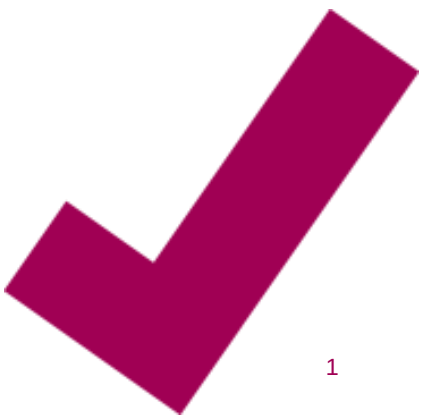
Positron Emission Tomography- Computed Tomography (PET-CT) in South Essex

The Clinical Case for Change

September 2015



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

Version number: 11

First published: September 2015

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Classification: Official

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1 Introduction

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

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

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

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

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

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

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

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

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

2 Background

2.1 What is PET- CT?

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

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

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

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

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

2.2 Commissioning of PET-CT

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

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

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

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

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

2.3 Current services in South Essex

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3 Clinical Case for Change

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

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

3.1 Why does the service need to change?

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

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

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

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

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

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

3.2 Mobile or fixed site location

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

3.3 Population Access and Patient Experience

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

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

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

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

3.4 PET-CT Use

3.4.1 Patient access

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

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

3.4.2 Multi-Disciplinary Team access

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

3.4.3 Radiotherapy planning

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

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

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

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

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

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

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

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

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

3.4.4 Chemotherapy

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

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

3.4.5 Non Cancer

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

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

3.5 Deliverability

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

3.6 Clinical Commissioning View

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

4 Impact Assessment

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

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

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

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

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

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

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

5 Recommendation

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

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

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

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

6 Public, Patient and Community Engagement

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

6.1 Timeline for Engagement

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

7 Next Steps and Timetable for Decision

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

Appendix One: Summary of Options

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

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

Appendix Two: Engagement Plan

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

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