Date: 7th May 2019
Our Ref: OJHOSC/SoS/PET-CT SCAN

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Secretary of State for Health and Social Care
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Copied to for information (via email):
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Oxfordshire Joint Health Overview and Scrutiny Committee
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Dear Secretary of State,

Re: Referral of the decision to name a preferred bidder and award the contract for PET CT scanning services in Oxfordshire

It is with the deepest regret that I am writing to you following a meeting of the Oxfordshire Joint Health and Overview Scrutiny Committee (OJHOSC) held on Thursday 4th April 2019.

At that meeting, the OJHOSC unanimously agreed to refer NHS England's proposal to make In-Health the preferred bidder of Cancer PET-CT scanning in Oxfordshire to you, as the Secretary of State for Health, pursuant to Regulation 23(9)(a) and (c) of the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013.

Background

PET-CT is a specialist diagnostic imaging service combining 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 is predominantly used in the staging and management of cancer and are only accessible through secondary care referral. 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.

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

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 oesophageal cancer.

In January 2016, NHS England conducted a 30-day period of engagement, across the country, to test the proposed design of the phase two procurement. The result of this informed a decision that allowed procurement to go ahead in 2017. The committee understands from NHS England that the decision to procure was three-fold:
firstly, a positive experience in phase one giving expansion of services and a reduced price. Secondly, the high level of demand and needed additional capacity for the future Thirdly, it was in line with current regulatory framework around procurement and contracts that exists.

The committee noted and discussed the results and format of the consultation and expressed it views on in the inadequacy on the range of responses. For the avoidance of doubt, the committee was only made aware of this engagement as part of our review in 2019.

Phase two of the procurement exercise began in May 2017 and again at no point was the OJHOSC informed or the assessment on substantive change made. In July of 2018, NHS England informed both OUH and InHealth of the outcome of the Lot 4 procurement exercise, with InHealth named as the preferred bidder for Thames Valley. Again, at no point was OJHOSC notified of the process or the outcome.

On the 24th January 2019, Dame Fiona Caldicott, OUH chairman, wrote to Arash Fatemian, Chair of HOSC, raising awareness that NHS England would likely be contacting HOSC in connection with the intention to award the contract for the regional PET-CT scanning service to private healthcare company, InHeath. The committee responded by inviting NHSE to present its proposals at its meeting of the 4th of April; the initiation of this process therefore had to come from OJHOSC and not, as is required from the commissioner.

At some point prior to the OJHOSC meeting on 4th April, NHS England agreed in principle that InHealth subcontract some of the work to OUH, to enable services to still be delivered from the Churchill Hospital.

OJHOSC was given the first opportunity to scrutinise the proposals at its meeting on 4th April 2019. As part of the meeting the committee heard many passionate appeals from campaign groups, residents, current and former patients, current and former clinicians and cancer specialists, County and District councillors and MP representatives in favour of the current World-leading provision and the outcomes for patients by the existing provision of service by OUH.

Reasons for Referral

Consultation & Engagement

The first that OJHOSC was made aware of the proposals came in a letter from OUH, requesting a chance to address the committee, as outlined above.

NHS England subsequently also confirmed their attendance. Such late engagement runs contrary to the established ways of working and the process NHS bodies and health service providers should follow in order to comply with their legal duties to consult health scrutiny bodies on substantial service development or variation proposals.

Once a proposal has been developed, formal consultation with stakeholders and the local health scrutiny body should take place prior to any wider public consultation. This is known as the 'pre-consultation' stage.

The objective of pre-consultation is to seek to build alignment between NHS commissioners and local authorities on the underlying case for change, and to ensure that proposals are holistic, have considered all viable options (that are clinically appropriate within available resources) and the benefits and impact on service users. NHS bodies and local authorities should work collaboratively with the aim of reaching broad agreement on the proposals.

Specifically, under Section 7 of the Health and Social Care Act (2001) the NHS is required to consult relevant overview and scrutiny committees on any proposals for substantial variations or developments of health services.

It is the view of the committee, that this stage has long since passed. Genuine pre-consultation on service provision should have taken place when the procurement for Lot 4 was being considered. To come with open arms at this late stage offering a consultation on the outcome, as NHS England have done, is in the view of the committee, a flagrant disregard for discharging statutory legal duties and engaging in due process.

Any reasonable interpretation of the legal scrutiny engagement process would have involved formal communication and engagement with the scrutiny committee before the procurement exercise begins.

The OJHOSC was even more surprised by this development as following a previous referral to the Secretary of State for Health and Social Care (your predecessor) it was suggested that the local Clinical Commissioning Group (CCG) as pertaining to that referral, and more generally all local health providers, should work together with HOSC to develop an open 'no-surprises' relationship that inspires public confidence.

Heeding this advice, NHS England (South Central) participated in a workshop between local providers and I am happy to report that steady progress is being made on this objective. Thus, it is all the more surprising that NHS England itself will chose to absolve itself of this responsibility and only offer a consultation on a provider as a preferred bidder.

Whilst the OJHOSC does acknowledge the offer made by NHS England to now engage in a full 12-week public consultation, by their own admission, NHS England have accepted that this will be on a consultation on the preferred bidder and not on outcomes and service delivery. Given that the formal consultation advice sets out the following:

"10. At the conclusion of the main public consultation phase, the proposing body (for example the lead commissioner) should decide the option that has the best balance of evidence and public support, based on all the discussions and information gathered during the previous stages of the process. The proposing organisation should then announce the

decision and communicate this to relevant stakeholders and partners, including relevant health scrutiny bodies."

The committee cannot see how a consultation on an outcome that has already been decided will fulfill the above criteria. Additionally, the approach that NHSE has taken is also contrary to the public law principles of consultation, namely: that consultation should be undertaken at a formative stage, that sufficient reasons should be given for the proposal, that enough time should be given for consideration and response; and that the responses should be conscientiously taken into account.

Further, the committee felt that had it sanctioned such a course of action, this would set a dangerous precedent for local providers and the Oxfordshire CCG who could then cite this process as an example and only engage once procurement decisions had been made, rather than at the point of service redesign consideration. This would run contrary to the advice that your office and the Independent Reconfiguration Panel (IRP) have previously provided to the committee and local providers on how to engage in a process which inspires public confidence.

Had NHS England followed due process, the committee could have highlighted concerns about the nature of Lot 4 at a much earlier stage. In particular, considering the World leading centre of excellence that has been established by OUH there should have been considerations around how this service could continue. It was the view of the committee that any procurement process which did not allow for consideration of this was to the wider detriment of the patient outcomes. If this is the first step that leads to the decline in research, innovation and training, then all current and future cancer patients around the UK will suffer.

Whilst the committee is well aware of the need to attempt a local settlement to address outstanding concerns, the approach taken by NHSE has meant the committee has not been engaged but has been presented with an outcome. There are therefore no further local steps the committee considers it could take that would have any impact on the outcome which has already been determined by NHSE.

Patient Outcomes

The committee also heard from both NHS England and the OUH on the quality of scan provided by fixed vs mobile scanners. Both sides failed to agree on the natural conclusion, but having heard detailed verbal and written testimony from eminently qualified specialists and experts, it was the view of the committee that this is highly sensitive equipment and given the need for calibration and as much detail as possible to ensure the best outcomes for patients, fixed scanning equipment would provide the better outcome. Whilst there might be identical machines being used for both fixed and mobile scanning, the committee was persuaded by the fact that moving locations could lead to different results for patients with a lesser amount of granularity being provided as a result of the constant movement and calibration of highly sensitive and advanced equipment. The committee was also convinced that the supporting health and care facilities in a static scanner would be far superior than that of a mobile unit.

Further, on the issue of patient outcomes, taking into account the world leading facility that has been set up at the Churchill Hospital by the OUH, the committee also heard evidence that the benefits to patient outcomes not only comes from the quality of scans, but the

availability of specialist clinicians, working together in multi-disciplinary teams, to understand the detailed outcomes from the scanning process. This process is strengthened when radiologist and clinicians are in the same room, discussing the results. Whilst this can happen remotely, the committee was not convinced of this alternative approach and feels strongly that deviation from the existing 'one team' approach would lead to a poorer outcome for patients.

Additionally, when patients undergo treatment at scanning sites, there are medical problems they encounter and Drs need to be on site to deal with issues (for example; reactions to tracer substances).

The committee is also concerned by the impact on patient outcomes from a possible two-tier service that may arise given the proposed agreement between NHS England and OUH to keep the Churchill as one of the locations for service provision. The committee feels that those visiting other locations, whilst benefitting from easier access, could have a poorer outcome given the combination of machines that are calibrated differently, potentially producing less accurate results, a lack of Dr's on site to deal with any health problems that may arise, and radiologists only communicating remotely with clinicians.

Finally, there is also the broader question of patient outcomes more generally. Given the existing service, the OUH is, alongside a provision that is highly regarded and receives referrals from all over the world for second, third, and even fourth opinions, producing countless research papers and training future generations of radiologists. The committee is concerned that any deviation from this service, and a procurement exercise that does not take this into account, could lead to a more general poorer outcome for future generations of cancer patients across the UK.

Procurement Process

The committee is concerned about the procurement process once InHealth was named as the preferred bidder. In particular, the committee has been made aware of an exchange of letters between lawyers for the OUH and NHS England in which the latter threatens the former with formal legal proceedings for raising concerns about the patient safety as part of the decision to name InHeatlh as the preferred bidder. Whilst the committee has not been made privy to such an exchange of letters, the contents have been reported on in the press, with The Guardian newspaper and Analise Dodds, MP for Oxford East, both having copies. Further, the committee has been made aware that is not the only incidence and that there may be a wider pattern of intimidation. Whilst we cannot verify these claims, the narrative that exists given this exchange of letters gives cause for deep concern over the openness and transparency of NHSE and any engagement over its service change programmes. In particular, the stifling of legitimate discussion by appropriate bodies about the nature of the proposal runs against the normal approach to consultation.

Conclusions

In summary as outlined above, OJHOSC feels that given the complete disregard for public engagement and scrutiny from NHS England throughout this process, with it being left to OUH to bring this to the committee's attention, the concerns about patient outcomes which could have been addressed had there been engagement with the scrutiny process as part of the legal requirement to do so, and concerns about the procurement process, there are sufficient grounds to refer the decision to the Secretary of State for Health and Social

Care. The committee also believes that as a result of the approach NHSE has taken, having already arrived at a decision and showing such arrogant disregard for discharging statutory legal duties and engaging in due process, all local steps to try and resolve this matter have been exhausted.

As such, for the reasons outlined above, the committee is referring to you the decision to name InHealth as preferred bidder and award the contract for the provision of PET-CT scanning services in Oxfordshire on the following grounds:

- Regulation 23(9)(a) – consultation on any proposal for a substantial change or development has been adequate in relation to content or time allowed
- Regulation 23(9)(b)- a decision has been taken without consultation and it is not satisfied that the reasons given for not carrying out consultation are adequate
- Regulation 23(9)(c) - the decision is not in the best interests of the health service or local residents;

I look forward to hearing your response.

Best regards,

Cllr Arash Fatemian
Chairman of Oxfordshire's Joint Health Overview and Scrutiny Committee

Enc.

1. Letter from Dame Fiona Caldicott to Cllr Fatemian
2. Report from NHSE to HOSC (4th of April)
3. Report from OUH to HOSC (4th of April)
4. Letter from InHealth to HOSC (for 4th April meeting)
5. NHSE 30 Day Engagement Guide
6. NHSE 30 Day Engagement Report
7. Letters and communication HOSC received regarding the issue from concerned clinicians and patients.