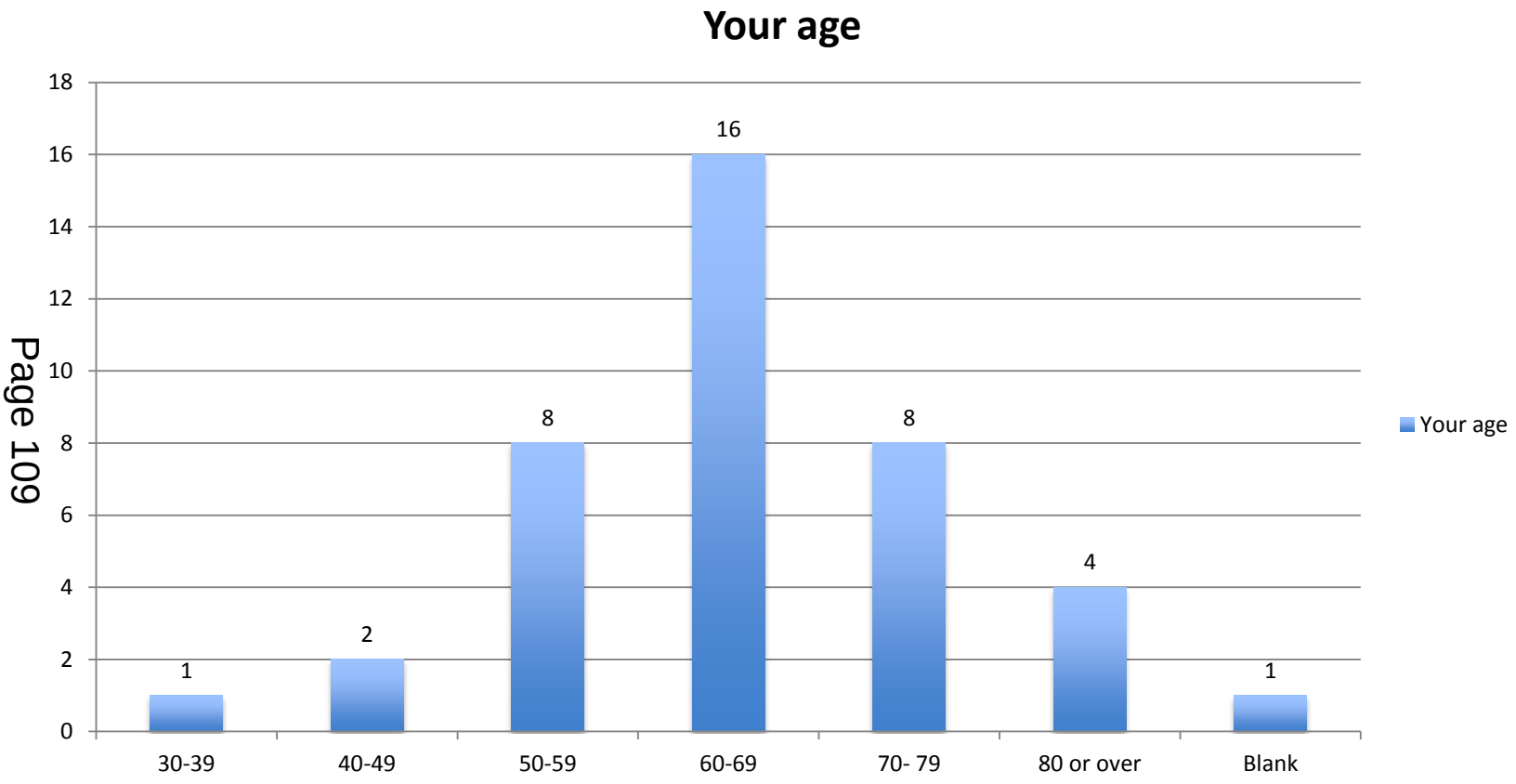
The services are good and very helpful

GP access to the scanner

Make sure the waiting area is comfortable with refreshments available for those accompanying patients as often long periods to wait

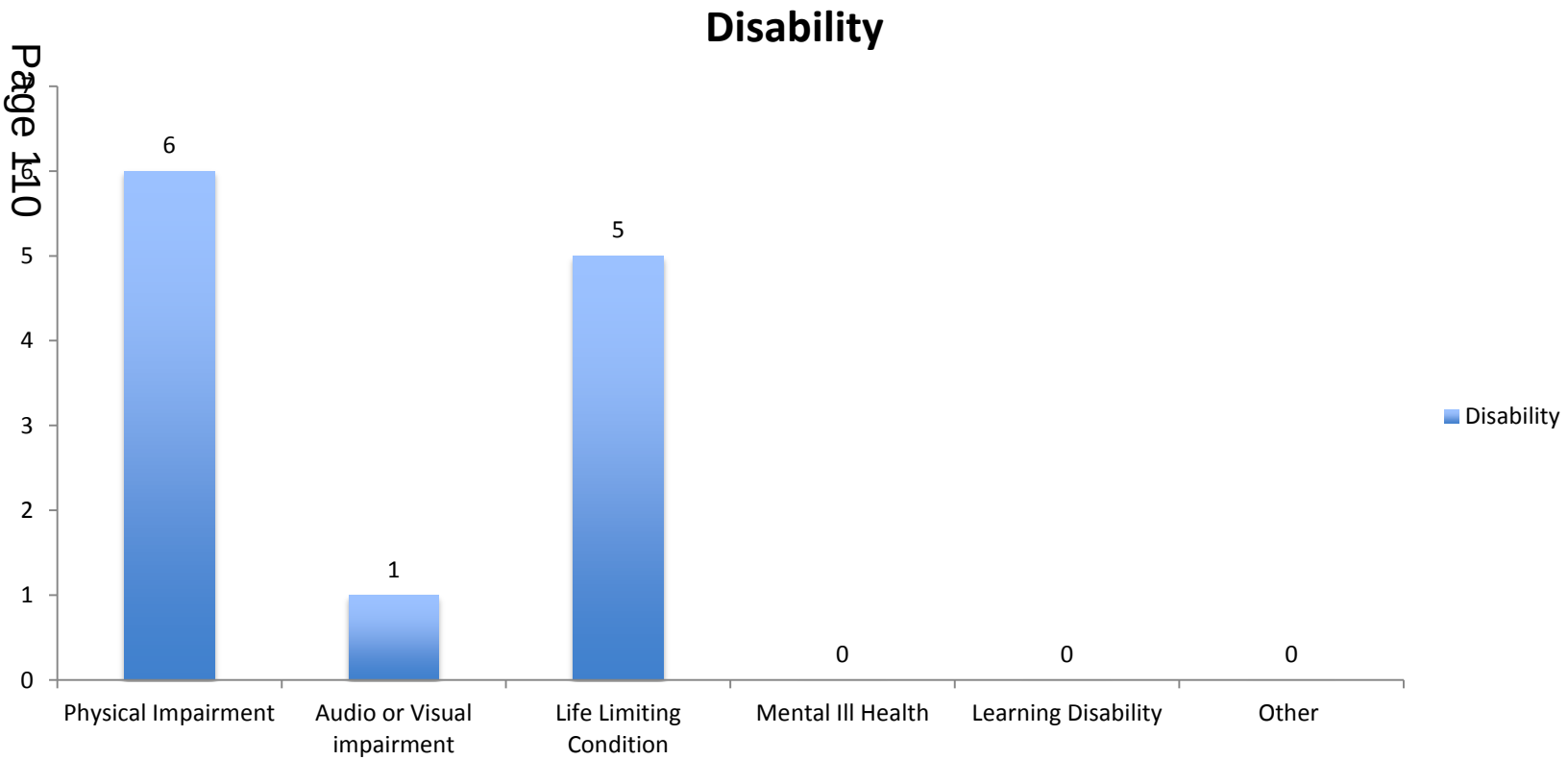
Parking – should have parking just for scanner patients x 2

Patient Survey Responses



Patient Survey Responses

10 patients considered themselves to have the following disabilities:



General Public Survey

- Public survey developed to:
  - Provide information on the two options for the long term location of the scanner
  - Seek views on what influences patient choice and preference when selecting a NHS service
  - Ask the public what they think the NHS should consider when deciding the location of the scanner

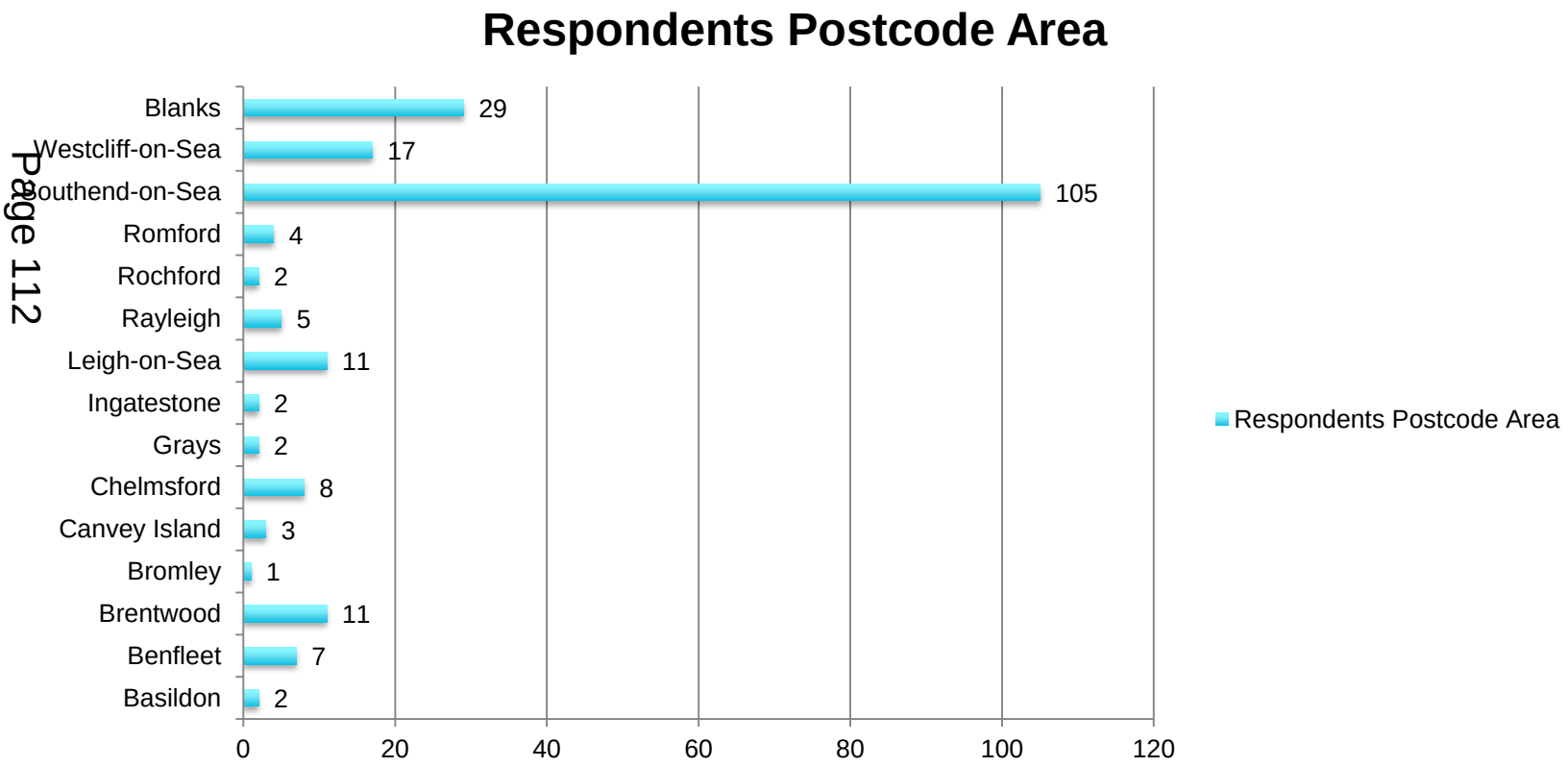
- Public survey circulated:
  - Through all communication channels
  - Made available at Roadshows and Community Group Meetings
  - Distributed via Community Group Members

- NHS England staff available at Roadshows and Community group meetings to respond to questions

- Survey available until April 16th

- 209 responses received in total

General Public Survey



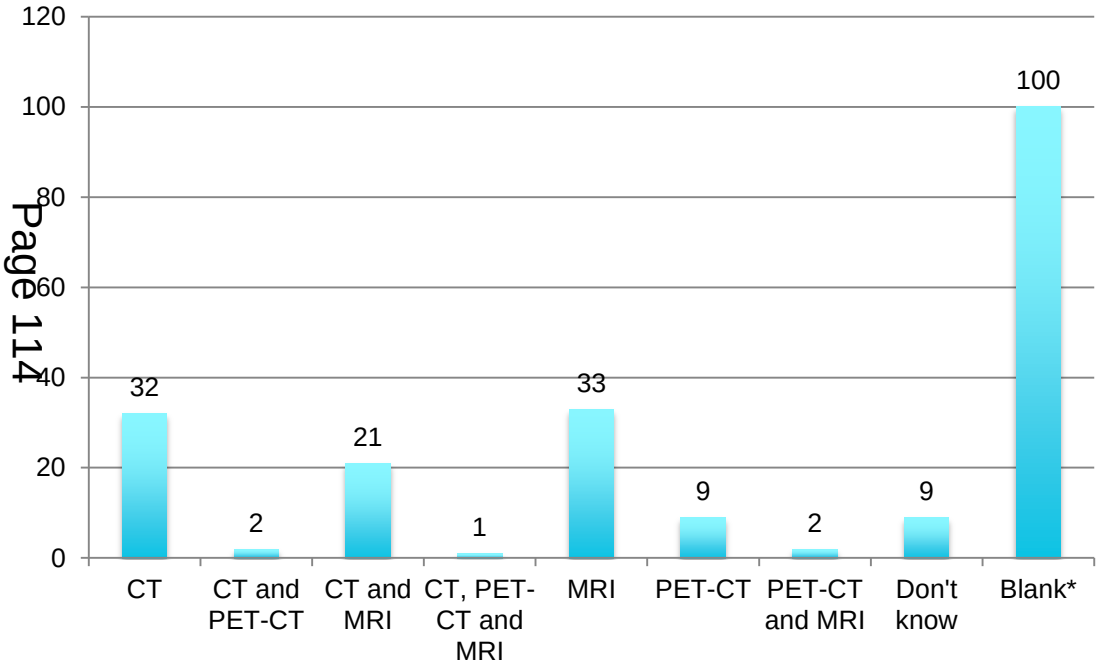
General Public Survey

	Yes	No	Don't know	Blank
Have you or a close relative been diagnosed with cancer in the last ten years?	102	98	9	0
Have you or a close relative had a scan?	128	73	3	5

If yes, which hospital?	Nos of respondents
Blank (includes those who replied "no" to whether they or their relative had a scan)	91
Southend	71
Basildon	15
Southend & Basildon	5
Colchester	3
Broomfield	2
Southend & Wellesley Hospital	2
There were 20 further responses all stating individual hospitals which can be made available if required	

General Public Survey

Do you know whether it was a CT scan, PET-CT scan, MRI scan?



* Includes those who replied no to whether the respondent or their relative had a scan

When asked what the scan was for there were 80 differing responses – the three with the most responses included:

- Cancer (11 respondents)
- Prostrate cancer/possible (7 respondents)
- Breast cancer (6 respondents)

The remaining responses can be made available if required

General Public Survey

"Where You Are Treated"

(With responses ranked in order of importance – No. 1 as 'most important' & No. 8 as 'least important')

Factors	Ranking									
	1	2	3	4	5	6	7	8	Blank	Tick
How quickly I can be seen	138	27	14	6	1	2	0	2	12	7
The amount of choice I have of appointment dates and times	11	29	16	31	36	27	17	13	25	4
Having all of my treatment at the same hospital, even if on different days	28	50	30	30	20	14	10	2	19	5(& 1 "very good")
How close the hospital is to where I live or work	23	17	25	26	30	36	14	9	21	7 (& 1 "Brentwood")
How good the public transport links are to the hospital	18	10	12	20	19	13	29	57	26	3(& 1 "good" & 1 "y")
How good the car parking is at the hospital	9	3	9	9	16	30	44	56	25	5(& 1 "very good", 1 "x" & 1 "no")
The reputation of the hospital	26	28	34	24	22	23	16	10	20	4(& 1 "good" & 1 "very good")
The difference it might help to have on the outcome of my treatment	32	34	28	24	19	15	22	8	22	3(& 1 "9" & 1 "very good")

N.B: - Several respondents may have ranked more than one factor equally, not given rankings to all/any factors or ticked boxes rather than give rankings "Where You Are Treated"

General Public Survey

"Where Services Are - Which is the most important factor you think we should consider in our plans for the permanent specialised PET-CT scanning service"

(With responses ranked in order of importance – No. 1 as 'most important' & No. 9 as 'least important')

Factors	Ranking										
	1	2	3	4	5	6	7	8	9	Blank	Tick
You should put the scanner on the site which has the larger number of inpatients who use the service	57	22	26	18	14	9	9	14	3	34	2 (& 1 "yes")
You should put the scanner on the site that has the shorter average journey times	29	16	15	30	41	19	14	3	0	38	2 (& 1 "x" & 1 "no")
You should put the scanner on the site near other services it needs to work closely with now	64	54	29	20	7	3	1	2	0	24	3 (& 1 "x" & 1 "yes")
You should put the scanner on the site near other services it may need to work closely with in the future to develop the latest techniques and treatments	61	58	36	11	9	3	1	3	1	21	3 (& 1 "x" & 1 "ok")
You should make sure that all journey times are under one hour	21	6	14	11	22	36	29	31	0	36	1 (& 1 "x" & 1 "ok")
You should make sure that all journey times are under 30 minutes	12	8	20	12	22	18	44	27	3	40	2 (& 1 "very good")
You should provide clear information for patients who need the scan	28	20	22	42	20	17	20	5	2	27	4 (& 1 "x" & 1 "all the time")
You should work with public transport to improve transport links	18	9	11	19	12	32	20	50	2	32	2 (& 1 "x" & 1 "yes")
Other	4*	3	0	1	2	0	2	5	67 **	124 ***	1

N.B: - Several respondents may have ranked more than one factor equally, not given rankings to all/any factors or ticked boxes rather than give rankings* includes 1 "staffing" ** includes 1 "cost" *** includes 1 "take mobility into account eg cannot walk"

General Survey Responses

The public were asked whether there was anything else they thought NHS England should consider in deciding on the location of the PET-CT service in South Essex and they were also invited to give additional comments. Their responses have been themed as follows:

- Location and travel 
- Clinical 
- Other 

General Public Survey Responses

NHS England

You should consider the number of people who cannot travel by car and use public transport

Husband an in-patient at Basildon last year, parking was dreadful (Southend much better) car park at Basildon long way from any of the clinics while Southend very convenient

Difficult to park at all hospitals

Parking and cost of parking

Ease of access with good parking or transport very important

Preference is Southend Hospital because of difficulty travelling by public transport

Age profile of people requiring this service e.g. 70 plus their ability to get to and from the hospital

Being diagnosed with cancer is very stressful. You need to have all treatment including scans at your local hospital. Travel adds to stress

Possibly Broomfield, Chelmsford or Colchester

The knock on effects to patients who then need other services, e.g. blood tests. Ensure the 'parent' does not make them use inconvenient locations

Consider patients who need a PET-CT scan who are either disabled or on critical list especially people with cancer or something similar

No. Southend should have it

I am mainly concerned with getting the best PET-CT service for patients in Mid Essex so I suggest that Broomfield should be considered an option

To be located near an existing site, that has an operating radiotherapy unit which is Southend

Fastest growth of low income population

Yes PET-CT should benefit both Thurrock and Southend on Sea, therefore Basildon Hospital site would be beneficial for both Basildon and Southend as more central

The cost of moving it, access to other services, existence of staff

Yes Basildon hospital should be made specialised hospital and Southend University Hospital should be District General Hospital

Should be kept in Southend using the hospital for the residents of Southend

Waste of money if the site at Southend University Hospital is not used as its already there

Southend Hospital should provide PET-CT for local cancer patients as priority

Bad experience approaching Basildon

General Public Survey Responses

Install in hospital that specialises in cancer treatment not one that is constantly in special measures or making newspaper headlines

Available out of normal working hours

If waiting times are long should consider accessing private facilities if possible

Most important factor would be locating all the specialist clinicians in the one facility would produce the best outcome

Install at specialist cancer hospital with offers other cancer treatments x 5 – more likely to create Centre of excellence x 2

As the Commission have provided their view presumably with long term view of cancer treatments in mind follow their recommendation

How many patients could you scan in a year?

To use established teams – built up over the years

Hospital should have high ratings for the quality of its services

Time taken to install and commission the PET-CTA reduce unavailability.

Length of time between scan and treatment

Should aim to work with the hospital that has the best outcomes and fewer failures. Availability of trained staff who are prepared to work over Saturdays and Sundays

Imperative that time is as short as possible before scan interpretation and diagnosis and seeing consultant for rapid treatment

We should listen to the clinical experts when it comes to complex services. The public won't be able to decide on what is best

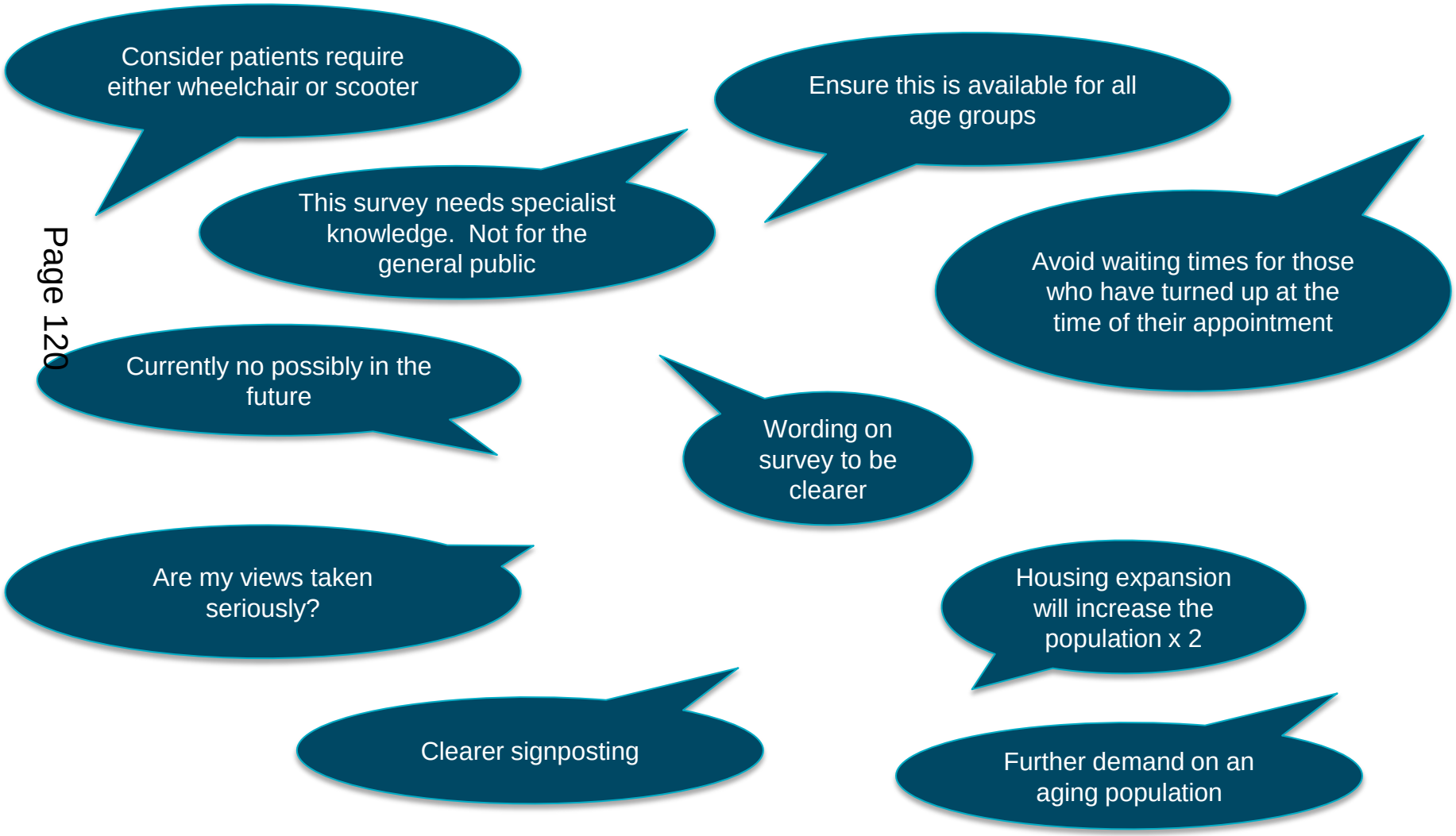
Does the PET-CT scanning service have to be main hospital based or has an outreach clinic been considered

Locating PET-CT in same location as physicists using CT/Radiotherapy makes sense as can use PET-CT imaging accuracy to enhance certain tumour treatments which reduced risk of collateral damage to other organs. Create Centre of excellence PET-CT just one technology – new advances in ultrasound and other techniques and next generation CT scanners may obsolete PET-CT in the future

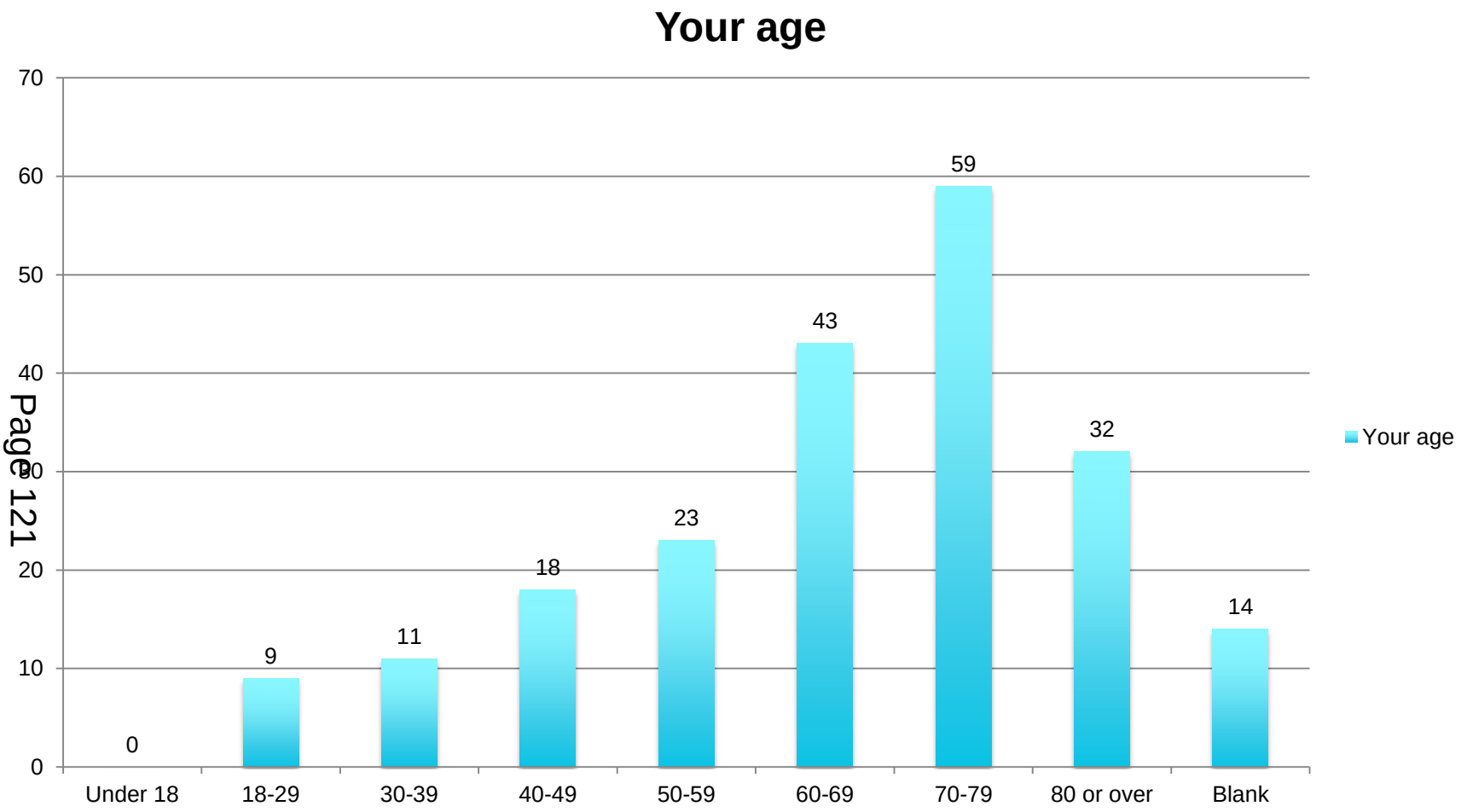
Ensure of the future progression of continued advice and intervention re memory clinic

The scanner should be put in the hospital where it can be used to best advantage

General Public Survey

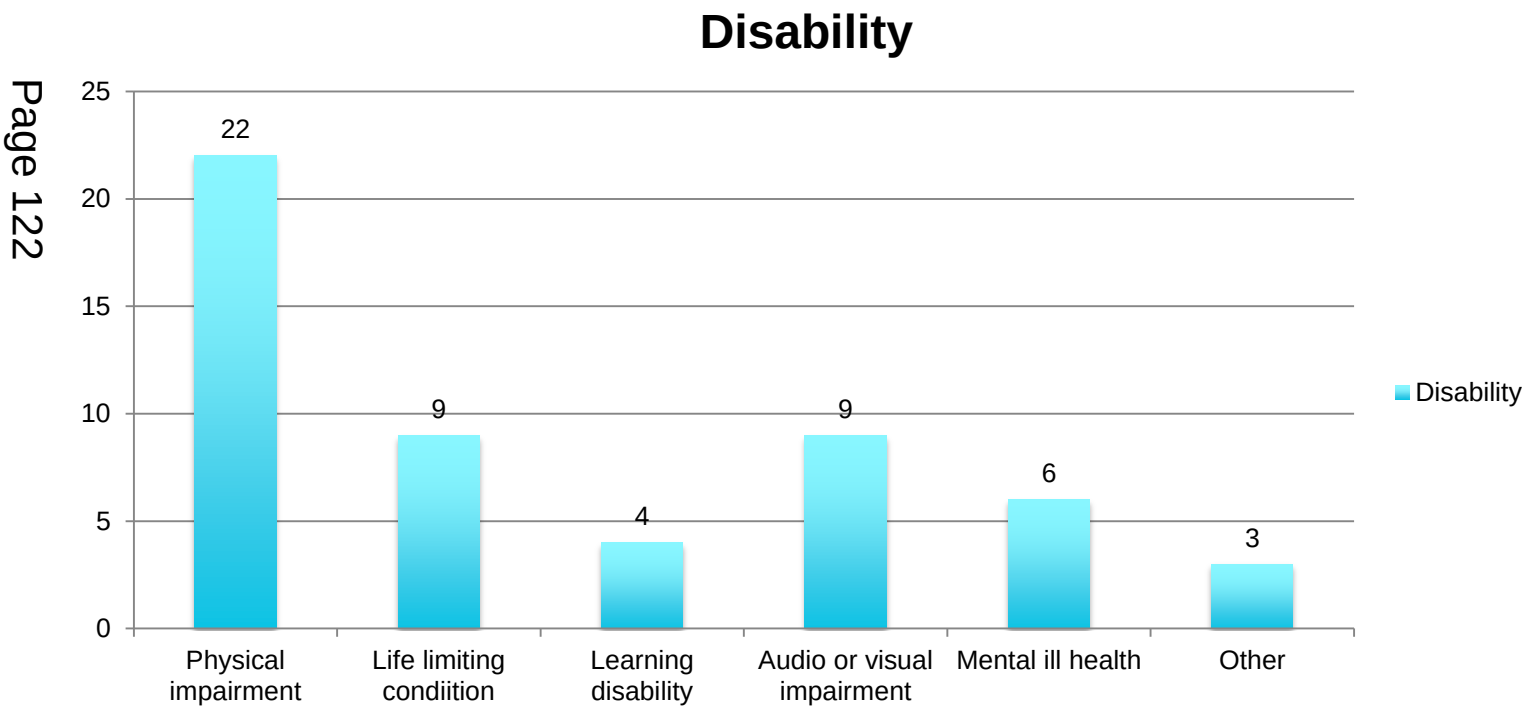


General Public Survey



General Public Survey

- 38 people considered themselves to have the following disabilities:



Face to face – Patients and Public

- A series of Roadshows were held across South Essex to give the opportunity for patients and the public to come along and talk to representatives from NHS England about the proposals for change and to complete the public survey.

- Communications were sent to over 35 stakeholder groups including patient and community groups providing information about the proposals for change and offering attendance at the meetings. As a result the following meetings were attended in addition to the Roadshows:
  - Essex Cancer Forum
  - Stifford Forum
  - Basildon and Brentwood CCG Patient and Community Reference Group (PCRG)
  - Lymphoma Support For You Group Meeting

- Surveys were completed at meetings and the following slides provide feedback received.

Face to face – Patients and Public (1)

Meeting	Feedback
Chelmsford Roadshow	Email sent by a patient/public who attended the Roadshow including the following "I am writing to advise that the information supplied for the public at Chelmsford Library on Wednesday 24/02/16 and which was provided by yourselves is not a balanced account of the arguments for and against co-location. The emails and letters sent by this consultant are included within the full data and a summary included in letters/emails feedback within this presentation
Rayleigh Roadshow	Concern that scanner at Southend was going unused. Concern that Southend Hospital had allowed the scanner to be placed there and wanted the matter to be resolved as soon as possible by NHS England
Stifford Forum	Recognised benefits of both options, noting the following: • Would rather have it locally • Would prefer it available on both sites • Issue with car parking on both sites
Basildon Roadshow	• Concern that NHS England needed to ensure that clinical expertise would help to shape the final decision • Concern regarding the naming of the survey • Follow up email expressing thanks for constructive meeting
Basildon and Brentwood CCG Patient and Community Reference Group (PCRG)	• Strong feeling that existing travel regimes should not alter for local patients and that no patients should have to travel further than they are currently doing so. • Strong feeling from the group that the PET-CT service should remain where it is at BTUH • Travel and access and the implications to people should the scanner move featured as a major issue for a number of attendees • Patient/public was in attendance and explained that he has undertaken extensive research on the matter of PET-CT for radiotherapy planning and is unable to find any evidence to support its use – just an idea at this stage and is one that may not come to fruition in clinical practice in the future. He noted that he is also unable to find any recommendation by the Royal College of Radiologists that supports the use of PET-CT for radiotherapy planning. Also noted that the cancer strategy although it mentions RT planning and PET-CT does not make the point that co-location is required • The group feel there are no compelling reasons either clinically or otherwise for the scanner to be moved to SUH • The future should be on the here and now and not on future applications and indications • A significant issue for one member was speed of diagnosis and his view was that location at BTUH would make speed of diagnosis for patients better • The focus should be on diagnosis, not on treatment, PET-CT is used for diagnostic purposes ***Continued on next slide***

Face to face – Patients and Public (1)

Meeting	Feedback
Basildon and Brentwood CCG Patient and Community Reference Group (PCRG) ***Continued from previous slide***	• There was a view that the scanner if at BTUH would be of superior quality than the one currently located at SUH • There was a view that patients and users views should be taken into consideration and that the group appealed to NHS England to leave the service at BTUH • Considerable stress and emotion in having to travel and then wait for results. Anything that increases the time that this takes, at the pre diagnosis stage, is an unacceptable part of the prospective cancer patients journey; especially if there is no need • Hundreds of patients go through Basildon and far more than go to Southend. This also includes patients from outside our area • The geographical element of patients travelling from Brentwood to Southend was taken into consideration. Patients will find it more difficult travelling to Southend. The decision to maintain the PET-CT scanner for diagnostic should remain at Basildon Hospital with the trained professionals. • Patients views are paramount • Most patients needing a PET-CT scan for diagnosis get it at Basildon without any problems. Most such patients do not go on to get radiotherapy • Concern was expressed that the EoE team have misrepresented expert opinion. They have said there are advantages to be gained from co-location with radiotherapy but that is not the consensus of expert opinion and the Royal College of Radiologists (the most appropriate experts have not expressed this view. • The quality of data put forward in the proposal by NHS England. The data confused radiotherapy and screening, apart from the inaccuracies • NHS England use too much 'jargon' and acronyms in their papers and presentations to members of the public • Action: NHS England to be contacted to confirm that the PCRG feel very strongly that the scanner should remain at Basildon listing all reasons raised above and to include any further comments received from the group post meeting

Face to face – Patients and Public (2)

Meeting	Feedback
Basildon and Brentwood CCG – Patient and Community Reference Group meeting ***Continued from previous slide***	Post meeting a further letter was received from patient/public who was in attendance at the meeting and a summary of the key points are shown below: • Concerned that the EoE team have misrepresented expert opinion. Have said there are advantages to be gained from co-location with radiotherapy but that is not the consensus of expert opinion and the Royal College of Radiologists • The EoE team are confused about the role of PET in radiotherapy planning as they misquote expert guidance. I have brought this to their attention with this email following the Chelmsford Roadshow. • No need to co-locate as the current service is functioning satisfactorily as are other services which are distant from radiotherapy units. The amount of information required from the PET scanner to the radiotherapy planning equipment can easily be transferred by simple IT connections or by a CD • National Cancer Strategy Recommendation 30 – response – South Essex is not a major treatment centre furthermore they specifically state that the funding should come be "as part of the national radiotherapy capital fund which means it should not be part of this contract • You consider PET-CT planning for radiotherapy is considered by experts to be superior to CT planning – response – it is clear to me that there are divided opinions on the subject and as research has been taking place for around 10 years with a clear conclusion it would be surprising if there were to be a major change in the existing position of NHS England. Which as explained to me by the specialist commissioning team at Skipton House which was they were not considering this at present. Therefore I do not see it as essential to see the material provided by the experts for further evaluation. I have also read the guidelines from the Royal College of Radiologists and the report from the Department of Health Cancer Policy Team on 'Radiotherapy in England'' and I cannot find recommendations for colocation. • You state that the South Essex Scanner is the only one not co-located with radiotherapy. My response is that reflects the distribution of the population and the decentralised nature of cancer services here. • You state that a scanner at Basildon would mean no scanner at Southend for the next 10-15 years – response – Phase 2 procurement is underway and it is not possible to make such a definite prediction. • Argument for co-location is based on the theory that it could be useful in the future but we will not know how much benefit nor to how many patients nor the detail of the equipment that would need to be used or even if the scanner currently in place would be suitable. We simply do not know if any patients would benefit from co-location with radiotherapy. • In respect of physics services there is little benefit as the physics team have little to do with scanning and they can easily travel to the scanner wherever it is located. There is no advantage to patients. • Therefore I suggest the section 'why might moving the scanner to Southend be better for patients?' be replaced by the statement that it will benefit those patients who can access Southend more easily than Basildon. You may also say that it would be the cheapest option. You could consider saying that it is because unpublished research may provide a reason in the future but I think most people would rather have a more definite reason. • It is also worth considering that patients being scanned in South Essex could have radiotherapy elsewhere, including London, Romford and Chelmsford • Since then I attended the 19th annual PET-CT conference to hear the leading European experts and they presented papers to show that PET-CT for radiotherapy planning remains a minority interest and having questioned many of them it is clear that all services can be provided at sites distant from radiotherapy. • In short there is no clinically valid reason for moving the service.

Feedback from Clinicians

Clinical Survey

- Clinical questionnaire developed to:
  - Understand impact on patients
  - Provide information on whether there is an impact on clinical pathways
  - Seek clinicians views on the two options for implementation of the permanent PCT-CT scanner
- Online questionnaire
- The link to the questionnaire was sent to the Medical Directors of the three main referring Trusts for cascade to clinical stakeholders. And to the Essex Strategic Clinical Network Groups by the Strategic Clinical Network – cancer.
- 19 responses received in total

Clinical Survey Responses

NHS England

Question 1
PET-CT is currently used to support the diagnosis and staging of some cancers how would a change of location of the existing PET-CT service in South Essex affect your patients?

Advantages	Disadvantages
Centralisation - avoiding unfilled slots Dependent on location – fast improved access, improved diagnosis, rapid throughput reducing patient journey time through process, safer outcomes	**Clinically:** ▪ Cardiothoracic Centre where all lung cancer Surgery is done for Essex ▪ Only centre in Essex where medical thoracoscopy for malignant effusion, endobronchial cryotherapy and endobronchial stenting is carried out ▪ Tertiary centre for thoracic and cardiac surgery ▪ Only centre to do Radial EBUS in Essex ▪ Bowel cancer screening service ▪ Large haematology unit ▪ PET-CT mostly used for cancers of the lung and hematological malignancy and therefore on site with tertiary referral thoracic surgery and haemoncology ▪ Used in diagnosis and monitoring of response to therapy for majority of lymphoma patients (one of largest users of scans) ▪ As a rheumatologist often see patients who require PET-CT scan to investigate for large vessel vasculitis and exclude cancers ▪ One of few accredited radiologists is based at BTUH (hematological) ▪ Active and busy upper and lower GI cancer MDT ▪ Clinical risk to patients if moved ▪ Delay a patients pathway ▪ Adverse impact on RTT outcomes ▪ Colorectal (liver mets) – patients would have to attend Basildon, Southend and Royal London ▪ Better for clinicians to have close working relationships with the radiologists reporting the PET-CT scans
	Geographically: ▪ Centrally located - between Chelmsford and Southend – convenient for patients ▪ Good road access ▪ If moved patients will have to do multiple visits at long distances ▪ If service continues to be provided in South Essex, Mid Essex patients will still have to travel ▪ Population served by Basildon Hospital/Thurrock patients (one of poorest populations in the country) would be impacted due to inadequate transport links to Southend. ▪ Central location logical for patients ▪ Patients who lived on western side of Essex would need to travel further to the scanner site and may result in reduced equity of access ▪ Difficult for Rheumatology patients to travel further

Clinical Survey Responses

Question 2
If the location of the PET-CT scanner in South Essex were to change how would the diagnostic and treatment pathways for your patients change?

Clinically:

- Might affect staging of lung cancer before and after surgery and EBUS, mediastinoscopy
- Cardiothoracic Centre for Essex is the Hub for MDT as all lung cancer cases in Essex have to be discussed with Basildon
- If patients choose to travel to London - scans at London Trusts with higher market forces factors will cost more and reduce income to the South Essex regional healthcare economy
- If changes expect delays in getting scans and scan results – detrimental effect on patient care
- Potential delays in overall pathways of patients
- Mid Essex pathway would change
- May delay the timely staging to initiate treatment
- Relocating would further fragment regional cancer pathways, an unnecessary extra step for the majority of patients
- 62 day cancer pathway could be impacted. As have Bowel Cancer Screening Programme at Basildon would have impact on this pathway
- Would have adverse delay in diagnosis and treatment, causing undue anxiety for patients and their families
- Increased fragmentation of care
- If compliance were to fall, may delay the pathways that are in place and could result in treatment delay.
- Do not envisage diagnostic and treatment pathways changing
- Pathway would stay the same

Geographically

- Patients may choose to go to London as better travel links
- Patients unable to travel may not be able to access the PET-CT scan.
- Majority of patients based around Basildon and would be too far to travel particularly if unwell and require urgent investigation
- Increasing distances from patients will result in reduced uptake, longer treatment pathway times affecting targets.
- Patients traveling further and to a place they are unfamiliar with. If siting of cardiothoracic centre and lymphoma treatment centre not changing patients would have to go to one hospital for treatment and another for their scan and many patients elderly and disabled by their cancers
- Would avoid the need to travel to London and would decrease the delays encountered

Clinical Survey Responses

Question 3
Noting that there will be one PET-CT scanner in South Essex where do you think this is best situated and why?

Where	Why
All bar one respondent suggested Basildon	▪ Geographically better for the patient – centrally located and easy access to all hospitals in region ▪ Patient access is easy, patient facilities are superior and there is enhanced safety ▪ Basildon covers a larger population than Southend Hospital (BTUH – 405,000, SH – 350,000) ▪ Mid Essex patients currently go to Basildon – minimum change for patients and staff at Broomfield Hospital however travel would still be a problem for some patients ▪ Best co-located with services that require currently recommended diagnostic PET (Basildon where lung surgery is or Broomfield (where upper GI and head and neck surgery are performed) ▪ Have sufficient experience in providing the service already ▪ The South Essex Bowel Cancer Screening Programme covers a catchment of 800,000. ▪ Cardiothoracic Centre at Basildon ▪ Has the only ARSAC license holder in the region necessary for the administration of the radio pharmaceutical ▪ Best location as patients from all three Trusts can get there easily and fair ▪ BTUH haematology service is largest in region and due to expand further meaning Mid Essex haematology patients will also be utilising the BTUH site ▪ Should be co-located with the specialist clinical pathways which utilise the service most. Highest users are lung and haematology and BTUH is the host site for both. Lung pathways are integrated with the regional tertiary cardiothoracic centre. Future developments for PET-CT include cardiac PET-CT which is currently NICE approved ▪ Scanner would be integrated in the main hospital imaging department and would have access to all the facilities and staffing, which are available in the main hospital ▪ Continue to see and treat many cancers especially haematology ▪ Even when refer onwards the results inform the decision and as such a central location is logical ▪ One of very few accredited radiologists able to perform the investigation ▪ Less central location will lead to delays in the pathway
Three respondents suggested Broomfield Hospital as alternative	▪ Co-located where services that require currently recommended diagnostic PET – where upper GI and head and neck surgery are performed. Haematology services are delivered on all sites although Basildon/Broomfield is a joint service ▪ Recognition that Broomfield may be outside the geographical area and create longer travelling times for significant group of patients ▪ Centrally as possible within target region. Ensures all are not to far and increases uptake – Chelmsford most central and good transport links

Clinical Survey Responses

Question 4 Where do your patients have chemotherapy?
Respondents employed by Basildon Hospital
Basildon x 12 responses
Haematology at Basildon
Depends on site and type of lesion
Lung cancer at Southend
Southend
Urological surgery at Southend
Radical ENT surgery at Broomfield, Chelmsford
Liver mets at Royal London
Not involved in cancer care
Not involved in cancer care
Unsure as do not deal with chemotherapy. Our rheumatology patients receive biologics and cycophosphamide if needed locally at Basildon
Respondents employed by Southend Hospital
Southend for solid tumours
Basildon for haematological cancers
Queens Romford for some brain tumours
UCLH for sarcoma
Respondent employed by Mid Essex Hospital Trust
Broomfield, Chelmsford
Volunteer at Mid Essex Hospital
Broomfield, Chelmsford

Clinical Survey Responses

Question 5 Where do your patients have their inpatient care?
Respondents employed by Basildon Hospital
Basildon x 9 responses
Haematology at Basildon
Lung cancer at Southend
Depends on site and type of lesion
Depends on admission diagnosis except for chemotherapy admitted to Basildon
Southend
Basildon DGH and CTC
Radical gynaecological surgery at Southend
Radical ENT at Chelmsford
Surgery liver mets at Royal London
Not involved in cancer care
All other cancer related complication are dealt with at Basildon like post chemo neutropenia, sepsis, chest drains, medical thoracoscopy, senting, endobronchial, cryotherapy and debulking
Respondents employed by Southend Hospital
Majority at Basildon
Some at Southend
Few at Broomfield, Chelmsford
Respondent employed by Mid Essex Hospital Trust
Broomfield, Chelmsford
Volunteer at Mid Essex
Broomfield, Chelmsford

Clinical Survey Responses

Question 6 : Is your hospital considered the lead hospital in South Essex for the following cancer types: If not which is the lead hospital?					
Respondent's hospital (total)	**The number of respondents identifying each hospital as the lead for the stated cancer :**				
	Lung	**Lymphoma**	**Upper GI**	**Head & Neck**	**Colorectal**
Basildon (16)	Basildon (13)	Basildon (13)	Mid Essex (8)	Mid Essex (8)	Basildon (10)
			Basildon (1)	Southend (1)	Southend (1)
	Southend (1)	Southend (1)	Southend (1)	Southend (1)	Southend (1)
Southend	These are diseases that often require multi-modal treatment with care at more than one site				
Mid Essex			Mid Essex (1)	Mid Essex (1)	
Other Mid Essex Volunteer			Mid Essex (1)	Mid Essex (1)	

Clinical Survey Responses

Question 7: For patients requiring surgery for the cancer listed, where does the surgery take place?					
Respondent's hospital (total)	**The number of respondents identifying each hospital as the lead for the stated cancer :**				
	Lung	**Lymphoma**	**Upper GI**	**Head & Neck**	**Colorectal**
Basildon (15)	Basildon (13)	Basildon (13)	Mid Essex (8)	Mid Essex (8)	Basildon (10)
			Basildon (1)	Southend (1)	Southend (1)
Southend	These are diseases that often require multi-modal treatment with care at more than one site				
Mid Essex			Mid Essex (1)	Mid Essex (1)	
Other Mid Essex Volunteer			Mid Essex (1)	Mid Essex (1)	

Clinical Survey Responses

Question 8: Are joint cancer multi disciplinary team meetings held for any of the cancers below? If so what is the lead hospital?				
	Basildon	**Southend**	**Mid Essex**	**Other (Volunteer) Mid Essex**
Lung	Yes (12)	None	Yes (1)	None
Lymphoma	Yes (9)	None	Yes (1)	None
Upper GI	Yes (3)	None	Yes (10)	Yes (1)
Head and Neck	None	Yes (1)	Yes (10)	Yes (1)
Colorectal	Yes (8)	None	None	None

Question 9: Does your Trust host the specialist cancer MDT for any of the following?				
	Basildon	**Southend**	**Mid Essex**	**Other (Volunteer) Mid Essex**
Lung	Yes (12)	Yes (1)	None	None
Lymphoma	Yes (12)	Yes (1)	None	None
Upper GI	Yes (5)	Yes (1)	Yes (1)	Yes (1)
Head and Neck	Yes (1)	None	Yes (1)	Yes (1)
Colorectal	Yes (9)	Yes (1)	None	None

Clinical Survey Responses

Question 10: Do you have shared hospital pathways of care for the following cancers and if so with which Organisation/Trust				
	Basildon	**Southend**	**Mid Essex**	**Other**
Lung	No (1) Yes Southend (3)	Yes Colchester (1)	No (1)	No (1)
Lymphoma	No (10) Yes Southend (2) Yes Mid Essex (1)	No (1)	No (1)	No (1)
Upper GI	No (9) Yes Mid Essex (5)	Yes Mid Essex (1)	No (1)	No (1)
Head and Neck	No (6) Yes Mid Essex (6) Yes Southend (1)	Yes Mid Essex (1)	No (1)	No (1)
Colorectal	No (11) Yes Southend (2)	No (1)	No (1)	No (1)

Clinical Survey Responses

Question 11: Where do your patients have radiotherapy (with curative intent)?	
Respondents Hospital Trust	**Hospital patients are sent to for radiotherapy**
Basildon	Southend (13)
Southend	Southend (1)
Mid Essex	Colchester (1)
Other (Mid Essex Volunteer)	Colchester (1)

Question 12: What proportion of patients that you refer for a PET-CT scan go on to receive radiotherapy by %?			
Basildon	**Southend**	**Mid Essex**	**Other (Volunteer Mid Essex)**
Up to 5% (5) 10-20% (5) 40-50% (1)	Not answered	Not answered	Don't know

Clinical Survey Responses

Question 13: How many patients per month do you refer for radiotherapy?				
	Basildon	**Southend**	**Mid Essex**	**Other (Volunteer at Mid Essex)**
Lung	5 patients (1)	1 patient (1)	None	Don't know
Lymphoma	Less than 1 (2)	None	None	Don't know
Upper GI	None	1 patient (1)	None	Don't know
Head and Neck	None	None	None	Don't know
Colorectal	None	None	None	Don't know

Clinical Face to Face Feedback

The Clinical Directors were given the opportunity to advise how best to engage Clinicians and as a result face to face meetings were held with:

- The three main referring Trusts:
  - Basildon
  - Southend
  - Mid Essex

- A Face to face meeting was held with the Mid Essex Primary Care Forum

- A summary of the feedback from this activity is included on the following slides

Clinical Face to Face Feedback

Feedback			
Meeting	Clinical	Location and Transport	Other
Mid Essex Primary Care Forum	Noted and understood co-location with radiotherapy long term strategy If radiotherapy planning using PET-CT can be made available it should be taken advantage of If there was not access to RT planning using PET-CT in South Essex, patients would likely flow to Colchester. Advantage if scanner relocated to Southend due to co-location of radiotherapy and future opportunity to use PET-CT for radiotherapy planning.	50% of patients attend Colchester scanner so potential move not as significant as for patients in other areas If relocated to Southend, some of their patients may choose to attend Colchester scanner as travel/access easier	Email follow up to meeting – case presented effectively and happy to work with team to understand if there will be any change in patient flows

Clinical Face to Face Feedback

Feedback			
Meeting	Clinical	Location and Transport	Other
Southend Hospital - Clinicians	SUH treats in excess of 220 lung cancers per year, all noted as radical receive a PET-CT. All with pulmonary nodules found on CT receive a PET-CT. More than 50% that have a CT go onto to have a PET-CT with careful triage of referral and GP x-ray could negate the need to do a CT and bring PET-CT further forward in the pathway, improving the experience and timing for patients reducing cost of CT as well as reduce demand on CT capacity which is already stretched Pilot of 10-15 patients under IHMI contract of above carried out – worked well. Not able to continue due to capacity and waiting time limitations of current PET-CT service Work carried out by Local Lung Cancer Network considering breaches last year. PET-CT earlier in pathway would vastly improve breach status for all referring trusts in South Essex. SUH see and treat more lung cancer patients than BTUH, BTUH provide thoracic surgery but not RT or chemo for solid tumors. Lung cancer resection rate at BTUH is low, SUH are sending some patients to London who have been denied resection at BTUH but are successfully operated on in London. 20% of resected patients referred by SUH for surgery in 2015 were operated on in London BTUH undertaken hematological chemo, not for SUH patients they are cared for at SUH and attendees not aware of any imminent plans to change this – however noting that Success Regime may change pathways of care, but not radiotherapy. Also approx. 10% of lymphoma patients have radiotherapy following their final response to therapy PET-CT this would continue to be at SUH, no plans to change. PET-CT is usually, in England and in Europe, located with other pertinent services as part of the cancer pathway i.e. radiotherapy Concern lack of capacity at present limiting patient experience and impacting negatively on waiting times – scanner breaks down regularly and has limited image quality – the SUH scanner which is a purpose built facility would be able to provide capacity more quickly than a build at BTUH. *Continued on next slide*	Situation of PET-CT not of significance to population of South Essex as already travel for services in regards to cancer, often to two or more Trusts Of consideration is colocation of other cancer services i.e. SUH undertake much more chemo than BTUH and radiotherapy patients are already travelling to SUH. *Continued on next slide*	No further comments recorded

Clinical Face to Face Feedback

Feedback			
Meeting	Clinical	Location and Transport	Other
Southend Hospital – Clinicians ***Continued from previous slide***	RT planning could be developed with PET-CT on site – currently are using PET elements but are having to fuse manually to align to planning CT but if co-located equipment could be aligned with no need to undertake manual process meaning that the diagnostic CT element of the PET-CT could be used much more efficiently to shape the RT. RT planning using PET could then be applied to H&N patients, brain patients, rectal patients and oesophagus patients requiring RT with much better effect than just CT as now. RT planning using PET element could also be applied to lymphoma patients but minority due to small numbers experiencing RT. Would also save on radiation exposure to both staff and patients. Also potentially reducing patient attendances and improving patient experience. Could start RT planning using PET-CT for a defined group of patients now, with no additional coast and without the need to undertake a specific RT planning PET-CT meaning the target area for RT much more defined therefore better outcome and experience longer term for patients if colocated so lasers and set up could be co-aligned, have a flat bed and have all facilities required for RT and planning. Lasers can't be aligned if PET-CT not on site. Med Physics and Nuclear Medicine at SUH, provide support in this regard to BTUH. Evidence to support use of PET-CT much earlier in the pathway for lung and Head and neck and probably oesophagus but more flexible capacity is required to meet cancer pathway times, current service cannot deliver sufficiently to allow this Lung cancer outcomes better than BTUH and can be evidenced SUH and BTUH have a joint lung cancer MDT weekly so services are already co-aligned, location of PET-CT immaterial in this regard Cancer patient traffic to PET-CT increasing and will continue to do so, efficiencies need to be built into the system to ensure can cope and manage demand. PET-CT co-located with chemo and RT will assist. Cardiac MR is preferred for cardiac perfusion scanning and is the model that has been followed by BTUH as opposed to PET-CT and although NICE note use of PET-CT as well as MR, MR is used alongside SPECT, do not see demand for PET-CT for cardiology increasing as BTUH have chose to follow MR route The Cardiologists who run CTC also based at Southend, Harlow and Basildon. Oncologists are also based at all three hospitals. Dementia – PET-CT not commissioned as main barrier no treatment – international trial will be announced in Autumn which could lead to more people using PET-CT but would need commissioning.	Patients have to travel round Essex for elements of care i.e. H&N and esophageal surgery at Mid Essex but all have a PET-CT and there is not a PET-CT at Chelmsford i.e. ENT patients attend 3 hospitals already i.e. Chelmsford on referral, BTUH or Colchester for PET-CT, Mid Essex for surgery and SUH or Colchester for Radiotherapy.	No further comments recorded

Clinical Face to Face Feedback

Feedback			
Meeting	Clinical	Location and Transport	Other
Mid Essex - Clinicians	Issues with the performance of the current service – not getting reports within timescales. Sometimes do not get the appointment for 2 weeks and then wait further for results Radiologist – not sure would have enough numbers to report PET-CT (advised report minimum 300 a year and would discuss out of meeting if wanted to report) Imperative that there is access to fixed site scanner which will allow more capacity and relieve issues with waiting times, should be located with radiotherapy Diagnose approximately 200 patients per year in lung and approximately 100 a year have a PET-CT scan for lung. Having a fixed site will increase capacity and it doesn't matter that it is based at Southend – makes much more sense to locate the scanner where the fixed site is now Mid Essex Clinicians will send their patients wherever they need to for a PET-CT scan – the decision that is being made is based on politics rather than on clinical evidence. Success Regime is focusing on Emergency/Urgent care and not on cancer where diagnostics are key and should be a priority area. Oncologists are employed across the three trusts. The concept of the cancer centre is virtual. Urology won't fit with the Essex Success regime if it goes to Colchester. Mid Essex hasn't had strong cancer leadership historically. Mid Essex has a very busy chemotherapy unit for lymphoma, this will continue, it is not envisaged that all lymphoma patients requiring chemo will go to Basildon–patients having chemotherapy on occasions need to be admitted via or attend A&E, they do so at their nearest site and usually where the chemo has been delivered, therefore chemo and A&E is helpful if on same site and easy to access by patient. The document presented by Basildon re the location of the scanner is riddled with political posturing – it is not a lung cancer centre, but provides lung cancer surgery only, from data about 20% of lung cancer patients have surgery, only 12% of those have it at Basildon the rest attend other sites i.e. Addenbrookes/London due to different approaches to surgical resection ***Continued on next slide***	Doesn't matter where scanner is located as patients will still have to travel and do travel all over Essex for elements of care i.e. large skin cancer practice at MEHT (melanoma) they travel to either Basildon or Colchester for PET-CT, could easily travel to Southend Doesn't seem to matter to the patients where the service is delivered as they have to travel from mid Essex. What is important is speed of access ***Continued on next slide***	Listening is not happening, decision has already been made Claire Panniker should have a view and be involved – should arrange a meeting with her The decision making process should be independent of Claire as she has conflict of interest as Chief Executive of Basildon, Mid Esex and Success Regime ***Continued on next slide***

Clinical Face to Face Feedback

Feedback			
Meeting	Clinical	Location and Transport	Other
Mid Essex – Clinicians ***Continued from previous slide***	Most radiotherapy for Mid Essex is carried out at Colchester but could go to Southend All oncology for Basildon and Mid Essex go for radiotherapy elsewhere Patients with haematology who live in mid (e.g Braintree) would come to mid Essex irrespective of haematology provision at Basildon Clinicians have overplayed the reasons for keeping the scanner at Basildon. Basildon is unwilling to see all three sites – they want everything at their site. Requires strong leadership as a whole Need permanent facility to allow research and trials PET-CT specific, and cancer using PET-CT If want to be able to do research need to have one site for all diagnostics – looking at out centres – could be in Wickford – outside of the acute hospital Where the location of the scanner is put should be more about systems available and how they talk to each other Infrastructure within the NHS is not in place – if IT systems worked better it wouldn't matter where the scanner was In US Centres don't do MRI but do PET for radiotherapy planning – we are not doing it this way because of logistical problems and lack of access, are overlaying MRI on CT planning scan but could access PET-CT for planning if it were available can't move forward with PET-CT radiotherapy planning due to current position which would have benefits for H&N, Lymphoma – mediastinal masses If carrying out a registration need alignment of radiotherapy and PET-CT talking to each other – better long term outcome for patients – head and neck cancer Probably not treating as many lung patients with radiotherapy as could be but this could change Imaging should be linked with research and should marry with Anglia Ruskin – radiology/Academy type school in Essex ***Continued on next slide***	Need to see the three sites as one rather than individual sites going forward. When PACs contract ends in 2017 there will be a joint service where all sites will have access to all imaging. Should be thinking of the Success Regime in relation to location and should think of triangle and put diagnostic services within the cenre of this – Hanningfield, Wickford etc.	Tribalism in Essex is an issue however this is political and beyond individual clinicians as there are joint and shared posts across the whole of Essex such as Oncology and most work very well together

Clinical Face to Face Feedback

Feedback			
Meeting	Clinical	Location and Transport	Other
Mid Essex – Clinicians ***Continued from previous slide***	Using logic should use the static service at Southend – if another decision is made it is not clinical it is political and would take longer to implement, need better and quicker access to PET-CT now Should be either supporting the Success Regime or not. Basildon patients are suffering on a weekly basis because issues with the PET-CT service Southend should go it alone and turn on the service If the scanner at Southend is not turned on within a month the Success Regime is blown out of the water – logic tells you it is the best site All three sites should be thought of as one site Irony that some Basildon patients go to Southend for their treatment Complex lung cancer patients requiring surgery sent to Brompton/Guys etc. not to Basildon Basildon do not have the infra structure – junior doctors to support all of the lung cancer surgery requirements In UK there is no lung cancer screening trial as it has stopped – data is coming from America and others, no firm plans to start lung cancer screening and if it were to happen more patients would require PET-CT so another scanner would be needed anyway No one is going to be the central base for a lung cancer screening in Essex without a national decision, it will be nationally led Lung cancer trial for potential screening is not going to expand in UK as haven't got the funding to carry on Cardiothoracic Centre currently does not meet the service specification When service specification finalised will do more thoracic service Send all complex thoracic surgery elsewhere as not able to do in Basildon Should look at the clinical strength in where services are delivered Note that physics team are located at Southend, physics are needed to support PET-CT generally and its use in radiotherapy planning		

Clinical Face to Face Feedback

Feedback			
Meeting	Clinical	Location and Transport	Other
Basildon – Clinicians	Upper GI rep – From a clinical perspective it doesn't make that much difference but it is in the interest of patients. The positioning of the static unit next to the existing urology unit makes sense Key role for upper GI treatment/maybe an evolving role using PET-CT to monitor early response to treatments – future role Chemo available here so if there is a protocol where PET would be beneficial we have those patients here as does Southend – argument is from pragmatic position. Use of PET will increase, demand will go up and may be a time when patients need more than one scan Significant increase in demand over the last year Issues with scanner at the moment is because the static is not installed – a static would provide a longer working day and more days of the week BTUH need to not be using PET too early or at least manage patients that are not appropriate for it. Hospital would need to look at the ratio as to how many patients need the PET – areas of uncertainty From lung cancer surgery point of view and from a staging point of view for lung cancer it is critical to have scanner at BTUH – widest experience center in the region.. The use of PET-CT for screening for lung cancer has been approved in America – this is likely to come to us in the next year or so – important to have scanner on site to deal with these developments Surgical rates for lung surgery are 20%. All of the sites see a lot of lung cancer patients we get 600 referrals each year. PET-CT is now coming in much earlier before a biopsy. Patients do receive chemo at Southend but treatment (surgery) at BTUH Role of PET-CT in relation to screening (lung nodules) – screening here would be a certain criteria anyone over 55 with significant smoking history would be screened and my go on to have PET-CT scan. Aim to increase the detection rate which is currently 20%. Any nodes over 8mm would be scanned. If BTUH are to have a lead role with the Success Regime we will need the scanner on site to support lung cancer screening service. ***Continued on next slide***	Patients do not want to be moving further when the test can be done locally, strongly believe the service should remain at BTUH Basildon is the most central point, the journey to SUH is difficult. Upper GI Network – majority felt that having the base at BTUH makes geographical sense as it is in the center of the patch. ***Continued on next slide***	Argument two fold, good service, demand is going up so keen to see a static unit rather than a mobile unit. Patient feedback that the timeliness of the service is most important to patients

Clinical Face to Face Feedback

Feedback			
Meeting	Clinical	Location and Transport	Other
Basildon – Clinicians ***Continued from previous slide***	Plans for BTUH to merge with Mid Essex team to provide a more robust service for patients with lymphoma, the patients will be receiving chemo at this site so would make sense to have the PET-CT scanner here as it is easier to get here and they are already coming here for lymphoma care. Currently patients have their chemo at Broomfield, in a few months time they will have their entire lymphoma cancer pathway delivered at BTUH Haematology pathway – CCG due to sign off this next week. BTUH in process of appointing 2 new consultants to cover expected increase in Lymphoma patients from Mid Essex BTUH also support harlow haematology patients Once amalgamation of heamatology service takes place opportunity for the Chelmsford patients to be placed at BTUH for relapsed lymphoma. Lymphoma is using PET-CT for that , increasingly realising there is a role. Opportunity for research if all in the pipeline. Alliance Medical have contract with GE and they want to call a national research programme. Trust is embarking on 2.5m rebuild in August which will involve redesigning the unit. It will have a reporting hub as part of success regime from an imaging point of view and want to be best in the region. Greatest number of registrars, two will align perfectly which will be seamless Cardiologist – clinical imaging specialised scans – moving towards cardiac PET and would be very useful if on site. Only reason not using because it is not available. Consultant Rheumatologist – lead for research and medicine BTUH is the highest recruiter for research. Have chemo at Southend for the age group they question whether would be bothered to do the treatment. For the stage and test and where we can keep them in house we go to mid Essex. Head and neck cancer patients travel all over the region. Bowel screening – have put in bid to be Essex Centre which will mean bowel scoping – when get it BTUH will be the host. ***Continued on next slide***	Travelling to the centre is much easier for patients Southend patients don't want to travel either. BTUH most accessible area, because of rail, road, public transport Demographic and accessibly close to 1m patients are closer to Basildon – geography for all patients is that this is the closest site, have links with Queens hospital, so if had a PET-CT the unit here would have patients from London.	

Clinical Face to Face Feedback

Feedback			
Meeting	Clinical	Location and Transport	Other
Basildon – Clinicians ***Continued from previous slide***	Cancer network the priority is to have a resolution to this it is impacting our diagnostic pathway. Need to think about bringing the PET-CT n earlier to lower bowel diagnosis for the 28 days. Looking Essex wide for accessibility thinking where the greatest use of PET-CT will be Trying to reduce fragmentation in the framework when patient is travelling outside of the area, it swings even further to delivering this and ensuring appropriate access Clinical contact is clear with current service for all, slightly superior for Basildon due to pathways. The only reason it has changed is because of a commercial interest Cardiothoracic we have a lot of need for PET-CT, there has been a lot of information published for PET-CT in relation to infections Patients need continuity they come here have their PET-CT scan, it is important to be able to offer this all under one roof. With regards to 2 week wait – patients are referred directly into the service and BTUH currently have 100% compliance for hematology pathway, no breaches, by changing location there would be a fragment within the service. Broomfield patients would be going to three sites if scanner moved		

Letters, emails, telephone calls and petitions

Summary of letters/emails/telephone conversations

Broken down into the following themes:

- Geographical and transport
- Location of the scanner
- Clinical
- Engagement exercise; and
- Other

Theme: Geographical and Transport	From
Feedback from meeting with Mid Essex GPs: If scanner were to relocate to Southend some of their patients (i.e. South Woodham Ferrers) may choose to attend the Colchester scanner because travel and access is easier than getting to Southend.	Mid Essex GPs
Journey time adds to stress as patient so having PET-CT scan close to home is essential as a patient for diagnostic purposes	Patient/Public

Summary of letters/emails/telephone conversations

Theme: Location of the scanner	From
Enquiry about location of PET-CT scanner following letter from constituent	James Duddridge MP
Enquiry from constituent to Jeremy Hunt MP – concerns re unused scanner at Southend and experiences of having a PET-CT scan carried out by Alliance Medical	Patient/Public
Letter sent to Jeremy Hunt MP on behalf of full Council meeting of 27.1.16 expressing concern over proposals (also included within engagement process)	Cllr J Kent, Leader of Thurrock Council
Response to request to provide feedback on proposed questionnaire presented at Essex Local Cancer Forum - having accessible diagnostic services on site is of huge benefit to patients locally. Questionnaire misleading in focusing on use of PET-CT for treatment when contract is for diagnostic purposes - Basildon is the Cancer Unit required to provide diagnostic investigations. Questionnaire does not address access for patients & keen to see how patients/service users will be involved in the consultation process	MacMillan Lead Cancer Nurse, Basildon & Thurrock NHS Trust
"Where do mid Essex patients go for PET-CT scans at present? " & "If new scanner is at Basildon, will provide increased capacity so that is preferred, as travel distance is shorter-queries if that is correct" & ""How did Southend get selected as an option for scanner? Mid Essex patients currently go to Basildon or Colchester, but not Southend. Surely Broomfield should be an option?" & Notes J Hubert's comment "that there is insufficient activity to justify 2 scanners in South Essex, but of course I am suggesting a scanner in mid Essex	Patient/Public Mid Essex Cancer Services User Group
I am supporting the campaign to keep the PET-CT scanner at Southend Hospital	Patient/Public
Had lung cancer & had a PET-CT scan at Basildon. Would have gone anywhere for treatment. Very angry that scanner has sat unused & Councillors have not made a decision	Patient/Public
Attended the Royal Society of Medicine PET-CT education event 14/15th March as a patient representative & provided a report of the event & circulated to clinical & management representatives at Southend Hospital on 30/03/2016. Patient Rep states in cover email that as he lives in Suffolk he has no preference for either site but "spending 2 days listening to the experts, there should be no argument and it must be located in Southend close to the RT facility".	Patient/Public
I looked at the form at the end of the notice. I wanted to respond, but realised that what I wanted to say is likely to favour the service being nearest to where I am. But these things have to be decided by considering, costs, availability of space, cost to users, ease of transport etc to help the maximum number of people. So I would rather leave it to those who know these facts"	Patient/Public
"I think this should be situated at Basildon as it is the most centrally situated hospital, covering people coming from Colchester, Thurrock, Basildon & Southend. My Daughter's experience using this scanner over the last 20 months has been good and we have travelled to Colchester on more than one occasion to get a scan done"	Patient/Public

Summary of letters/emails/telephone conversations

Theme: Clinical	From
I note that you stated “and all the independent experts advised us that the co-location of the two services was ideal” but I do not consider that to be a fair summary of expert opinion in respect of the issues in South Essex. It may represent the views of experts involved in research in respect of the utility of PET in radiotherapy planning but not those experts involved in delivering the service to the people of Essex” How many patients who have PET-CT go on to have DXT? Remains concerned that Q&A paper speaks of the benefits of co-location without giving any evidence. "South Essex needs a clinical service for cancer staging, the arguments for co-location are separate & should not be used in this discussion” Further questions – in summary: 1) No need for co-location 2) Challenges statement that PET-CT planning for radiotherapy is superior to CT 3) Not possible to be sure location at Southend would mean no provision at Basildon for next 10-15 years	Patient/public
Supportive of hub & spoke method developed since 2005 in the UK for delivery of PETCT services, that construction has largely been based around cancer centres with fixed site PETCT facilities. Not aware of sufficient evidence to date from the UK or Europe that demonstrates the need for co-location of PETCT with radiotherapy planning & is not aware that PETCT is widely used in radiotherapy planning at the moment, although recognises that should this approach develop, co-location may be of use from a staffing & resource viewpoint, noting however that with advances in fusion software and image presentation it may not be entirely necessary, what is important is that images can be retrieved & used to guide radiotherapy planning if required	Tel. Conv. with Dr B Neilly, from the British Nuclear Medicine Society
Feedback from meeting with Mid Essex GPs: 50% of their patients attend the Colchester scanner therefore the potential move is not as significant to their patients as others. If radiotherapy planning using PETCT can be made available it should be taken advantage of. If there were not to be radiotherapy planning using PETCT made available in South Essex their view was that it was likely their patients would flow to Colchester where both are co-located. If the scanner were to relocate to Southend it would be an advantage due to the co-location of radiotherapy planning & future opportunity to utilise PETCT for radiotherapy planning.	Mid Essex GPs
Re: draft clinical questionnaire: “It appears the focus of the questionnaire is tilted more towards treatment planning and not sufficiently towards use of PETCT- an important tool in diagnostic/imaging of the most common cancers referred towards hospital. Increasing capacity for diagnostics & imaging for earlier diagnosis of cancer has been emphasised in the report of independent cancer task force “Achieving World Class Cancer Outcomes – Strategy for England 2015-2020” BTUH have noted significant increase in 2WW referrals in last 2 years which will put immense pressure on diagnostic/imaging services in future. Thurrock CCG serves some of the most deprived localities in Essex & England. Access to diagnostic/imaging services is important service for Thurrock residents. Having accessible diagnostic capacity on site at BTUH will be beneficial for cancer patients referred by Thurrock GPs. Submission from AML had specified that they would install a permanent fixed site facility for PETCT at BTUH to replace the mobile scanner service (visiting twice a week). Approximately 1200 patients per year currently use this facility. All of the information asked in the questionnaire relate to cancer pathways and should be available at network/trust level.”	Dr K Padki Thurrock CCG

Summary of letters/emails/telephone conversations

Theme: Clinical	From
"Likely to be increased local need for service based at Basildon in response to pressure to have "2 week" wait discussion at GP level, most patients who go through haemotology for PET-CT diagnosis do not need radiotherapy - why add to their stress by making them take an unnecessary journey?"	Patient/Public
1) Wish to share clinicians views at Basildon for clarity 2) Seeking best outcome for population affected by the decision 3) No clinical case to change location of PET-CT scanner at Basildon, Basildon most appropriate site, to locate at Southend to facilitate radiotherapy planning will be wrong decision & will disadvantage the vast majority of patients using service for desinated purpose of cancer diagnosis 4) Re: static PETCT provision-contract was awarded on basis of location at Basildon in a permanent suite within exisitng imaging dept. 5) Many advantages to permanent accommodation inc. co-location with clinical radiology support 6) Cost will be borne by provider(built into their bid)- would be in place if provider had not requested a review 7) Delivery possible in 3-6 month timescale - current delay is 9 months due to review 8) ARSAC licence holder (Dr Anil Kumar) successfully led services at Basildon for last 8 years with ongoing support of other clinicians who report under his licence 9) Current contract is specifically for diagnostic PETCT, review requested by provider for move due to radiotherapy planning being potential growth area for PETCT 1 10) No advantage to co-location at site of radiotherapy for planning, seperaste location does not preclude ability to use PETCT for planning, Basildon well paced to deliver service as in other locations where radiotherapy & PETCT not co-located 11) Patient access remains primary consideration for location, your own analysis shows minority from Southend area - 39% v 61% from Basildon & further afield 12) Have alerted you to planned integration of Mid Essex & Basildon clinical haemotology services, which must be considered 13) Challenges for cancer treatment in Essex well documented, imperative that diagnosis pathways are not further fragmented. Location at Basildon supports diagnosis of lung & haemotology patients appropriately with better outcomes ***Continued on next slide***	Clare Panniker - Chief Executive, Basildon University Hospital

Summary of letters/emails/telephone conversations

Theme: Clinical	From
14) Mobile scanner at Basildon available 7 days a week, regularly used by AML 4 days & extra added when needed & more frequent than other centres in East of England. Service highly rated by patients & clinicians 15) New contract requires AML to install static scanner at Basildon - site identified, made available well in advance, in main radiology dept, next to general nuclear medicine dept, good for patient safety as trained staff available as well as all patient amenities 16) Scanner will be latest generation, will deliver less radiation than older machine, installation would usually take less than 3 months (no more than 3-6 months as per original consultation with Alliance Medical) and plans further advanced than other East of England centres will be superior to modular build 17) Cardiac PET a potential growth area, unlike radiotherapy planning has been part of national clinical indications list since 2013, have strong case for introducing at tertiary cardiothoracic centre in Basildon – superior technique, more accurate, delivers substantially reduced radiation dose compared to existing SPECT service, NICE estimate demand for non invasive cardiac imaging to be 4000 studies per million every year – 70% of this met by Nuclear Cardiology and 30% Cardiac MRI. 18) Physicists not needed on site for a diagnostic and staging service (required for set up but not routine operation) Alliance Medical will have own physicists to provide support when needed 19) Will continue to try and minimise press exposure and will support PET-CT service whatever the outcome	Clare Panniker - Chief Executive, Basildon University Hospital ***Continued from previous slide***

Summary of letters/emails/telephone conversations

Theme: Engagement Exercise	From
Re: draft clinical questionnaire: "We are very concerned that the focus of the questionnaire appears to relate only to treatment and not as PET as a diagnostic. This appears to be a narrow focus. It is also unclear how the questionnaire will add to the detailed demand information that is readily available:- 1. All of the questions relate to pathways. All of this information is readily available via the trusts and the Cancer Network- No questions facilitate expression of a preference or clinical opinion regarding location. 2. The questionnaire is biased; immediately focused upon treatment and not on diagnostic PET-CT which is the basis of the contract 3. No issues regarding patient access are addressed 4. The identification of patients requiring Diagnostic PET-CT only (not referred out for treatment) is not addressed 5. The percentages requested will not be readily available to clinicians – this does not support a good response rate 6. The supporting information should specify that radiotherapy planning is possible at any location although logistically easier to deliver if co-located"	Dr C Skinner-BTUH
Re: draft clinical questionnaire: "Is it the intention that this will go out to individual hospitals to be completed as one submission or to individuals? The latter may only be able to comment on their own cancer sites. The problem I see is that it is an information gathering tool rather than a consultation document. The questionnaire does not canvas the opinion of the clinicians it is simply asking for data that could be obtained from the trusts in one submission. There is no question asking where they think the scanner should be located and the reasons why. We do not ask what the patient benefits would be."	Dr N Rothnie-Southend
Will clinical team from Basildon hospital be included?"	Patient/public
Issues & concerns formally raised around Communications & Engagement plan for South Essex PET-CT Service Review at HOHS meeting on 09/12/15	Cllr. J Reeves, Chair HOHS
Request for update on public engagement timetable	Patient/public
Letter sent to Jeremy Hunt MP from Cllr J Kent, Leader of Thurrock Council on behalf of full Council meeting of 27/01/16 expressing concern over engagement process (see also above 'location' re: proposals)	Cllr J Kent, Thurrock

Summary of letters/emails/telephone conversations

Theme: Engagement Exercise	From
"Feedback on structure/content of questionnaire - wholly concerned with treatment, diagnosis not referred to. Geography ignored, seems decision already made that diagnosis & treatment must be on same site, states that scanner at Basildon twice a week - not true, often 3 or 4, how do you get meaningful data on diagnostic use from this questionnaire." Finds questionnaire overall biased towards final sentence on page 3. "It does not seem fair and transparent."	Patient/Public
Thanks for email & discussion at Southend Library event on 9/03/2016. Attachments sent helped to clarify some extra issues. Thinks consultation process is fair Believes NHS England recommended co-location of PET-CT with RT in Southend as part of national plan. Feels survey suggests recommendation has been ignored. Suggests current survey is flawed - not attracted enough people to roadshows to make a decision on behalf of patients & the public, judging by response rate to survey. Aware of patient benefits at Basildon, aware currently higher demand at Basildon than Southend. Seeks assurance that the "Success Regime: A Whole System Intervention" will be fully taken into account & technical reasons for recommendation to install at Southend will be published online "Is the process that is being undertaken by NHS England regarding the location of PET-CT scanner in South Essex a consultation or a survey? What is the difference between a consultation and a survey as far as NHS England is concerned?"	Patient/Public
Expresses concerns about the quality of the information provided throught the engagement process to which he states he has sought clarification. Has not had a clear reply to question of which services are being commissioned. States NHS specification does not include PET-CT scans for radiotherapy planning but that documentation provided refers to advantages of co-location & this could mislead, also that it refers to expert opinion but does not detail which experts or the strength of the recommendations - believes engagement information does not represent a consensus view of experts. Mr Watts complains that the information provided is biased & that this bias be considered when evaluating the public response, alternatively an unbiased fact sheet could be sent to the respondents that they may re-evaluate their views	Patient/Public

Theme: Other	From
Concern expressed that procurement choice & competition operating in patient's best interests	Patient/Public

Summary of Petition

Petition started by The Echo newspaper registered on www.change.org titled https://www.change.org/p/nhs-england-get-southend-hospital-s-vital-cancer-scanner-up-and-running

- A vital piece of cancer fighting equipment, worth £2.5million, has been sitting idle and unused for almost 18 months.
- The Echo has launched a campaign urging NHS England to get the hi-tech PET-CT cancer scanner up and running now.
- Patients are being forced to travel from south Essex to London for treatment because of a row over where the scanner, which has been sitting at Southend Hospital since November 2014, should be based.
- The row broke out after Councillors and clinicians in Thurrock argued the equipment should be based at Basildon Hospital, so it is in the middle of south Essex.
- The Echo says enough is enough, and it doesn't matter where the scanner is based- just get it working.

The petition has 1367 supporters at the 14th June, 2016 however has not been presented to NHS England as yet.

There are over 350 comments of which the majority ask that the scanner that is at Southend Hospital is used as soon as possible.

Appendix 4

PET-CT in South Essex

Analysis of Bus Travelling Times: June 2016

CCG office postcodes have been used to create reference points to calculate average bus travelling times. If travelling to either site by bus from the 6 CCG office locations, at different times of the day, the following applies:

11.30 Monday morning	To Basildon Hospital.	To Southend Hospital.	Quickest/Easiest
NHS Basildon and Brentwood CCG SS14 3HG	46 minutes 0 changes	63 minutes 2 changes	BTUH
NHS Thurrock CCG RM17 6SL	54 minutes 0 changes	74 minutes 1 change	BTUH
NHS Southend CCG SS2 6HT	59 minutes 0 changes	14 minutes 0 changes	SUH
NHS Castle Point and Rochford CCG SS6 7QF	88 minutes 0 changes	35 minutes 0 changes	SUH
NHS Mid Essex CCG CM2 5PF	96 minutes 1 changes	93 minutes 1 change	SUH
NHS West Essex CCG CM16 6TN	111 minutes 4 changes	116 minutes 3 changes	EQUAL*
09.00 Wednesday morning	**To Basildon Hospital.**	**To Southend Hospital.**	**Quickest/Easiest**
NHS Basildon and Brentwood CCG SS14 3HG	46 minutes 0 changes	77 minutes 2 changes	BTUH
NHS Thurrock CCG RM17 6SL	63 minutes 0 changes	78 minutes 1 change	BTUH
NHS Southend CCG SS2 6HT	61 minutes 0 changes	14 minutes 0 changes	SUH
NHS Castle Point and Rochford CCG SS6 7QF	80 minutes 0 changes	35 minutes 0 changes	SUH
NHS Mid Essex CCG CM2 5PF	96 minutes 1 change	93 minutes 1 change	SUH
NHS West Essex CCG CM16 6TN	113 minutes 4 changes	116 minutes 3 changes	EQUAL

15.00 Thursday afternoon	To Basildon Hospital	To Southend Hospital	Quickest/Easiest
NHS Basildon and Brentwood CCG SS14 3HG	46 minutes 0 changes	80 minutes 2 changes	BTUH
NHS Thurrock CCG RM17 6SL	54 minutes 0 changes	81 minutes 1 change	BTUH
NHS Southend CCG SS2 6HT	61 minutes 0 changes	14 minutes 0 changes	SUH
NHS Castle Point and Rochford CCG SS6 7QF	80 minutes 0 changes	38 minutes 0 changes	SUH
NHS Mid Essex CCG CM2 5PF	96 minutes 1 change	93 minutes 1 change	SUH
NHS West Essex CCG CM16 6TN	104 minutes 4 changes	129 minutes 3 changes	EQUAL

If travelling by bus on a Monday morning at 11.30 and assuming patients from West Essex have equal access to both sites, 64% of people would have easier access to BTUH and 42% to the SUH site.

If travelling by bus on a Wednesday morning at 09.00 and assuming patients from West Essex have equal access to both sites 52% of people would have easier access to BTUH and 54% to the SUH site.

If travelling by bus on a Thursday afternoon at 15.00 and assuming patients from West Essex have equal access to both sites 64% of people would have easier access to BTUH and 42% to the SUH site.

A change in location of the scanner would have some impact on patients travelling from the BTUH area if travelling by bus, however in this context, bus travel, irrespective of location of the service or time of the day, is often lengthy and difficult particularly for those in poor health.

Approximately 5% of PET-CT patients told us they travel by bus (according to our patient survey), 0.006% of the total population or around 71 patients (based on contracted activity for 2016/17, although the increased demand we have seen so far this year could mean this number rises to around 92 patients if the trend continues).

Consequently, at the slowest time of day for travelling to Southend, 0.0038% of the local population (approximately 53 people each year) would be affected by longer travelling times if the service were to move. Conversely, 0.0032% (approximately 45 people per year) would benefit from shorter travelling times.

Local Services, Local Solutions

11 August 2016
Ref: BW/108

Thurrock HOSC
Attn: Cllr Victoria Holloway
Via email to: vholloway@thurrock.gov.uk

Dear Councillor Holloway

Proposed merger between NEP and SEPT

We are writing to continue to keep you up to date on progress with the proposed future merger between our Trusts. We are being very open about the proposals. A report is submitted to our public Board meetings every month providing a general overview. We publish a regular briefing for our staff and involve them in the planning for the proposed new organisation. We are communicating and engaging directly with our Foundation Trust Members and have established a service user and carer reference group to assist us with key aspects of the planning. Their first meeting is later this month.

No decisions have been made yet. We remain very keen to keep you updated with progress so that you can advise if any proposals may require further consideration. We are due to attend Essex County Council HOSC in September 2016 to discuss the proposed merger and we would be delighted to offer the same opportunity to your HOSC. If you would like us to attend a meeting to update your members directly, please do contact us.

In the meantime, we thought it may be helpful to you to have a brief recap of information we have provided to you previously and an update on our latest progress:

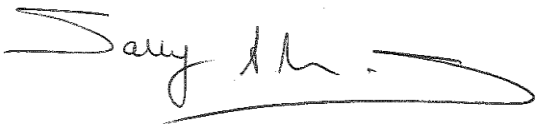
In September 2015 both Trusts agreed to explore a potential merger in line with the closer collaboration principles supported by the national NHS Five Year Forward View, the regional Essex Mental Health review, and the Essex Success regime. Based on the outcomes from exploratory workshops with our clinicians and managers, in December 2015 both Boards agreed to move to actively pursuing a proposed merger. In January 2016, we submitted an Outline Business Case (OBC) for merger to Monitor (now called NHS Improvement), the regulator of NHS Foundation Trusts. Monitor's review of the OBC did not identify any problems that would stop proposals progressing to the next stage, so now staff from both Trusts are working together on development of a Full Business Case (FBC) to go to both Trust Boards in November 2016.

The FBC will demonstrate the anticipated benefits of the proposed merger – in particular, the benefits to patients and service users. We anticipate that these would include a better ability to recruit and retain key clinicians; better access to more specialist expertise; fewer out-of-area placements and so on. NHS Improvement will review the agreed Full Business Case from December 2016 and will give it a rating.

The final decision to merge rests with both Trusts' Councils of Governors. It is anticipated that this decision would be taken in February/ March 2017. Subject to the outcome of this approvals process, the aim would be for a completely new NHS Foundation Trust to be authorised and operational from April 2017.
Both Trusts are committed firmly to acting only in the best interests of our patients and this will be the deciding factor in discussions and in decision-making. Additionally, the merger process involves rigorous due diligence to ensure that proposals are appropriate to meet the needs of patients, staff and both organisations. In the meantime, it remains "business as usual" for both Trusts for the foreseeable future. Any proposed changes to services after a merger would be subject to appropriate consultation with those affected.

We look forward to hearing from you in due course.

Yours sincerely,



Sally Morris
Chief Executive, SEPT
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Christopher Butler
Interim Chief Executive, NEP
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Cc: Local Authority and CCG Commissioners

15 September 2016	ITEM: 8
Health & Wellbeing Overview and Scrutiny Committee	
Learning Disabilities Health Checks	
Wards and communities affected: All	**Key Decision:** Not applicable
Report of: Jane Itangata - Senior Commissioning Manager – Mental Health & Learning Disabilities	
Accountable Head of Service: Mandy Ansell – (Acting) Interim Accountable Officer	
Accountable Director: Not applicable	
This report is: Public	

Executive Summary

Everyone with a learning disability aged 14 and over is entitled to have an annual health check. Health checks have been shown to identify health issues that were previously unknown in recognition that many people with a Learning Disability experience more health problems and have a lower life expectancy.

NHS England is responsible for commissioning directed enhanced services (DES) linked to national priorities and agreements. As directed, the opportunity to provide LD Health Checks under the DES is offered to all GP contract holders across Midlands and East (East).

A recent consultation with stakeholders in Thurrock identified that there were significant concerns about the completeness and quality of health checks, and that to improve the quality and coverage of health checks in Thurrock multiple interventions were needed along the service user's pathway. These interventions would involve service users, carers, social services, GPs, the third sector, and the Clinical Commissioning Group (CCG) in Thurrock.
Clearly a different approach was required to meet the requirements of delivering health checks in Thurrock going forward.

This report provides an update on the action plan to deliver the changes.

1. Recommendation(s)

1.1 The Health and Wellbeing Overview and Scrutiny Committee are asked to note the progress made on the work plan to improve the quality and uptake of health checks by people with Learning Disabilities in Thurrock.

2. Introduction and Background

2.1 Reports have been presented previously to HOSC on 1st December 2015 and 16th February 2016 by NHS Public Health England giving background to the LD Health Checks Directed Enhanced Service (DES) agreement and performance in Thurrock and actions that would be taken to improve both quality and uptake of the checks.

3. Issues, Options and Analysis of Options

3.1 NHS England is responsible for commissioning the Learning Disabilities Health Checks with surgeries. The arrangement with surgeries is voluntary and in 2014/15 only 29% of people registered with a Learning Disability in Thurrock received a health check.

Since April 2014 GPs have also been required to complete a Health Action Plan as part of the Health Check, to help ensure that actions from the Health Check are taken forward. This however has not been consistently done.

There were also concerns about the completeness and quality of Health Checks as well as completeness and accuracy of data held on LD registers. To improve the quality and coverage of Health Checks in Thurrock and address previous years of below average performance an alternative approach was needed.

3.2 To this end the CCG from 1st April has entered into co-commissioning arrangements with NHS Public Health England to deliver the LD Health Checks. This means that an alternative service will be in place to undertake health checks for people who cannot access these from their GP surgeries.

The co-commissioning between NHS England and Thurrock CCG will provide opportunity to use evidence and co-production techniques to design interventions to enhance the routine activities available to support health, check delivery and to create sustainable processes in Thurrock and deliver high levels of access to high quality health checks.

3.3 Information provided by NHS Public Health England indicates majority of Practices with the exception of 5 had signed up by 30th of June 2016 to deliver the health checks

3.4 Practices have highlighted some support will be required to enable them deliver the checks, and the CCG primary care team is working to facilitate the assistance. This will include training, cleansing the Registers to ensure the right READ codes are used and entering information accurately into the database

3.5 Quarter 1 data was not available at the time of writing this report however checks are being undertaken by the Practices that have signed up. The CCG

commissioners have requested NHS Public Health England to facilitate access to CQRS (the data extraction and payment system) to support the monitoring and efficient data updates.

3.6 The CCG has reached an Agreement in Principle arrangement with The GP hubs to provide health checks for people unable to access these from their Practices. This will provide an alternative and more flexible option as hubs operate on longer opening hours. This option will also ensure a seamless approach in implementing the Health Action Plans.

3.7 To further support people access the health checks the CCG is working with Thurrock Lifestyle Solutions in collaboration with Healthwatch on an engagement programme to address barriers that may inhibit people from attending the appointments. A launch event is scheduled in October.

3.8 The CCG is also working with Thurrock Lifestyle Solutions to review the format of the Health Action Plans and ensure that any identified needs are supported in a more tailored way.

3.9 Appendix 1 summarises the work plan that the CCG has developed to deliver the LD health checks in Thurrock in 2016/17.

4. Reasons for Recommendation

4.1 This paper is not for recommendation but for information and to update the Committee on the work plan that has been developed to deliver the LD health checks in Thurrock in 2016/17.

5. Consultation (including Overview and Scrutiny, if applicable)

5.1 N/A

6. Impact on corporate policies, priorities, performance and community impact

6.1 The expectation is this approach will improve the access to and quality of the health checks and promote better health outcomes for people with Learning Disabilities as a result of:

- the detection of unmet, unrecognised and potentially treatable health
- targeted actions to address health need.

7. Implications

7.1 **Financial**

N/A as NHS England commissioned

7.2 **Legal**

N/A – NHS England commissioned service within the legal framework of commissioning Enhanced Services (ES)

7.3 **Diversity and Equality**

N/A – NHS England QIA framework

7.4 **Other implications** (where significant) – i.e. Staff, Health, Sustainability, Crime and Disorder)

None

8. Background papers used in preparing the report

None

9. Appendices to the report

Appendix 1 - Learning Disabilities Health Checks – Work Plan 2016/17

Report Author:

Jane Itangata
Senior Commissioning Manager – Mental Health & Learning Disabilities
NHS Thurrock CCG

Learning Disabilities Health Checks – Work Plan 2016/17

Area	Objectives	Tasks/Actions	Progress

Thurrock Clinical Commissioning Group (CCG) and NHS England joint working arrangements	• Governance arrangements
	• Commissioning arrangements
		• Amending the CCG constitution to incorporate co-commissioning arrangements with NHS Public Health England
		• Establishing a Memorandum of Agreement (MoA) to define the commissioning arrangements
		• Commissioning an alternative service to undertake health checks for people:
		  ○ who cannot access these from their GP surgeries
		  ○ whose surgeries are not signed up to deliver the checks
		• Commissioners access to CQRS (data extraction and payment system) to enable efficient data updates and monitoring
			• The CCG constitution was amended and signed off by the CCG Board in April 2016.
			• The Memorandum of Agreement (MoA) was ratified between the CCG and NHS Public Health England in March 2016.
			• An Agreement in Principle has been reached between the CCG and the GP hubs to deliver the alternative service option.
			• Contract variations are being worked on to formalise this agreement
			• Pathways are also being developed to ensure the seamless delivery including support for the Health Action Plans
			• The CCG has written to NHS Public Health England requesting access to the CQRS

Implementation – Primary Care	• Sign up by surgeries	• Establish a list of surgeries that have signed up to deliver the	• NHS Public Health England has indicated that 5 surgeries had not

(Surgeries)	indicating intent to deliver health checks • Delivering the checks – action plans • Learning Disabilities (LD) register updating	health checks in 2016/17 • Establish a list of surgeries not signing up • Define a monitoring process and ownership of this including setting "KPIs" • Surgeries to complete an Action Plan Template indicating what support they will require to effectively deliver the checks • Data cleansing exercise to ensure the LD registers in primary care are accurate and the correct READ codes are being used	signed up by the deadline of 30th June. • The CCG's primary care team is working very closely with surgeries to provide support as necessary including data cleansing, organising additional training etc. • An Information Sharing Agreement is being processed between SEPT and Basildon and Thurrock University NHS Foundation Trust (BTUH) to ensure people with LD are identified and supported appropriately when they present at the hospital
Implementation – Community	• Support to access health checks	• Providing support to people with LD and their families to enable them attend the health checks • Reviewing the format of the Health Action Plans so that support is better tailored to meet needs identified during the checks	• The Commissioners are liaising Thurrock Lifestyle Solutions to develop an approach that will support carers, families and people with LD access the health checks • Thurrock Lifestyle Solutions will draw up an engagement programme with support from Healthwatch to facilitate better access.

15 September 2016	ITEM: 9
Health & Wellbeing Overview and Scrutiny Committee	
2015/16 Annual Complaints and Representations Report	
Wards and communities affected: All	**Key Decision:** Non Key
Report of: Anas Matin, Statutory Complaints and Engagement Manager	
Accountable Head of Service: Les Billingham, Head of Adult Social Care	
Accountable Director: Roger Harris, Corporate Director of Adults, Housing and Health	
This report is public	

Executive Summary

The annual report for Thurrock Council on the operation of the Adult Social Care Complaints Procedure covering the period 1 April 2015 – 31 March 2016 is attached as Appendix 1. It is a statutory requirement to produce an annual complaints report on adult social care complaints.

The report sets out the number of representations received in the year, including the number of complaints, key issues arising from complaints and the learning and improvement activity for the department.

A total of 324 representations were received during 2015-16 as detailed below:

- 166 Compliments
- 54 Complaints
- 23 Concerns and issues
- 16 MP enquiries
- 45 Member enquiries
- 4 Ombudsman enquiry
- 12 MEP
- 4 ILF Appeals

1. Recommendation(s)

1.1 That the scrutiny committee consider and note the report.

2. Introduction and Background

2.1 This is the annual report for Thurrock Council on the operation of the Adults Social Care Complaints Procedure covering the period 1 April 2015 – 31 March 2016. It is a statutory requirement to produce an annual complaints report on Adults Social Care complaints.

2.2 The Adults social care complaints procedure is operated in accordance with the Local Authority Social Services and National Health Service Complaints (England) regulations 2009.

3. Issues, Options and Analysis of Options

3.1 This is a monitoring report for noting, therefore there is no options of analysis.

3.2 Summary of representations received 2015/16

- 166 Compliments
- 54 Complaints
- 23 Concerns and issues
- 16 MP enquiries
- 45 Member enquiries
- 4 Ombudsman enquiry
- 12 MEP
- 4 ILF Appeals

Appendix 1 provides a detailed summary regarding the above.

4. Reasons for Recommendation

4.1 It is a statutory requirement to produce an annual complaints report on adult social care complaints. It is best practice for this to be considered by Overview and Scrutiny. This report is for monitoring and noting.

5. Consultation (including Overview and Scrutiny, if applicable)

5.1 This report has been agreed with the Adult Social Care senior management team.

6. Impact on corporate policies, priorities, performance and community impact

6.1 All learning and key trends identified in the complaints and compliments reporting has a direct impact on the quality of service delivery and performance. Reporting ensures that valuable feedback received from service users and carers is captured effectively and regularly monitored with the primary focus on putting things right, or highlighting and promoting where services are working well.

7. Implications

7.1 Financial

Implications verified by: **Kay Goodacre**
Finance Manager

There are no specific issues arising from this report.

7.2 Legal

Implications verified by: **Solomon Adeyeni**
Solicitor

There are no legal implications as the report is being compiled in accordance with regulation 18 of the Complaint Regulations.

7.3 Diversity and Equality

Implications verified by: **Rebecca Price**
Community Development Officer

The Council's complaints system has been designed to provide an effective means for service users or their representatives to complain about the quality or nature of services and to satisfy those who complain or comment that they have been dealt with promptly, fairly, openly and honestly. The Council is committed to promoting equality of opportunity for all. We will always take into consideration issues of age; disability; gender reassignment; marriage and civil partnership; pregnancy and maternity; race; religion or belief; sex, and sexual orientation during the complaints process to ensure that an equitable service is available to all. There are no specific diversity issues arising from this report.

7.4 Other implications (where significant) – i.e. Staff, Health, Sustainability, Crime and Disorder)

- None

8. Background papers used in preparing the report (including their location on the Council's website or identification whether any are exempt or protected by copyright):

- None

9. Appendices to the report

- Appendix 1 – Adult Social Care Complaints and Representations Annual Report 2015/16

Report Author:

Anas Matin
Statutory Complaints & Engagement Manager
HR, OD & Transformation

Adult Social Care Complaints and Representations

Annual Report 2015-16

Thurrock Council

Anas Matin
Statutory Complaints & Engagement Manager
HR, OD & Transformation

June 2016

Contents

1. Introduction

This is the annual report for Thurrock Council on the operation of the Adult Social Care Complaints Procedure covering the period 1 April 2015 – 31 March 2016. It is a statutory requirement to produce an annual complaints report on Adult Social Care complaints. The Adult social care complaints procedure is operated in accordance with the Local Authority Social Services and National Health Service Complaints (England) regulations 2009.

Thurrock adult social care arranges and supports provision of a wide range of commissioned and in house care, to support people to live independently in their homes and to increase levels of choice and control over the support they receive. It also supports residential or nursing care when this becomes necessary. The department also has lead responsibility for safeguarding adults and provides some services jointly with Health.

The report provides a summary analysis in relation to the number of representations received and processed in relation to adult social care, including details of the complaints received, the key issues arising and learning for the department.

2. The Complaints Process

The Local Authority Social Services and National Health Services Complaints Regulations (England) 2009 changed the process for handling complaints within Adult Social Care on 1 April 2009. The revised regulations aligned the complaint processes for Adult social care and Health to enable joint handling of complaints across both services.

The Complaints Procedure is a one stage process:

Stage 1 – Council aims to resolve a complaint using a variety of methods

Staff are encouraged to resolve issues at the first point of contact, in line with good practice as outlined by the Local Government Ombudsman.

The complaints procedure provides the Council with an additional means of monitoring performance and improving service quality, as well as an important opportunity to learn from complaints and service user feedback.

3. Roles and Responsibilities

The Department of Health Guidance requires local authorities to have a Complaints Manager responsible for the management of the complaints procedure.

In order to contribute effectively to service development, the complaints management function is based within HR, OD & Transformation.

The Complaints and Engagement Manager also has responsibility for Children's Social Care complaints and representations and produces a separate Annual Report for these.

4. Leaflets and Information

The complaints leaflet is distributed electronically to all service teams and front line services. Information on making a complaint or providing feedback is available on the Thurrock Council website.

The complaints procedure has been reviewed during 2014/15. As the statutory guidance remains unchanged for adult social care complaints, there are no fundamental changes to the process. However under the Care Act 2014, there are proposals to introduce an Appeal System for assessments and funding which may run alongside the complaints procedures. The proposals have not been finalised and therefore no changes will be made to the current complaints procedure.

Adult social care welcomes feedback about its services. This can be received via a complaints form, telephone contact, in person, writing or emailing the complaints team and through the call centre.

5. Advocacy for vulnerable people

Thurrock Council commissions advocacy services including Mental Capacity advocacy encompassing Deprivation of Liberty Safeguards. It is available for people who have substantial difficulty in understanding decisions that need to be made or in expressing their views, when there is no one else who can assist or speak on the person's behalf. The scope of our contract covers, older people with mental health aged 65 and over, adults of working age with mental ill health and adults who have a learning disability or sensory impaired aged over 18yrs.

The service is independent of statutory organisations and service provider agencies. POhWER is the main commissioned provider for advocacy within Thurrock and supports service users with various concerns and queries across a range of services including housing, social care and debt management.

6. *Summary of Representations received*

A total of 324 representations were received during 2015-16 which is a decrease of 32 (9%) on the previous year (356), as detailed below:

Complaints	54
MP	16
Member enquiries	45
MEP	12
Concerns	23
Ombudsman enquiries	4
ILF Appeals	4
Compliments	166
Total Representations	**324**

Total Representations Received 2014-2016

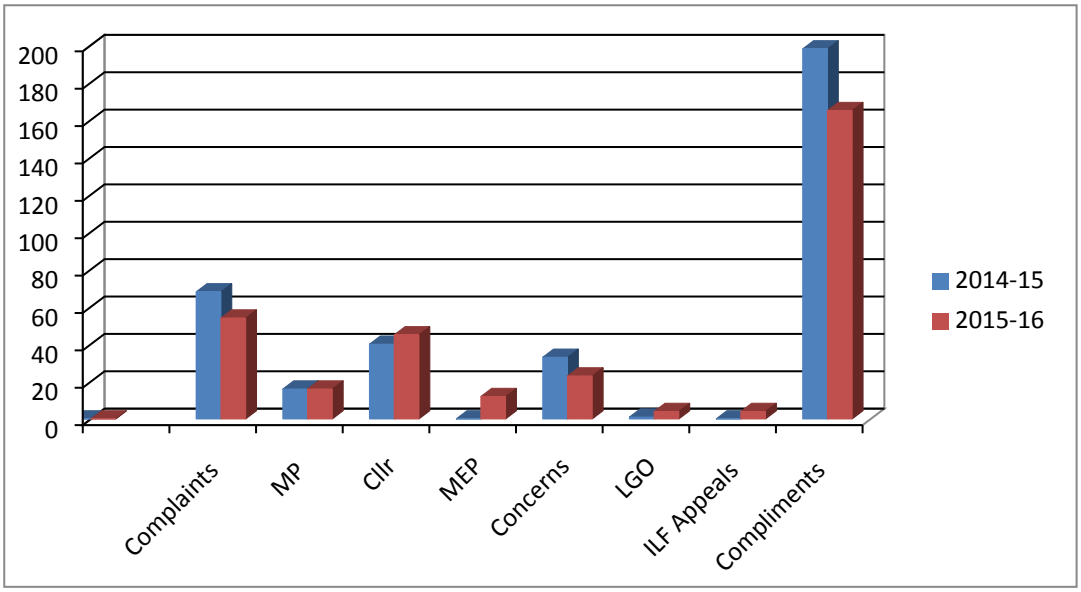

Table 1

It is essential that all teams delivering services formally capture and record complaints. This includes any commissioned services.

Feedback is recorded as received from service users by telephone, email and in writing as well as in person.

Other complaints and representations are referred directly to Ascfeedback as received by the Corporate Complaints team and the service teams directly. All complaints are acknowledged within 3 working days as set out in the statutory guidance.

7. Complaints

The department received a total of 54 complaints in 2015/16, which is a decrease of 21% on the number of complaints (68) received for 2014/15. During this reporting period, the department dealt with 8976 referrals and 4360 service users were receiving a service under social care, including residential and nursing care.

Trends in complaints received from 2010-2016 are detailed in Table 2.

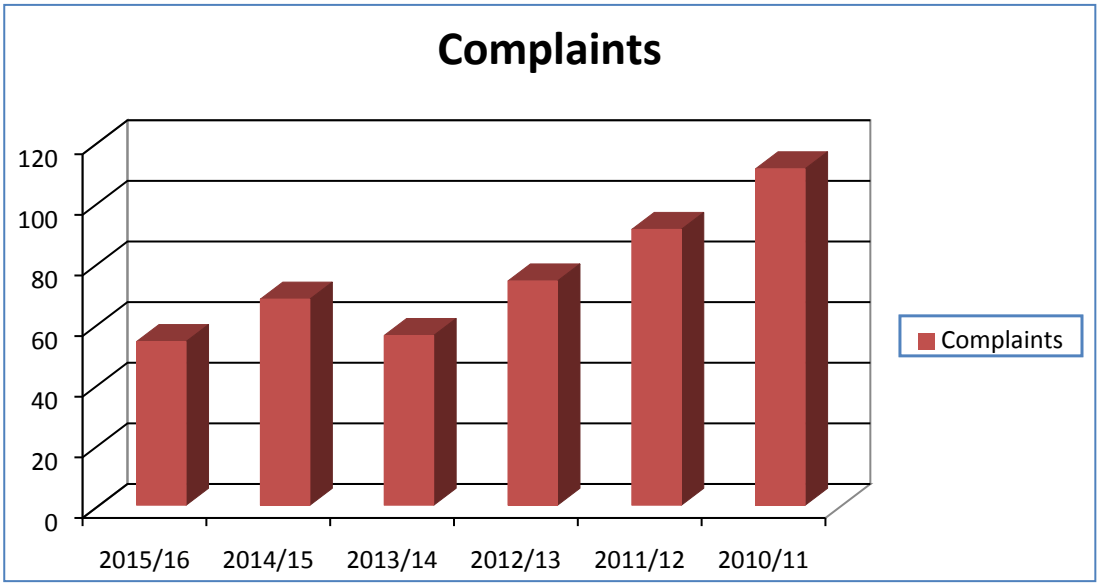

Table2

Table 2 indicates that the previous declining trend of complaints have not changed, hence this year there is a decrease of 21%. It is difficult to pin point a single reason for this decrease. However, the decrease in complaints maybe be attributed to domiciliary care providers not forwarding all the complaints to the local authority and may well be involved in dealing with it directly; front line services are able to resolve issues very quickly; complainants may be reluctant to make complaints; and in addition to the complaints team providing a satisfactory response to a service users query (at the point of contact).

8. Complaints breakdown by Service for 2014-16

Internal Provider

Service	2014/15	2015/16
Blue Badge	3	0
Customer Finance	5	6
Occupational Therapy	5	2
Safeguarding	1	0
Collins House	1	4
Reablement Team	0	4
Complex Care & Transition Team	0	4
Early Intervention and Prevention East	3	3
Early Intervention and Prevention West	1	4
Basildon Hospital	3	0
CM Mental Health	2	1
Intervention & Transition	1	0

Performance Quality	1	0
Short break Service	2	0
Emergency Duty	2	0
Kynoch Court	2	1
Legal Services	0	1
Outreach Service	0	1
Out of Jurisdiction	0	1
Locality 8	0	1
Community Solutions Team	0	1
Other**	3	0
Sub Total	**35**	**34**

Table 3 a

**Legal Services (1), SEPT (1) and Daycentre Transport (1)

External Provider:

Service	2014/15	2015/16
Triangle care	0	1
Grays Court Care	1	1
Hollywood Rest Home	1	0
Bennett Lodge	1	1
Bluebell Court	3	0
John Stanley	4	4
Grapecroft (now Willow Lodge)	2	0
Sanctuary Care	10	3
TLS	2	0
TLC	3	0
Kynoch Court	2	1
Merrie Loots	0	1
Piggs Corner	0	1
Temp Exchange	1	6
PoHwer	0	1
Balfour Court	1	0
Whitecroft	1	0
Oak House	1	0
Sub Total	**33**	**20**

Table 3 b

Table 3 a (a+b)	**35**	**34**
Table 3 b	**33**	**20**
Grand Total	**68**	**54**

9. Complaint issues

Complaint Issue	2014/15	2015/16
Assessment/Decision Making	4	4
Communication	4	2
Service Quality and Care	23	18
Delays in Service	6	4
Finance/Charging	10	6
Late appointments	0	2
Missed appointments	0	4

Safeguarding	1	2
Welfare	0	1
Staff conduct	12	10
Vexacious	0	1
Other*	8	0
Total	**68**	**54**

Table 4

- *Missed carer appointments, transport issues, incorrect medication, legal issues*

Table 4 shows that issues concerning staff conduct, quality of care and service quality were the main reasons for complaints during 2015/16.

10. Externally Commissioned Services

The Care Quality Commission requires all care providers to have in place clear and robust complaint procedures. Anyone who receives a service from an externally provided service will usually complain directly to the provider and these will be responded to in accordance with the provider's own complaints process. Feedback received by the Council about externally provided services is closely monitored by the Contract and Compliance team in line with the statutory Contracts Monitoring Framework. This helps to identify any areas of poor performance which require additional monitoring and support.

Direct Payment Scheme

Personal budgets, when taken as a direct payment, are used to pay for support for services such as homecare, or to employ a personal assistant (PA). The Council has a contract with ECDP, for the delivery of the Direct Payment Support Service for Thurrock residents to manage the scheme and raise awareness of how social care users can have greater choice and control in relation to their care.

Residential Care

The Council commissions independent care home providers for service users requiring residential care, based on an assessment of their individual needs. Any complaints received regarding commissioned providers are referred to the Home provider to investigate in accordance with their own complaints procedure. The Care Quality Commission requires all providers to have effective complaint procedures in place. This is regularly monitored by the Council's Contract Compliance team.

There were approximately 736 service users receiving residential care (including nursing care funded by adult social care) during 2015/16. For the same period, 9 complaints were received by the Council which is a slight decrease of 4 on the previous year (13). Generally, the issues most frequently complained about are in relation to the quality of care received by the service user and the charges for care**.**

Providers have a duty to log and investigate complaints received directly by their service. There were 106 complaints registered by fifteen residential providers, which were investigated in accordance with the provider's own complaint procedure. Of those, 40 were upheld and 64 were not upheld and two complaints were still in progress at the end of the reporting period.

We will pursue a proactive policy to ensure that all complaints, its outcomes and learning identified are reported to the council. Contracts and Commissioning will monitor this vigorously.

Domiciliary care

There is a high demand for home care within Thurrock and the commissioned provider agencies work closely with Thurrock's commissioning and contract teams to ensure that service users receive care packages that directly meet their needs.

Approximately 929 service users received externally provided home care services during 2015/16. The issues raised as complaints were mainly in relation to the quality of care provided, delays to home visits, communication issues and funding. The provider agencies generally respond directly to service users and their families when responding to complaints and concerns about their service.

Complaints made directly to the Council will be investigated if the response submitted by the care provider is not satisfactory to the complainant. For complaints directly received by the commissioned services, 22 complaints were investigated directly by three home care providers. Fourteen complaints were upheld, 8 complaints were not upheld.

The Council's Contract Compliance Monitoring Team discusses all key issues arising from complaints on a regular basis with providers and ensures that any outstanding issues and key themes arising from complaints are addressed.

In all instances for complaints regarding adult social care, the complaints procedure may be superseded by the Safeguarding procedure if a referral is made which identifies safeguarding alerts. The complaint will be placed on hold awaiting the outcome of the safeguarding investigation.

11. Response Times

Since the introduction of the Social Services and National Health Service Complaint Regulations in 2009, the only mandatory requirement is that complainants should receive acknowledgement within 3 working days. The legislation allows flexibility, where it is negotiated that a complaint investigation be formally investigated within three months and the overall timescale for a complaint to be resolved within six months. If there is further delay, a new action plan must be negotiated. However the department's aim is to resolve most complaints within 20 working days.

The time limit for making a complaint is within 12 months of the matter being complained about. However, the Council can exercise its discretion to allow complaints that are made over the 12 month rule, where it is satisfied that the complainant had good reason and where it is still possible to investigate the complaint effectively and fairly.

Thirty five percent of the 38 completed complaints exceeded 20 working days. Where complaints were complex by nature or required a multi-agency response, hence the response timescale was extended. There were 13 complaints that were incomplete at the end of the reporting period and 3 were either withdrawn or outside the jurisdiction. In all cases, the complainant is kept involved and informed of the progress of the complaint.

12. Complaint outcomes

Decision	2014/15	2015/16
Upheld	15	15
Partially Upheld	10	9
Not Upheld	24	14
Withdrawn or Cancelled	15	1
Out of Jurisdiction	0	2
In progress	4	13
Total	**68**	**54**

Table 5

Of the 38 complaints completed, 39% were upheld, 24% partially upheld and 37% were not upheld. Table 5 indicates that in the previous year 2014/15, the majority of completed complaints were not upheld. For 2015/16, the majority of completed complaints were upheld, for reasons that the investigation did find a fault by the service and/or that correct processes were not followed by the service team or provider.

Further details regarding complaint outcomes and those complaints that were upheld are set out under the 'Learning from Complaints' section of this report.

13. Policy Work

Thurrock is a member of the Eastern Regional Complaints Group and Public Sector Complaints Network. Information is shared on a periodic basis in terms of key national legislative changes that affect the complaints process, in addition to any relevant key learning from specific complaints, including public reports from the Local Government Ombudsman. The complaints Manager has established positive links with the relevant colleagues and staff members and will be taking matters forward and attend future meetings.

The Complaints Manager has also established links with the London Complaints Group Managers' chair and will be attending future meetings in London to ensure any learning is captured.

Furthermore, the Complaint Manager is also aware of the National Complaints Managers Group (England) and intends to become its member in due course. So that Statutory complaints and benchmarking can be viewed in line with national perspective.

14. Local Government Ombudsman

If a complainant is not satisfied with the outcome of the investigation, they have the right to take their complaint to the local Government Ombudsman and at any time. However, the Ombudsman may refer the complaint back to the Local Authority if it has not been fully considered through the complaints procedure.

The Ombudsman investigates complaints of injustice caused by 'maladministration' or 'service failure'. The Ombudsman cannot question whether a Council's decision is right or wrong simply because a complainant disagrees with it. The Ombudsman must consider whether there was fault in the way the decision was reached. If there has been fault, the Ombudsman considers whether there has been an injustice, and if there has, a remedy will be suggested.

There were four cases received from the Ombudsman for this reporting year compared to 1 received in the previous year, as detailed below:

Case 1:

Service user's daughter complained in regards to the care received by her father. It was an agency complaint; the agency concerned was at fault. The complaint outcome: there was **maladministration and injustice** found by the Ombudsman and compensation awarded.

Case 2:

This case was a prematurely approached by the service user's solicitors to the LGO. The council have duly responded to the LGO and the case is now closed.

Case 3:

This case has been duly responded to by the council in regards to a query and is awaiting a decision from the LGO. The issues surrounding this case related to charges that the service user's solicitors are disputing.

Case 4:

This case failed to carry out an assessment of needs for the complainant's mum. The council provided apology and this was accepted by the LGO. The complaint outcome was **maladministration** but no injustice.

15. Concerns/enquiries

Apart from complaints, the complaints team recorded all other representations received about adult social care services, as it is required to do. Representations can be positive comments and feedback or queries regarding a service.

The complaints team recorded 23 concerns and issues for this reporting period which is a slight decrease on the previous year (33). Concerns are successfully resolved within the teams, without the need to record them as formal complaints. If the concern cannot be resolved, it will be become a complaint and be processed in accordance with the complaints procedure.

16. MP and Member enquiries

The complaints team also records MP and Member enquiries that are received on behalf of service users regarding adult social care. Complex queries and work pressures has resulted in some responses exceeding the 10 working day timescale and response times will be a priority focus for improvement during 2016/17.

MP enquiries remained the same as previous year. Member enquiries have increased on the previous year see below:

		2013-2014	2014-2015	2015-2016
Members	Volume	39	40	45
	on time	39	36	35
Total	**% on time**	**100%**	**90%**	**78%**

MP	Volume	12	16	16
	on time	12	14	13
Total	**% on time**	**100%**	**88%**	**81%**

Table 7

17. Compliments

Compliments are expressions of positive feedback. There was a slight decrease (166) in compliments this year compared with 198 recorded last year.

What they have said:

"Thank you to all the staff for all the love and care you have all given Mum during her stay, thank you very much." **Collins House**

"A call from the above SU who said she wanted to speak to the manager of Community Solutions. She said that you were very very professional and very nice. She said that you were very kind and you were not patronising. Mrs D also said that you were professional and really helped. Well done Jo, good job - Steve." **Community Solutions Team**

"Thank you so much Christina for all the support you have given to S and me! We really do appreciate all that you have done for us." **Complex Care & Transition Team**

"Just to let you know I spoke with Mr B today who cares for his Mother, he wanted to thank you for all your help he said you have saved him, he knows now he is doing a good job caring for his Mum, and he said he can't thank you enough for all your help and advice. He says he was "broken" until you came along to help him." **Early Intervention and Prevention East**

"Mrs S telephoned to say that the team are brilliant and she has no complaints. Also, the carers are all lovely." **Joint Re-ablement Team**

"Just wanted to make you aware of a compliment that I received today about the whole of ASC from a family member of a SU in Kynoch Court. This gentleman has memory issues and was found wandering around the complex 1 week ago. He said that the staff at Kynoch responded well and called out the RRAS team. The RRAS team responded in 20 minutes and all equipment was in place within a week and a re-assessment had happened. The son said that he was impressed with the service and made him feel more secure that dad was there as he lived in Kent." **Kynoch Court**

"My mother has now received a trolley and toilet frame which she is finding most helpful. Thank you to all concerned in organising this." **Occupational Therapy Team**

"Can I just add what a great chap Francis is and what a great job he is doing for our lonely people." **Local Area Co-ordinator**

Mrs W's daughter of Service User, comments as follows: Thank you for your help and support. It has been much appreciated. I would like to thank you for suggesting the Extra care scheme. Mum and I both feel that Piggs Corner is a very happy place and are confident that she will be well cared for by the team working there. They are so dedicated to the elderly. This is evidenced by their happy smiles as they work, in their conversations with and overt care of other residents and EVERY resident looks happy and is keen to recommend the place - you can't get better feedback than that! Once again Les, thank you

so much for your support.” **Piggs Corner**

“Absolutely fantastic - your email has brightened up my Monday no end! I've copied Baroness Finllay, the new Chair of the National Mental Capacity into this email just for information. Baroness Finlay - an example of some great innovative local MCA work. The kind we hope the Forum might spark in those parts of the country where implementation is currently poor.” **Safeguarding Team**

Service User's daughter, as follows: "Thank you for letting me know and thank you for all your hard work." **Basildon Hospital Team**

18. Learning from Complaints

Complaints that are upheld or partially upheld identify areas of learning for the service or provider involved. These are recorded on a learning log and actioned. The learning is highlighted in the quarterly reports for Senior Management and cascaded to service teams. Listed below is the learning that was identified from 3 different case studies during 2015-16.

Case study 1

This complaint centred on a Residential Care Home; an assessment was carried out by their social worker, and it concluded that the service user could be moved to a Supported Living Accommodation. Thus a substantial savings can be made as soon as this policy was implemented.

Once the parents became aware of the assessment and council’s possible plan to place the service user to a Supported Living Accommodation; they made a complaint stating that it would be detrimental to move the service user due to their medical condition. However, the complaint was mainly due to the lack of information and not knowing the differences between Residential Care Home and Supported Living Accommodation.

The complaints team arranged an alternative dispute resolution (ADR) meeting. The meeting was attended by the parents of the service user, direct line manager of the social worker involved in the case, and the team manager for the service area.

The ADR meeting was an opportunity to have a face to face discussion between the parents, team managers and the complaints team to clarify some of the misunderstandings and this aided towards a positive resolution.

The resolution meeting clarified some of the issues and identified key action points that needed to be taken forward in order to resolve this complaint:

a) By agreeing to provide a written policy between the differences of the two services i.e. as in paragraph 2 above.

b) To complete outstanding assessments so that professional and medical evidences are up to date.

Upon receiving the written policy and medical assessment reports by the parents; they were able to compare between the two services and were inclined in favour of the Supported Living Accommodation, as this was more beneficial to the service user.

- The key learning from this complaint is to have a face to face discussion through a meeting.

- It is imperative to have a written policy document highlighting the differences between the two approaches as in paragraph 2.

- Thirdly, by engaging with the service user's parents; thus prevented further escalation to the LGO.

The complaint was resolved and the family were happy with the approach undertaken.

Case study 2

Service user's mother complained about several issues:

- To change current social worker and the team manager as the mother felt the family was not being listened to.
- Lack of communication.
- Family disagreed with moving the service user from current Hospital placement.

A service manager was requested to investigate this complaint from Adult Social Care and met up with the mother. Various aspects were discussed about the complaint. The meeting produced some positive results see below:

Firstly, it allowed establishing sound rapport with the family and the council; gained a good insight into the reasons why the complaint was made. It also allowed the building of trust between the family and local authority. It facilitated a better communication and tackled any misunderstanding.

Service Manager's view was that whatever the circumstances we must appreciate people's feelings and emotions, and help them channel in an appropriate manner. The complainant felt that she was being listened to and her concerns were being addressed; hence, this is one of the best ways of resolving complaints.

- The learning from this complaint is not to become defensive when a complaint is made.
- Ensure good communication is established through face to face meeting.
- If there is a genuine reason for a request to change a social worker, this should be looked at very carefully and necessary action should be undertaken to resolve matters. However, every case is different and it should be judged on its merits. In this case, which was high risk, a decision was taken to change Social Worker to support both the worker and the family.

As a result of the above meeting and by undertaking necessary actions, this complaint was closed on the basis that the complainant was happy with the outcome and the social worker was changed.

Case study 3

This complaint centred on an invoice that was issued “incorrectly” according to the service user’s family for the following reasons:

- A meeting was arranged in January 2016, for the service user’s care funding to be transferred to the NHS.
- The scheduled meeting was attended by the NHS and Care Home, but the social worker from Adult Social Care was unable to attend the meeting.
- The same meeting was re-arranged in February 2016, and the care funding was transferred to the NHS.

This is a complex area of funding based on the Decision Support Tool (DST), even if the social worker had attended the first meeting in January, there was no guarantee that the care funding would have been transferred to the NHS. Conversely, the family was fully aware of the deteriorating health condition of the service user, and they were correct in saying that had the meeting went ahead in January, the care funding would have been transferred, as this is what had materialised in subsequent meeting in February.

Upon investigating this case a bit further, it transpired that the service area responsible for this area of work was immensely under resourced. Hence, it was perhaps very difficult to attend the meeting in January and this had led to the complaint.

At present the service area does not have a dedicated staff for the DST work and there are a large number of cases which is causing bottle neck. Additionally, if a staff member becomes sick, there would be a similar sort of problem in the future. Hence, this is an area of immense interest and needs further investigation. Appropriate SWOT analysis of the service area concerned and by undertaking a balanced approach may save the LA resources and funding as well as future complaints.

However, the learning from this complaint can be summarised in the following:

- Although there is a shortage of resources and this will be the future way forward given the current reality the whole country is facing.

- Any meeting arranged by the social worker, should be cascaded to the relevant team and other members should be aware of such meeting.

- If one person cannot make the scheduled meeting, then this should be attended by another staff member in order to make a swift decision.

- This will allow the smooth transition of care funding to the NHS on time and the LA does not have to foot the bill for another month on this occasion.

- This approach will surely save the council from future complaints and save money.

The complaint was resolved by cancelling the invoice issued for January as the family had a valid point.

19. Training

Teams will receive complaints handling training sessions throughout the year. This is to highlight good customer care, responding to complaints, meeting timescales, the

importance of learning from complaints and compliments and to promote the expertise available from the Complaints Manager (in assisting complaints management).

The Workforce Planning and Development team also provides an e-learning course on handling complaints.

Face to face and telephone advice is regularly provided to team managers in order to respond to complaints and concerns in a timely manner, in addition to identifying appropriate learning.

20. Going Forward

- The complaints' team will provide ongoing training and advice to teams in regards to complaints handling through regular emails, writing policy documents, telephone advice and face to face meetings; (as this is an ongoing policy).

- Any learning from complaints will be identified and thus lead to service improvement. The complaints' team will monitor this on a monthly basis by keeping an up to date spreadsheet and copies of Complaints Learning Forms and Investigation logs.

- The introduction of 'alternative dispute resolution' has been implemented and proving to be quite successful. This will improve the working relationship between service users and service providers.

- The Complaints team intend to provide training to all new managers, deputy managers and senior practitioners through regular workshop.

- Work closely with operational services to ensure that all new service users are aware of complaints.

- The Complaints Manager will continue to work closely with community and user groups to ensure all feedback about adult social care is captured and to engage user participation regarding the changes to services and their experiences.

- Working closely with external partners such as Health, advocacy groups and relevant stakeholders will remain a key focus for 2016/17.

- Complaints activity and learning will continue to be reported to the department throughout the year and disseminated to all staff.

- Response times and quality of responses will be the primary areas for staff training and monitoring.

- A new response template has been introduced to improve the quality of responses in order to achieve better outcomes, consistency, and standardisation.

- A new process map has been introduced for learning from complaints.

- The complaints manager has engaged in meeting services managers and their team managers in order to understand each service in a better and informed

manner, so that a robust complaints management service can be provided to our service users.

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15 September 2016	ITEM: 10
Health & Wellbeing Overview and Scrutiny Committee	
Improving Standards in Primary Care	
Wards and communities affected: All	**Key Decision:** Non-key
Report of: Ian Wake, Director of Public Health	
Accountable Head of Service: Ian Wake, Director of Public Health	
Accountable Director: Ian Wake, Director of Public Health	
This report is Public	

Executive Summary

This report describes some of the challenges relating to the provision of GP services in Thurrock and proposes two initiatives; strengthening the role of Patient Participation Groups, and a Long Term Condition GP Balanced Score Card that aim to improve the standards of clinical care provided by our GPs locally.

The report and initiatives described within it support a wider programme of Primary Care Improvement as set out by Cabinet Portfolio Holder for Health and Education, in his report to Thurrock Full Council meeting in July 2016.

1. Recommendation

1.1 That HOSC comments on the two initiatives proposed within it.

2. Introduction and Background

2.1 This report sets out a range of innovate approaches to improve clinical standards in Primary Care.

2.2 Thurrock is served by 33 GP practices, commissioned by NHS England. NHS Thurrock Clinical Commissioning Group (CCG) also has a small Primary Care Development Team that work with GP practices as a 'critical friend' to improve clinical quality and strategically manage the Primary Care future provider landscape. This involves very close working with Thurrock Council, other NHS providers and the third sector to deliver programmes such as the new Integrated Healthy Living Centres.

2.3 Thurrock CCG inherited a local GP provider landscape from NHS South Essex PCT that is facing significant challenge. Thurrock has the fourth most 'under-doctored' CCG population in the country. In 2014/15 the average number of patients per FTE GP in England was 1321, whilst in Thurrock it was 2072. Levels of under-doctoring in Thurrock are not evenly distributed between different GP practice populations. All but four GP practices have levels of under-doctoring that are worse than the England average. The most under-doctored practice has a ratio of patients: FTE GP that is over five times the England average. Furthermore, analyses by Public Health identified a strong positive correlation between levels of under-doctoring at GP practice population level, and levels of deprivation. As such, practice populations with the highest levels of morbidity and mortality are likely to be the worst served in terms adequate numbers of GPs.

2.4 The Care Quality Commission CQC is an independent regulator of health and social care providers in England. Its responsibilities include regularly inspecting and rating services provided by GP practices. A new system of inspection and regulation was introduced in 2015 which provided an overall rating of *"Excellent"*, *"Good"*, *"Requires Improvement"* or *"Inadequate"* based on five domains relating to whether the practice is safe, effective, caring, responsive and well-led. To date 20 GP practices have been inspected by the CQC in Thurrock. Of these 10 received an overall CQC rating of *"Good"*, five of *"Requires Improvement"* and five of *"Inadequate"*. A full list of Thurrock GP Practices and their latest CQC rating is shown in Appendix A.

2.4.1 The CQC's inspection regime of GP practices is based on nationally agreed metrics. However, given the variation in clinical quality between different GP practices at a local level, there is also merit in developing locally agreed metrics that are relevant to addressing the health issues faced by local communities.

2.5 Variation in Primary Care is a major public health and system's sustainability issue in Thurrock. Inadequate GP practices will both have a significant impact negative impact on the health of the population they serve, and are likely to drive costs elsewhere in the health and social are system. As such, the council's Public Health Team have been working very closely to support NHS Thurrock CCG to help improve the situation. This paper describes two new proposed initiatives within a wider programme of work; strengthening Patient Participation Groups and a GP Long-Term Conditions Balanced Score Card.

2.6 Ensuring high quality GP services in Thurrock is absolutely essential in achieving high quality outcomes for patients locally, and ensuring our local health and social care system's financial sustainability. Over 70% of all NHS consultations between clinicians and patients occur in GP practices, and over 90% of the population will consult their GP at least once a year. GPs act a "gate keeper" to access of more expensive elements of treatment provided by hospitals and also play an enormous role in managing patients with Long Term Conditions, the spend on which now accounts for over three quarters on the entire NHS budget in England. There is clear evidence that delivery of

high quality long term condition management within Primary Care results in fewer emergency hospital admissions and better health outcomes for patients. Approximately a third of clients entering the ASC system in Thurrock do so following an emergency hospital admission. As such, improving the clinical quality of long term condition management by GPs locally is also likely to reduce demand for Adult Social Care services.

3. Strengthening Patient Participation Groups

3.1 From April 2016 it has been a contractual requirement for all GP practices in England to form a Patient Participation Group (PPG) during the year and make reasonable efforts to it to be representative of the practice population. PPGs can play a key role in assisting GP practices to improve patient care including:

- Advising the practice on the patient perspective
- Providing a mechanism for patients to make positive suggestions about the practice and how it can improve
- Encouraging and organising health promotion activities within the practice and amongst the wider population it serves
- Communicating with the wider patient body
- Running volunteer services and support groups to support patients and the services of the practice
- Influencing the work of the practice or the wider NHS to improve commissioning
- Fundraising to improve services provided by the practice

3.2 PPGs in Thurrock are currently undeveloped, with some GP practices yet to set up an effective PPG, and others having a poor level of engagement from their practice populations.

3.3 Public Health proposes to work with NHS Thurrock CCG and Thurrock Healthwatch to deliver a new programme Patient Participation at GP practice level. Healthwatch will help support practices to set up a PPG where one currently doesn't exist, including engaging and recruiting patients, and will deliver a training programme including a free resource pack to those PPGs that are already operating. The training programme will increase the understanding and confidence of PPG members on issues such as PPG roles and responsibilities. Members of the Thurrock Public Health Team will support the delivery of the training programme by providing GP Practice population specific profiles that identify the main health needs of the practice population. The accompanying resource pack has been developed by Thurrock Healthwatch based on a model of best practice from the National Patients' Association and includes:

- Starting a patient group - guidance sheet
- Terms of reference template
- Patient group member role and responsibilities guidance

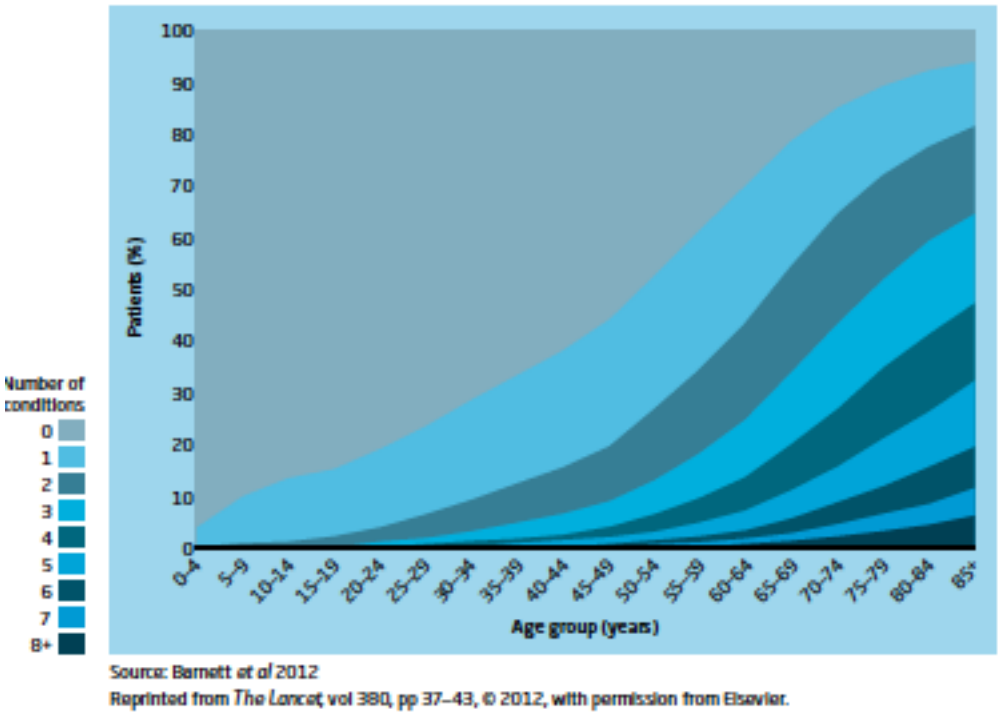
- Confidentiality policy and agreement for volunteers
- Meeting agenda template
- Patient group information leaflet
- Patient group template poster
- Development checklist

Whilst the setting is different, the skill set required to be an effective local school governor or a member of a successful PPG is very similar. As such we will also explore how officers of the council responsible for health and education can further work together to offer leadership and capacity in the training of both school governors and members of Patient Participation Groups.

3.4 GP Long-Term Conditions Balanced Scorecard

When the NHS was founded in 1948, 48% of the population died before the age of 65. By 2011, that figure had fallen to 14%[1] and continues to fall. In England, average life expectancy at aged 65 is now 21 years for women and 19 years for men. However as people age they are progressively more likely to live with complex co-morbidities, disability and frailty. 70% of health and social care spend is on people with long term conditions[2] and most people over 75 live with two or more long term conditions. (Figure 1).

Figure 1



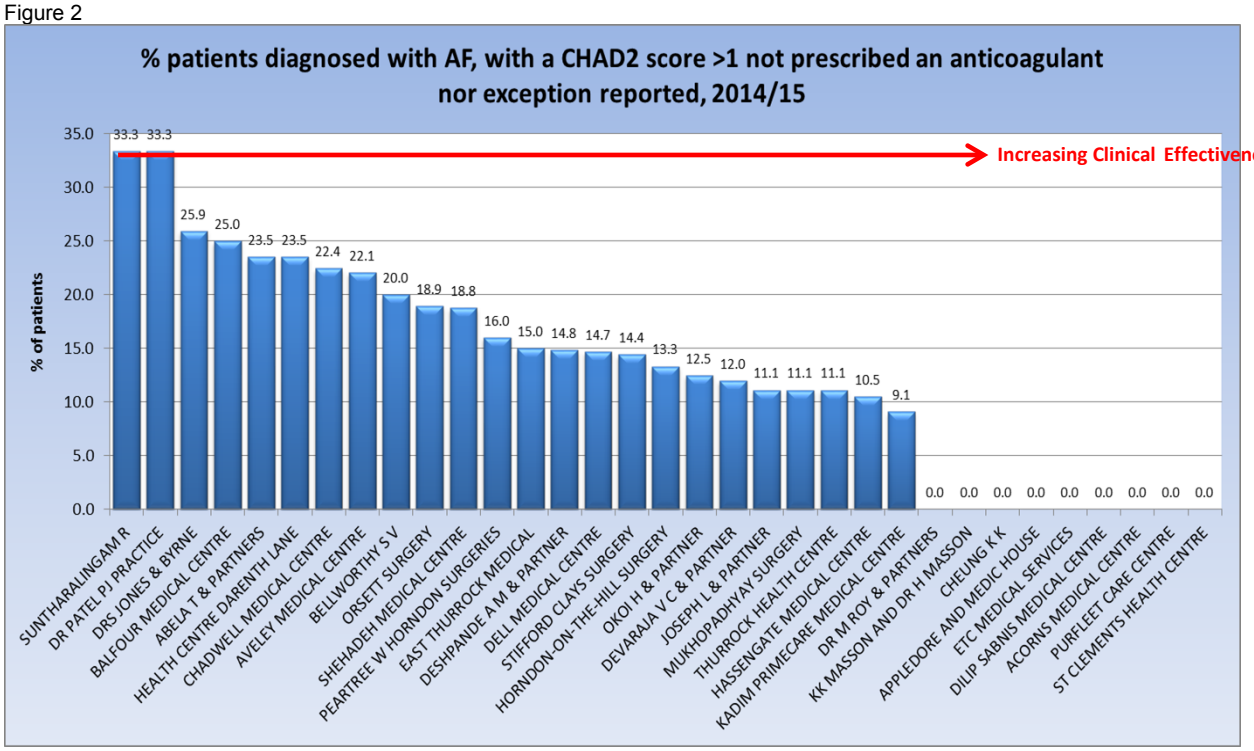
Source: Barnett *et al* 2012
Reprinted from *The Lancet*, vol 380, pp 37–43, © 2012, with permission from Elsevier.

3.5 A population living longer but not necessarily healthier lives creates some fundamental issues for the current system. Health and social care systems have failed to keep up with this dramatic shift. As such embedding effective

tertiary prevention (clinical activity that aims to keep patients with long-term-conditions as well as possible) within Primary Care is absolutely essential in maintaining public health, reducing the growth in demand through emergency hospital admissions and Adult Social Care packages and ensuring that our local Health and Social Care remains financially and operationally sustainable.

3.6 There is currently an unacceptable variation in the quality and effectiveness of long term condition clinical management programmes delivered at GP practice level in Thurrock which is leading to unnecessary emergency hospital admissions and serious and preventable health events such as strokes and heart attacks in some of our patients. An example of this is set out in figure 2. National Institute of Clinical Excellence (NICE) guidance states that all patients diagnosed with Atrial Fibrillation (AF) with a CHAD2 score >1 (a standardised clinical assessment tool that identifies stroke risk) must be prescribed anticoagulant medication in order to reduce their stroke risk, unless a patient falls into a cohort where they have another clinical contraindication that makes this dangerous, and/or they actively refuse to engage/comply with the clinical intervention (known as exception reporting). Figure 2 shows the percentage of patients diagnosed with AF at GP practice level who have **not** been prescribed an anti-coagulant medication and are **not** exception reported. These patients are being unnecessarily put at a high risk of stroke through failure of the practice to identify and prescribe a simple and low cost pharmacological intervention.

Figure 2



3.7 Caution should be advised before drawing firm conclusions on the reasons that lie behind the variation demonstrated in figure 2, which is also found

across a wide range of other tertiary prevention clinical indicators. Underlying factors could include variation between practices in terms of patient need/demand levels; clinical practice; practice staff skill-mix; levels of under-doctoring; and practice management/administrative skill/capacity. GP practices operate as independent private contractors and as such neither NHS England nor NHS Thurrock CCG or Thurrock Council has direct management control on GPs. However, highlighting variation in performance between practices directly to local clinicians, and assisting them to identify patients who need clinical interventions that reduce their risk of serious health events are two mechanisms that the Director of Public Health has employed successfully at Basildon and Brentwood CCG to improve patient care. Over-stretched clinicians, juggling competing clinical demands from patients, who are often served by inadequate levels of systematic/proactive administrative support, are sometimes unaware of the identities of all patients that require clinical interventions to keep them well.

3.8 It is proposed that the Thurrock Healthcare Public Health Team will work with NHS Thurrock CCG's Primary Care Development Team and the CCG's Clinical Executive Group to create and agree a Long Term Conditions Management Balanced Score Card and individual tailored GP practice reports. Public Health informatics staff are currently analysing the latest Hospital Episode Statistics (HES) and Primary Care Quality Outcomes Framework (QOF) data sets to identify the clinical interventions undertaken within GP practices that have the biggest impact on unplanned hospital admissions, and where there is the greatest variation between practices. The top eight interventions will be placed within the score card, showing each practice's performance, and shared with all practices on a quarterly basis. Public Health and the CCG's Primary Care Development Team will also construct "SystmOne" (the GP clinical database system used to hold patient records in all but two practices in Thurrock) queries, that can be run at GP practice level that will allow practice managers and clinicians to identify patients on Long Term Conditions registers that require clinical interventions to help keep them well. The scorecard will also include metrics that relate to the success of the development and operation of each GP practice's PPG.

3.9 When implemented in Basildon and Brentwood CCG by the author, this approach facilitated sharing of best clinical practice between high and low performing practices, and an immediate and continued improvement in long term conditions management of patients across the entire CCG population. Examples of the scorecard and individual GP practice report successfully implemented are shown in Appendix B.

3.10 The Thurrock Joint Health and Wellbeing Board (H&WBB) will receive data presented in the LTC Management Score card on a quarterly basis in order to track progress on LTC management improvement amongst member practices. The H&WBB will act as the "delivery arm" of this programme, using this data to nurture peer support amongst GP practices whilst ensuring an effective partner challenge relationship amongst Board members.

3.11 It is expected that the Public Health analyses required to identify the indicators will be completed by the end of September 2016, and that engagement with clinicians and agreement of the final process will be complete by December 2016, with a go live date in January 2017.

3.12 The two initiatives set out in this paper are examples of how the Thurrock Public Health Team will dedicate practical resources to assist and support GP practices to better engage with and care for their patients. In addition to the Council's plans to deliver four Integrated Healthy Living Centres in partnership with NHS and third sector stakeholders, we will seek to use capital and planning functions more effectively to allow high performing GP practices to expand. Equally, in conjunction with NHS Thurrock CCG and Healthwatch Thurrock we will increase patients' knowledge and understanding of the results of CQC inspections in order to help patient practice populations interpret the content of CQC GP Practice reports and what this may mean for them. We will also continue work with NHS England, as the commissioners of GP practices to ensure that they swiftly address issues of unacceptable quality in Primary Care highlighted by the CQC.

4. Reasons for Recommendation

4.1 Comment on these two new initiatives from as wide a number of stakeholders as possible is vital to ensure their success.

5. Consultation (including Overview and Scrutiny, if applicable)

5.1 Both programmes set out in this paper have been discussed and are supported by NHS Thurrock CCG and Healthwatch Thurrock. The LTC Management Scorecard is already a key objective under Goal E –*Healthier for Longer* in the Thurrock Joint Health and Wellbeing Strategy 2016-2021, which has already been widely consulted on and approved by both Thurrock Council and NHS Thurrock CCG's Board.

6. Impact on corporate policies, priorities, performance and community impact

6.1 These two initiatives support a wider programme of work to improve Primary Care in Thurrock as set out in the new Thurrock Joint Health and Wellbeing Strategy 2016-2021 and Public Health Service Transformation Plan 2016-17. They also support the work of the Council's Customer Service and Demand Management Board, and Transformation Plans and will contribute to financial sustainability of both Thurrock Council and the wider local Health and Social Care Economy.

6.2 The two initiatives will impact positively on local patients by ensuring their voice is strengthened at GP practice level, and that their care is improved.

7. Implications

7.1 Financial

Implications verified by: **Kay Goodacre**
Finance Manager

There are no direct additional financial costs arising from this report. All costs of the programme will be met from use of existing Public Health staffing resources. It is expected that the approach will deliver financial savings in terms of reduced health and social care demand. These are in the process of being modelled and will be set out in the Annual Report of the Director of Public Health 2016, that will be published in November 2016.

7.2 Legal

Implications verified by: **Chris Pickering**
Principal Solicitor

This report sets out 2 proposals for monitoring and improving GP care within the Borough. The report highlights the necessary consultation before implementation. Any other legal implications are contained within the report.

7.3 Diversity and Equality

Implications verified by: **Becky Price**
Community Development Officer
Community Development and Equalities Team

The initiatives outlined in this report will tackle the challenges of 'under-doctoring' and the under-development of Patient Participation Groups in Thurrock. They have been developed in conjunction with the NHS Thurrock CCG and Healthwatch Thurrock and form part of the Thurrock Joint Health and Wellbeing Strategy 2016-2021.

Through implementation, the proposals are expected to impact positively on local patients by ensuring their voice is strengthened at GP practice level, and that local Primary Care is improved overall.

7.4 Other implications (where significant) – i.e. Staff, Health, Sustainability, Crime and Disorder)

None

8. Background papers used in preparing the report (including their location on the Council's website or identification whether any are exempt or protected by copyright):

None

9. Appendices to the report

APPENDIX A - CQC Ratings for Thurrock GP Practices

APPENDIX B - Example of LTC Management Balanced Scorecard and Individual Practice Report implemented at BBCCG

Report Author:

Ian Wake
Director of Public Health

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Appendix A

CQC Ratings for Thurrock GP Practices

GP PRACTICE	OVERALL CQC RATING
Dr Leighton, Aveley Medical Centre	Good
Dr Jones, Rigg-Milner Medical Centre	Good
Dr Mohile , Chadwell Medical Centre	Inadequate
Dr Roy, Southend Road, Stanford-le-Hope	Good
Dr Suntharalingam, Health Centre, Tilbury	Inadequate
Dr Abela, Chafford Hundred Medical Centre	Requires Improvement
Drs Davies & Jayakumar, Peartree Surgery South Ockendon	Report Awaited
Dr D'Mello, The Surgery, Rowley Road, Orsett	Good
Dr Tressider, Hassengate Medical Centre, Stanford-le-Hope	Good
Dr Bansal, Balfour Medical Centre, Chadwell St Mary	Report Awaited
Dr Deshpande, Neera Medical Centre, Stanford-le-Hope	Inadequate
Dr Headon, the Health Centre, Stifford Clays	Requires Improvement
Dr Bellworthy, Sancta Maria Centre, South Ockendon	Requires Improvement
Dr Pattara & Dr Raja, The Horndon Surgery,	Good
The Shehadeh Medical Centre, Tilbury	Inadequate
Dr Yadava, East Thurrock Road Medical Centre, Grays	Not Yet Inspected
Dr Joseph, The Surgery, Grays	Not Yet Inspected
Dr Abeyewardene, Dell Medical Centre, Grays	Good
Dr Kadim, Primecare Medical Centre, Grays	Not Yet Inspected
Dr Yasin, The Health Centre, South Ockendon	Good
Drs Masson, The Surgery, Grays	Good
Dr Cheung, Ash Tree Surgery, Corringham	Good
Dr Ramachandran, Medica House, Tilbury	Requires Improvement
Dr Okoi, Derry Court, South Ockendon	Report Awaited
Dr Gorai, East Tilbury Medical Centre,	Not Yet Inspected
Dr Devaraja, the Sorrells, Corringahm	Requires Improvement
Dr Otim, Dilip Sabnis Medical Centre, Chadwell St Mary	Not Yet Inspected
Dr Ajetunmobi, Acorns, Queensgate Centre, Grays	Not Yet Inspected
Dr Nimal Raj, Purfleet Care Centre	Not Yet Inspected
Dr Hannan, St Clements Health Centre, West Thurrock	Not Yet Inspected
Dr Jathesenaikabahu, Thurrock Health Centre	Good
Dr Patel, Sai Medical Centre	Inadequate

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Appendix B

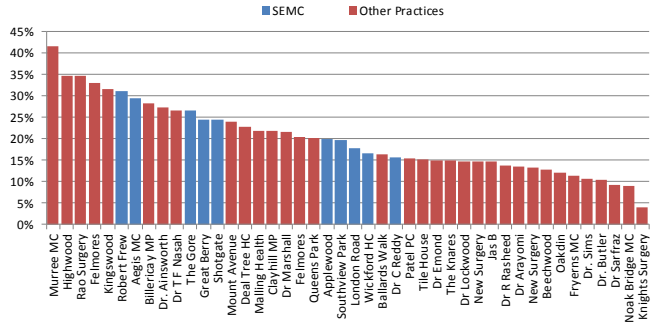
Example of LTC Management Balanced Scorecard and Individual Practice Report implemented at BBCCG

Public Health Locality Prevention Report

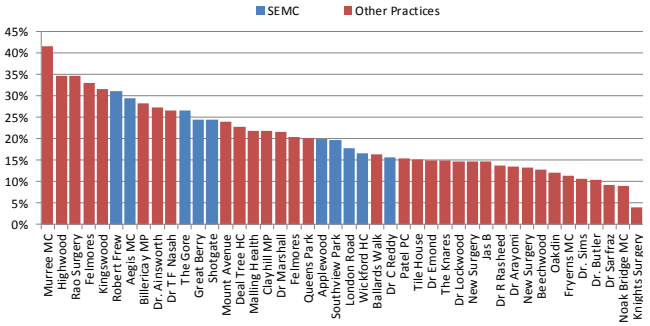
Please select locality to update graphs: SEMC

Hypertension

Hypertension Register with no BP recorded in last 9 months

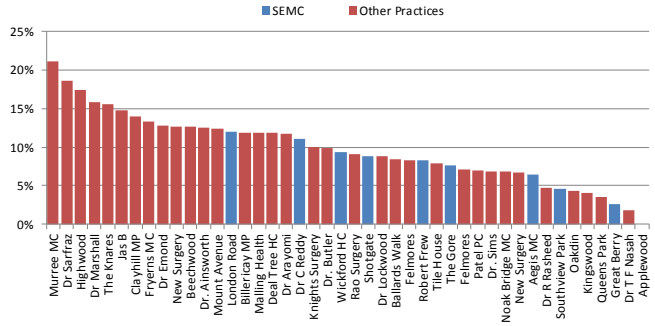


Hypertension Register without a controlled blood pressure of 150/90 or less in the last 12 months

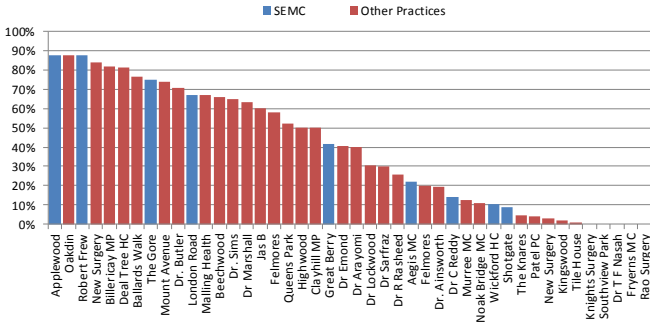


Atrial Fibrilation

All patients on practice AF registers that have not had an CHAD2 score recorded

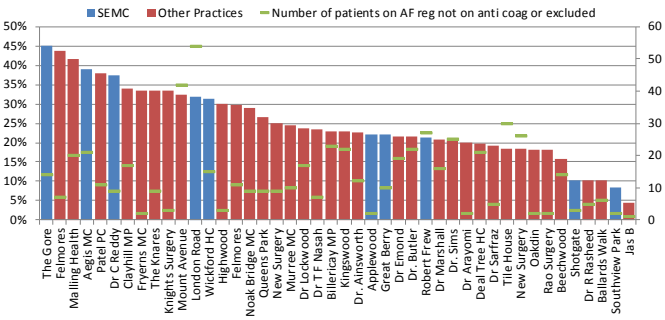


All patients on practice AF registers with a CHADS score less than 2 that is older than 12 months

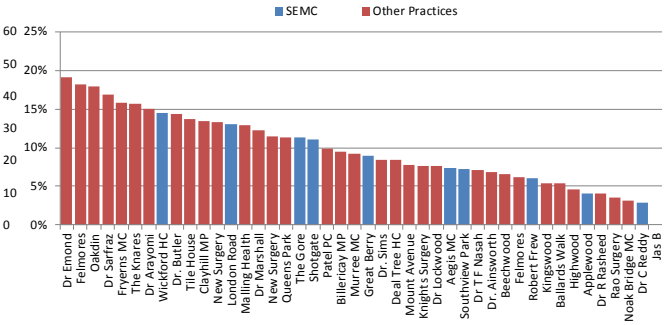


Coronary Heart Disease (CHD)

Patients on AF register (CHADS score 2 or more) not on anticoagulant or excluded



CHD Register without a controlled blood pressure of 150/90 or less in the last 12 months



GP Practice Based Prevention Report

Data Extracted 26 January 2015

F81666 Noak Bridge Medical Centre **Partnership and BIC**

The following metrics have all been demonstrated to relate to a GP practice population's risk of an unplanned care admission for circulatory disease

Disease Prevention Area	Metric	Current %	Absolute number of patients requiring review	CCG Rank (1 = best, 44 = worst)	Dec %	Direction
Hypertension	Patients on Hypertension Register without a BP recorded in the last nine months	9.07%	46	2	11.40%	⇧
	Patients on Hypertension Register without a BP >150/90 or less recorded in the last 12 months	9.47%	48	5	13.30%	⇧
Atrial Fibrillation	% of patients on the AF register without a record of a CHAD2 score	6.82%	3	11	8.25%	⇧
	% of patients on the AF register with a CHAD2 score >=2 not anticoagulated or excepted.	29.03%	9	29	37.10%	⇧
	% of patients on the AF register with a CHAD2 score <2 that is older than 12 months	11.11%	1	13	11.11%	⇔
Coronary Heart Disease	% of patients on the CHD register without a BP recorded that is <=150/90	3.19%	3	3	23.50%	⇧
Stroke/TIA	% Stroke/TIA register that do not have a recorded BP of 150/90 or less in the last 12 months	3.92%	2	4	4.70%	⇧
	% Stroke/TIA Register that do not have a recording of being on antiplatelet, anticoagulant or excluded	31.37%	16	9	3.73%	⇧
Health Checks	Health checks completed as a % of practice target. *number HCs still required to hit target.	55%	43*	16	45%	⇧

In order to identify your patients that require review please run the Public Health SystmOne reports that we have produced and published for you.

All PH Locality Reports are to be found under 'Clinical Reporting'.

- Open up the **'Essex'** folder in the clinical reporting tree
- Open up the **'Essex CC Vikki Ray'** folder within 'Essex'
- Select the suite of reports under **'PH Locality Reports'**

Each report that is numbered corresponds to the graphs presented in the PH Locality Report dashboard.

Any further questions please contact vikki.ray@essex.gov.uk

15 September 2016	ITEM: 11
Health & Wellbeing Overview and Scrutiny Committee	
Carers Support, Information and Advice Service	
Wards and communities affected: All	**Key Decision:** Key
Report of: Catherine Wilson: Strategic Lead – Commissioning and Procurement	
Accountable Head of Service: N/A	
Accountable Director: Roger Harris – Director of Adults, Housing and Health	
This report is Public	

Executive Summary

This report details the preferred option for the procurement of a Carers Support, Information and Advice Service for Carers aged 18 and over. The proposed changes to the current service ensure that the Council is fully compliant with our responsibilities under the Care Act 2014 and in line with best practice. The specification for future service is in development and this report asks the committee to agree the future design of the service.

1. Recommendation(s)

1.1 For HOSC to approve the future design of the Support, Information and Advice Service for Carers.

2. Introduction and Background

2.1 The current provision for Carers Support, Information and Advice is due to expire in January 2017. The service is required to meet the needs of vulnerable people and ensure the Council continues to meet legislative requirements. As such, we are seeking approval for developments to the service in line with legislation and local development.

2.2 Thurrock Council has a duty (please see appendix 1 which details our requirements under the Care Act 2014) to facilitate the provision of a Carers support, information and advice service for Carers aged 18 and over. The Care Act 2014 defines a 'Carer' as an adult who provides or intends to provide care for another adult needing care.

2.3 The 2011 national census for England, Wales and Northern Ireland concludes a significant increase in the number of Carers since the last census.

- The number rose from 5.22 million in 2001 to 6 million in 2011. This is an increase of 629,000 over the 10 year period.
- Of these 2.2 million people are undertaking caring responsibilities in excess of 20 hours a week and 4 million in excess of 50 hours a week.
- It is anticipated that the number of Carers are likely to increase in the future as people are living longer and with more complex needs.
- The age profile shows the peak age for caring is 50 to 59 and that 1 in 5 people in this age group (1.5 million across the UK) are providing some unpaid care.

2.4 In 2014 the total population of Thurrock was 157.705 (ONS end-year estimates 2011). Out of this the census identifies that:

- 5.5% (8674 Residents) provides 1-19 hours of unpaid care a week
- 1.4% (2208 Residents) provides 20-49 hours unpaid care a week
- 2% (3154) provide 50 or more hours of unpaid care per week

This means there are an estimated 14,036 Carers resident in Thurrock.

2.5 Thurrock Council currently commissions Thurrock Mind to provide a Carers Support, Information and Advice Service (CARIADs) for Carers aged 18 and over. In the period April 2015 to March 2016, 342 Carers received a service from Cariads.

2.6 The current contract value is £117,118.36 per annum and is commissioned to provide:

- Support: support groups, counselling services for Carers, ad-hoc therapeutic and health promoting activities, Carer training and early identification
- Information and Advice: Telephone and drop in services, newsletter, Carers week and Carers rights events, maintain Carers support directory and carers support pack, provide input to council web-based information
- Appropriate staffing to support the delivery of the service

3. Issues, Options and Analysis of Options

3.1 Current provision of carers support, information and advice has been reviewed to ensure it meets the current and future needs of Carers in Thurrock and our responsibilities under the Care Act.

3.2 As part of the review, 3 options were identified and presented to the Departmental Management Team (DMT) for Adult, Housing and Health.

1. **To remain the same** - Continue to commission the service as set out in the current specification at the current price (£117k per annum)
2. **To Increase the capacity** - Continue to commission the service at the same price (£117k per annum) but increase the capacity to meet the identified growth in future carers. The specification will also be changed to

reflect our commitment to the Asset Based Community Development (ABCD) model and to ensure that there is an equality of access across all locations within the borough.

3. **To delegate the majority of our responsibilities** - Devolve most functions including assessments and budget allocation (excluding safeguarding and charging) to the new provider.

4. Reasons for Recommendation

4.1 DMT reviewed all 3 options. Their **preferred option is number 2 – To increase capacity for the same contract price.**

Although the current service providers have worked hard to increase awareness of Carers and identify where support and information can be given (as identified in the figures provided in sections 2.3 and 2.4), there is still more to be done in order to ensure that Thurrock fulfils the commitments made to carers through the Thurrock Carers Strategy 2012-2017 and to reach those not yet receiving support.

4.2 Option 1 no longer meets Thurrock Council's new responsibilities under the Care Act and is not consistent with the ABCD model.

4.3 Option 3 would increase cost at a time of austerity. There is a risk that devolving the budget and thereby control, could result in larger support packages and increased cost. There would also be an addition cost of the organisation carrying out these functions.

4.4 As such the service specification for the preferred model (option 2) is currently being reviewed and updated to ensure we meet the needs of a greater number of Carers. A number of priorities have been identified through reviewing examples of best practice and engagement with service users and stakeholders (see section 5 of report). This research and feedback has been used to review the key objectives (appendix 2) But the highlights of these include:

- Building a greater presence in the community and raising the profile of the service to ensure Carers are aware of its availability and to enable earlier identification of carers
- Raising the profile of Carers across Thurrock including with statutory and community organisations as well as with partners in Health services.
- To work closely with GPs and IAPT services to ensure that Carers are identified and offered the support they require in a timely and responsive manner
- Provide equitable services that all Carers can access regardless of their location or circumstance

5. Consultation (including Overview and Scrutiny, if applicable)

5.1 Current service users and key stakeholders were engaged in July 2016 with regarding the current service provision. This feedback has shaped future service development (option 2) by ensuring increased access to support, information and advice at a time and a place which meets their needs.

6. Impact on corporate policies, priorities, performance and community impact

6.1 The tender of a Carers Support, Information and Advice service primarily meets the priority 'To improve health and well-being'. By commissioning this service, we will continue to ensure that the needs of carers are met.

7. Implications

7.1 Financial

Implications verified by: **Jo Freeman**

Management Accountant (Social Care & Commissioning)

The service already forms part of the 16-17 base budget and as this will be re-tendered within the current financial envelope there will be no financial implications.

Please note one member of staff remains under the employment of Thurrock Council.

7.2 Legal

Implications verified by: **Rosalind Wing**

Adult Social Care Solicitor

The service changes recommended in this report simply aim to bring Thurrock's support, information and advice for carers service into line with current legislation (the Care Act 2014) and the Thurrock Carers' Strategy 2012-2017. Assuming this can be achieved within the existing budget, the legal implications are simply that Thurrock will be complying with its obligations under the above-named Act and Strategy

7.3 Diversity and Equality

Implications verified by: **Natalie Warren**

Natalie Warren, Community Development and Equalities Manager, Adults, Housing and Health Directorate

A Community and Equality Impact Assessment will be carried out prior to commissioning the new services
The purpose of this tender is to increase the identification and access of carers to support, information and advice.

7.4 **Other implications** (where significant) – i.e. Staff, Health, Sustainability, Crime and Disorder)

N/A

8. Background papers used in preparing the report (including their location on the Council's website or identification whether any are exempt or protected by copyright):

- N/A

9. Appendices to the report

- Appendix 1 – Summary of conditions and requirements set out in the Care Act 2014
- Appendix 2 – Key Objectives for the service

Report Author:

Kelly Redston

Integrated Commissioner

Adult Social Care

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Appendix 1

Summary of conditions and requirements set out in the Care Act 2014

The Care Act 2014 received royal assent in May 2014. The Care Act covers adult social care in England only. The Children and Families act 2014 includes new duties for the assessment of young carers and the parent carers of children under 18. Part one of the new Act consolidates and modernises the framework of social care law. The Care Act brings those funding their own care into the care system with obligations on local authorities relating to information and advice, universal services, assessments and market shaping. The act strengthens the rights and recognition of carers in the social care system, including, for the first time giving carers a clear right to receive services.

Section 1 establishes the 'well-being principle' – an overarching approach that local authorities should take when exercising their responsibilities under the Act. Well-being covers a range of outcomes such as physical, mental and emotional well-being. It also covers participation in work, education and training and social and economic well-being

Section 2 places a new duty on local authorities to provide or arrange for services, facilities or resources which prevent or delay the development of, or reduce the need for care and support of adults. The Act requires local authorities to provide information and advice relating to care and support locally, including types of care and support, the provider's people can choose from, how to access care and support, how to raise concerns about safeguarding and how to access independent financial advice.

The Act makes it clear that both adults (needs assessments) and carers (carers assessments) should be assessed on the appearance of need and regardless of what the local authority thinks the level of their need and regardless of the ir financial resources. The assessment must consider how the persons needs impact upon their well-being and the outcomes they wish to achieve in day to day life. The adult's needs assessment must focus on the outcomes of the person and the authority must also consider the carer. For carers this means 2 significant changes, it removes the requirement to ask for an assessment and it removes the requirement for the carer to be providing substantial care on a regular basis.

Section 14 of the Act sets out that a local authority may charge for services including carers' services. It gives local authorities the power to charge for services it is under duty to provide, i.e. those that meet the eligible needs of either the adult needing care for their own services or the carer for their own services. Such a charge can only cover the cost that the local authority incurs in meeting the needs.

Under the Act local authorities can delegate a majority of their functions with the exception of safeguarding, charging and duties to co-operate and integrate. A local authority may also authorise a third party to exercise on its behalf its functions relating to direct payments.

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Appendix 2

Draft Key Objectives for Specification

The support services need to be of good quality to support Carers in Thurrock. The key principles have been translated into the following key service objectives:

- Ensure that Carer's in Thurrock are well informed and signposted to information and advice and universal services
- Identify unknown Carers and provide with appropriate support, information and advice
- Specifically target and engage with under-represented Carer groups
- Develop support that is personalised for both the Carer and cared-for person.
- Work with council Teams to promote and encourage direct payments for Carers and those they support
- Provide low level emotional and practical support for Carers via telephone and drop-in services
- Develop and facilitate Carer support groups in accordance with Carer requirements
- Provide support to Carers which helps to sustain a caring role and avoid a crisis that might adversely affect or end it (for example information and/or training)
- Raise awareness of, and be the local champion for Carers issues
- Raise the overall profile of Thurrock Carers and their contribution with professionals (including Council staff and local employers) and the wider public
- Form close working relationships with GP practices, hospitals, IAPT local statutory and voluntary organizations and council departments to raise the profile of Carers, to enable identification of hidden Carers and improve support for known Carers and creating opportunities for earlier intervention
- To utilize the closer working relationships with other organisations in Thurrock, including primary care and the voluntary sector, to identify Carers (including those funding their own care) and to ensure they receive access to local information advice and guidance
- Work closely with the Young Carers Service in Thurrock to identify areas for joint working and smooth the transition for young Carers moving into adult services
- To ensure 'the wellbeing principle approach' is applied and that Carers are supported to achieve positive physical, mental and emotional wellbeing principles as well as outcomes relating to participation in work, education, training and social and economic wellbeing
- Involve Carers fully in the design, planning and running of services and encourage and support Carers to become peer supporters and volunteers. Develop and facilitate a local Carers forum which is representative of the demographics of Thurrock Carers

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15 September 2016	ITEM: 12
Health & Wellbeing Overview and Scrutiny Committee	
Procurement of the Healthy Lifestyles Service	
Wards and communities affected: All	**Key Decision:** Key Decision – spending above £500K
Report of: Councillor James Halden, Portfolio Member for Education and Health	
Accountable Head of Service: Tim Elwell-Sutton, Consultant in Public Health	
Accountable Director: Ian Wake, Director of Public Health	
This report is Public	

Executive Summary

This report sets out the proposals for the procurement of a new Healthy Lifestyles Service for a contract, to commence on 1 April 2017.

Current services are delivered by a range of providers delivering different elements of the service, with limited cross referral ability. Service Users can self-refer but will need to go to each different provider to receive a service and there is minimal control on duplication of provision.

All of the current contracts expire on 31st March 2017. A significant element is delivered by NELFT, with the Council a co-client on the CCG contract with NELFT which cannot be extended after this date. Other services are provided through a grant funding arrangement.

The current budget across all services to be included within the contract is £736,875.

Currently, unit costs are high, particularly when considering outcomes achieved. It is proposed that the Service is tendered as a Lead Provider Model, with a single point of access and referral, thus making it easy both for self-referral and referrals from professionals (GPs/Maternity Services etc.). The Lead Provider will develop and maintain a database of Service Users, assess needs, and allocate individuals to specific programmes of service (which may be across more than one element where necessary. The Lead may also deliver some of the activities and services, or these may be provided by sub-contracted partners within the community. The Lead Provider will be encouraged to sub-contract with smaller community providers where appropriate to retain plurality of service provision. The new contract will be more flexible and able to be scaled to meet varying targets across the different service areas, dependent on need and changing priorities.

Realistically, £200K per annum savings should be delivered from procurement of this re-modelled service.

This report will be presented to Cabinet to request permission to proceed to tender in October 2016.

1. Recommendation(s)

Health & Wellbeing Overview and Scrutiny Committee is recommended to:

1.1 Comment on the proposed process to commence procurement of the Healthy Lifestyles Service contract prior to its submission to Cabinet.

2. Introduction and Background

2.1 Thurrock Public Health currently commissions a number of individual healthy lifestyle services through a single provider (NELFT) including: weight management, smoking cessation, MECC (Making Every Contact Count), NHS health checks, and community weight management programmes. Exercise on Referral is provided by Impulse Leisure and has been a one-year pilot programme.

2.2 The current budget is split as follows:

Contract	**Provider/s**	**2016-17 Budget**
Tier 1 and 2 Weight Management Services	NELFT and some community providers through grant agreements	£122,375
NHS Health Checks/CVD Risk Management Public Health Services Contract	NELFT	£253,500
New Tobacco Control and Smoking prevention	NELFT	£361,000[1]
Total Spend[2]		**£736,875.00**

2.3 This fragmented arrangement with limited interaction between Providers means that it can be both difficult to access (multiple entry points) and Service Users could receive a weight management service from more than one Provider, taking a place away from another potential recipient.

[1]Plus £34,000 for the ASSIST licence and an additional performance bonus potential of up to c. £10K for NELFT on quitters.

[2] The Exercise on Referral budget (PH) is currently c. £55,000 per annum. The CCG contribute to this service additionally. This service is under consideration for inclusion within the Lead Provider Model (see Section 4.6) but further savings would not be anticipated.

2.4 The cost of the current services is expensive, in terms of the outcomes achieved. Public Health is not able to track individuals on their longer term success and return to the programme (relapse) and therefore the strategic benefits are as yet unproven. Future budget cuts and the removal of the ring-fence on the Public Health Grant in 2018/19 put the sustainability of the services, in their current form, at risk.

2.5 In terms of performance, targets have not been met for Smoking Cessation and the Health Check programme – although Health Checks was still one of the best performing in the region and above national averages. Weight Management targets were achieved in part and there were significant differences across the different providers.

2.6 As current contracts end in March 2017, it is appropriate to reconsider the model in terms of delivery, management, monitoring and cost. This paper sets out the options and new model for procurement.

2.7 The Healthy Lifestyles Contract should be seen within a much wider framework of strategic work to improve health and wellbeing within Thurrock. For example, Public Health and working closely with the Council's Planning, Regeneration and Transport functions to capitalise on opportunities create healthier environments that encourage physical activity such as walking and cycling.

3. Issues, Options and Analysis of Options

Timescale and Procurement Route

3.1 The tender now falls under the Public Contracts Regulations' "Light Touch Regime" as the whole life value is above £625,000. This requires advertisement in OJEU and compliance with certain EU Procurement Directive standards.

3.2 Additionally, within this procurement it is important to include a minimum of two months for implementation because if there is a change in contractor, it is likely there will TUPE transfer of staff at contract change-over as well as the contractual and administrative set-up necessary to deliver the service.

3.3 A report will be presented to Cabinet in October 2016 requesting permission to go out to tender with a view to a new contract start date of 1 April 2017.

New Service Outcomes and Deliverables

3.4 The proposed new service would include the following elements:

- Smoking Cessation / Harm Reduction including e-cigarettes (Tier 2)
- Health Checks
- Weight Management (Tier 2)

- Making Every Contact Count (MECC)
- Onward referrals within and outside of the service (e.g. to Tier 3 Weight Management, and mental health services such as IAPT)
- Signposting to universal services

3.5 The benefits of including the Exercise on Referral scheme within the Lead Provider Model is currently under consideration. It is a direct referral by GPs or Healthcare professionals and the benefits of including this are more limited. A cost benefit analysis will be undertaken before the decision is made.

3.6 In terms of Health and Wellbeing Strategy outcomes, the Service will clearly contribute towards E1-E3 (Healthier for Longer) (green), but also can make a significant contribution to D1-3, E4 and C4 (yellow).

Goals	**A. Opportunity For All**	**B. Healthier Environments**	**C. Better Emotional Health And Wellbeing**	**D. Quality Care Centred Around The Person**	**E. Healthier For Longer**
Objectives	A1. All children in Thurrock making good educational progress	B1. Create outdoor places that make it easy to exercise and to be active	C1. Give parents the support they need	D1. Create four integrated healthy living centres	E1. Reduce obesity
	A2. More Thurrock residents in employment, education or training.	B2. Develop homes that keep people well and independent	C2. Improve children's emotional health and wellbeing	D2. When services are required, they are organised around the individual	E2. Reduce the proportion of people who smoke.
	A3. Fewer teenage pregnancies in Thurrock.	B3. Building strong, well-connected communities	C3. Reduce social isolation and loneliness	D3. Put people in control of their own care	E3. Significantly improve the identification and management of long term conditions
	A4. Fewer children and adults in poverty	B4. Improve air quality in Thurrock.	C4. Improve the identification and treatment of depression, particularly in high risk groups.	D4. Provide high quality GP and hospital care to Thurrock	E4. Prevent and treat cancer better

3.7 A suite of Key Performance Indicators and data requirements will be developed to accurately measure both the performance of the Contractor(s) and the overall success of the programme against the Health and Wellbeing Strategy Outcomes. Measures will need to be flexible as priorities change over the 3-5 year term of the contract.

Service Model and Procurement Options

3.8 A range of different options were considered for both the model and procurement route, including maintain separate services, single provider (all

elements) and either tender or bring the service in-house. The service model options considered are set out in Appendix 1 to this report.

Recommended Service Model Option - Lead Provider

3.9 A Lead Provider will deliver a Healthy Lifestyle programme through a Single Point of Access/Referral (and shared data) with services delivered through primary care, outreach and direct commissioning of community programmes to meet specified outcomes.

This has the following advantages:

- Greater potential for lower cost contract as each section supports the other (resource sharing) and absorbs potential losses
- Only one organisation to manage
- Allows for local community services to be incorporated on a framework
- Data returns from one source
- One procurement process
- Single Point of Access/Referral, supporting appropriate service allocation, data sharing and monitoring.
- Ability to provide a more holistic service to users who have multiple needs.
- Relatively scalable to meet future budget changes

3.10 With regard to the procurement options, the value determines the need to go out to a full open procurement exercise, using the “Light Touch” rules.

3.11 Officers did consider whether any element of the service could be brought in-house; however alongside the extensive timescale to undertake the insourcing exercise, additional procurement activity would be required for some directly commissioned community services, together with an IT system to manage client assessment and referral. Delivery of savings is less achievable through this route.

3.12 It is therefore recommended to put the service through an open market tender to ensure the opportunity for savings and innovation. A large NHS or Private Sector provider would also be more likely to be able to meet the Council’s requirement to flex resources over the term of the contract as priorities and funding changes.

3.13 A “Lead Provider” does not mean a single provider, or “one size fits all” provision. It is envisaged that where appropriate, the Lead Provider will sub contract with smaller providers including those in the community and voluntary sector to retain the plurality of provision in healthy lifestyle programmes.

4. Reasons for Recommendation

4.1 This report is submitted to Health Overview and Scrutiny Committee for comment prior to proceeding to tender for a contract with a whole life cost

valued above £750K. The total estimated value for this contract over the maximum 5 year period of delivery is c. £3.15 million.

5. Consultation (including Overview and Scrutiny, if applicable)

5.1 This proposal has been discussed and agreed with internal and external stakeholders including CCG, Primary Care and current providers.

5.2 Health Overview and Scrutiny Committee is asked to consider and agree this proposal.

6. Impact on corporate policies, priorities, performance and community impact

6.1 The contract aims to meet corporate priorities through the delivery of high quality services in all elements.

The following two examples show how priorities will be delivered through the contract:

Priority	**Delivered By**
Improve Health and Wellbeing	Clearly this is the fundamental scope of the Service. The service aims to reduce the prevalence of obesity, smoking and increase healthy lifestyles. Service Users will be tracked throughout and after the programme/s to determine the long term benefits. Inclusion of the NHS Health Checks Programme should help in the identification of yet undiagnosed conditions that can be treated early to reduce long term health care costs.
Encourage and promote job creation and economic prosperity (and Social Value Act)	Clear targets to be set around volunteering, training and employment opportunities for local people

7. Implications

7.1 Financial

Implications verified by: **Jo Freeman**
Management Accountant

The procurement aims to implement one contractual arrangement from a number of service budgets within or below the current annual price. The contract will be scalable to enable it to adjust to priorities and changes in

funding availability during the maximum 5 year term as the ringfence on the Public Health Grant is removed in 2018/19.

7.2 **Legal**

Implications verified by: **Kevin Molloy**
Solicitor

This report is seeking approval from Health Overview and Scrutiny Committee for in principle agreement to tender the contract noted in the report. The proposed procurement is estimated well above the EU threshold for "Health" services (£625K) within the new Light Touch Regime of the Public Contracts Regulations 2015. This means that there is a legal requirement to competitively tender the contract via the Official Journal of the European Union (OJEU).

Taking the above into account, on the basis of the information in this report, the proposed procurement strategy should comply with the Regulations and the Council's Contract Rules.

The report author and responsible directorate are advised to keep Legal Services fully informed at every stage of the proposed tender exercise. Legal Services are on hand and available to assist and answer any questions that may arise.

7.3 **Diversity and Equality**

Implications verified by: **Natalie Warren**

Community Development Officer

The Service will be available across the whole community, responsive to gender and or culturally specific need. A Community And Equality Impact Assessment will be carried out to identify specific actions to include in the specification so to ensure the needs of target areas and groups of people with protected characteristics are met, as well as ensuring ease of access to services. Bidders' achievement of similar outcomes for a range of target groups and areas will be tested as part of the tender process.

7.4 **Other implications** (where significant) – i.e. Staff, Health, Sustainability, Crime and Disorder)

None

8. Background papers used in preparing the report (including their location on the Council's website or identification whether any are exempt or protected by copyright):

None

9. Appendices to the report

Appendix 1: Options for Service Model and Procurement Route

Report Authors:

Sue Bradish
Public Health Manager

Stefanie Seff
Corporate Procurement Strategy & Delivery Manager

Appendix 1:
Service Model Options

Model	Description	Advantages	Disadvantages
As is (No Change)	Healthy Lifestyle programmes continued to be commissioned with the current Provider (NELFT) alongside additional community programmes	• Good relationship with Providers (NELFT and Community Providers) • NELFT have established relationships with local primary care and pharmacy services	• Limited opportunity for innovation • May be difficult to achieve savings • Previous reductions have led to fewer front line staff • Difficult to justify in procurement terms
Individual Services	Healthy Lifestyle programmes are procured on an individual basis (eg. smoking, weight management) with the expectation of a variety of providers being awarded contracts	• Healthy competition to ensure the best provider chosen • Competitive pricing and specialisms • Standalone providers allows for easy decommissioning of specific services • Community services could be targeted more effectively • Autonomy of services	• Increased data collection resource • Potential loss of provider relationships with primary services, pharmacies • Duplication of usage (by Service Users) and management/administration costs • Several procurement processes and contract awards, and more contract management.
Lead Provider Service	Lead Provider delivers a Healthy Lifestyle programme through a Single Point of Access/Referral (and shared data) with services delivered through primary care, outreach and direct commissioning of community programmes to meet specified outcomes	• Potentially lower cost contract as each section supports the other (resource sharing) and absorbs potential losses • Only one organisation to manage • Can specify local services and supports community providers • Data returns from one source • One procurement process • Single Point of Access/Referral,	• Potential for higher company overheads and reduction on staffing levels – though this can be managed through commissioning and management process • Dependent on the provider, may lose relationship with primary care, pharmacies.

Model	Description	Advantages	Disadvantages
		supporting appropriate service allocation, data sharing and monitoring. • Ability to provide a more holistic service to users who have multiple needs. • Fairly scalable in terms of moving budget figures	
All Inclusive Service	One provider responsible for direct delivery of all services (possibly with some commissioning through LESs (Locally Enhanced Services) with primary care. Using an internal health trainer type model to provide outreach.	• One service so management is simple • Costs easy to trace and manage service users • There may be savings in overheads • Control is potentially better	• Service difficult to disaggregate if failing in part • May miss some potential opportunities in commissioning of specialist providers • Impact on local organisations may be negative.

Overall, the Lead Provider model is most likely to deliver the mix of services the Council requires, at a cost effective price.

15 September 2016	ITEM: 13
Health & Wellbeing Overview and Scrutiny Committee	
Re-Procurement of the Integrated Adults Substance Misuse Treatment Service	
Wards and communities affected: All	**Key Decision:** Key Decision – spending above £500K
Report of: Councillor James Halden, Portfolio Member for Education and Health	
Accountable Head of Service: Tim Elwell-Sutton, Consultant in Public Health	
Accountable Director: Ian Wake, Director of Public Health	
This report is Public	

Executive Summary

This report sets out the proposals for the re-procurement of the Integrated Adults Substance Misuse Treatment Service contract ("the Service") which provides a recovery-focussed adult drug and alcohol treatment system within Thurrock. The current contract expires on 31 March 2017 and a new contract will be put in place for 1 April 2017.

The current contract has been in place since 1 April 2014 and was awarded to Kent Council for Addiction (KCA). As part of a corporate merger, Addaction acquired KCA in the summer of 2014 and took over the responsibility of the contract. There have been some issues with the quality and safety of the service which are currently being addressed. Because of these and given that Addaction did not win the contract in their own right, officers have decided not to exercise the optional two year extension and instead will take the contract to the market. This will also provide the opportunity to further integrate the service, with the inclusion of additional responsibilities, and look to generate additional savings.

The residential detox budget is currently held by Public Health – but clients are referred directly by the Service Provider – and therefore we have little control over spend. In the new arrangement, the budget will be transferred to the Provider to ensure there is sufficient leverage on cost control. It is envisaged that the funding for this will reduce as more clients are supported in the community.

It is envisaged that a competitive procurement exercise will secure an overall saving of £90 - £100K

Council and external stakeholders including the CCG and Primary Care have been consulted to finalise the requirements.

1. Recommendation(s)

Health & Wellbeing Overview and Scrutiny Committee is recommended to:

1.1 Comment on the re-procurement of the Integrated Adults Substance Misuse Treatment Service.

2. Introduction and Background

2.1 The current contract was awarded to KCA on 1st April 2014 for a period of three years with a two year extension option.

2.2 There have been some issues with the quality and safety of the service which are currently being addressed. It is now felt that in order to further improve delivery and ensure a fully integrated approach, whilst at the same time delivering cost savings, it should go through a full market tender.

2.3 The opportunity provided here for a re-procurement allows for improvements in specification scope, style, content (integrated services) and performance management to support and incentivise good service delivery.

2.4 The cost of the current Adult Treatment and Prescribing contract is £1,006,000 for 2016/17, and there are five additional, related services provided outside of this contract but within the Drugs and Alcohol budget.

Service	**Cost**
Residential Detox and Rehabilitation	£100,000
Supervised Consumption	£25,000
Drug Testing Kits	£10,000
Advocacy Service	£33,000
Dual Diagnosis Worker	£60,000
Total additional services	£228,000
Addaction Contract	£1,006,000
Adult DAAT Budget Total	**£1,234,000**

2.5 The re-tender of the Service through a competitive process should allow some economies of scale and allow the entire scope of additional services, with the exception of the Advocacy provision, to be delivered at a cost lower than the current budget figure for 2017/18 although savings are unlikely to be considerable. Moving forwards, as targets and priorities change, the contract will be scaled according to need.

2.6 The current Advocacy Service will not be re-procured after it ends on 31 March 2017 as Service Users are able to access these services through Adult Social Care (Advocacy and Carers Support). The new service specification for the Integrated Service will require the Provider to deliver Service User Involvement (feedback and peer mentoring) plus general signposting to other services.

3. Issues, Options and Analysis of Options

Timescale and Procurement Route

3.1 The tender now falls under the Public Contracts Regulations' "Light Touch Regime" as the whole life value is above £625,000. This requires advertisement in OJEU and compliance with certain EU Procurement Directive standards.

3.2 Additionally, within this procurement, it is important to include sufficient time for implementation because, if there is a change in contractor, it is likely there will also be significant TUPE transfer of staff at contract change-over. Transfer of client records and set up of the new service to ensure it is safe and ready for operation on 1st April is a complex and time-consuming process for any new Provider, as well as for the Council.

3.3 Subject to approval by Health Overview and Scrutiny Committee, this report will be submitted to Cabinet in October for confirmation and the tender will be issued mid to late October with a contract start date of 1 April 2016.

Contract Specification

3.4 The Contract will be established and priced flexibly, to ensure that it can be scaled to meet changing service user needs alongside funding priorities during the (maximum) five year term.

3.5 Key requirements of the Service are to deliver a safe and effective integrated service to Thurrock residents aged 18 years and over, their families and friends who are experiencing issues with drug and/or alcohol use.

3.6 The integrated service will incorporate the core adult treatment functions plus the prescribing function, supervised consumption, needle exchange service, community and residential detox and rehab, the dual diagnosis service, drug testing kits and all associated cost related to such an integrated service.

3.7 The service will operate an outreach and prevention function on a needs-basis. It will also develop and maintain a thriving recovery community to ensure residents can exit treatment and live free from dependency or risk of relapse.

4. Reasons for Recommendation

4.1 This report is submitted to Health Overview and Scrutiny Committee to comment on the re-tender for a contract with a whole life cost valued above £750K. The total estimated value for this contract over the maximum 5 year period of delivery is c. £6 million.

5. Consultation (including Overview and Scrutiny, if applicable)

5.1 This proposal has been discussed and agreed with internal and external stakeholders including the Community Safety Partnership, CCG and Primary Care.

5.2 This report is presented to Health & Wellbeing Overview and Scrutiny Committee for agreement.

6. Impact on corporate policies, priorities, performance and community impact

6.1 The contract aims to meet corporate priorities through the delivery of high quality services both at the early intervention and treatment recovery stages.

The following two examples show how priorities will be delivered through the contract:

Priority	**Delivered By**
Improve Health and Wellbeing	Clearly this is the fundamental scope of the Service. Included is preventative work as well as treatment and recovery
Encourage and promote job creation and economic prosperity (and Social Value Act)	Clear targets to be set around volunteering, training and employment opportunities for local people – including service users in their recovery phase

7. Implications

7.1 Financial

Implications verified by: **Jo Freeman**
Management Accountant

The procurement aims to secure a contract with additional integrated services within or below the current annual price. The contract will be scalable to enable it to adjust to priorities and changes in funding availability during the maximum 5 year term as the ring-fence on the Public Health Grant is removed in 2018/19.

7.2 **Legal**

Implications verified by: **Kevin Molloy**
Solicitor

This report is seeking approval from Health Overview and Scrutiny Committee to tender the contract noted in the report. The proposed procurement is estimated well above the EU threshold for "Health" services (£625K) within the new Light Touch Regime of the Public Contracts Regulations 2015. This means that there is a legal requirement to competitively tender the contract via the Official Journal of the European Union (OJEU).

Taking the above into account, on the basis of the information in this report, the proposed procurement strategy should comply with the Regulations and the Council's Contract Rules.

The report author and responsible directorate are advised to keep Legal Services fully informed at every stage of the proposed tender exercise. Legal Services are on hand and available to assist and answer any questions that may arise.

7.3 **Diversity and Equality**

Implications verified by: **Rebecca Price**
Community Development Officer

The Service will be available across the whole community, responsive to gender and or culturally specific need as well as needs relating to the particular substance misuse, and the Provider must demonstrate they are an equal opportunities employer. This will be tested as part of the tender process.

7.4 **Other implications** (where significant) – i.e. Staff, Health, Sustainability, Crime and Disorder)

The Service will link with the Community Safety Partnership via Public Health to ensure it is responsive to identified need within the borough.

8. Background papers used in preparing the report (including their location on the Council's website or identification whether any are exempt or protected by copyright)

None

9. Appendices to the report

None

Report Authors:

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Public Health Manager

Stefanie Seff
Corporate Procurement Strategy & Delivery Manager

Health Overview & Scrutiny Committee
Work Programme
2016/17

Dates of Meetings: ~~9 June 2016~~, 15 September 2016, 10 November 2016, 17 January 2017, 15 March 2017

Topic	Lead Officer	Requested by Officer/Member
9 June 2016		
Items raised by HealthWatch	Kim James	Members
PET CT Scanner	NHS England	Members
Public Health Grant	Ian Wake – Tim Elwell-Sutton	Members
Thurrock Cancer Joint Strategy Assessment Needs	Ian Wake - Funmi Worrell	Members
Success Regime	Andy Vowles, Project Director for ESR	Members
Domiciliary Care	Roger Harris / Catherine Wilson / Michelle Taylor	Members
15 September 2016		
Items raised by HealthWatch	Kim James	Members
Learning Disability Health Checks	Mandy Ansell	Members
Adult Social Care (ASC) Complaints and Representations Annual Report 2015/16	Anas Matin	Officers
Procurement of Healthy Lifestyles Service	Stefanie Seff / Tim Elwell-Sutton	Officers
Re-Procurement of the Integrated Adults Substance Misuse Treatment Service	Stefanie Seff / Tim Elwell-Sutton	Officers

Last Updated: August 2016

Primary Care Balance Scorecard	Ian Wake	Members
Carers Support, Information and Advice Service	Catherine Wilson	Officers
PET CT Scanner	NHS England	Officers
NEP and SEPT Merger	Andy Brogan (Deputy CEO) Nigel Leonard (Executive Director Corporate Governance)	Officers
10 November 2016		
Shaping the Council Budget Update - Change to the Fees and Charges	Sean Clark	Members
Items raised by HealthWatch	Kim James	Members
Cancer Deep Dive	Funmi Worrell	Members
Success Regime	Wendy Smith	Members
Domiciliary Care – New service model and proposed procurement	Roger Harris / Catherine Wilson / Michelle Taylor	Members
2016 Annual Public Health Report	Ian Wake	Members
Community Alarm	Les Billingham	Officers
Regeneration, Air Quality and Health	Ann Osola	Members
17 January 2017		
Shaping the Council Budget Update - Change to the Fees and Charges	Sean Clark	Members
Items raised by HealthWatch	Kim James	Members
Thurrock Joint Health and Wellbeing Strategy	Ceri Armstrong	Members
Integrated Healthy Living Centres	Ian Wake	Members

15 March 2017		
Shaping the Council Budget Update - Change to the Fees and Charges	Sean Clark	Members
Items raised by HealthWatch	Kim James	Members

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