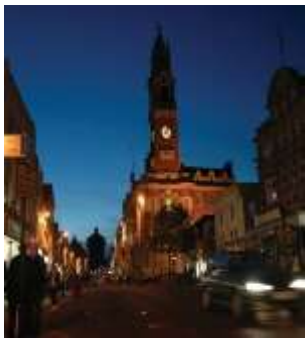
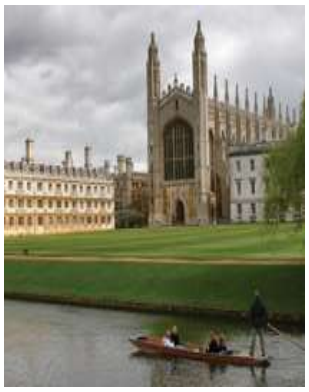
APPENDIX 2

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

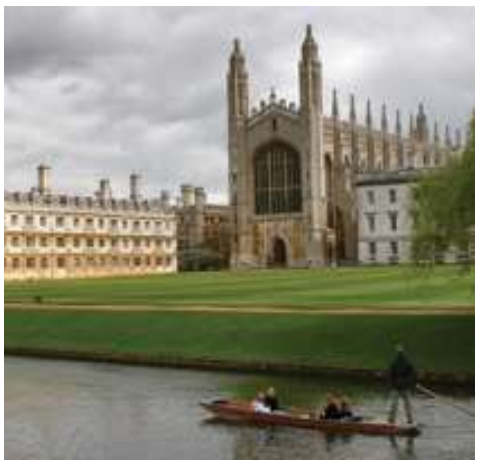
NHS England, Midlands and East Specialised Commissioning on

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

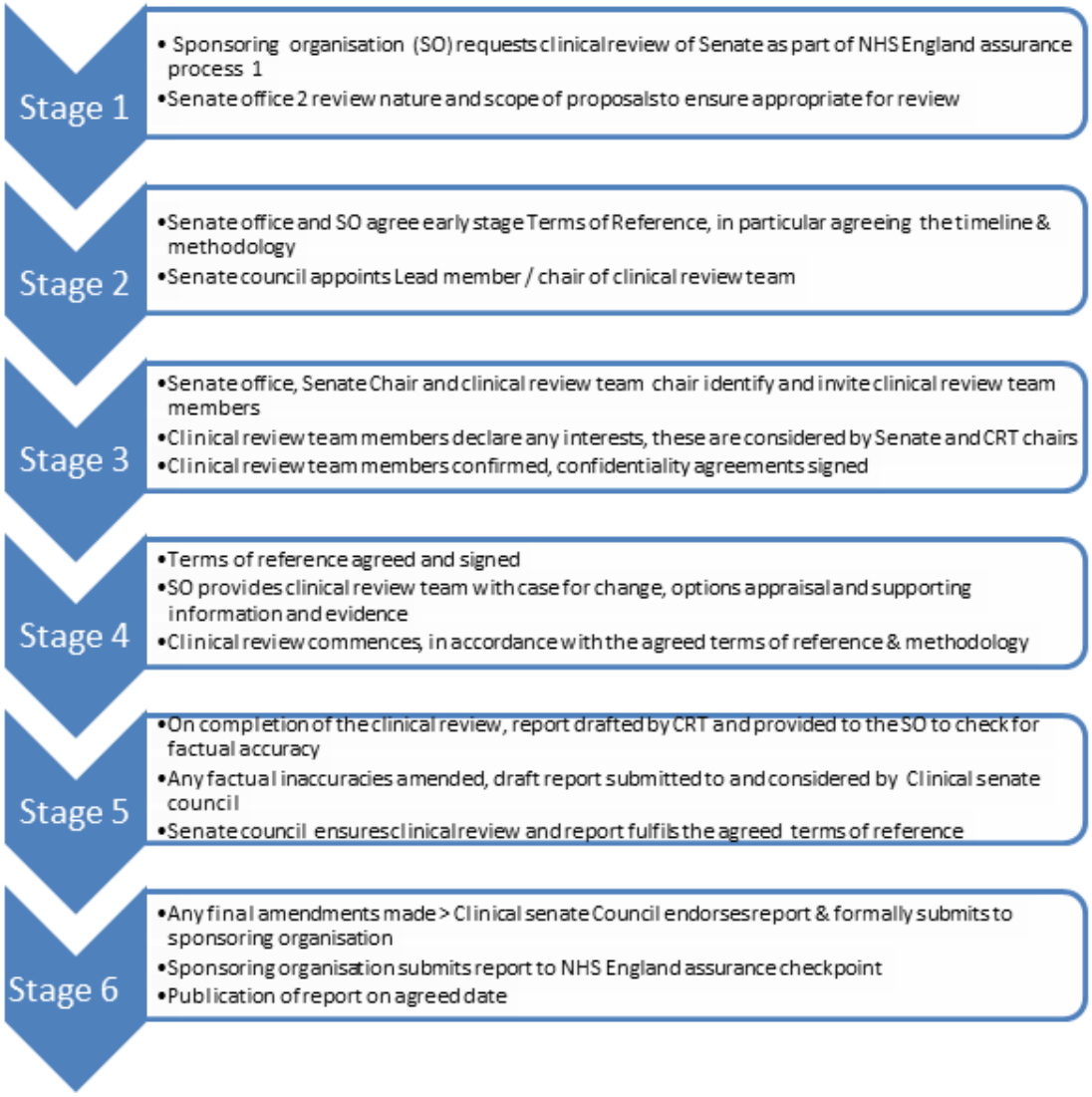
Clinical review team will:

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