

Councillor Arash Fatemian
BY EMAIL: arash.fatemian@oxfordshire.gov.uk

The John Radcliffe
Headley Way
Headington
Oxford
OX3 9DU
Tel: 01865 221000

24 January 2018

Dear Councillor Fatemian

Re: Positron Emission Tomography and Computed Tomography (PET-CT) contract award by NHS England - quality of care and patient safety concerns

I am writing to you because we understand that in the near future you will receive a letter from NHS England in connection with its award of the contract for the regional Positron Emission Tomography and Computed Tomography (PET-CT) scanning service to a private healthcare company, InHealth.

This service is currently provided by us at Oxford University Hospitals in the Cancer Centre at the Churchill Hospital in Oxford.

NHS England has indicated that it will be contacting HOSCs in Oxfordshire, Berkshire, Wiltshire and Buckinghamshire about this significant change in treatment for patients with cancer.

I am writing to request an opportunity for our clinicians to give evidence at the next available Oxfordshire HOSC meeting about the implications of this decision for the delivery of PET/CT scanning for cancer patients' safety and good quality outcomes.

We would also like to invite you and other HOSC members to come to the Churchill Hospital to meet with the PET-CT team and see the service being provided.

We are concerned about the impact of this proposed change on the quality and safety of PET-CT treatment for cancer patients for a number of reasons.

For example, it would mean that very sick patients at the Churchill would need to travel off site for a scan which could have a negative impact on their health.

And it would have a negative impact on multi-disciplinary working because the reporting radiologist would not be attending multi-disciplinary meetings where patients' care and future treatment plans are discussed.

From the Chairman's Office
Oxford University Hospitals NHS Foundation Trust

As a regional centre of excellence for cancer treatment, our clinical teams take a holistic and individual approach to their care of people living with cancer – treating the whole person and taking a broad overview of each patient’s care pathway – and this would be put at risk by separating PET-CT treatment from the rest of the pathway.

We would be happy to provide you with a more detailed briefing on this issue if that would be helpful.

Please do not hesitate to get in touch with me via my Executive Assistant, Claire Wilnecker to take this matter forward on 01865 227151 or via email claire.wilnecker@ouh.nhs.uk.

I look forward to hearing from you.

Yours sincerely,

A handwritten signature in black ink, reading "Fiona Caldicott". The signature is written in a cursive style and is centered on the page.

Dame Fiona Caldicott MA FRCP FRCPsych
Chairman

REPORT FOR THE OXFORDHSIRE HEALTH OVERVIEW AND SCRUTINY COMMITTEE 04 APRIL 2019

Provision of PET-CT services

SUMMARY

PET-CT is a specialist imaging service. It is predominantly used in the staging and management of cancer, however, use in other areas is expanding. In England, PET-CT services are provided on a network basis.

Following a public procurement to select a provider of PET-CT scanning services for the Thames Valley area, NHS England has appointed InHealth Ltd as the Preferred Bidder. InHealth was selected as the Preferred Bidder because its tender response achieved a higher evaluation score against both the technical (service quality and patient access) and financial evaluation criteria included within the procurement.

Under InHealth's tender proposals for the Thames Valley, PET-CT will be delivered from a network of three new scanning locations. Each of these locations is based within an existing healthcare facility and situated within large population conurbations across the Thames Valley area, namely; Oxford, Milton Keynes and Swindon.

The proposals would have meant a change of service location in Oxford with the service being based at the GenesisCare facility in Littlemore, which is approximately four miles by road from the current scanning location at the Churchill Hospital site. However, InHealth's tender response also expressed a commitment to work collaboratively with Oxford University Hospitals NHS Foundation Trust (OUH) which would enable the current Churchill Hospital site to be retained. This was fully supported by NHS England, which does not want to remove access to PET-CT from the Churchill site.

The outcome of the procurement was communicated to both InHealth and OUH on 26 July 2018. The subsequent delay in implementation has allowed all parties to reach an in-principle agreement to work collaboratively. This means that OUH, working with InHealth, would continue to provide a service in Oxford from the Churchill site alongside new locations in Swindon and Milton Keynes. NHS England is committed to this course of action and aims to secure formal agreements with both parties during the course of April - May 2019.

NHS England recognises that OUH have expressed some concerns about the future service provision for Lot 4. These are dealt with in the body of the report. Importantly, all parties have agreed to develop the partnership based on four key service principles; with the prime focus being on the patient perspective, both access and experience. All parties believe that this approach will provide a path to resolve any residual issues and will help to clarify any remaining misconceptions about the provision of the service. These matters are set out within the body of the report.

It is NHS England's assessment that the in-principle proposals represent an improvement in access for people resident in Swindon and Milton Keynes and no change to service provision in Oxford. As such, it is considered that a moderate period (6 weeks) of public engagement across the whole geography of the lot would provide the opportunity to brief all stakeholders on the service improvements planned and secure valuable feedback about the proposed change to assist NHS England in the decision-making process. As part of the public engagement process, NHS England intends to publish an analysis of the impact on travel times, a summary of which is provided within the body of the report. In view of the District Council elections and taking into account [Cabinet Office guidance](#), public engagement will not commence prior to 02 May 2019.

NHS England would welcome the advice of Oxfordshire's joint Health Overview and Scrutiny Committee (HOSC) as to whether the public engagement activities (as set out in Appendix 4) will now fully discharge our statutory duties relating to public involvement.

BACKGROUND

Clinical Service

PET-CT is a specialist diagnostic imaging service that is predominantly used in the staging and management of cancer. However, the modality is also used in a growing number of non-oncology indications, particularly neurosciences and infectious diseases. As with other diagnostic imaging services, PET-CT scans are predominantly delivered on an outpatient basis and form a discrete component of the clinical pathway. PET-CT scans are only accessible through secondary care referral.

PET-CT combines both a computed tomography (CT) scan with a positron emission tomography (PET) scan to provide highly detailed three-dimensional images of the inside of the body. The scanning process involves the injection of a mildly radioactive isotope (sometimes referred to as a 'tracer') into the body about an hour prior to the scan taking place. The tracer is detected by the PET-CT scanner, as it collects in different parts of the body. By analysing the areas where the tracer has and has not accumulated, it is possible to work out how well certain body functions are working which, in-turn, helps to identify abnormalities.

The most commonly used (circa 90-95% of all scans) tracer is 18F-fluorodeoxyglucose, or 'FDG'. NHS England commissions several different tracers for use in specific clinical indications, these are generally referred to as 'non-standard tracers'.

A PET-CT service will typically serve a local catchment of referring secondary care providers, each delivering cancer services and hosting a range of cancer Multi-Disciplinary Teams (MDTs) and specialist MDTs. The majority of PET-CT services refer patients that require scans involving non-standard tracers to a small number of centres that are able to deliver these scans, historically based in either London or Manchester. Such referral arrangements also exist where patients need a PET-CT scans under general anaesthetic (GA), however, this is very rarely required because

most scans are undertaken on an ambulatory basis and, where required, sedation is preferable to GA.

NHS England's national Service Specification sets out that on receipt of a referral, the PET-CT service is responsible for patient booking, co-ordinating an appropriate supply of radioactive isotopes, sourcing previous scans, acquiring and reporting the PET-CT image and subsequent communication of the scan and report to the referring clinician. This process should normally be delivered within seven working days or specific time intervals as indicated by treatment plans. The service must also provide support to MDTs and ensure that 10% of all PET-CT scans must be 'double reported' by an independent external clinician as part of a national programme of audit and peer review. This approach is referenced by the Royal College of Radiologists Hybrid Imaging Guidance (2016).

Commissioning context

PET-CT services are nationally prescribed and since 2013 have been solely and directly commissioned by NHS England, using a national Service Specification and Clinical Commissioning Policy, the latter setting out both the clinical uses of PET-CT and the specific tracers that are commissioned.

The service has seen significant and rapid expansion over the course of the last two decades as the technology has moved out of a mostly research setting and into routine clinical use. This shift has resulted in rapidly rising activity levels. Despite the high level of growth, the overall scanning rate per head of population in England is considered to be generally lower than many European comparators. Access to local scanning capacity is a key factor in the scanning rate and therefore, increasing both capacity and ease of access are both seen as important enablers of satisfying what may be latent demand.

NHS England's assessment is that PET-CT services in England are yet to reach a steady state in terms of growth and, therefore, more capacity will be required over the coming decade. For this reason, the procurement, whilst not guaranteeing set activity levels, did forecast that growth would continue by circa 9-10% over the course of the next decade. Securing both increased capacity and access at an affordable price over the contract term are, therefore, important strategic objectives within the procurement.

Historically, the provider landscape for PET-CT services in England has been mixed, with independent sector, charitable organisations and NHS providers involved, either separately or in partnership. Indeed, NHS England completed a first phase of national procurement during 2014-15 which involved re-tendering contracts initially let by the Department of Health to two independent sector providers, Alliance Medical Ltd and InHealth Ltd.

The mixed nature of the landscape has undoubtedly benefited both patients and clinical teams, in the form of more local access, and commissioners because it has allowed for significant capital investment to be made over a relatively short timeframe, allowing scanning capacity to keep-up with rapidly rising demand.

Phase II Procurement

NHS England formally approved a second phase of procurement, covering the other 50% of the market, to commence in 2017. The procurement offered 11 lots to the market, including the Thames Valley geography (Lot 4), and a contract term of up to ten years (7+3).

The decision to procure PET-CT services was taken because, under the current legislative and regulatory framework, there was a compelling case to do so. This decision was informed by an assessment of competition in the market, comprising a Prior Information Notice, together with a period of public engagement about the procurement approach. A [report](#) of findings of public engagement, together with the changes that NHS England made to the procurement approach has been published.

The procurement approach was designed to secure long-term service sustainability, improve service quality and consistency and ensure that the benefits of scale and efficiency are appropriately shared with commissioners. These aims were captured in four strategic objectives for Phase II, which were reflected in both the design of the procurement and the evaluation criteria. These are:

- **Sustain integrated and reliable care pathways.** High-performing pathways are well-integrated and seamless for both patients and clinical teams. PET-CT service providers may change because of the procurement, but care pathways must not be adversely disrupted. Within the procurement, this led to a focus on referral and booking processes, the use of IT to transfer images and reports around the whole of the network and timeliness of the service. It also enabled referral and access arrangements to be put in place for non-standard tracers.
- **Secure a service that is high quality and value for money.** Maximising value from healthcare resources is important, in the context of PET-CT this led to a focus on ensuring compliance with the national Service Specification and Clinical Commissioning Policy. It also sought to secure greater service efficiency and, through this, improved value for money. Whilst research activity was not included within the procurement, all bidders were required to demonstrate that scanning equipment would meet technical specification accreditation requirements, such as those set by the UK PET Core Lab, to support research.
- **Ensure sufficient capacity to meet future needs.** Historic and forecast growth is significant and therefore the procurement was designed to secure optimal equipment utilisation, modern workforce practices and fair reimbursement mechanisms so that sufficient capacity is available over the contract term.
- **Avoid reducing competitive pressures in the market.** This was particularly the case in terms of the supply of radioactive isotopes, where the market is highly concentrated. As a result, phase II involved separate procurements to secure both scanning service providers and suppliers of radioactive isotopes. Similarly, lot limits were also included in both procurements.

Composition of Lot 4

Each of the eleven scanning services Lots was constructed based on an assessment of current patient pathways and existing networks of care. As such, each Lot was defined by a network of referring Trusts, reflecting that PET-CT is accessible only through secondary care referral, which were termed 'principal referring organisations'. The network of principal referring organisations in Lot 4 was defined, as follows:

- Buckinghamshire Healthcare NHS Trust, accounting for 9.16% of referral activity within the Lot;
- Great Western Hospitals NHS Foundation Trust, accounting for 5.76% of referral activity within the Lot;
- Milton Keynes University Hospital NHS Foundation Trust, accounting for 4.51% of referral activity within the Lot;
- Oxford University Hospitals NHS Foundation Trust, accounting for 65.46% of referral activity within the Lot; and
- Royal Berkshire NHS Foundation Trust, accounting for 13.27% or referral activity within the Lot¹.

Importantly, the procurement did not seek to disrupt or prohibit referring organisations from enabling individual patients to access PET-CT services further afield. Typically, such referrals are because a patient requires a scan involving a non-standard tracer or very specialist clinical expertise, including scans under general anaesthetic (GA). At present, very few centres offer the full range of commissioned tracers and only a handful are able to deliver scans involving GA.

At the time of data submission to NHS England in 2016, OUH did not undertake any scans involving commissioned non-standard tracers. Furthermore, OUH have also confirmed that any patients requiring a scan under GA would be referred to Leeds, stating that this has never been requested since the inception of the service in 2005.

PROCUREMENT OUTCOME

Evaluation of Tender Responses

Tender responses were assessed in accordance with the evaluation criteria contained within the procurement, as follows:

- Selection Questionnaire – Pass/Fail
- Invitation to Tender (Annex – ITT Questions):
 - Minimum Criteria – Pass/Fail;
 - Legal (Pass/fail);

¹ Activity proportions are based on the results of a 2015-16 data collection baseline exercise undertaken by NHS England with incumbent providers during 2016.

- Technical: Service / Quality – 9 questions attracting 50% of the overall score weighting;
- Technical: Patient Access – 1 question attracting 10% of the overall score weighting; and
- Finance – (i) 3 questions relating to the Bidding organisation's financial model, attracting 20% of the overall score weighting; and (ii) Price, attracting 20% of the overall score weighting.

The technical and financial questions were designed to test the ability of each bidder to deliver the national Service Specification and associated commissioning policy and were based around the four strategic objectives, i.e., integration, quality and value for money and capacity and access.

Each tender response was evaluated according to an agreed evaluation methodology, which included:

- Individual evaluation conducted by each evaluator and used an online system called “Award”;
- Moderation, where evaluators discussed their individual scores to determine a final moderated score. The moderation meetings were structured by Lot and by area (e.g. Technical – Service / Quality, Technical – Patient Access, Finance).

Each evaluator met predetermined qualification and experience criteria (Appendices 1-3) and arrangements were put in place to prevent any actual or perceived conflict of interest. Each Moderation Meeting was independently chaired.

InHealth's Proposals for the Thames Valley (Original)

InHealth Ltd has been identified as the Preferred Bidder for Lot 4, having achieved a higher evaluation score against the technical (service quality and patient access) and finance criteria.

The InHealth service will be led by an experienced PET-CT doctor who holds an Administration of Radioactive Substances Advisory Committee (ARSAC) license and who will have managerial responsibility for delivery of all aspects of the service.

The proposed service locations included within InHealth's tender response are:

- GenesisCare, Sandy Lane West, Peters Way, Littlemore, Oxford, OX4 6LB;
- Great Western Hospital NHS Foundation Trust, Marlborough Road, Swindon, SN3 6BB; and the
- InHealth Diagnostic Imaging Centre, Milton Keynes, South Fifth Street, Milton Keynes, MK9 2FX.

InHealth planned to commence service delivery using mobile scanners based at the Oxford and Swindon sites, both within existing healthcare facilities and using existing mobile pads. Over the course of the first year of the contract, the Oxford site would become a static facility. The Milton Keynes service was planned to commence as a new static facility during the first year. The Swindon site was planned to transition into a fixed static unit during 2023/24.

Importantly, whilst the InHealth bid sought to quickly move towards a network of static sites, the use of mobile scanners is in-keeping with the national Service Specification and does not prevent the delivery of any commissioned uses of PET-CT. Linked to this point, all InHealth's PET-CT mobile scanners can safely accommodate in-patient activity.

InHealth's proposed PET-CT equipment is able to deliver intravenous (IV) contrast CT scans, as part of PET-CT scanning. The proposals included the arrangements for those patients that require emergency support, specifically that all scanning services would be delivered by staff with Life Support training and that there would be access to either a hospital-based resuscitation team, a Radiologist or a registered medical officer, i.e., a doctor. This is in-keeping with the requirements of the national Service Specification.

In-accordance with NHS England's Invitation to Tender requirements, InHealth also proposed to use a fully integrated RIS/PACs solution across Lot 4. This enables prior diagnostic images and PET-CT scans and reports to be safely and efficiently transported across the network.

InHealth's Proposals for the Thames Valley (Revised)

The in-principle agreement between NHS England, OUH and InHealth means that all parties are now working towards the following arrangements:

- The Churchill Hospital site;
- Great Western Hospital NHS Foundation Trust; and
- Milton Keynes University Hospital NHS Foundation Trust.

InHealth will commence service delivery on both the Great Western Hospital and Milton Keynes Hospital sites using a mobile PET-CT unit on each site for two non-consecutive days, each week. The operational days will be finalised with local clinicians to align with MDT's and out-patient oncology clinics. Each operational day will consist of 12 hours, scanning up to 20 patients, the patients being a blend of out-patients and in-patients. Each of these locations will transition to a fixed scanning facility:

- The Milton Keynes Hospital will have a fixed PET-CT scanning department in 2021/22; and
- The Great Western Hospital will have a fixed PET-CT scanning department in 2023/24.

Both Trusts are expanding their services to build their own dedicated Cancer Centre's, and InHealth have already begun discussions about locating the fixed PET-CT scanning departments within these centres. The move to static scanners will be aligned with these developments and therefore the move to static scanners may happen earlier.

This ensures that the services will be delivered from a network of acute hospital sites and will enable inpatients on all three sites, rather than solely at the Churchill site, to

benefit from PET-CT scans without the need of hospital transportation. This approach will retain and preserve OUHs research portfolio.

Under the in-principle arrangement, InHealth's clinical lead will work collaboratively with OUH's PET-CT clinicians, who will continue to provide clinical reporting for the service and meet, as a minimum, the requirement that 10% of scans should be double reported. The joint service will also benefit from the proposed RIS/PACS arrangements and will be supported by a local Medical Physics service.

As part of reaching an in-principle decision to work collaboratively, all parties have agreed to develop the partnership in accordance with four key principles:

- To build on the service that already exists in Oxford – retaining the Churchill Hospital site, in terms of both equipment, including the new scanner, and staffing.
- To focus on the patient perspective – access and experience – when undertaking the more detailed work to support the partnership.
- To involve the cancer clinicians/network in discussions about PET/CT scans in cancer pathways.
- To be as flexible as possible to sustain the Oxford service as a centre of excellence.

By working in accordance with these principles, all parties have committed to resolving any residual issues, such as the need to maintain OUH ways of working at the Churchill site, in a constructive and patient-focussed way.

Travel time analysis

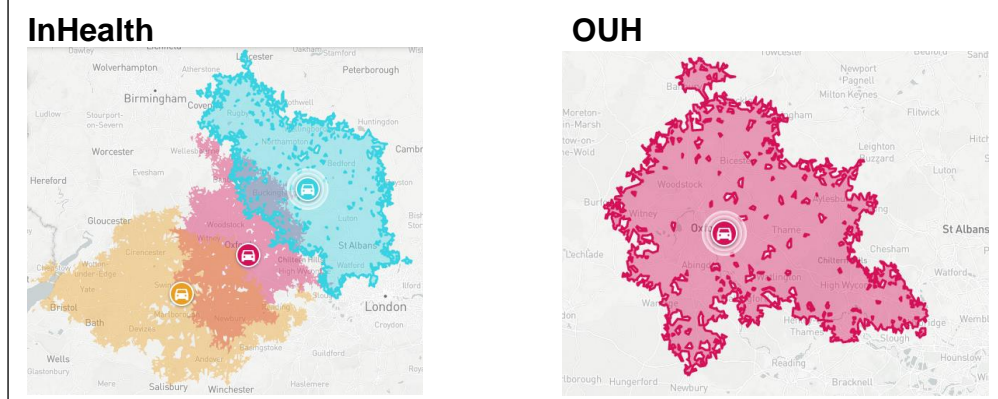
Following completion of the tender response evaluation, an assessment of the impact of the proposed Lot 4 outcome on travel times was made. This found that the proposal to deliver PET-CT services from InHealth's network of three sites would significantly improve access compared to the existing single site model.

The analysis was conducted using an online tool called TravelTime Platform for each site in each configuration, using the postcode as the reference. The resulting maps show the areas that can reach the site in question within a 30, 45 and 60 minute timeframe, using either car or public transport. Because the Lot covers a large geography, 60 minute driving time is considered to be the most useful comparator (Figure 1).

InHealth's proposed three-site service configuration, with each site being closely situated to large populated hubs, offers clear patient access improvements with whole population able to access services within the 60 minute driving time measure (Figure 1). This is particularly the case for people resident in Milton Keynes, Swindon and Newbury.

The in-principle service configuration retains the benefits of the InHealth proposals for the populations of Milton Keynes, Swindon and Newbury and means that there is no impact for Oxford population.

Figure 1: 60 minute drive time access



NEXT STEPS

NHS England, OUH and InHealth have already discussed what will be the next steps to develop the detail of the partnership agreement and the supporting contractual and financial arrangements. There will be further meetings taking place in the next two months to progress the work, involving two parallel workstreams: clinical and contractual/financial.

The leads from each organisation have been identified and there will be senior officer oversight to ensure the work progresses at pace and reaches a conclusion. There will also be joint discussions about the overall phasing of implementation to factor in the timetable for opening-up the new services in Milton Keynes and Swindon.

CONCLUSION & RECOMMENDATIONS

NHS England is committed to ensuring that the Thames Valley population benefit from high-quality PET-CT services. It is our view that the partnership arrangements provide distinct benefits in terms of expanded access in Milton Keynes and Swindon, whilst also preserving the Churchill Hospital site.

It is therefore recommended that the Oxfordshire joint Health Overview and Scrutiny Committee:

- Support the partnership plan; and
- Support moderate public engagement to be undertaken in-parallel with progressing partnership discussions as set out in Appendix 4.

Appendix 1: Lot 4 Technical – Service / Quality Evaluation Panel

ROLE	CRITERIA
Chair	Independent individual with no evaluation role. The Chair will be responsible for maintaining order in, and directing, moderation meetings and will take no part in the scoring process other than to ensure that scores and rationale are compliant with the published scoring methodology.
2 X Radiologist / Nuclear Medicine Physician	Required to be currently employed as a radiologist / nuclear medicine physician at consultant level in the NHS and to have at least 5 years direct experience at consultant level in clinical PET-CT in the UK.
Medical Physics Expert	Required to be currently employed as an MPE supporting nuclear medicine and PET-CT services. Must have at least five years' (within the last ten years) experience of supporting the delivery of PET-CT services in the UK.
NHS England Commissioner	Required to be employed by NHS England in a specialised commissioning role and be expert in the commissioning of healthcare services. Must have at least five years' (within the last ten years) experience of health service management in the UK.

Appendix 2: Lot 4 Technical – Patient Access Evaluation Panel

ROLE	CRITERIA
Chair	Independent individual with no evaluation role. The Chair will be responsible for maintaining order in, and directing, moderation meetings and will take no part in the scoring process other than to ensure that scores and rationale are compliant with the published scoring methodology.
NHS England Communications and Engagement Specialist	Required to be directly employed by NHS England in a specialised commissioning role and be expert in patient engagement and communications.
NHS England Commissioner (X2)	Required to be employed by NHS England in a specialised commissioning role and be expert in the commissioning of specialised commissioning services.

Appendix 3: Lot 4 Financial Evaluation Panel

ROLE	CRITERIA
Chair	Independent individual with no evaluation role. The Chair will be responsible for maintaining order in, and directing, moderation meetings and will take no part in the scoring process other than to ensure that scores

	and rationale are compliant with the published scoring methodology.
NHS England Qualified Accountant (X3)	Qualified Accountant expert in health care finance and directly employed by NHS England in a specialised commissioning role.

Appendix 4: Lot 4 Proposed Engagement Activities

The following engagement activities will be undertaken to support implementation of the procurement outcome.

- Publication of the proposed approach to delivering PET-CT services in the Thames Valley including the new arrangements for access on the NHS England website. Contact details will be provided for members of the public, staff, patient groups and other interested stakeholders to comment by email or in writing.
- A briefing will be provided (similar to this one) for other HOSCs in the Thames Valley to alert them to the proposals and give them the opportunity to comment on the proposals and invite NHS England and InHealth to future meetings if required.
- A briefing will be prepared and sent to all Thames Valley MPs and local Health Watch's giving them the opportunity to comment on the proposals.
- Hold a face to face or online meeting for local patient groups and relevant local healthcare charities affected by the proposals in Oxford. We welcome suggestions from the HOSC and Health Watch as to which organisations should be invited.
- Briefing on the proposed change to be sent to NHS England's cancer clinical reference groups and their registered stakeholders. Members of the public and other stakeholders can [register](#) on the NHS England website to receive these updates.
- Analysis of the outcome of the engagement along with a summary of responses and any changes made to the proposals as a result will be shared electronically with all the key audiences engaged and all those who submitted comments at the end of the engagement period.

Appendix 5: Weblinks

Cabinet Office Pre-election period guidance:

<https://www.gov.uk/government/publications/election-guidance-for-civil-servants>

Engagement report:

<https://www.england.nhs.uk/publication/pet-ct-phase-ii-design-of-procurement-engagement-report/>

Stakeholder registration page:

<https://www.england.nhs.uk/commissioning/spec-services/get-involved/crg-stake-reg/>



Oxford University Hospitals

NHS Foundation Trust

**REPORT FOR OXFORDSHIRE JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE
THURSDAY 4 APRIL 2019**

OXFORD UNIVERSITY HOSPITALS (OUH) NHS FOUNDATION TRUST REQUEST FOR HOSC SCRUTINY OF FUTURE PROVISION OF THE THAMES VALLEY REGIONAL PET-CT SERVICE, CURRENTLY PROVIDED BY OUH AT THE CHURCHILL HOSPITAL

Background

Oxford University Hospitals (OUH) NHS Foundation Trust currently provides the Thames Valley regional Positron Emission Tomography and Computed Tomography (PET-CT) service in the Cancer & Haematology Centre at the Churchill Hospital in Oxford.

This service is commissioned by NHS England – this means that NHS England is responsible for any decisions about the contract to provide this service.

OUH has held the contract since 2005 and carries out 5,000 scans per year on 2 PET-CT scanners which are owned by the Trust.

OUH request for HOSC scrutiny

OUH Chairman, Dame Fiona Caldicott, wrote to the HOSC Chairman on 24 January 2019 because we understood that he was likely to be contacted by NHS England in connection with its intention to award the contract for the regional PET-CT scanning service to a private healthcare company, InHealth.

NHS England had indicated that it would be contacting HOSCs in Oxfordshire, Berkshire, Wiltshire and Buckinghamshire about this significant change in treatment for patients with cancer.

We requested an opportunity to give evidence at the next available Oxfordshire HOSC meeting about the implications of this decision for the quality and safety of patient care.

We are grateful to be given this opportunity at the HOSC meeting on 4 April 2019.

In her letter to the HOSC Chairman on 24 January 2019, Dame Fiona Caldicott wrote:

“We are concerned about the impact of this proposed change on the quality and safety of PET-CT treatment for cancer patients for a number of reasons.

“For example, it would mean that very sick patients at the Churchill would need to travel off site for a scan which could have a negative impact on their health.

“And it would have a negative impact on multi-disciplinary working because the reporting radiologist would not be attending multi-disciplinary meetings where patients’ care and future treatment plans are discussed.

“As a regional centre of excellence for cancer treatment, our clinical teams take a holistic and individual approach to their care of people living with cancer – treating the whole person and taking a broad overview of each patient’s care pathway – and this would be put at risk by separating PET-CT treatment from the rest of the pathway.”

Our concerns for the quality and safety of patient care – and for training and research – if the PET-CT service is no longer provided at the Churchill Hospital

Our Trust Board, Council of Governors, clinicians and patients are all concerned about the impact on the quality and safety of patient care if we no longer provide the PET-CT service.

We have raised these concerns with NHS England which commissions this service.

The Trust Board is committed to working collaboratively in partnership with both NHS England and InHealth in order to maintain and improve the quality and safety of care for patients requiring PET-CT scans in the Thames Valley region.

This commitment includes face-to-face meetings involving the Trust’s Chief Executive and Medical Director – and other Directors as required – as well as senior clinicians from the PET-CT service.

We asked our senior radiologists, oncologists and surgeons to summarise their concerns in order to provide clinically-led evidence to HOSC.

These concerns are grouped under the 3 headings of quality, safety, and training and research.

1. Quality issues

- OUH is at the leading edge of PET-CT imaging quality and has led the world in defining the role of PET-CT scans for sarcomas and oesophagal cancer
- OUH provides a longer uptake of FDG (the radioactive drug, or tracer, used in scanning to show differences between healthy and diseased tissue), longer scan time and better image reconstruction – in short higher quality scans – than the proposed service
- All Thames Valley scans are currently reported by two consultants whose training and specialist interest is PET-CT – the proposed service would see scans sent out to reporters elsewhere in the country who would not be available in the same way to the multi-disciplinary team (MDT)
- 20% of patients having a PET-CT scan at the Churchill have a CT scan using intravenous (IV) contrast dye at the same time, which reduces patients’ exposure to radiation (and thus their risk of developing a further cancer) and also reduces travel costs because they don’t need to come back to hospital for the CT scan separately – we do not believe the proposed new provider can provide this service
- On average 5 patients a week have their PET-CT scan carried out as part of planning for radiotherapy treatment, which means radiation can be targeted more effectively to cancerous tumours and therefore is safer for patients – using PET-CT for radiotherapy planning is the gold standard in all major cancer centres but we understand the proposed new provider is not intending to provide this service
- If the PET-CT service is no longer provided by OUH at the Churchill Hospital, the reporting radiologist will not be at MDT meetings to discuss and plan patients’ care – this will reduce the effectiveness of these meetings and impact on quality of care
- OUH is installing a new digital PET-CT scanner following a successful bid for funding by the University of Oxford to the Government’s Industrial Strategy Challenge Fund – this would give patients scanned in Oxford access to one of the most advanced PET-

CT machines in the world but this opportunity will be lost if the regional PET-CT service is no longer provided by OUH at the Churchill

2. Safety issues

- Patients having a scan at the Churchill have on occasion fallen ill and required an immediate intervention, for example being transferred to the Emergency Department (A&E) at the John Radcliffe Hospital or to an inpatient ward
- If the PET-CT service is no longer provided by OUH at the Churchill, inpatients would have to be transferred off-site by ambulance for scans
- The PET-CT service at the Churchill is able to scan immobile patients who require a hoist and children (6+) – because the proposed service uses mobile scanners, it will not be possible to scan patients who require a hoist or children
- It is imperative that there is a doctor on site when scanning is performed, if the staff carrying out the scans have queries which require medical input or if patients are ill – the Churchill service has doctors specialising in PET-CT on site but the proposed service does not

3. Training and research issues

- All patients having a PET-CT scan at the Churchill are given the opportunity to take part in world leading research which is improving cancer care – these are technically complex scans, often with new drugs, and this opportunity will not be available if the PET-CT service is no longer provided at the Churchill
- Oxford has led the world in research to push forward PET-CT scanning, for example we helped to develop and optimise a new, improved PET image reconstruction – we were the first centre in the world to do so, it has now been adopted globally
- If the PET-CT service is no longer provided by OUH at the Churchill Hospital, this would have a negative impact on PET-CT research and training in Oxford
- OUH prides itself on being a teaching hospital trust, and indeed has trained many consultants who are now working all over the country – this opportunity will be lost for the future as it is not possible to train consultants outside a recognised and approved centre, using fixed and not mobile scanners

Listening to patients

Following recent media coverage both nationally and locally, there has been significant concern expressed by many different parties including cancer patients past and present; clinicians; publicly elected governors who represent our local communities on our Council of Governors; local MPs who have been contacted by concerned constituents.

While much of this public debate has focused on issues such as the outsourcing of clinical services to private companies – and the lack of consultation or engagement with patients and key stakeholders about a significant change to services – our focus remains our concerns about the impact on the quality and safety of patient care.

These concerns are exemplified by a letter written by a cancer survivor to the *Oxford Times* which he copied to the Trust for information.

“A few years ago I had the bad luck to contract cancer of the bowel. I had the good luck to be treated at the outstanding Churchill Hospital.

“One of the many bad sides of cancer is the time you spend having scans. For me it made a great deal of difference that the PET-CT scans I had were carried out in the Churchill, by highly skilled (and always kindly) staff working closely with the oncologists.

“Whatever the other issues are in the proposal to outsource this service in the future, it simply doesn’t take into account the feelings of patients. When you have cancer, it matters a lot to your state of mind to know you are being treated by a single established team.”

Dr Bruno Holthof
Chief Executive
Oxford University Hospitals NHS Foundation Trust

Mr Nick Maynard
Trustwide Cancer Lead & Consultant Upper GI Surgeon
Oxford University Hospitals NHS Foundation Trust



MAKING HEALTHCARE BETTER

Beechwood Hall, Kingsmead Road
High Wycombe, Bucks HP11 1JL
t: +44 (0) 1494 560 000
www.inhealthgroup.com

Cllr Fatemian
Oxfordshire County Council
County Hall
New Road
Oxford
OX1 1ND

Wednesday 3rd April, 2019

Dear Cllr Fatemian,

Thank you for the invitation received today to attend the HOSC tomorrow on Thursday 4th April. I can confirm that I will attend with my colleague Ralph Toop, Head of PET-CT, for your agenda item on Regional PET-CT Scanning Services. We will be pleased to contribute where appropriate, although it seems that much of the background and clarity should be covered in the respective inputs from NHSE and OUH. I have provided some further information below, which hopefully provides some context and supports the papers from NHSE and OUH. I would be grateful if this statement could be published on your website alongside the related items.

As one of the UK's leading providers of PET-CT services, InHealth has delivered diagnostic imaging in partnership with the NHS for more than 20 years. We have carried out 15,000 PET-CT scans annually, with a patient satisfaction rate of over 99%. Our highly skilled, specialist team are experts in the provision of this service and operate advanced scanners across the UK to deliver modern, efficient services for patients.

By way of background, in 2005, the UK had only a handful of PET scanners servicing the population. At that time, the NHS started to develop partnerships with independent providers, such as InHealth, to accelerate the availability of this technology in order to bring high quality, efficient scanning services to patients during their cancer pathway. Today, there are over 70 PET-CT scanners in the UK, fixed and mobile, demonstrating the growth in this much-needed diagnostic technology.

InHealth's preferred bid for the service commissioned by NHS England was based on a range of factors, including clinical and service quality, improved patient access, investment in equipment, value for the taxpayer, and extension of services across the Thames Valley region for cancer patients who currently travel to Oxford for PET-CT scans. We understand the contract award is consistent with national policy in planning for growth in demand for PET-CT.

Our experience of delivering more than 2 million scans, tests and examinations each year has shown that convenience is a key priority for patients in accessing services as close to home as possible.





MAKING HEALTHCARE BETTER

The geographic extension of the service to Swindon and Milton Keynes, combined with the continuation of services in Oxford, represents a progressive solution for patients requiring PET-CT scans, as part of their cancer pathway.

The InHealth mobile PET-CT scanner intended to be used in the early years of this service is the only one of its kind in Europe, and only the second in the world on a mobile. It has a 128slice CT, which not all dedicated CT fixed scanners have installed. Similar mobile scanners are currently successfully in operation by InHealth and provide high quality services at Barts Hospital, Royal Marsden Hospital and St George's Hospital in London. The use of mobile scanners as a supplement to capacity and extension of geography is frequently part of an overall solution – moving the scanning service to the patient and not the patient to the scan.

The particular scanner uses FlowMotion™ technology which combines Siemens Healthineers standard-setting PET-CT with a unique system design to enable the continuous motion of the patient table, which returns increased image quality, greater patient comfort, and shorter scanning times. The scanner is up to 200% improvement in signal-to-noise ratio for better image quality, lower dose or faster scan speed. Patients, meanwhile, benefit from a larger bore scanner of 78cm, and an increased patient weight of up to 227kg, resulting in a greater patient demographic being scanned.

InHealth has proactively managed a full range of patients including hoist, immobile and inpatients, with recent examples shown in the NHS PET-CT South contract where InHealth managed up to 15,000 patients per year. The majority of PET-CT scans are for outpatients and the segmentation by stage, type and geography is a key part of patient preparation and booking.


In terms of reporting of scans, InHealth has a cohort of PET-CT reporters to supplement reporting for the region where necessary, and in addition we will seek to support and train local reporters as we establish the new service locations, initially through mobile services before fixed sites are in place.

InHealth is a long-experienced and well-respected NHS provider in both hospital and out-of-hospital settings. Our priority is, and always has been, to support the NHS in providing high quality services to patients and we hope to work collaboratively with Oxford University Hospitals to further develop healthcare solutions for the local population.

Yours sincerely,

A handwritten signature in blue ink, appearing to read "Bradford", with a horizontal line underneath.

Richard Bradford
Chief Executive Officer



**Proposed
procurement of phase
2 PET-CT services:
Guide to 30 day
engagement period**

OFFICIAL

NHS England INFORMATION READER BOX

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Medical	Commissioning Operations	Patients and Information
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Document Purpose	Guidance
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Additional Circulation List	
Description	This guide supports an engagement period asking for patient, public and provider views on a proposed procurement process for PET-CT services. The document explains the PET-CT services to be procured, the proposed design of the procurement process and how people can contribute their views.
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Superseded Docs (if applicable)	N/A
Action Required	N/A
Timing / Deadlines (if applicable)	The engagement period runs from 7 Jan 2016 to 5 Feb 2016
Contact Details for further information	Nicola McCulloch Senior Programme of Care Manager – Cancer Skipton House 80 London Road, London SE1 6LH

Document Status

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Proposed procurement of phase 2 PET-CT services

Guide to 30 day engagement period

Version number: 1

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1 Introduction

1. In 2014, NHS England carried out a procurement process for around 50% of positron emission tomography-computerised tomography (PET-CT) activity, known as PET-CT phase 1. The National PET-CT contract replaced two contracts, PET-CT North and South, which were running out.

2. NHS England now intends to carry out a phase 2 procurement process for PET-CT activity not included in phase 1.

3. The aim is to procure services that:

- reduce health inequalities and improve patient experience and access to care
- achieve the best clinical outcomes for patients
- ensure an equitable access to, experience of and outcomes from services across the country
- ensure that all providers work to a consistent service specification
- ensure adequate PET-CT provision in the future
- provide best value for money.

4. The proposed process will seek bids from providers to deliver services in 9 different lots that are geographically defined – though it is possible for there to be multiple PET-CT sites within each lot. In addition, the proposal includes a maximum single price for scans, and a limit on the number of lots any one bidder can be awarded to maintain plurality of supply.

5. The procurement process will ask bidders to propose solutions that limit any inequity and maximise quality, access, patient experience and value for money, and specify the locations from which services will be delivered. This does mean that the location of PET-CT services could potentially change from where they are currently provided. However, until the procurement process is more advanced, we will not know the extent of any impact nor where it will be felt. This is because we will not have sight of proposed solutions until later in the process, and therefore any proposed changes to service location or the potential impact for patients. At that later point, any potential change in location of PET-CT services may need public involvement and consultation.

6. NHS England is now to conduct a 30 day period of engagement to test the proposals prior to beginning the procurement. It also seeks views on potential mitigation for any change in location of PET-CT services that could be built into the service requirements for bids.

7. This guide sets out the proposed procurement process and describes how you can have your say.

2 Background

2.1 What is PET-CT?

8. PET-CT, or positron emission tomography-computerised tomography, is used to produce detailed three-dimensional images of the inside of the body. An advantage of a PET-CT scan is that it can show how well certain parts of your body are working, rather than just showing what it looks like. PET-CT is particularly helpful for investigating confirmed cases of cancer, but is used in other conditions as well.

2.2 How are PET-CT services provided currently?

9. The PET-CT services to be included in this phase 2 procurement are provided in England by a variety of fixed and mobile facilities through 15 providers. These include NHS Trusts, independent sector organisations and third sector providers.

10. Demand for PET-CT has grown significantly, and this is expected to continue for four main reasons:

- clinicians are increasingly reliant on the service for diagnostic purposes and radiotherapy planning
- the increase in the prevalence of cancer
- a rise in the number of applications for PET-CT
- improved access for patients.

11. There were around 41,000 PET-CT scans in 2014-15, with a maximum capacity among providers estimated to be approximately 93,600 scans. The number of scans is expected to continue to grow at around 14% a year, which would see around 84,700 scans in 5 years' time and 163,900 scans in 10 years' time.

2.3 How will the procurement process work?

12. The proposed approach for the procurement consists of several stages over a period of a few months:

- There has already been some pre-procurement market engagement to gauge levels of interest among potential providers.
- This guide accompanies the current stage: pre-procurement public engagement.
- Following the engagement and having taken responses into account, the procurement will begin with publication of the procurement documents.
- The procurement process will begin with potential providers asked to complete a pre-qualification questionnaire (PQQ).
- The intended approach would then see providers asked to submit initial bids in a first round Invitation to Tender (ITT).
- Any bidders that do not meet a set of minimum criteria would be deselected at this stage.
- Depending on whether the first round bids for a lot propose a change of location for PET-CT services, there may be a need for public involvement and consultation for that lot.
- The intention would be for a second ITT round and assessment to follow prior to detailed evaluation.
- Preferred Bidders will be identified for each lot.
- Finally, contracts will be finalised and services commence.

2.4 What is the design of the lots in this procurement process?

13. Presently, there are 15 providers of the PET-CT services included in this procurement exercise. NHS England proposes to run a competitive tender to provide PET-CT services in 9 lots.

14. The use of 9 lots means the number of providers and sites for PET-CT services could increase or decrease. It does not necessarily mean any reduction in providers (providers could collaborate in bids) or locations from which the services are provided (there can be multiple sites in any lot).

15. The lot design follows consideration of:

- geographic location of the populations served by PET-CT services included in Phase 2
- market interest and maximising the benefit of a competitive process
- compliance with applicable procurement legislation
- the aim of maximising potential for investment in PET-CT services and obtaining value for money
- feedback received from engagement with regional commissioners.

16. The proposal is for PET-CT services currently provided in the **North West** to be tendered **as two lots**. The main reasons for this are to avoid disruption to the contract through the devolution of budgets and greater local decision making to the greater Manchester area, and in response to local commissioner feedback.

17. In the **East Midlands**, the proposal is to have **a single lot**. The primary reason for this is the geographic separation of this service from any of the other regional services.

18. PET-CT services in the **South West Midlands** would be tendered as **a single lot**, with the potential that overall income from a single lot will better support investment than two separate lots.

19. The **Home Counties** would have **a single lot** under these proposals. The reasoning includes that a single lot may encourage improved access to patients, rather than including this population as part of a London lot.

20. Services in **Greater London** would be tendered **as three lots**: North & South West; North, Central & East; and South East London. The main reasons are to maintain current clinical networks and collaborative working, and to align with future commissioner plans around populations.

21. PET-CT services on the **South Coast** would be tendered as **a single lot**. It is thought that overall income would better support investment more than two separate lots, and there would be some beneficial economies of scale and efficiencies in purchasing equipment and the tracers used in PET. However, there is an argument that two separate lots would align with commissioner feedback, potentially providing plurality of service.

22. An exercise to test market interest has been carried out in which organisations were invited to express interest in the future delivery of PET-CT services. The expressions of interest covered all the geographical areas listed above. Most of the

organisations advised that they would consider submitting a bid either individually or in partnership with other Trusts or any other Provider.

2.5 What if bidders propose a change in location of PET-CT services?

23. The procurement process will ask bidders to specify the locations from which services will be delivered. This does mean that the location of PET-CT services could potentially change from where they are currently provided. However, until the procurement process is more advanced, we will not have sight of proposed solutions, and therefore any proposed changes to service location or the potential impact for patients. At that later point, any potential change in location of PET-CT services may be the subject of public involvement and consultation.

24. It is already the case that many patients have to travel out of their local area for a PET-CT scan. If the location of the service changes, patients that currently don't have to travel far may have to in future. Conversely, some patients who currently have to travel may get a more local service.

25. During this engagement process, we are seeking suggestions of potential mitigation for any change in location of PET-CT services that could be built into the bidding requirements.

2.6 Other details of the procurement process

26. The procurement process will encourage bidders to propose innovative solutions that:

- facilitate patient access to the service
- accommodate interdependencies with associated services
- reflect current clinical networks.

27. A limit on the number of contracts awarded to any one provider is proposed to maintain supply from a range of providers, though there is no limit to the number of bids that a provider can submit.

28. Currently, prices for scans vary across the providers of Phase II PET-CT services, with some offering a range of prices per scan depending upon the PET tracer used.

The majority of PET-CT scans are carried out using fluorodeoxyglucose 18 F or "FDG" as a tracer, the remainder make up approximately 3% of scans.

The proposal is to ask providers to submit a single price for scans in their bids.

3 Engagement process

3.1 Why are we asking for feedback on this procurement process?

29. NHS England will carry out a 30 day engagement period with patients, public, providers and other interested parties to test the lotting strategy and to inform the subsequent procurement process. We want to raise awareness and understanding of

the procurement process and to get useful responses on the design of the procurement process

3.2 What are we seeking views on?

30. We are seeking feedback to the following questions:

1. Do you agree with the proposal to request a single unit price for all PET-CT scans in a lot area, regardless of tracer, service location or patient condition?
Please provide comments to support your answer.
2. Do you agree with the proposed lot structure?
Please provide comments to support your answer.
3. Do you agree with the proposal to restrict the maximum number of lots awarded to any individual provider? (Current thinking being no more than 3 out of the 6 lots outside of London and 1 out of 3 in London)
Please provide comments to support your answer.
4. What characteristics do you consider important for patients when accessing PET-CT services, e.g. quality of the service, quality of the outcome, travel distance, accessibility by public transport, car parking, hours/times the service is available?
Please provide comments.
5. Do you agree with the proposed minimum criteria an ITT submission must satisfy prior to being considered further?
Please provide comments to support your answer.
The proposed minimum criteria are:
 - confirmation of compliance with the [service specification](#)
 - the submitted scan price being equal to or less than the maximum scan price.
6. Are there any other criteria that should be applied at this stage?
Please provide comments.

3.3 How can I make my views known?

31. NHS England is carrying out public engagement for 30 days from 7 January 2016 to 5 February 2016.

32. We would like to hear from anyone with an interest in the provision of these PET-CT services – patients, public, providers and any other groups.

33. An online survey for feedback can be found here:
<https://www.engage.england.nhs.uk/>

34. Responses will be public documents and all, or any part of a response, may be put in the public domain. If it is necessary to refer to any confidential information in your response, it must be included in a separate document which is very clearly marked as confidential on each page. NHS England is governed by the Freedom of Information Act 2000 and Data Protection Act 1998. While we would seek to respect the confidentiality of any information provided, respondents should be aware that we may be obliged to release even confidential information under these Acts. You must therefore ensure that there is a clear lawful basis for submitting any confidential data.

35. Any comments that relate to services or issues outside the scope of this engagement will be noted and passed on accordingly.

36. NHS England will not be able to provide individual replies to any submissions unless they relate to the mechanics of accessing and responding to the engagement questions.

4 Reporting on the engagement process

37. Following the engagement period, NHS England will review all the feedback received. All relevant feedback will be considered and used to inform the next stage of the procurement process. NHS England will produce a report of the feedback received and ensure it is distributed to those that have taken part in this engagement process.



**PET-CT Phase II
design of
procurement -
engagement report**

NHS England INFORMATION READER BOX**Directorate**

Medical	Operations and Information	Specialised Commissioning
Nursing	Trans. & Corp. Ops.	Commissioning Strategy
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Publications Gateway Reference: 06706

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Additional Circulation List	
Description	This report details the engagement activity which has taken place in designing the Phase II procurement for positron emission tomography and computed tomography (PET-CT) services covering specific geographical areas in England, which were not covered by Phase I procurement.
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Action Required	n/a
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PET- CT Phase II design of procurement – engagement report

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This information can be made available in alternative formats, such as easy read or large print, and may be available in alternative languages, upon request. Please contact england.npoc-cancer@nhs.net.

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1 Background to the engagement process

1. In 2014, NHS England carried out a national procurement for positron emission tomography and computed tomography (PET-CT) services covering specific geographical areas in England, known as Phase I. This exercise accounted for around 50% of the total PET-CT activity delivered in the NHS in England. The national PET-CT contract that was put in place replaced two contracts, PET-CT North and South, which were close to expiring.
2. Following the Phase I award of contract, NHS England undertook a review of service provision in the areas not included within Phase I and developed proposals for a second phase of procurement.
3. NHS England conducted a 30 day period of engagement from 7 January 2016 to 4 February 2016 to test the proposed design of the Phase II procurement. This document summarises the feedback received and how NHS England has taken it into account in the way it will carry out the procurement.
4. NHS England now intends to carry out a Phase II procurement to secure PET-CT services for the areas not included in Phase I. The procurement is due to formally commence during May 2017, in order to secure services to be delivered from 01 April 2018.
5. NHS England's objectives for the Phase II procurement, which have been developed following consideration of the public engagement responses and the further work that these responses led to, are:
 - **Sustain integrated and reliable care pathways.** High-performing pathways are well-integrated and seamless for both patients and clinical teams. PET-CT service providers may change as a result of the procurement, but care pathways must not be adversely disrupted.
 - **Secure a service that is high quality and value for money.** Maximising value from healthcare resources is important, this means reducing variation in service provision and price.
 - **Ensure sufficient capacity to meet future needs.** Optimal equipment utilisation, modern workforce practices and fair reimbursement mechanisms will ensure that sufficient capacity is available in the system to meet demand.
 - **Avoid reducing competitive pressures in the market.** The concentrated standard tracer supply market gives rise to risks of reduced competitive pressures, particularly if the procurement results in further market concentration and plurality of supplier is lost. This could be damaging for the PET-CT sector as a whole in the long-term.

1.1 Summary of the procurement proposals included within the public engagement

6. NHS England proposed a procurement process that would seek bids from providers to deliver services in nine different lots that are geographically defined – though it is possible for there to be multiple PET-CT sites within each lot. In addition, the proposal included a maximum single price for scans and a limit on the number of lots any one bidder could be awarded in order to maintain plurality of supply.

7. The procurement process would ask bidders to propose solutions that addressed any inequity and maximised quality, access, patient experience and value for money, and specify the locations from which services will be delivered. This would mean that the location of PET-CT services could potentially change from where they are currently provided. However, until the procurement process is more advanced, we would not know the extent of any impact nor where it would be felt. This is because we will not have sight of proposed solutions until later in the process, and therefore any proposed changes to service location or the potential impact for patients. NHS England would need to consider its patient involvement duty in light of any potential change in location of PET-CT services.

8. As well as testing the procurement proposals, the engagement sought views on potential mitigation for any change in location of PET-CT services that could be built into the service requirements for bids.

9. The engagement was publicised via the NHS England website and through communications to NHS England stakeholders (including NHS organisations, charities, patient organisations, industry, partner organisations and professional bodies) an engagement guide was published explaining the proposed procurement process and described how stakeholders could engage with the process.

10. The engagement included a series of six questions for stakeholders to consider. Responses to the questions could be submitted via an online portal. This feedback is summarised in section 2.1 of this report. .

11. Two focus groups were held with patients and members of the public to introduce and explain the proposed procurement and explore what aspects of the service are important to support positive patient experiences. The feedback from this activity is summarised in section 2.2 of this report.

12. Three webinars were held to introduce and explain the proposals for Phase II procurement to stakeholders, enabling them to respond formally to the engagement. This feedback is summarised in section 2.3.

2 Summary of engagement findings

2.1 Summary of responses received through consultation portal

13. There were a total of 311 responses to the online survey. Responders were able to select between a number of different responder categories, as follows:

- Patient/Public - 47 people;
- Service Provider/Industry - 33 people;
- Professional – 189 people;
- Other – 12 people; and
- Anonymous – 2 people.

Finally, 28 people responded as a combination of two or more categories.

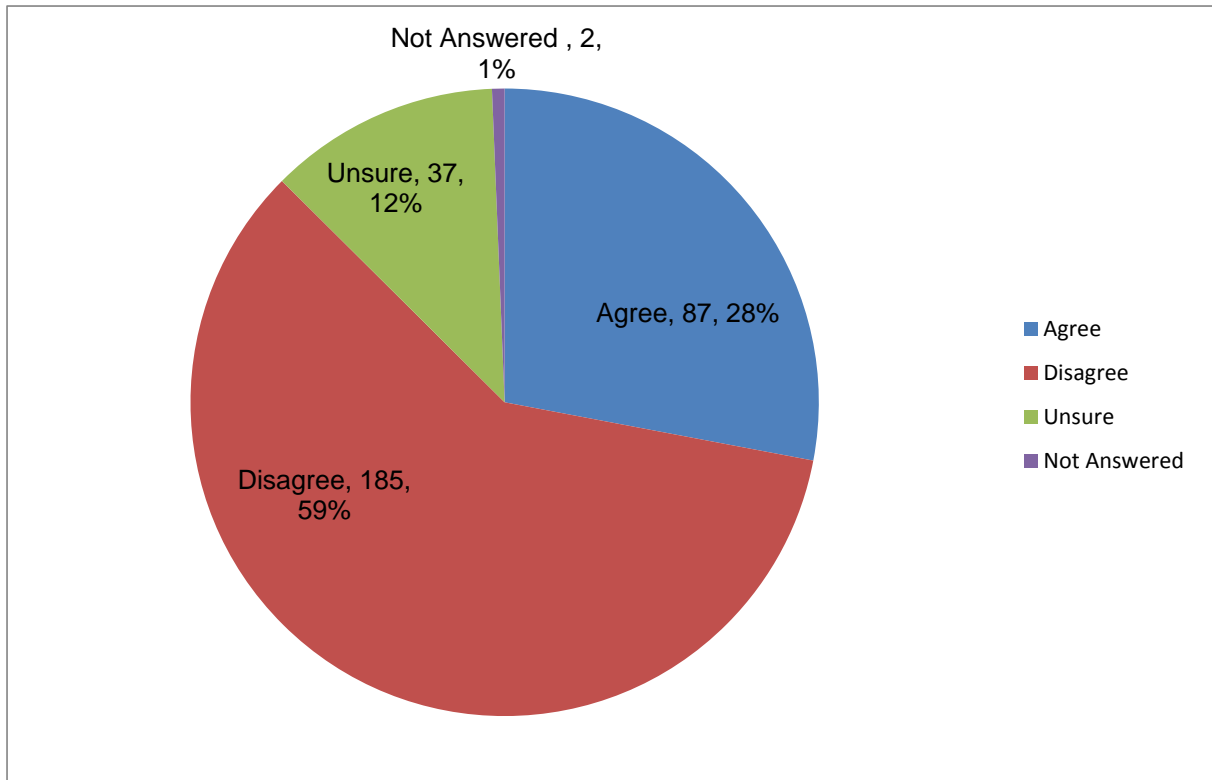
14. Included within the 'Other' category were: three commissioners and two Clinical Commissioning Groups (CCGs), Imaging Research, the Chair of a Patient support group chair in Merseyside, the Royal College of Radiologists, the Royal College of Physicians, a Professional Society and two administrative personnel.

15. As well as providing responses to the survey questions, most respondents qualified their view with free-text comments.

16. A summary of the themes arising in the comments has been included along with the quantitative response to each question. In addition to responses through the portal, a number of organisations submitted written responses. These submissions are also included in the summary below.

2.1.1 Feedback to Question 1

17. Question 1. Do you agree with the proposal to request a single unit price for all PET – CT scans in a lot area, regardless of tracer, service location or patient condition?

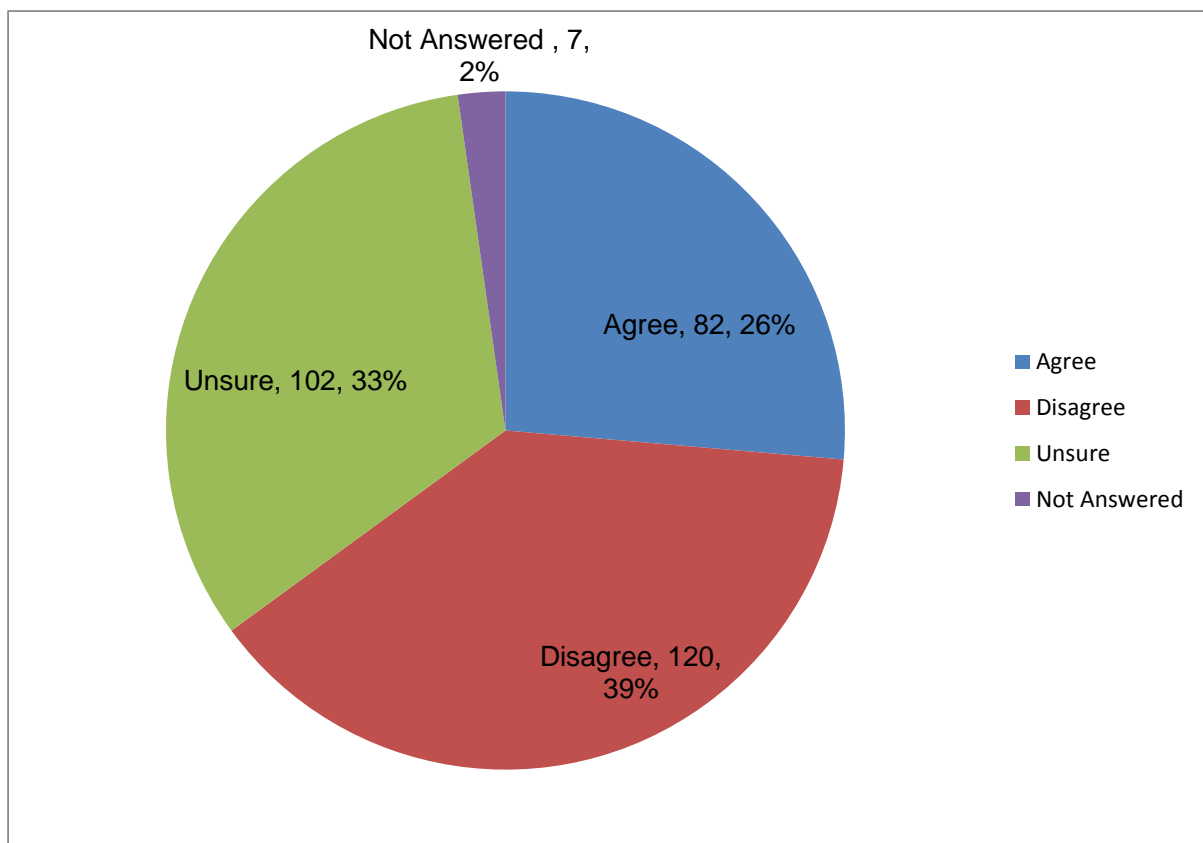


18. A majority of respondents disagreed (59%) that there should be a single unit price for all PET – CT scans in a lot area, regardless of tracer, service location or patient condition.

19. There were numerous comments concerned over how a single price, fixed for ten-years would allow providers to manage circumstances such as increases in the price of tracers and the difference between the prices of novel tracers.

2.1.2 Feedback to Question 2

20. Question 2. Do you agree with the proposed lot structure?



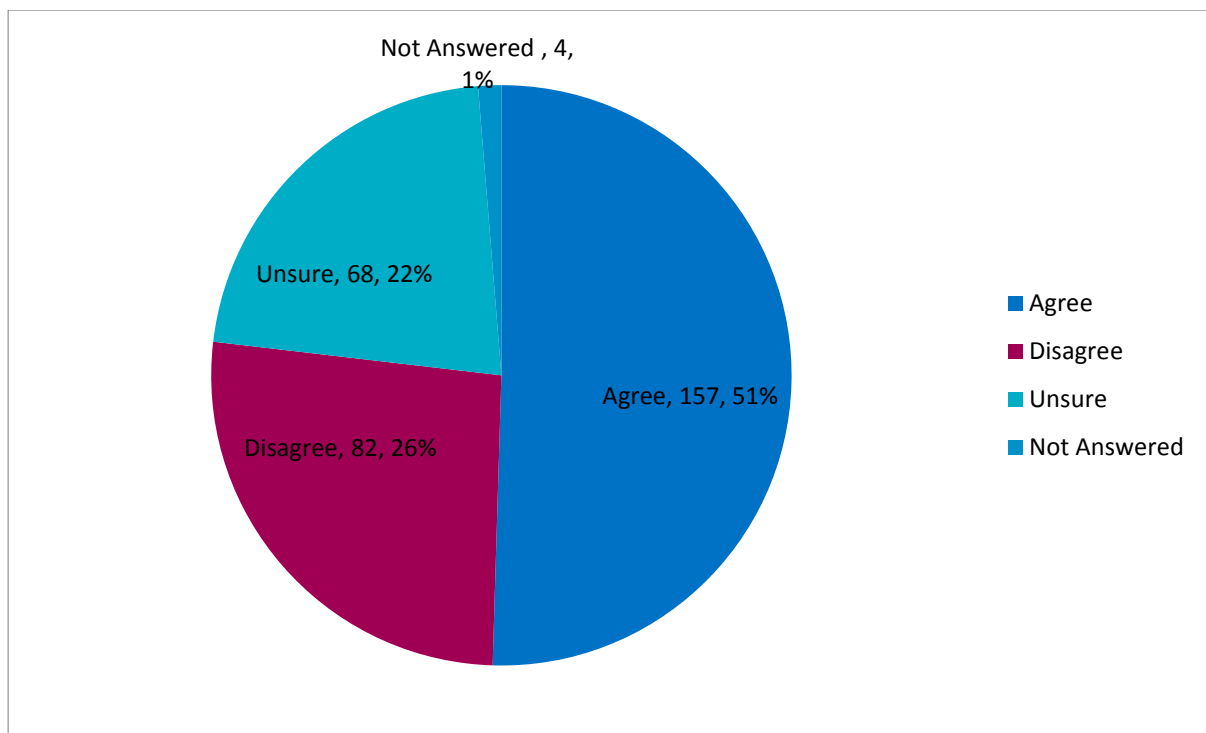
21. Feedback on the proposed lot structure was more finely balanced with more respondents (39%) disagreeing with the proposal compared to those who did agree (26%). About a third of respondents stated that they were unsure (33%).

22. A review of the free-text comments reveals that there is concern over changes to the geography of lots and the impact that may have on established patient pathways and in terms of increased travel times for patients and their carers if locations of services were to change. There were several comments that this would cause unnecessary disruption for existing well-established services.

23. Around a third (33%) of respondents stated they were unsure of whether they agreed or disagreed with the proposed lot structure. This was largely down to feeling that the information that they received in the engagement guide was not sufficient for them to have an informed opinion.

2.1.3 Feedback to Question 3

24. Question 3. Do you agree with the proposal to restrict the maximum number of lots awarded to any individual provider? (Current thinking being no more than 3 out of the 6 lots outside of London and 1 out of 3 in London)



25. A little over half of respondents (51%) agreed with the proposal to restrict the maximum number of lots awarded to any individual provider. Although around a quarter of respondents (26%) disagreed with the proposal and 22% were unsure of whether they agreed or not with the proposed lot structure.

26. The feedback indicated that those that agreed (51%) felt that the proposal would help to provide plurality of supply which in turn would prevent a monopoly by one single provider.

2.1.4 Feedback to Question 4

27. Question 4. What characteristics do you consider important for patients when accessing PET – CT services?

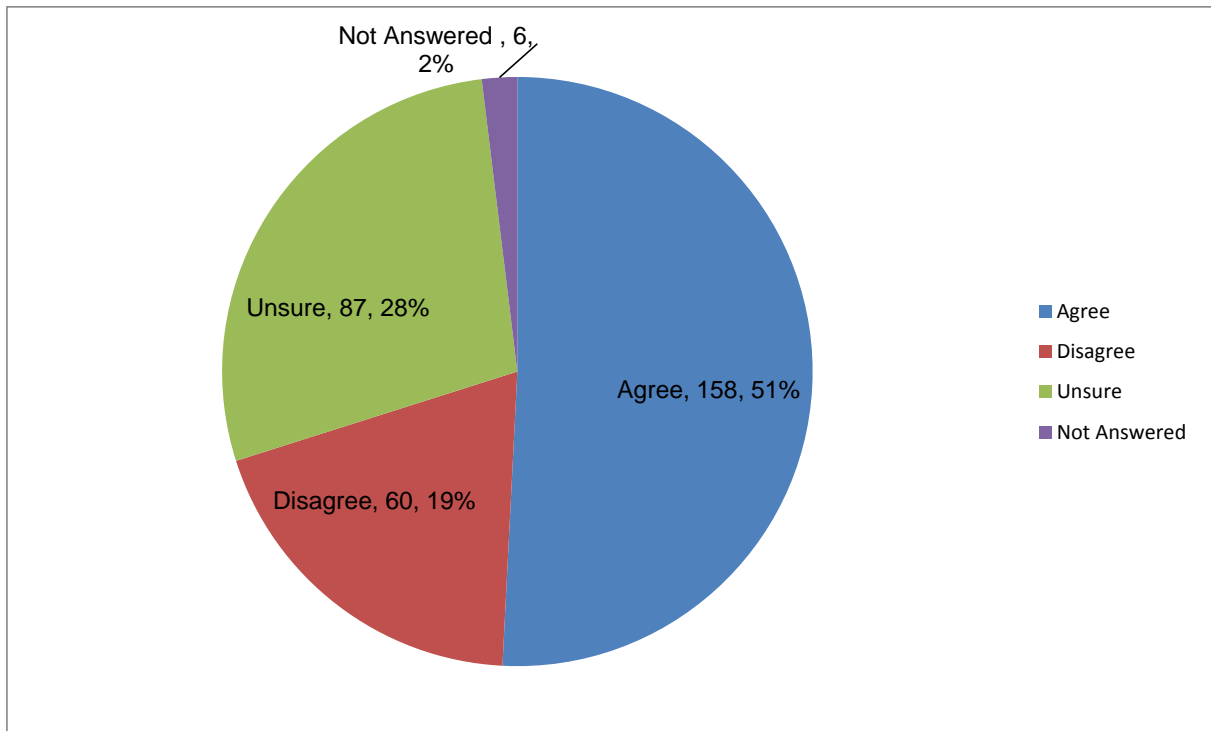
28. The majority of comments stressed the importance of the following 10 characteristics.

- Shorter travel times to reach sites;
- Affordable parking facilities with enough spaces;
- Appointment availability;
- A preference for static over mobile sites;
- Access to multidisciplinary team (MDT) networks;
- Access to real-time scan reporting systems;
- Good transport connections around sites;
- Co-location with existing services;
- Patient choice of site;
- Highly skilled staff;

- Cutting-edge diagnostics equipment;
- Commitment to research and development;
- Value for money.

2.1.5 Feedback to Question 5

29. Question 5. Do you agree with the proposed minimum criteria an ITT (Invitation to Tender) submission must satisfy prior to being considered further?



30. A little over half of respondents (51%) agreed with the proposed minimum criteria an Invitation to Tender submission must satisfy prior to being considered further. 28% of respondents felt they were unsure with the proposal, and 19% said they disagreed with the proposal.

31. There were several comments on the criterion that the submitted scan price must be equal to or less than the maximum scan price. Some felt that this did not account for instances where a higher scan price is needed to pay for a more expensive tracer. Others felt that it would only work if different prices were allocated for the different types of tracer. Several respondents felt that this would disadvantage centres that provide more specialist and complex scans.

2.1.6 Feedback to Question 6

32. Question 6. Are there any other criteria that should be applied at this stage? Please provide comments.

33. Most of the comments were very similar to the responses received to Question 4. However, there were numerous comments stating that the efficiency of image acquisition and real-time reporting of images should be incorporated. Also many felt that commitment to research and development and clinical trials was an important criterion that should be applied to the process.

2.2 Summary of face to face engagement

34. Two focus groups were held with individuals representing patients and public perspectives. The objective of the focus groups was to identify what a good PET –CT service would look like and to identify any potential impacts the procurement would have on patients. The main questions and issues emerging from this included the following.

- **Potential impacts on patients and the public if the location of current PET – CT services were to change**

Participants expressed concerns around potential changes to the distance of travel and complexity of journey to get to a scan appointment. This included the impact for people accompanying the patient to the scan appointment. There was concern that some locations may have better transport routes than others (rural locations often have very infrequent bus services). It was advised by the group that as part of the procurement process NHS England should ensure that the evaluation criteria for bids considered:

- complexity of the journey;
- average length of the journey for the catchment population; and
- access to public transport links.

- **The importance of co-locating with existing cancer centres**

Several participants felt that it is important to ensure that there was no break in MDT approaches to care and treatment and that it was ideal to be diagnosed and treated in the same site. However, the group agreed that the scan could be done locally as long as there was no disruption in being able to see their clinical team. The discussion underlined the importance of sustaining integrated care pathways, even where providers of services along a pathway may be different.

- **Single price**

The point was raised that “different tracers incurred different costs” and it was questioned whether this “can be pulled out of a single price”. A member of the group also asked whether “London sites would stand to potentially lose out with a single price”, due to the increase in the need for more complex services. The group felt it was very important to review the financial model and allow for prices to change periodically.

- **Communications skills and training of staff**

This was felt to be important to ensure a good overall patient experience of PET – CT services. In particular it was noted that staff should have training to be able to help patients that have anxiety or claustrophobia to avoid cancellation of scan appointments (a video was suggested to illustrate what a PET – CT scan involved). It was noted by several people that this already existed in most PET – CT services, but the group felt that it should be a requirement of all service providers.

- **Appointment availability**
The number of appointments available and the timings/days of available appointments affects patient experience and should be a consideration of the procurement process.
- **IT and digital infrastructure**
Scan reports should be available immediately across sites and to all MDTs that are involved in patient care. Scan reports should also be accessible at the time of any review appointments.
- **Research & Development**
A few members of the group felt that it was important to ensure that any changes in location of services fitted in with any research programmes being carried out. A question was raised about “whether there would be funding incorporated in the single price for research and development?”

2.3 Summary of webinar engagement

34. Three webinars were carried out during the 30 day engagement period, with more than 60 participants joining the sessions (in some cases, several people joined the webinars on a single computer/phone line). The webinars offered a chance for participants to ask questions about the proposed procurement plans and to raise issues for NHS England to consider in its approach to procurement. The main questions and issues emerging from these webinars included:

- **Single price**
The majority of questions in the webinars concerned the intention to ask bidders to provide a single scan price below a maximum value.

Most often there was concern over how a single scan price would account for cost differences between the different tracers used in PET-CT imaging. These started from how bidders might come up with a blended price for tracers, whether scan prices would be assessed in each lot separately, what mix of tracers NHS England might expect to see in a service and how NHS England might set a maximum scan price. But further issues were identified too.

It was pointed out that service providers cannot control the price at which they buy all PET-CT tracers. The participant suggested that providers could then be held to ransom by tracer suppliers, and wondered if the answer is to procure services for FDG (the tracer used in the majority of scans) and have separate prices for other tracers.

A number of people asked how developments and innovations in scanning involving new and more expensive tracers could be included in a single scan price set into a long-term contract. And there were questions on what would trigger a review of a scan price included in a contract, should there be new developments, or how often would there be review of prices.

A few participants worried that some PET-CT scans were more complex or took longer and that this had cost and resource implications. They stated that

this would be difficult to account for in putting forward a single scan price in a bid. There was concern that providers currently carrying out a higher proportion of more complex scans (either using more costly tracers or having more complex cases) would be disadvantaged. Alternatively, the potential for commercial pressure to influence clinical decision-making was mentioned, in whether or not to carry out a scan that costs more on an individual.

Several participants asked how a single scan price could incorporate the cost of training staff (medical doctors, radiographers and scientists) and support research using PET-CT. These aspects may be more expensive, with participants wanting to make sure these opportunities are protected. Some wanted to know that there would be a level-playing field for those providers that carry out significant amounts of training and research.

- **Lots**

There were a few questions about the lots proposed for any procurement of these PET-CT services. Some participants asked for confirmation on how the procurement process might work with different lots (e.g. “Will NHS England be looking for a prime contractor for each lot?”; “In the event of a change of location of service in one lot necessitating further public engagement or involvement, will this slow procurement in other areas where there may be no change?”). Another question asked if NHS England was expecting providers to compete or collaborate, where there might be multiple current providers in a single geographical lot.

There was a question on what the criteria would be in deciding whether the South Coast area would end up being offered as one lot or two. Other participants asked about service provision where current providers might cross lot boundaries, and whether patients from one area might be referred into a different lot to receive a particular type of scan.

- **Patient choice**

One question that came up in two webinars was how the proposed tendering exercise might affect patient choice in selecting a PET-CT provider.

- **Considerations in procurement design**

Some participants wanted to know a bit more about the procurement approach and any specifications that might be required of bidders. These included: a request to know more about what would be in the Pre-Qualification Questionnaire (PQQ); whether the Invitation to Tender (ITT) process would include indicative activity levels for PET-CT scans; will a market-forces factor be applied in any maximum scan price; whether a single IT solution would be required over each of the lots; and a desire to have more information about the auditing of reporting for any organisation awarded the contract.

- **The basis for procurement**

A few participants wanted NHS England to provide more of a case for why procurement was being considered for these services. There was a feeling that this round of procurement was different to Phase 1 (a first-round of

procurement of PET-CT services where two national contracts were coming to an end), which largely replaced mobile scanners with static ones.

- **Information on procurement process**

There were a few questions asking for information on the proposed procurement process: likely timescale; contract start date; planned term of any contract; and whether bidders would be restricted to current providers.

- **Questions on engagement**

One or two participants commented that the engagement was asking specific questions on the design of the process without there being procurement documents available to allow informed answers. A further participant wished for a greater amount of patient engagement in the design of the procurement process, noting that many patients might find responding to the online survey difficult. A postal address was provided.

3 How NHS England has considered the feedback

35. The procurement design has been revised substantially from that presented within the Public Engagement guide and these were formally approved by NHS England in April 2017.

36. Table 1 summarises the feedback received by question and the action that has been recommended, however, the headline changes include:

- The procurement structure is now split between: (i) scanning services and supply of novel tracers (those produced in a radiopharmacy facility); and (ii) supply of standard tracers (those produced in a cyclotron).
- The pricing mechanism now reflects the split procurement structure and includes: (i) a fixed and marginal approach for scans; (ii) a fixed price for each novel tracer; and (iii) a fixed price for supply of standard tracer.
- The geography of Phase II has been divided into eleven Lots, an increase of two on those proposed within the Public Engagement documentation. This change has been made to ensure that existing well-established care networks will not be adversely affected by a change of PET-CT provider.
- The evaluation of bids has been strengthened. Responses to service and quality questions will be required to meet a minimum threshold score for each and every question, failure to demonstrate an acceptable level of quality will result in disqualification.
- In addition to technical service and financial questions, bidders will also be required to respond to a specific question relating to patient access, equalities, health inequalities and patient experience. This is a further measure being taken as a result of the feedback obtained through the engagement process and will help ensure that services, commissioned as a result of the procurement process, meet the needs of patients.

Table 1

We asked	You said	We did
<p>Do you agree with the proposal to request a single unit price for all PET – CT scans in a lot area, regardless of tracer, service location or patient condition?</p>	<p>Agree - 28% Disagree – 59% Unsure – 12 %</p>	<p>The points raised by responders were considered and the Phase II procurement approach has been revised substantially.</p> <p>The procurement will not require a single unit price for PET CT scans regardless of tracer, service location or patient condition. Instead, different prices will apply to the different components of the service, such as: (i) scan and reporting services; (ii) novel tracers; and (iii) standard tracers.</p> <p>A marginal rate will also be introduced to better reflect how scan and reporting services are organised and delivered. The introduction of marginal rates is designed to better link activity volume with the fixed and non-fixed costs of care.</p> <p>These changes have been made to enable bidders to submit sustainable and competitive, long-term prices as this is in the best interests of patients and taxpayers alike.</p> <p>NHS England recognises that costs of care do sometimes vary by geography. As such, it is expected that the prices submitted by bidders will vary across the different lots. As such, Market Forces Factor uplifts will not be applied.</p>
<p>Do you agree with the proposed lot structure?</p>	<p>Agree – 26% Disagree – 39% Unsure – 33%</p>	<p>Following consideration of the concerns raised in relation to the proposed nine lot structure, further work was undertaken to better understand existing patient pathways. The lot structure has been substantially revised.</p> <p>Phase II now contains 11 lots, which are geographically defined by Primary Referring Organisation (i.e., Hospitals). This represents an increase of two lots on the number originally proposed. The changes impact on the South Coast, which was particularly commented on by responders, and South-West Midlands because it was felt that there was no existing history or commonality of care pathway. NHS England recognises that, where patients move between a number of</p>

		<p>different hospitals along the same care pathway, it is particularly important for clinicians and multi-disciplinary teams (MDTs) to be supported by diagnostic services that operate in a consistent way.</p> <p>Responders highlighted the need for some patients to be able access scans in different places. The procurement now includes a mechanism to enable referral to other services where there are particular clinical factors. For example, scans for rare indications, where there may only be a handful of PET-CT specialists in the field able to report images; or where there are a number of geographically close Lots, such as those in London.</p> <p>Because of the concerns raised about travel and access to scanning services and the need to sustain integrated care networks and pathways, the procurement will stipulate that scanning services must be provided from within the geography of the Lot. This is to help to minimise the potential disruption on patients, ensure seamless care and sustain integrated care networks. To further ensure that winning bidders meet the needs of patients, all bidders will be required to answer a question relating to patient access, equalities, health inequalities and patient experience.</p>
<p>Do you agree with the proposal to restrict the maximum number of lots awarded to any individual provider? (Current thinking being no more than 3 out of the 6 lots outside of London and 1 out of 3 in London).</p>	<p>Agree – 51% Disagree – 26% Unsure – 22%</p>	<p>The mechanism to restrict the number of lots awarded to any bidder has been retained, however some changes have been made to reflect the revised procurement approach and lot structure and the differences in lot size, as follows:</p> <ul style="list-style-type: none"> • Scan and reporting services and novel tracers: no more than 4 out of 8 lots outside of London and 1 out of 3 in London; and • Standard tracers: no more than a 60% share of the total Phase II activity can be awarded to any individual bidder.
<p>What characteristics do you</p>	<p>Numerous</p>	<p>NHS England have considered the points</p>

consider important for patients when accessing PET – CT services?	comments received, please see point 27 on page 9 of this document	raised and have included in the procurement a requirement for Bidders to describe how their proposed service will consider and incorporate access, patient experience and inequity in service provision. The response to this question will be evaluated and scored.
Do you agree with the proposed minimum criteria an ITT (Invitation to Tender) submission must satisfy prior to being considered further?	Agree – 51% Disagree – 19% Unsure – 28%	No changes are proposed. NHS England has reviewed, with expert clinical advice, the minimum criteria a Bidder would be expected to meet. It has been concluded that Bidders must meet an overall minimum service threshold score. This has been further strengthened to require a minimum threshold score for each question within the service and quality assessment in order to ‘pass’ that aspect of the evaluation. This will help to ensure a high standard of quality is achieved as a result of the procurement.
Are there any other criteria that should be applied at this stage? Please provide comments.	Please see point 32 of page 11 of this document	The objectives for Phase II have been developed in response to the feedback received and the further development work undertaken by NHS England. The evaluation process has been reviewed and developed so that bidders capability and capacity to deliver these objectives and the service specification will be rigorously tested.

4 Next Steps

37. NHS England is committed to involving people in the consideration of service change proposals and is mindful of its duty in this regard. Therefore, alongside the public engagement report, there will be a number of webinars offered to members of the public and patient associations. This will provide an opportunity to ask questions and receive further information about the Phase II procurement. These will take place ahead of the procurement commencing.

38. It is also anticipated, as the procurement progresses, that further engagement activities may be required to ensure that people are involved in the process.

Letters to HOSC on PET Scanning: 4th April 2019

15th March 2019: Mr and Mrs Watts

Ms Dean

I understand that you are the Support Officer for the Oxfordshire Health Overview and Scrutiny Committee. I would be grateful if you could bring our concerns about the matter laid out below to the attention of the correct people or let me know how to do so direct.

We are shocked that NHS England has decided to put the provision of PET-CT scanning services at the Churchill Hospital within the Oxford University Hospitals NHS Foundation Trust in the hands of a private company, taking it away from the excellent integrated service provided by the Churchill. As this decision may well have an impact on patients, we understand that it is the duty of your committee to review this after which it can refer the decision to the Secretary of Health and Social Services for further review. We trust that the Oxfordshire Committee will take this action.

Richard and Sheelagh Watts

17th March 2019: Mrs Hutchinson

Dear Sir or Madam

In light of the decision by NHS England to award the contract for cancer scans to InHealth, I thought that you might be interested in my recent experience of their service in delivering an echocardiogram.

My appointment with them was for 15th December at their clinic in Bicester. On the Friday evening at eight o'clock, I received a 'phone call to say that the appointment was postponed. I was given a date for a Sunday in January.

As requested, I arrived fifteen minutes before the appointment time with a list of my medications and measurements of my height and weight as requested.

There was no one at reception and after ten minutes, I began to search for a staff member. I found a delivery man who told me that the clinic was closed. Nevertheless, I waited and eventually, a young woman appeared from one of the rooms.

Our conversation was brief. She did not want my data and only spoke to me to issue instructions. At the end of the scan, I was dismissed with a perfunctory, "You can go".

My experience reinforces my belief that you only get what you pay for.

Patients deserve a better service.

Yours sincerely

Marie Hutchison (Mrs.)

19th March 2019: Professor Harris

Department of Oncology

Medical Oncology

Professor Adrian L. Harris BSc Hons MB ChB MA DPhil FRCP

FMedSci MD DSc

Head of Section, Head of Hypoxia & Angiogenesis Group

**Weatherall Institute of Molecular Medicine, John Radcliffe
Hospital,**

Osler Road Headington, Oxford, OX3 9DS, UK.

PA Samantha Oats Tel:+44(0)1865 222457 Email: aharris.lab@imm.ox.ac.uk



Tuesday 19th March 2019

Re. Cancellation of PET-CT Scan service provided by Oxford University Hospitals team in favour of private company InHealth in Oxford.

Dear MPs and councillors,

I write with major concern, as I am the Professor of Medical Oncology at Oxford University and the National Health Service there, and this a major development which will be to the great detriment of patientcare.

This relates to NHS England forcing through contracts against the interests of the local hospital and patients and the doctors supporting them and lowering the standard of care and access.

The Oxford University Churchill Hospital has provided a superb standard of care for PET-CT scanning since 2005, which is internationally recognised. The great advantage of it being done in hospital is that we know the consultants that read the scans, they can attend out multidisciplinary team meetings, which has contributed to the excellent standard of care. The new system would be private scans done in portable

machines, and the doctors that read these could be anywhere in the country, and **certainly will not be able to attend our multidisciplinary teams** and could be different doctors every time. We know nothing about the calibre of these doctors, although we do know 4 times more findings are missed on outsourced CT scan than on local ones [The Times on 18 March, reasons for excess deaths from emergency surgery]. CT scan is an integral part of the PET-CT scan.

I know from personal experience how important it is to have the ability to talk to the consultant doing the scans, it often changes the interpretation, and they can suggest further tests, which is not going to be feasible if they are scattered consultants across the country who have different schedules, whereas here, we are all working together with set schedules and multidisciplinary teams.

Also, because there will be **no doctors present when the scans are done**, whereas they are in the Churchill in the hospital, special CT scans using contrast cannot be done. So that means any patient having a scan privately cannot have extra injections if necessary, so a more dangerous and less informative type of scan. So why are our patients being subjected to this poor quality?

Access for patients is a key issue. The new Cancer Centre, which is a 'jewel in the crown' for the Churchill Hospital, was specifically designed so imaging could be readily done for cancer patients with the state of the art PET-CT scanner down the corridor, from where patients are seen for their chemotherapy and radiotherapy. There is also very easy access for inpatients and those even on stretchers or in wheelchairs. If any of you have seen the portable PET scanners, you will know how difficult such access will be for anyone in a wheelchair. So, we have purposely designed a superb centre for patients who will no longer be able to access it.

There is a critical issue in terms of **arrangements for patients if things go wrong** in scanning, transport and organisation with the outpatients and inpatients, which is already sorted out with the Health Service.

The private company made a contract bid, which **does not include training of junior doctors**. Of course, training doctors, radiology staff, radiographers and nurses in **critical in the Health Service to maintain our expertise**, and this will not be part of the role of the private scanning. This scheme is very unfair competition that they do not have to cost for training and we will fail in our training needs

Oxford itself has a **fantastic reputation for its PET -CT centre and large research funding** from MRC CRUK, and others, many millions of pounds per year, to develop imaging techniques, to look at tumour metabolism, brain metabolism, important for dementia research and cancer research. As a result of having these special scans, patients can often be offered **new drugs and new treatments** that they will not get elsewhere. A recent example of this was done in prostate cancer where a new scanning agent, tested at the Churchill hospital, has been licenced nationally and made changes to the ability to manage prostate cancer.

Additionally, we have the **top quality** PET-CT scanners available in Europe, the latest editions with the software provided for free because of the quality of our work: a recognition of the standard. Patients being scanned with the **new contract will get**

inferior scans with inferior interpretation, when we already have available to us the best. What will happen to these machines? Will they be moth-balled, is that money wasted? What about the depreciation cost that the hospital will have to pay for unused machines?

The **extra funding** that comes with research contracts helps maintain the nursing and medical expertise in Oxford, which is at a much greater level than if funded by the NHS alone. Many of the trainees involved go onto become the consultants here, proving the super standard of care for which Oxford is renown.

So, on many accounts: the quality of the scans and the risks to the patients; the lack of training for our juniors and the lack of ability to do our research for patient benefit; this is a disaster. It is made worse by the fact that we do not know anything about the contract bidding, how the contracts were reviewed and what the contract has actually included. Clearly, if the hospital and university included all of the above, it would be more expensive, but much better value in the long run and better quality.

Finally, there is the **reliability and reputation of the company and its culture top-down**. We have already seen the disastrous results of working with inappropriately vetted companies in the NHS. I enclose an article about the most senior director of the company receiving the contract.

I am therefore calling for the Trust and local Health purchasers to appeal against this, to stop NHS England from forcing this on us, for all the bids to be open and to see how the decisions were made, and to reverse this decision which is so bad for Oxfordshire patients.


Yours sincerely,



Adrian L. Harris

Additional information provided with letter above: Professor Harris

The directors of InHealth

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Directors & Secretaries

For a full in-depth analysis on each of these directors, click any of the links below

Name	Role	Date Of Birth	Appointed ▲	Resigned
Ms Bibi Rahima Ally	Director	Jan 1960	29 Sep 2005	30 Sep 2005
Mr Martin Robert Henderson	Director	Sep 1969	29 Sep 2005	30 Sep 2005
Mr Martin Robert Henderson	Company Secretary	Sep 1969	29 Sep 2005	30 Sep 2005
Mr Philip James Whitecross	Company Secretary	Oct 1963	30 Sep 2005	14 Nov 2007
Mr Philip James Whitecross	Director	Oct 1963	30 Sep 2005	31 Oct 2012
Mr Alan James Gibson	Director	Jul 1955	30 Sep 2005	12 May 2008
MR IVAN HAROLD BRADBURY	Director	May 1946	01 Jan 2006	-
SIR ARTHUR DAVID CHESSELLS	Director	Jun 1941	01 Jan 2006	-
Mrs Sarah Louise Bricknell	Company Secretary	Apr 1964	14 Nov 2007	15 Apr 2015
Mrs Sarah Louise Bricknell	Director	Apr 1964	03 Jul 2008	15 Apr 2015

Note behaviour of Sir Arthur [Tim] Chessels

Executive wins £2.2m for being ogled and kissed

by TAHIRA YAQOOB, Daily Mail

A one-time nurse who built up a multi-million pound business empire found her success was not enough to protect her from sex discrimination.

Former Entrepreneur of the Year Kate Bleasdale says she was degraded by male fellow-directors who sent her sexually explicit e-mails, ogled her breasts and kissed her in front of clients.

Now the mother-of-four has won a record compensation award of £2.2million.

Combined with her shares in the company, her payout will top £ 4million. She intends to spend some of the money helping other women set up in business.

Mrs Bleasdale, 41, was the brains behind the walk-in Medicentre doctors' surgeries.

However, the behaviour of three board members left her 'severely depressed and close to a nervous breakdown', she claimed.

She said she was belittled by director Rob Moores, who twice asked her whether she was pregnant, and company chairman Sir Tim Chessels, who kissed the top of her head during a presentation to clients and in front of colleagues.

The pair stared at her breasts during a board meeting, she claimed, while director Nick Martin sent her racist, sexist and sexual e-mails on a regular basis.

The men seemed to find 'enjoyment and pleasure' in putting her down, she said. 'I could not believe the viciousness of the attack.'

'I think that if I had been a man with a few grey hairs, fitted into the club, then it would have been much less threatening.'

At the same time she discovered that Sir Tim, former head of the Legal Aid Board and chairman of the Hermes pension fund in the City, was paying a lower-ranking colleague more than her.

The 'bullying' and 'vicious treatment' came to a head in November 2000, when Sir Tim told her the board wanted to replace her because the company was about to be floated again and had no faith in her 'style'.

<https://www.dailymail.co.uk/news/article-147564/Executive-wins-2-2m-ogled-kissed.html>

Communication dated 28th March- linked to letters above: Professor Harris

Following on the apparent about turn on the Oxford scanners, there are several points related to my previous letter that remain outstanding and cannot be resolved without giving the contract OUH. The 'new deal' will

use the Churchill scanner and doctors for Oxford patients, but it will be controlled by a private company still. This is **not a U-turn it is direct privatisation of the NHS with all the issues below**

- 1 **All 'profits' from scans from private patients and funded trials will go to private company** not to the hospital, where the staff and scanners are, so no reinvestment for our benefit from our work.
- 2 This will result in **loss to the local NHS of at least £1 million per year** based on previous years.
- 3 **Patients in Swindon and other areas now having to be scanned in a hospital car park**, when this is against the NHS's own paper on PET-CT stating that where possible, it should be performed in fixed-sites-these need to be built, but meanwhile they should continue to come to Oxford.
- 4 **Patients in Oxfordshire will have a 2 tier system**, one in hospital car parks with poor access machines, but the Oxford patients at the Churchill. The new scanners at Oxford are 10 times more sensitive than mobile ones-would patients be willing to travel for better scans and reporting-they haven't be asked. The patients scanned in mobiles cannot have the complex scans using state of the art technology used in Oxford. In - patients, immobile patients, patients requiring a hoist cannot be scanned on mobiles, where are they going to be scanned?
- 5 **Quality of reporting mobile scans.** The cover for the mobiles is being provided by a doctor in her late 60s, who is going to provide this cover when she is away. The doctors in Oxford have made it clear that they do not wish to be involved with this service, which they think has a significant number of potential disadvantages for patients. Who is going to report the scans performed on the mobiles, as the doctors in Oxford have said that they are not going to do so. Where are they going to send them, as there are no other PET-CT reporters working in these hospitals.{NB statement by CEO on this has never been agreed with any staff]
- 6 **Research**-not able to do it and not discussed and major detriment to Oxfordshire patients

Oxford itself has a **fantastic reputation for its PET -CT centre and large research funding** from MRC CRUK, and others, many millions of pounds per year, to develop imaging techniques, to look at tumour metabolism, brain metabolism, important for dementia research and cancer research. As a result of having these special scans, patients can often be offered **new**

drugs and new treatments that they will not get elsewhere. A recent example of this was done in prostate cancer where a new scanning agent, tested at the Churchill hospital, has been licenced nationally and made changes to the ability to manage prostate cancer.

The **extra funding** that comes with research contracts helps maintain the nursing and medical expertise in Oxford, which is at a much greater level than if funded by the NHS alone. Many of the trainees involved go onto become the consultants here, proving the super standard of care for which Oxford is renown.

7 Company states iv injections can be used-but no details on safety or how this can be done.

Further questions to be answered re the bid itself\;

- 1 Why is an NHS service being handed to a private company, particularly when they admitted to NHSE and the Trust, that actually although they bid for the service in Oxford they cannot provide it, as they did not fulfil the requirements for the tender**
- 2 If the proposed service is so excellent, why did NHSE mislead the local Oxford CCG and the TVCA, telling them that they couldn't discuss it and wouldn't review the tender, when there was no reason for it not to be openly discussed**
- 3 Why did NHSE send a letter from lawyers to the Trust threatening to sue if anyone raised concerns about clinical standards and care**

19th March 2019: Mr Lawrence

Dear Julie,

I apologise if you're not the right person but I should like the following to be considered by the *Oxfordshire Health Overview and Scrutiny Committee* when (hopefully) NHS England attends the committee meeting on April 4th to explain the situation regarding the re-procurement of PET-CT scanning at the Churchill hospital, Oxford.

As a member of the public I emailed NHS England as follows:

I should like to understand:

- a) The reasons behind the decision (and why it's in the best interests of patients)
- b) How the InHealth's performance will be monitored to ensure it optimises patient outcomes and provides value for money
- c) Why this particular company was chosen given that doubts have been expressed on the firm's merits (<http://nhsforsale.info/private-providers/inhealth.html>)

d) To what extent patient representatives were involved in (or consulted about) the decision, and will be involved in the monitoring of the firm's performance for the duration of the contract.

Please let me know where I can find this information. I'm sure you'll agree that transparency is important for there to be trust in the political process and the commissioning process, and that taxpayers (patients) need re-assurance that:

- a) their money is being wisely
- b) patients' best interests are being served
- c) the decision makers and the implementers are publicly accountable

I have asked NHS England for this information but in their reply they advised me to “speak to the Clinical Commissioning Group for Oxford with this enquiry”. Oxfordshire Clinical Commissioning Group they tell me that it's not their decision so can't help me, but it is the responsibility of NHS England.

Would it be possible for the committee to ask this of NHS England on behalf of concerned patients?

I look forward to hearing from you,
Yours sincerely,
Rob Lawrence

26th March 2019: Cecelia Gould

Dear Councillor Fatemian,

I am writing to you on behalf of the Council of Governors who represent the patients and staff of Oxford University Hospitals NHS Foundation Trust.

The proposed loss of the PET-CT scanner services on the Churchill Hospital site to a private provider elsewhere is causing tremendous anxiety to patients suffering from cancer. They wish to be seen at the Churchill Hospital where they receive their treatment and have full confidence in the multidisciplinary teams who care for them. These teams are crucial in the planning and treatment of care for what are often complex cases.

Governors also want to express concern that sick patients will have to be transferred out of the hospital, not only causing them discomfort but also putting added strain on the ambulance service.

The PET-CT scanners at the Churchill are essential in the training of both future radiographers and radiologists, of which there is a national shortage.

The Trust and Governors have received hundreds of contacts from patients about the change in the provision of this service to a private contractor.

We urge members of the Health Overview and Scrutiny Committee to refer such an important matter to the Secretary of State for Health, unless NHS England agrees to retain the current PET-CT service at the Churchill.

Yours sincerely,

Cecilia Gould
Lead Governor
On behalf of Oxford University Hospitals Council of Governors

26th March 2019: Dr Kenworthy-Browne

Dear Julie Dean

Would you please provide copies of this letter to all members who will be attending on 4th April.

This is the substance of a letter from Professor Adrian Harris.

I am in his total support.

Sincerely,

Dr Michael Kenworthy-Browne

FRCP FRCGP

01895358112

The Oxford University Churchill Hospital has provided a superb standard of care for PET-CT scanning since 2005, which is internationally recognised. The great advantage of it being done in hospital is that we know the consultants that read the scans, they can attend out multidisciplinary team meetings, which has contributed to the excellent standard of care. The new system would be private scans done in portable machines, and the doctors that read these could be anywhere in the country, and **certainly will not be able to attend our multidisciplinary teams** and could be different doctors every time. We know nothing about the calibre of these doctors, although we do know 4 times more findings are missed on outsourced CT scan than on local ones [The Times on 18 March, reasons for excess deaths from emergency surgery]. CT scan is an integral part of the PET-CT scan.

I know from personal experience how important it is to have the ability to talk to the consultant doing the scans, it often changes the interpretation, and they can suggest further tests, which is not going to be feasible if they are scattered consultants across the country who have different schedules, whereas here, we are all working together with set schedules and multidisciplinary teams.

Also, because there will be **no doctors present when the scans are done**, whereas they are in the Churchill in the hospital, special CT scans using contrast cannot be done. So that means any patient having a scan privately cannot have extra injections if necessary, so a more dangerous and less informative type of scan. So why are our patients being subjected to this poor quality?

Access for patients is a key issue. The new Cancer Centre, which is a 'jewel in the crown' for the Churchill Hospital, was specifically designed so imaging could be readily done for cancer patients with the state of the art PET-CT scanner down the corridor, from where patients are seen for their chemotherapy and radiotherapy. There is also very easy access for inpatients and those even on stretchers or in wheelchairs. If any of you have seen the portable PET

scanners, you will know how difficult such access will be for anyone in a wheelchair. So, we have purposely designed a superb centre for patients who will no longer be able to access it.

There is a critical issue in terms of **arrangements for patients if things go wrong** in scanning, transport and organisation with the outpatients and inpatients, which is already sorted out with the Health Service.

The private company made a contract bid, which **does not include training of junior** doctors. Of course, training doctors, radiology staff, radiographers and nurses is **critical in the Health Service to maintain our expertise**, and this will not be part of the role of the private scanning. This scheme is very unfair competition that they do not have to cost for training and we will fail in our training needs

Oxford itself has a **fantastic reputation for its PET -CT centre and large research funding** from MRC CRUK, and others, many millions of pounds per year, to develop imaging techniques, to look at tumour metabolism, brain metabolism, important for dementia research and cancer research. As a result of having these special scans, patients can often be offered **new drugs and new treatments** that they will not get elsewhere. A recent example of this was done in prostate cancer where a new scanning agent, tested at the Churchill hospital, has been licenced nationally and made changes to the ability to manage prostate cancer.

Additionally, we have the **top quality** PET-CT scanners available in Europe, the latest editions with the software provided for free because of the quality of our work: a recognition of the standard. Patients being scanned with the **new contract will get inferior scans with inferior interpretation**, when we already have available to us the best. What will happen to these machines? Will they be moth-balled, is that money wasted? What about the depreciation cost that the hospital will have to pay for unused machines?

The **extra funding** that comes with research contracts helps maintain the nursing and medical expertise in Oxford, which is at a much greater level than if funded by the NHS alone. Many of the trainees involved go onto become the consultants here, proving the super standard of care for which Oxford is renown.

So, on many accounts: the quality of the scans and the risks to the patients; the lack of training for our juniors and the lack of ability to do our research for patient benefit; this is a disaster. It is made worse by the fact that we do not know anything about the contract bidding, how the contracts were reviewed and what the contract has actually included. Clearly, if the hospital and university included all of the above, it would be more expensive, but much better value in the long run and better quality.

Finally, there is the **reliability and reputation of the company and its culture top-down**. We have already seen the disastrous results of working with inappropriately vetted companies in the NHS. I enclose an article about the most senior director of the company receiving the contract.

27th March 2019: Grizelda George

Dear Julie

I'm writing in support of Professor Harris's letter expressing his concerns about proposed arrangements to privatise PET-CT at the Churchill. I should be most grateful if you would forward my email to appropriate recipients - Dame Fiona Caldicott, Dr Bruno Holthof, and others.

Professor Harris has argued very persuasively in support of the existing NHS static scanning arrangements already in place at the Churchill.

I learned about the proposals to privatise in disbelief. We used to have a visiting portable CT scanner at the Horton until we were able to have our own static scanner. It was cramped and very limiting. Having our own static scanner transformed ease of access for patients and doctors, also making scans much safer for patients who might require medical intervention whilst on the scanner. Anyone who is in a position to compare portable and static scanners would view portable scanning arrangements as hugely inferior.

Close association with local radiologists, able to discuss your requirements, assist in interpreting scans, and attend MDT meetings, is also a huge benefit.

I write not only as a retired Horton consultant, but also the wife, daughter and mother of patients who have required PET or PET-CT scans, one of whom is booked for another PET-CT at the Churchill in the near future. This will be compared with a previous scan. Such comparisons could be difficult following a transition to privatisation unless rules about access to images on NHS and private systems have changed. Please uphold local high standards.

Yours sincerely
Grizelda George. MA DPhil FRCS FRCM

29th March 2019: Gillian Coates

Cancellation of PET-CT Scan service provided in Oxford by Oxford University Hospitals team in favour of a private company *InHealth*.

I write to you with serious concerns at the decision to cancel the above in favour of a private company. The impact of this decision will have immense consequences for patients who currently receive a service which is excellent and has a world-wide reputation.

There is no clear rationale why this was decided and it seems adequate consultation with stakeholders was not sufficiently undertaken. At a time when the National Health Service is under immense scrutiny this decision seems to go against the ethos of the NHS, that it is provided first and foremost for the delivery of excellent health care for its patients.

I am aware of the concerns expressed so eloquently by Professor Adrian Harris from the Department of Oncology at the Churchill and I fully support the points he makes.

I hope that you feel able to raise this matter with the relevant Minister in order to seek a delay so that a full and convincing explanation can be given why this decision was taken and, more importantly, to get it reversed. The service at OU hospitals must be retained.

Yours sincerely

Gillian Coates

2nd April 2019: Dr Richard Sidebottom

Dear Julie, If appropriate please could my comments below be considered by the committee reviewing PET services at the meeting this week.

Re: Informal training for radiologists in PET-CT interpretation.

I am a radiologist now working at Cheltenham and the Royal Marsden. I completed my registrar training at Oxford in 2017. Although I did not require to become expert at reporting PET imaging for my subspecialty interest of breast imaging, I wanted to be skilled at understanding PET-CT primarily for my role in the MDT. The PET radiologists gave me training tailored to my needs during the last few months of my training. This kind of relatively informal educational opportunity is very valuable and is vital to training specialists in many areas of radiology. It should be recognised in addition to the more formal training of registrars with a nuclear medicine subspecialty. I am concerned that this would be impossible or hard to arrange if the service was not supplied by the in house team.

On another note my mother had a sarcoma for which she required several PET-CT scans at the Churchill. She was seen very quickly with the scans reported promptly and has nothing but praise about the care she received from this department.

Thanks

Dr Richard Sidebottom

GMC 6027102

3rd April 2019: Mr & Mrs Roberts



47 High St
Standlake
OX297RH
26 03 2019

For the attention of the health and overview scrutiny committee Oxfordshire County Council
Sir/ M/s

It has just come to my notice that the health and Overview scrutiny committee of Oxfordshire County Council is looking into the proposal to transfer the PET-CT scanning service from the Oxford University Hospitals Trust to a private company (In Health) The evidence suggests that this transfer would not be in the best interests of patients or the high reputation of the Churchill Hospital.

At present the service for cancer patients at the Churchill is provided by highly qualified and experienced clinicians. It takes place on site as part of the wider treatment that patients receive. According to the governors of the OUH trust 41,000 scans are carried out annually and it would seem to me that with the the quality of this service being so good, the case for transfer to the private provider would be very tenuous at best and it also raises questions about whether the same wonderful service could be guaranteed to be in the best interests of patients if this privatisation was to go ahead

We all know that the reputation of the Churchill is very high and a world leader in this field and whether the transferring of this sort of provision into private hands with profit being the prime motive rather than the quality of the provision of the service.

In addition it has recently been proposed by NHS England that services be kept within the NHS to avoid money being wasted on competitive bids and this idea is being viewed favourably by the health Minister Matt Hancock .

Yours faithfully B H Roberts and Mrs T Roberts

B H Roberts Jenny Roberts